

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

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

Run Date: 08/12/2016  
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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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,311,074.95	ADJUSTMENTS	223,779.01
COVERED CHARGES	7,222,990.80	CONTRACTUAL ALLOW	4,384,357.67
NON-COVERD CHARGES	88,084.15	TOTAL MEDICAID LIAB	2,838,633.13
		LESS: COB	10,717.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,827,915.77

TOTAL NUMBER OF ADMISSIONS 381

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	983		0	516,993.00		25,623.00
ROUTINE NURSERY	123		0	59,895.00		2,304.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,106		0	576,888.00		27,927.00
SPECIAL CARE SERVICES						
CCU	153		0	193,698.00		0.00
ICU	204		0	178,035.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	4		0	2,788.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	361		0	374,521.00		0.00
TOTAL ACCOMODATIONS	1,467		0	951,409.00		27,927.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,355,379.67	0.00	OTHER LAB	23,587.39	0.00
MED/SURG SUPPLY	761,169.24	441.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,048,892.68	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	134,066.16	0.00	OTHER THERAPEUTIC SVC	0.00	333.90
CT SCAN	270,536.44	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	124,880.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	42,800.10	0.00	MRI SERVICES	46,846.80	0.00
IV THERAPY	29,600.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	501,252.42	3,509.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	72,635.55	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	566,842.34	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	94,874.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	386,336.15	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	54,373.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	46,758.17	0.00	INJECTABLE DRUGS	229,196.53	0.00
RADIOLOGY THERAPEUTIC	165.18	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,234.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	16,364.10	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,089.23	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	218,042.37	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	24,445.42
OTHER IMAGING SERVICE	36,938.03	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	71,686.91	9,934.15			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,640.10	194.84			
AUDIOLOGY	3,672.90	0.00			
CARDIOLOGY	87,042.16	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,116.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,650.95	19,209.39			
			TOTAL ANCILLARY	6,271,581.80	60,157.15
			TOTAL ACCOMODATIONS	951,409.00	27,927.00
			TOTAL CHARGES	7,222,990.80	88,084.15

Report : CLM-0800-0  
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GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014280064877	08/18/14 - 08/21/14	10/13/14	0.00	2,533.65	0.00	0.00	0.00
614	2014309083488	10/19/14 - 10/25/14	11/10/14	0.00	2,635.50	0.00	0.00	0.00
614	9815046000014	09/07/14 - 09/09/14	02/23/15	0.00	2,240.02	0.00	0.00	0.00
614	2215121018964	02/04/15 - 02/10/15	05/04/15	0.00	3,539.55	0.00	0.00	0.00
614	2015162082202	05/25/15 - 05/29/15	06/15/15	0.00	3,539.55	0.00	0.00	0.00
614	2015288083675	11/21/14 - 11/25/14	10/19/15	0.00	3,883.95	0.00	0.00	0.00
614	5215362002745	07/02/15 - 07/04/15	02/22/16	0.00	3,539.55	0.00	0.00	0.00
615	2016001002417	04/30/15 - 06/04/15	01/04/16	0.00	2,533.65	0.00	0.00	0.00
TOTAL				0.00	24,445.42	0.00	0.00	0.00

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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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	08/01/14	THROUGH	07/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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Process : CLMJ0800  
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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,211,019.03	ADJUSTMENTS	377,307.55
COVERED CHARGES	6,870,231.22	CONTRACTUAL ALLOW	4,694,352.45
NON-COVERD CHARGES	340,787.81	TOTAL MEDICAID LIAB	2,175,878.77
		LESS: COB	2,937.32
		LESS: COPAYMENT	5,413.25
		REIMBURSEMENT	2,167,528.20
		ALL OTHER	1,935,104.08
		FEE SCHEDULE-LAB	124,101.42
		INJECTABLE DRUGS	108,322.70
		TOTAL NUMBER OF CLAIMS	3,989

PHOEBE SUMTER MEDICAL CENTER  
 126 US HWY 280 W  
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 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	504,627.95	1,095.41	OTHER LAB	68,735.81	0.00
MED/SURG SUPPLY	380,558.74	3,703.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	320.00
RADIOLOGY-DIAGNOSTIC	349,123.06	17,396.66	OTHER THERAPEUTIC SVC	0.00	578.80
CT SCAN	1,069,412.53	40,325.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	82,777.26	24,593.19	FEE SCHEDULE LAB	685,301.91	72,228.35
EKG/ECG	95,018.02	6,011.25	MRI SERVICES	335,948.20	6,937.35
IV THERAPY	279,831.48	9,904.55	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	654,465.47	35,383.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,071.60	376.79	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,698.16	10,133.54	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	117,019.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,114,961.02	6,805.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	94,795.52	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,194.69
LABORATORY PATHOLOGIC	0.00	294.00	INJECTABLE DRUGS	413,135.74	42,173.85
RADIOLOGY THERAPEUTIC	84,839.91	330.36	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,655.30	1,411.20	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,222.63	2,331.78	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	65,252.14	3,361.71	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	80,316.38	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	194,832.16	21,676.01			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,284.30	0.00			
ONCOLOGY	6,714.80	0.00			
NUCLEAR MEDICINE	34,469.40	14,799.17			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	46,077.80	11,836.78			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,052.58	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	41,032.35	5,584.38			
			TOTAL ANCILLARY	6,870,231.22	340,787.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,870,231.22	340,787.81

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,589.17	ADJUSTMENTS	0.00
COVERED CHARGES	20,402.94	CONTRACTUAL ALLOW	6,392.49
NON-COVERD CHARGES	4,186.23	TOTAL MEDICAID LIAB	14,010.45
		LESS: COB	14,004.45
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

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

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

PROVIDER NUMBER  
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PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,367.42	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,035.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,910.32	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,892.63	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,563.88	418.67
EKG/ECG	480.90	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,479.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,487.60	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	16.34	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	560.06	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	501.90	1,874.93			
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	0.00	0.00			
			TOTAL ANCILLARY	20,402.94	4,186.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	20,402.94	4,186.23



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

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

PROVIDER NUMBER  
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	358,799.74	ADJUSTMENTS	485.46
COVERED CHARGES	350,737.07	CONTRACTUAL ALLOW	322,586.43
NON-COVERD CHARGES	8,062.67	TOTAL MEDICAID LIAB	28,150.64
		LESS: COB	0.00
		LESS: COPAYMENT	1,245.00
		REIMBURSEMENT	26,905.64
		TOTAL NUMBER OF CLAIMS	516

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE SUMTER MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
126 US HWY 280 W	000000019A	SERVICE DATES	08/01/14	THROUGH	07/31/15
AMERICUS,GA 31719-8645		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,715.32	0.00	OTHER LAB	2,395.76	0.00
MED/SURG SUPPLY	9,078.06	330.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,388.65	2,447.08	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,061.05	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	322.35	0.00	FEE SCHEDULE LAB	33,304.77	2,294.55
EKG/ECG	3,847.20	240.45	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,185.47	339.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	180,357.89	439.14	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,584.12	443.18
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	344.97	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	118.97	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,355.35	1,182.64			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	22.11	0.00			
			TOTAL ANCILLARY	350,737.07	8,062.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	350,737.07	8,062.67



SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	693.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	418.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,892.63	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,558.36	17.81
EKG/ECG	240.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,516.99	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	225.02	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,652.69	1,910.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,652.69	1,910.44

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

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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	492,534.09	ADJUSTMENTS	103,355.58
COVERED CHARGES	486,269.02	CONTRACTUAL ALLOW	353,965.89
NON-COVERD CHARGES	6,265.07	TOTAL MEDICAID LIAB	132,303.13
		LESS: COB	0.00
		LESS: COPAYMENT	210.00
		REIMBURSEMENT	132,093.13
		TOTAL NUMBER OF CLAIMS	23

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,996.56	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,775.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,594.13	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,299.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	413.70	FEE SCHEDULE LAB	7,736.38	1,111.47
EKG/ECG	480.90	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	32,008.88	903.66	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	41,817.19	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	584.37	1,169.86	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,231.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,296.82	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	249,448.26	1,961.94
RADIOLOGY THERAPEUTIC	36,856.88	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,726.73	85.01	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,309.72	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.	2,955.82	0.00			
ONCOLOGY	1,678.70	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,471.83	619.43			
			TOTAL ANCILLARY	486,269.02	6,265.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	486,269.02	6,265.07

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

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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	08/01/14	THROUGH	07/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,367,941.75	ADJUSTMENTS	142,727.17
COVERED CHARGES	2,298,842.75	CONTRACTUAL ALLOW	1,179,170.54
NON-COVERD CHARGES	69,099.00	TOTAL MEDICAID LIAB	1,119,672.21
		LESS: COB	22,132.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,097,540.10

TOTAL NUMBER OF ADMISSIONS 217

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	990		0	493,020.00		49,584.00
ROUTINE NURSERY	4		0	908.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	994		0	493,928.00		49,584.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	83		0	93,202.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	83		0	93,202.00		0.00
TOTAL ACCOMODATIONS	1,077		0	587,130.00		49,584.00



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

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

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165,781.27	0.00	OTHER LAB	3,765.00	0.00
MED/SURG SUPPLY	83,478.55	100.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	423,981.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,390.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	108,270.00	1,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,674.06	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	33,460.00	0.00	MRI SERVICES	21,804.00	0.00
IV THERAPY	222,266.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,795.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,051.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	96,312.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,910.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,110.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,917.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,861.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	312,639.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,282.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,832.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	148.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,811.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,089.36
OTHER IMAGING SERVICE	1,132.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,750.00	16,425.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	70.00	0.00			
CARDIOLOGY	14,489.00	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	35,643.00	0.00			
			TOTAL ANCILLARY	1,711,712.75	19,515.00
			TOTAL ACCOMODATIONS	587,130.00	49,584.00
			TOTAL CHARGES	2,298,842.75	69,099.00

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
336	2215107014694	04/08/15 - 04/13/15	04/20/15	0.00	1,089.36	0.00	0.00	0.00
TOTAL				0.00	1,089.36	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,655,033.07	ADJUSTMENTS	74,214.94
COVERED CHARGES	1,497,453.27	CONTRACTUAL ALLOW	1,165,599.78
NON-COVERD CHARGES	157,579.80	TOTAL MEDICAID LIAB	331,853.49
		LESS: COB	395.16
		LESS: COPAYMENT	1,194.00
		REIMBURSEMENT	330,264.33
		ALL OTHER	281,364.69
		FEE SCHEDULE-LAB	45,772.62
		INJECTABLE DRUGS	3,127.02
		TOTAL NUMBER OF CLAIMS	1,486

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

PROVIDER NUMBER  
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,995.87	1,968.58	OTHER LAB	8,010.00	0.00
MED/SURG SUPPLY	49,728.18	873.37	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	70.00	EDUCATION & TRAINING	0.00	112.00
RADIOLOGY-DIAGNOSTIC	84,827.00	673.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	163,833.00	23,749.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,898.00	219.00	FEE SCHEDULE LAB	434,296.90	78,466.10
EKG/ECG	18,710.00	70.00	MRI SERVICES	52,481.00	2,453.00
IV THERAPY	147,443.00	2,015.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	53,276.32	4,947.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,285.00	5,333.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,975.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	16,815.00	1,595.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	203,212.00	915.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,461.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,971.87	13,896.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,757.00	231.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,593.00	359.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	370.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,151.13	823.27
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	119.00
OTHER IMAGING SERVICE	23,234.00	3,842.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,468.00	6,570.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,981.00	2,583.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,658.00	4,475.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,555.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,837.00	851.00			
			TOTAL ANCILLARY	1,497,453.27	157,579.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,497,453.27	157,579.80

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

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

Run Date: 08/12/2016  
Run Time: 01:09:10  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
950	5914329002564	11/11/14 - 11/11/14	12/01/14	0.00	119.00	0.00	0.00	0.00
TOTAL				0.00	119.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
Run Time: 01:09:44  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,117.66	ADJUSTMENTS	0.00
COVERED CHARGES	17,766.43	CONTRACTUAL ALLOW	-1,398.01
NON-COVERD CHARGES	9,351.23	TOTAL MEDICAID LIAB	19,164.44
		LESS: COB	19,162.24
		LESS: COPAYMENT	2.20
		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

APPLING HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 163 E TOLLISON ST 000000052A SERVICE DATES 09/01/14 THROUGH 08/31/15  
 BAXLEY,GA 31513-0120 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	233.50	45.00	OTHER LAB	421.00	0.00
MED/SURG SUPPLY	597.46	40.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,420.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,730.00	6,732.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,766.00	0.00	FEE SCHEDULE LAB	3,621.00	164.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,829.00	360.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87.00	75.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,381.00	561.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	77.47	248.23
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,541.00	360.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,062.00	359.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	154.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	253.00			
			TOTAL ANCILLARY	17,766.43	9,351.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,766.43	9,351.23



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

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

Run Date: 08/12/2016  
Run Time: 01:09:45  
Page: 10

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

PROVIDER NUMBER  
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	115,548.88	ADJUSTMENTS	323.64
COVERED CHARGES	109,418.45	CONTRACTUAL ALLOW	100,971.51
NON-COVERD CHARGES	6,130.43	TOTAL MEDICAID LIAB	8,446.94
		LESS: COB	0.00
		LESS: COPAYMENT	264.00
		REIMBURSEMENT	8,182.94
		TOTAL NUMBER OF CLAIMS	151

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,677.86	65.00	OTHER LAB	842.00	0.00
MED/SURG SUPPLY	1,526.13	32.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,770.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,531.00	1,135.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,115.00	3,197.00
EKG/ECG	1,000.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,258.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	489.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	452.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	683.00	150.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,170.00	115.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,393.46	535.44
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	257.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	154.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	109,418.45	6,130.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	109,418.45	6,130.43

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: 08/12/2016  
Run Time: 01:09:48  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,503.28	ADJUSTMENTS	0.00
COVERED CHARGES	4,194.90	CONTRACTUAL ALLOW	2,150.88
NON-COVERD CHARGES	308.38	TOTAL MEDICAID LIAB	2,044.02
		LESS: COB	2,038.02
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	291.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	31.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	163.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,336.00	32.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	323.00	205.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,628.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	127.46	40.38
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	283.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,194.90	308.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,194.90	308.38

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000052A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 01:09:48  
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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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 02:31:16  
 Page: 1

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,116,918.45	ADJUSTMENTS	1,786,165.62
COVERED CHARGES	27,486,360.45	CONTRACTUAL ALLOW	18,067,727.96
NON-COVERD CHARGES	1,630,558.00	TOTAL MEDICAID LIAB	9,418,632.49
		LESS: COB	54,124.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,364,507.62

TOTAL NUMBER OF ADMISSIONS 1,087

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,785		109	3,306,311.00		1,235,798.00
ROUTINE NURSERY	81		0	42,862.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,866		109	3,349,173.00		1,235,798.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	835		0	1,108,841.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		213	0.00		171,147.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	835		213	1,108,841.00		171,147.00
TOTAL ACCOMODATIONS	6,701		322	4,458,014.00		1,406,945.00

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

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

Run Date: 08/12/2016  
 Run Time: 02:31:16  
 Page: 2

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,086,718.73	0.00	OTHER LAB	56,465.00	0.00
MED/SURG SUPPLY	2,209,393.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,453,860.27	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	656,538.00	0.00	OTHER THERAPEUTIC SVC	0.00	3,555.00
CT SCAN	1,152,097.00	30,952.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	240,144.65	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	127,995.00	0.00	MRI SERVICES	239,132.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,012,824.00	146.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	93,247.00	0.00	REHAB THERAPY	159.00	0.00
RESPIRATORY SERVICES	879,747.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	140,045.00	332.00	AMBULANCE	0.00	0.00
GI SERVICES	136,611.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	831,112.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	176,149.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	91,567.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	136,653.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	161,955.19	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	73,347.29	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	197,090.32	1,854.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	9,992.00	TRAUMA RESPONSE	0.00	3,688.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,943,517.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	105,466.00	13,770.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	198,908.00	159,324.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	82,290.00	0.00			
AUDIOLOGY	2,835.00	0.00			
CARDIOLOGY	468,274.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,331.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,875.00	0.00			
			TOTAL ANCILLARY	23,028,346.45	223,613.00
			TOTAL ACCOMODATIONS	4,458,014.00	1,406,945.00
			TOTAL CHARGES	27,486,360.45	1,630,558.00



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

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

Run Date: 08/12/2016  
 Run Time: 02:31:25  
 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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,312.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,108.00	CONTRACTUAL ALLOW	1,977.20
NON-COVERD CHARGES	204.00	TOTAL MEDICAID LIAB	17,130.80
		LESS: COB	17,130.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	2,232.00		204.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4		0	2,232.00		204.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	4		0	2,232.00		204.00

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

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

Run Date: 08/12/2016  
 Run Time: 02:31:25  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,499.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,189.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,781.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	264.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,613.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	237.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,996.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	271.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,247.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,649.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	130.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,876.00	0.00
			TOTAL ACCOMODATIONS	2,232.00	204.00
			TOTAL CHARGES	19,108.00	204.00

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

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

Run Date: 08/12/2016  
Run Time: 02:31:27  
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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,572,179.96	ADJUSTMENTS	512,112.83
COVERED CHARGES	15,989,834.44	CONTRACTUAL ALLOW	11,845,822.91
NON-COVERD CHARGES	1,582,345.52	TOTAL MEDICAID LIAB	4,144,011.53
		LESS: COB	2,087.47
		LESS: COPAYMENT	16,825.14
		REIMBURSEMENT	4,125,098.92
		ALL OTHER	3,016,782.31
		FEE SCHEDULE-LAB	287,627.95
		INJECTABLE DRUGS	820,688.66
		TOTAL NUMBER OF CLAIMS	9,240

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	307,224.60	29,125.00	OTHER LAB	86,735.00	543.00
MED/SURG SUPPLY	686,281.00	691.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	650,292.00	16,072.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,905,435.00	166,627.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	92,627.00	37,177.22	FEE SCHEDULE LAB	2,058,588.34	227,985.62
EKG/ECG	118,480.00	900.00	MRI SERVICES	545,515.00	21,744.00
IV THERAPY	771,605.00	11,815.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,117,345.62	165,645.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,059.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	101,356.00	20,650.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	116,562.00	6,234.00	AMBULANCE	0.00	0.00
GI SERVICES	237,685.39	36,177.61	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,026,683.33	7,370.67	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	218,575.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,200.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,153,880.60	454,545.14
RADIOLOGY THERAPEUTIC	1,025,542.00	163,610.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,382.00	9,958.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,691.00	3,270.12	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	243,815.56	1,518.00	TRAUMA RESPONSE	0.00	3,688.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	130,517.00	0.00
LITHOTRIPSY	13,112.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	452,395.00	33,312.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	25,868.00	12,558.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	268,459.00	13,318.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	200,659.00	103,067.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	120,002.00	309.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	251,462.00	32,234.76			
			TOTAL ANCILLARY	15,989,834.44	1,582,345.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,989,834.44	1,582,345.52

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	139,958.00	ADJUSTMENTS	0.00
COVERED CHARGES	90,894.00	CONTRACTUAL ALLOW	16,753.46
NON-COVERD CHARGES	49,064.00	TOTAL MEDICAID LIAB	74,140.54
		LESS: COB	74,006.52
		LESS: COPAYMENT	134.02
		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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,663.00	63.00	OTHER LAB	543.00	0.00
MED/SURG SUPPLY	3,841.00	5,846.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,430.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,591.00	21,197.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,618.00	1,280.00
EKG/ECG	903.00	0.00	MRI SERVICES	0.00	1,734.00
IV THERAPY	3,055.00	446.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,223.00	2,943.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,951.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	202.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	828.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,310.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,501.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,535.00	305.00
RADIOLOGY THERAPEUTIC	5,270.00	7,857.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,776.00	0.00	TRAUMA RESPONSE	0.00	903.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,780.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,748.00	4,716.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,813.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,572.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	515.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	90,894.00	49,064.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	90,894.00	49,064.00

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

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

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

PROVIDER NUMBER  
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	312,681.92	ADJUSTMENTS	741.15
COVERED CHARGES	294,836.89	CONTRACTUAL ALLOW	272,069.32
NON-COVERD CHARGES	17,845.03	TOTAL MEDICAID LIAB	22,767.57
		LESS: COB	42.67
		LESS: COPAYMENT	807.09
		REIMBURSEMENT	21,917.81
		TOTAL NUMBER OF CLAIMS	407

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	868.00	0.00	OTHER LAB	1,719.00	0.00
MED/SURG SUPPLY	5,381.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,976.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,827.00	6,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	124.03	FEE SCHEDULE LAB	61,514.89	8,219.00
EKG/ECG	2,637.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	23,512.00	92.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,054.00	808.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	125,617.00	156.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,011.00	723.00
RADIOLOGY THERAPEUTIC	4,254.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	62.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	180.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	397.00	823.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,827.00	0.00			
			TOTAL ANCILLARY	294,836.89	17,845.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	294,836.89	17,845.03



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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,943.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,943.00	CONTRACTUAL ALLOW	2,730.43
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,212.57
		LESS: COB	2,206.57
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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

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

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	53.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	343.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,973.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	315.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,078.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	94.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,943.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,943.00	0.00

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,096,164.20	ADJUSTMENTS	121,826.14
COVERED CHARGES	2,725,337.64	CONTRACTUAL ALLOW	2,200,325.54
NON-COVERD CHARGES	370,826.56	TOTAL MEDICAID LIAB	525,012.10
		LESS: COB	0.00
		LESS: COPAYMENT	360.00
		REIMBURSEMENT	524,652.10
		TOTAL NUMBER OF CLAIMS	90

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,509.80	1,102.00	OTHER LAB	2,833.00	0.00
MED/SURG SUPPLY	321,143.00	56.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,045.00	10,503.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,956.00	11,700.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,115.03	FEE SCHEDULE LAB	62,015.00	6,950.00
EKG/ECG	4,900.00	1,691.00	MRI SERVICES	2,890.00	0.00
IV THERAPY	118,029.00	1,770.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	353,503.40	43,700.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,953.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,354.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,014.08	3,533.92	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,414.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	30,298.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,200.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	902,076.36	228,943.25
RADIOLOGY THERAPEUTIC	191,120.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,864.00	53.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	422,692.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,004.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,380.00	891.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,577.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	144,051.00	53,240.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,716.00	3,377.76			
			TOTAL ANCILLARY	2,725,337.64	370,826.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,725,337.64	370,826.56

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

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

Run Date: 08/12/2016  
Run Time: 02:32:13  
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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,644.00	ADJUSTMENTS	0.00
COVERED CHARGES	55,505.00	CONTRACTUAL ALLOW	5,778.97
NON-COVERD CHARGES	139.00	TOTAL MEDICAID LIAB	49,726.03
		LESS: COB	49,666.03
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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

Run Date: 08/12/2016  
 Run Time: 02:32:13  
 Page: 16

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
 000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110.00	110.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	191.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,180.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	881.00	11.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	1,889.00	18.00
RADIOLOGY THERAPEUTIC	39,440.00	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	1,661.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	153.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	55,505.00	139.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	55,505.00	139.00

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 01:10:34  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000074A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,168,855.20	ADJUSTMENTS	4,509,611.06
COVERED CHARGES	63,412,569.59	CONTRACTUAL ALLOW	46,340,270.18
NON-COVERD CHARGES	2,756,285.61	TOTAL MEDICAID LIAB	17,072,299.41
		LESS: COB	117,663.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,954,635.97

TOTAL NUMBER OF ADMISSIONS 1,931

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,025		112	5,983,243.00		1,767,299.00
ROUTINE NURSERY	1,169		28	1,413,695.00		537,512.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		49.00
TOTAL ROUTINE	8,194		140	7,396,938.00		2,304,860.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	914		1	2,055,586.00		2,249.00
NICU	346		1	1,030,758.00		3,000.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,260		2	3,086,344.00		5,249.00
TOTAL ACCOMODATIONS	9,454		142	10,483,282.00		2,310,109.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,140,081.07	106,411.20	OTHER LAB	316,699.00	918.00
MED/SURG SUPPLY	3,208,168.17	23,521.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,275,595.97	23,343.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	965,885.96	489.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,153,792.00	5,596.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	207,299.93	636.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,812,808.06	5,757.00	MRI SERVICES	559,439.00	2,234.00
IV THERAPY	666,497.00	3,940.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,241,713.00	4,968.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,657,778.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,125,519.02	3,094.43	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	235,537.50	373.00	AMBULANCE	0.00	0.00
GI SERVICES	412,794.00	2,802.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,392,979.00	333.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	522,522.00	596.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	531,687.97	0.00	INJECTABLE DRUGS	2,014,498.62	31,260.50
RADIOLOGY THERAPEUTIC	171,720.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	148,028.20	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	109,626.82	262.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	408,575.00	11,800.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	317.00	13,585.00	TRAUMA RESPONSE	0.00	77,152.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,360,956.93	0.00
LITHOTRIpsy	19,210.00	0.00	NO CC/INVALID REV CODE	0.00	15,612.00
OTHER IMAGING SERVICE	360,380.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	554,423.70	79,207.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	268,719.00	29,097.00			
AUDIOLOGY	88,047.00	0.00			
CARDIOLOGY	1,637,575.00	3,189.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	130,562.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	229,851.67	0.00			
			TOTAL ANCILLARY	52,929,287.59	446,176.61
			TOTAL ACCOMODATIONS	10,483,282.00	2,310,109.00
			TOTAL CHARGES	63,412,569.59	2,756,285.61



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
392	2015035070843	01/06/15 - 01/27/15	02/09/15	0.00	731.00	0.00	0.00	0.00
392	2015040023866	01/15/15 - 01/27/15	02/16/15	0.00	731.00	0.00	0.00	0.00
-1	2315043000172	12/19/14 - 12/26/14	03/02/15	0.00	731.00	0.00	793.19	0.00
392	2015050047983	02/04/15 - 02/12/15	02/23/15	0.00	640.00	0.00	0.00	0.00
392	2015058058383	02/09/15 - 02/20/15	03/02/15	0.00	1,462.00	0.00	0.00	0.00
392	2015062038868	02/23/15 - 02/26/15	03/09/15	0.00	731.00	0.00	0.00	0.00
392	2015064069557	02/18/15 - 02/25/15	03/09/15	0.00	640.00	0.00	0.00	0.00
392	2015072058349	02/15/15 - 02/25/15	03/16/15	0.00	731.00	0.00	0.00	0.00
392	2015077064308	03/04/15 - 03/11/15	03/23/15	0.00	4,611.00	0.00	0.00	0.00
392	2015082018047	03/06/15 - 03/08/15	03/30/15	0.00	1,462.00	0.00	0.00	0.00
392	2015083050980	03/10/15 - 03/17/15	03/30/15	0.00	731.00	0.00	0.00	0.00
392	2015089019647	03/17/15 - 03/20/15	04/06/15	0.00	731.00	0.00	0.00	0.00
618	2015313028578	10/15/14 - 11/03/14	11/16/15	0.00	1,680.00	0.00	0.00	0.00
TOTAL				0.00	15,612.00	0.00	793.19	0.00

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

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

Run Date: 08/12/2016  
 Run Time: 01:11:39  
 Page: 4

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	96,165.73	ADJUSTMENTS	0.00
COVERED CHARGES	89,056.73	CONTRACTUAL ALLOW	46,100.32
NON-COVERD CHARGES	7,109.00	TOTAL MEDICAID LIAB	42,956.41
		LESS: COB	42,956.41
		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	13		2	11,557.00		5,078.00
ROUTINE NURSERY	6		0	5,334.00		1,320.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	19		2	16,891.00		6,398.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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		2	16,891.00		6,398.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,777.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,698.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,668.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,165.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,551.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,644.00	0.00	MRI SERVICES	1,892.00	0.00
IV THERAPY	179.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,908.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,163.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	428.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,193.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	755.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	492.00	0.00	INJECTABLE DRUGS	2,061.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,251.00	711.00			
AUDIOLOGY	540.00	0.00			
CARDIOLOGY	1,800.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	72,165.73	711.00
			TOTAL ACCOMODATIONS	16,891.00	6,398.00
			TOTAL CHARGES	89,056.73	7,109.00

Report : CLM-0804-0  
Process : CLMJ0800  
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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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,129,140.63	ADJUSTMENTS	1,284,396.33
COVERED CHARGES	31,589,938.75	CONTRACTUAL ALLOW	26,250,681.19
NON-COVERD CHARGES	1,539,201.88	TOTAL MEDICAID LIAB	5,339,257.56
		LESS: COB	46,346.68
		LESS: COPAYMENT	14,004.09
		REIMBURSEMENT	5,278,906.79
		ALL OTHER	4,446,252.98
		FEE SCHEDULE-LAB	527,395.60
		INJECTABLE DRUGS	305,258.21
		TOTAL NUMBER OF CLAIMS	11,930

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	717,141.79	126.00	OTHER LAB	315,522.00	568.00
MED/SURG SUPPLY	768,912.88	6,119.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	267.00
RADIOLOGY-DIAGNOSTIC	1,258,736.60	11,456.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,939,589.00	113,029.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,181.00	15,969.06	FEE SCHEDULE LAB	5,563,760.13	323,145.04
EKG/ECG	409,150.04	45,443.00	MRI SERVICES	679,146.00	21,428.00
IV THERAPY	1,364,636.00	16,239.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,027,787.00	97,288.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,969.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	284,619.34	5,447.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	135,495.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	210,038.00	2,805.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,705,297.89	20,842.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	373,273.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,560,789.50	471,577.40
RADIOLOGY THERAPEUTIC	267,800.00	112,430.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,132.00	8,738.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	27,808.00	3,001.26	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	972.00	26,047.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	111,049.32	1,176.00	TRAUMA RESPONSE	0.00	53,042.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	323,205.30	0.00
LITHOTRIPSY	38,420.00	0.00	NO CC/INVALID REV CODE	0.00	1,680.00
OTHER IMAGING SERVICE	891,706.00	116,247.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	145,826.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	949,383.00	10,626.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,064,801.00	48,795.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	500,084.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	894,707.96	5,670.90			
			TOTAL ANCILLARY	31,589,938.75	1,539,201.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,589,938.75	1,539,201.88

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

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

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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015205059415	07/13/15 - 07/13/15	07/27/15	0.00	1,680.00	0.00	0.00	0.00
TOTAL				0.00	1,680.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	444,369.30	ADJUSTMENTS	0.00
COVERED CHARGES	401,861.34	CONTRACTUAL ALLOW	258,141.23
NON-COVERD CHARGES	42,507.96	TOTAL MEDICAID LIAB	143,720.11
		LESS: COB	143,554.75
		LESS: COPAYMENT	165.36
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 147

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,407.50	21.00	OTHER LAB	2,466.00	0.00
MED/SURG SUPPLY	6,632.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,404.00	3,324.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	38,088.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,073.00	2,014.00	FEE SCHEDULE LAB	57,235.64	5,481.96
EKG/ECG	1,228.00	0.00	MRI SERVICES	4,966.00	0.00
IV THERAPY	20,443.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,444.00	20,634.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	193.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,352.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,802.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,002.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,674.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,687.96	5,989.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,272.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,785.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,813.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,821.07	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,678.00	1,717.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,518.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,381.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	35,331.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,220.41	270.00			
			TOTAL ANCILLARY	401,861.34	42,507.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	401,861.34	42,507.96



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

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

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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,259,882.59	ADJUSTMENTS	1,938.41
COVERED CHARGES	1,235,202.16	CONTRACTUAL ALLOW	1,190,760.54
NON-COVERD CHARGES	24,680.43	TOTAL MEDICAID LIAB	44,441.62
		LESS: COB	245.29
		LESS: COPAYMENT	1,609.56
		REIMBURSEMENT	42,586.77
		TOTAL NUMBER OF CLAIMS	791

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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,256.29	0.00	OTHER LAB	10,931.00	0.00
MED/SURG SUPPLY	5,087.90	498.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,428.00	876.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,195.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	231,690.81	6,581.46
EKG/ECG	11,973.00	0.00	MRI SERVICES	9,781.00	1,892.00
IV THERAPY	43,782.00	314.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,878.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,070.43	1,155.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	318.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	740,884.00	198.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,175.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,181.69	9,959.05
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	472.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	153.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	299.74	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,140.00	2,734.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,977.30	0.00			
			TOTAL ANCILLARY	1,235,202.16	24,680.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,235,202.16	24,680.43

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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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,715.38	ADJUSTMENTS	0.00
COVERED CHARGES	34,536.38	CONTRACTUAL ALLOW	26,782.33
NON-COVERD CHARGES	179.00	TOTAL MEDICAID LIAB	7,754.05
		LESS: COB	7,736.05
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	702.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	192.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,138.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,462.69	0.00
EKG/ECG	307.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,893.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	358.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,102.00	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	11,381.19	179.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	34,536.38	179.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,536.38	179.00

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

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

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

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

PROVIDER NUMBER  
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,393,646.78	ADJUSTMENTS	128,726.17
COVERED CHARGES	2,264,664.00	CONTRACTUAL ALLOW	1,890,771.08
NON-COVERD CHARGES	128,982.78	TOTAL MEDICAID LIAB	373,892.92
		LESS: COB	0.00
		LESS: COPAYMENT	473.01
		REIMBURSEMENT	373,419.91
		TOTAL NUMBER OF CLAIMS	64

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

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

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

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

PROVIDER NUMBER  
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,879.17	0.00	OTHER LAB	1,425.00	0.00
MED/SURG SUPPLY	97,693.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,254.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,803.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	64,395.82	5,872.59
EKG/ECG	5,526.00	9,672.00	MRI SERVICES	0.00	0.00
IV THERAPY	90,778.00	197.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	286,465.00	468.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,091.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,918.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,000.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,501.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	554,860.56	35,817.19
RADIOLOGY THERAPEUTIC	32,453.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,315.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	613,637.18	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,458.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,711.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	316,163.00	76,821.00			
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	80,336.62	135.00			
			TOTAL ANCILLARY	2,264,664.00	128,982.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,264,664.00	128,982.78

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

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

Run Date: 08/12/2016  
Run Time: 01:14:51  
Page: 17

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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000118A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,047,213.62	ADJUSTMENTS	37,439.38
COVERED CHARGES	1,968,853.27	CONTRACTUAL ALLOW	1,444,480.58
NON-COVERD CHARGES	78,360.35	TOTAL MEDICAID LIAB	524,372.69
		LESS: COB	2,269.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	522,103.08

TOTAL NUMBER OF ADMISSIONS 110

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	323		0	204,782.00		8,204.20
ROUTINE NURSERY	37		0	23,375.30		2,641.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	360		0	228,157.30		10,845.70
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	39		0	47,365.60		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	39		0	47,365.60		0.00
TOTAL ACCOMODATIONS	399		0	275,522.90		10,845.70



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	529,292.84	0.00	OTHER LAB	5,002.60	0.00
MED/SURG SUPPLY	219,967.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	279,570.10	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,442.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,734.30	17,942.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	29,287.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,567.70	0.00	MRI SERVICES	10,311.50	0.00
IV THERAPY	4,958.80	30,832.65	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	132,838.40	6,042.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,935.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	72,944.56	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,992.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,130.20	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,267.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,509.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	20,942.80	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,603.20	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	156,665.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,943.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,944.20	12,697.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,252.20	0.00			
AUDIOLOGY	2,140.50	0.00			
CARDIOLOGY	1,106.10	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	1,978.10	0.00			
			TOTAL ANCILLARY	1,693,330.37	67,514.65
			TOTAL ACCOMODATIONS	275,522.90	10,845.70
			TOTAL CHARGES	1,968,853.27	78,360.35

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,543.88	ADJUSTMENTS	0.00
COVERED CHARGES	9,309.98	CONTRACTUAL ALLOW	2,334.56
NON-COVERD CHARGES	233.90	TOTAL MEDICAID LIAB	6,975.42
		LESS: COB	6,975.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1	0	634.00	25.40
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1	0	634.00	25.40
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	0	0	0.00	0.00
TOTAL ACCOMODATIONS	1	0	634.00	25.40

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,341.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,850.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	85.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	208.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,999.30	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	399.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,675.98	208.50
			TOTAL ACCOMODATIONS	634.00	25.40
			TOTAL CHARGES	9,309.98	233.90

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

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

Run Date: 08/12/2016  
Run Time: 01:19:20  
Page: 5

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,009,599.38	ADJUSTMENTS	7,168.47
COVERED CHARGES	1,543,440.56	CONTRACTUAL ALLOW	1,111,937.85
NON-COVERD CHARGES	466,158.82	TOTAL MEDICAID LIAB	431,502.71
		LESS: COB	1,079.35
		LESS: COPAYMENT	1,128.00
		REIMBURSEMENT	429,295.36
		ALL OTHER	388,699.64
		FEE SCHEDULE-LAB	40,595.72
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,388

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,347.69	133,650.37	OTHER LAB	13,088.60	0.00
MED/SURG SUPPLY	103,811.96	289.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	191.80	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	131,918.50	1,937.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	170,105.50	77,482.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,853.70	5,710.53	FEE SCHEDULE LAB	485,498.75	129,789.31
EKG/ECG	37,109.07	3,488.30	MRI SERVICES	55,932.00	4,929.90
IV THERAPY	8,399.60	21,568.45	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,282.23	9,387.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	403.80	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,278.10	4,752.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,461.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	32,221.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	273,721.53	56,333.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,591.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,875.10	2,725.33	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,169.50	728.50	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	6,970.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,577.90	8,272.73			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,130.20	4,474.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,166.60	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	60,688.23	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,837.80	446.10			
			TOTAL ANCILLARY	1,543,440.56	466,158.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,543,440.56	466,158.82

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

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

Run Date: 08/12/2016  
Run Time: 01:19:46  
Page: 7

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,876.55	ADJUSTMENTS	0.00
COVERED CHARGES	6,160.17	CONTRACTUAL ALLOW	1,831.82
NON-COVERD CHARGES	3,716.38	TOTAL MEDICAID LIAB	4,328.35
		LESS: COB	4,328.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	503.57	186.18	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	482.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	816.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,790.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,347.20	17.40
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	307.60	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	1,414.30	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,129.60	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	600.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,280.70	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,160.17	3,716.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,160.17	3,716.38

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,330.98	ADJUSTMENTS	50.00
COVERED CHARGES	139,202.95	CONTRACTUAL ALLOW	127,702.95
NON-COVERD CHARGES	28,128.03	TOTAL MEDICAID LIAB	11,500.00
		LESS: COB	0.00
		LESS: COPAYMENT	459.00
		REIMBURSEMENT	11,041.00
		TOTAL NUMBER OF CLAIMS	230



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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	708.45	9,722.33	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,817.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,227.60	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,842.20	6,523.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,111.40	5,223.90
EKG/ECG	2,501.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	910.80	1,590.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	394.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	71,575.20	3,878.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,189.90			
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	113.60	0.00			
			TOTAL ANCILLARY	139,202.95	28,128.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	139,202.95	28,128.03

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,328.63	ADJUSTMENTS	0.00
COVERED CHARGES	4,083.13	CONTRACTUAL ALLOW	916.12
NON-COVERD CHARGES	1,245.50	TOTAL MEDICAID LIAB	3,167.01
		LESS: COB	3,167.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,461.73	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	56.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	987.80	160.70
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	108.80	PROFESSIONAL FEES	0.00	380.80
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,577.40	595.20	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,083.13	1,245.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,083.13	1,245.50

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	105,349.69	ADJUSTMENTS	0.00
COVERED CHARGES	96,781.22	CONTRACTUAL ALLOW	70,907.97
NON-COVERD CHARGES	8,568.47	TOTAL MEDICAID LIAB	25,873.25
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	25,858.25

TOTAL NUMBER OF CLAIMS 5

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	987.40	6,236.37	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41,398.22	229.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	196.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,790.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,711.40	142.90
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	202.40	847.10	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,601.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	913.40	296.10	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	619.30	816.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,716.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,054.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	589.50	0.00			
			TOTAL ANCILLARY	96,781.22	8,568.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	96,781.22	8,568.47

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

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

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000118A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 03:03:00  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,648,295.84	ADJUSTMENTS	275,890.00
COVERED CHARGES	4,605,912.97	CONTRACTUAL ALLOW	2,854,115.73
NON-COVERD CHARGES	42,382.87	TOTAL MEDICAID LIAB	1,751,797.24
		LESS: COB	53,808.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,697,988.67

TOTAL NUMBER OF ADMISSIONS 272

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	508		0	369,352.00		3,635.78
ROUTINE NURSERY	87		0	53,001.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	595		0	422,353.00		3,635.78
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	496		0	658,546.18		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	496		0	658,546.18		0.00
TOTAL ACCOMODATIONS	1,091		0	1,080,899.18		3,635.78

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	366,456.13	0.00	OTHER LAB	12,692.21	0.00
MED/SURG SUPPLY	329,101.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	757,646.84	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	58,426.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	306,178.13	1,590.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,612.21	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	21,102.73	0.00	MRI SERVICES	39,651.90	0.00
IV THERAPY	28,435.85	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	106,344.79	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	54,764.32	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	197,058.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	33,304.02	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	146,685.47	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,793.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	19,542.95	0.00	INJECTABLE DRUGS	701,381.47	0.00
RADIOLOGY THERAPEUTIC	5,079.53	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,022.30	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,191.37	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,641.00	6,442.04	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,096.72	542.58	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	56,288.27	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,519.41
OTHER IMAGING SERVICE	26,126.92	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	43,123.07	23,652.96			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	31,905.08	0.00			
AUDIOLOGY	3,386.60	0.00			
CARDIOLOGY	112,590.38	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,530.47	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,852.55	0.00			
			TOTAL ANCILLARY	3,525,013.79	38,747.09
			TOTAL ACCOMODATIONS	1,080,899.18	3,635.78
			TOTAL CHARGES	4,605,912.97	42,382.87



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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015197047602	06/24/15 - 07/05/15	07/20/15	0.00	1,629.83	0.00	0.00	0.00
615	5215362010641	08/18/15 - 08/20/15	02/22/16	0.00	3,259.75	0.00	0.00	0.00
615	5215362013975	08/27/15 - 08/29/15	02/22/16	0.00	1,629.83	0.00	0.00	0.00
TOTAL				0.00	6,519.41	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
 Run Time: 03:03:03  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,000.75	ADJUSTMENTS	0.00
COVERED CHARGES	23,000.75	CONTRACTUAL ALLOW	16,691.10
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,309.65
		LESS: COB	6,309.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	0		0	0.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	0		0	0.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	5,272.22		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	5,272.22		0.00
TOTAL ACCOMODATIONS	4		0	5,272.22		0.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	519.54	0.00	OTHER LAB	1,222.72	0.00
MED/SURG SUPPLY	910.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,860.23	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	104.79	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,084.16	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	201.94	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	740.91	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	780.66	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,528.44	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	313.21	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,461.05	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,728.53	0.00
			TOTAL ACCOMODATIONS	5,272.22	0.00
			TOTAL CHARGES	23,000.75	0.00

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

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

Run Date: 08/12/2016  
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Page: 6

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,025,049.62	ADJUSTMENTS	312,915.46
COVERED CHARGES	6,586,589.44	CONTRACTUAL ALLOW	5,169,824.77
NON-COVERD CHARGES	438,460.18	TOTAL MEDICAID LIAB	1,416,764.67
		LESS: COB	2,710.66
		LESS: COPAYMENT	5,165.06
		REIMBURSEMENT	1,408,888.95
		ALL OTHER	1,107,516.91
		FEE SCHEDULE-LAB	255,568.44
		INJECTABLE DRUGS	45,803.60

TOTAL NUMBER OF CLAIMS 5,086

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

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

Run Date: 08/12/2016  
 Run Time: 03:03:04  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	134,372.64	1,148.69	OTHER LAB	25,340.39	404.77
MED/SURG SUPPLY	244,436.14	6,626.07	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	65.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	251,389.28	1,199.17	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	955,094.71	39,272.04	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,534.64	2,736.56	FEE SCHEDULE LAB	1,649,168.61	186,576.11
EKG/ECG	69,806.00	706.79	MRI SERVICES	173,270.60	3,758.40
IV THERAPY	133,111.80	2,134.52	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	202,194.23	5,342.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,696.53	6,801.69	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,201.86	218.52	AMBULANCE	0.00	0.00
GI SERVICES	136,807.32	3,781.08	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,323,892.65	7,015.35	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,230.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	227,871.89	50,142.96
RADIOLOGY THERAPEUTIC	302,176.71	665.45	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,595.40	170.55	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,102.83	3,441.62	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,224.46	2,480.39	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	61,019.94	10,637.06
LITHOTRIPSY	57,289.02	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	164,612.64	23,796.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	40,726.37	15,768.64			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	142,458.42	57,868.62			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	54,156.99	4,383.15			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	99,686.14	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	62,121.13	1,318.26			
			TOTAL ANCILLARY	6,586,589.44	438,460.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,586,589.44	438,460.18

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

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

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

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,066.30	ADJUSTMENTS	0.00
COVERED CHARGES	10,715.25	CONTRACTUAL ALLOW	9,552.50
NON-COVERD CHARGES	4,351.05	TOTAL MEDICAID LIAB	1,162.75
		LESS: COB	1,156.75
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

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

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

PROVIDER NUMBER  
 000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	221.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	327.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209.58	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,639.53	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,998.45	796.93
EKG/ECG	201.94	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	415.61	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	100.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,766.43	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	260.48	416.48
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	314.34	397.59			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,715.25	4,351.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,715.25	4,351.05

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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	233,756.39	ADJUSTMENTS	728.22
COVERED CHARGES	229,304.12	CONTRACTUAL ALLOW	209,374.41
NON-COVERD CHARGES	4,452.27	TOTAL MEDICAID LIAB	19,929.71
		LESS: COB	26.95
		LESS: COPAYMENT	599.00
		REIMBURSEMENT	19,303.76
		TOTAL NUMBER OF CLAIMS	358



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,117.52	0.00	OTHER LAB	404.77	0.00
MED/SURG SUPPLY	6,114.61	155.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,783.57	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,777.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	331.74	FEE SCHEDULE LAB	45,400.63	1,330.64
EKG/ECG	1,918.43	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,312.58	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,529.56	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	252.90	100.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	125,453.11	181.89	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	364.68	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,305.55	2,037.36
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,568.71	314.34			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	229,304.12	4,452.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	229,304.12	4,452.27

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

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

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
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

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	92,334.67	ADJUSTMENTS	0.00
COVERED CHARGES	91,114.06	CONTRACTUAL ALLOW	74,201.71
NON-COVERD CHARGES	1,220.61	TOTAL MEDICAID LIAB	16,912.35
		LESS: COB	0.00
		LESS: COPAYMENT	180.00
		REIMBURSEMENT	16,732.35

TOTAL NUMBER OF CLAIMS 3

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

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

PROVIDER NUMBER  
 000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	125.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	226.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	104.79	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,403.58	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	247.13	83.84
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	10.03	0.00
RADIOLOGY THERAPEUTIC	55,507.62	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	644.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	489.07	492.77			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	91,114.06	1,220.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	91,114.06	1,220.61

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

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

Run Date: 08/12/2016  
Run Time: 03:03:48  
Page: 15

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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 02:57:35  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,257,001.18	ADJUSTMENTS	371,131.27
COVERED CHARGES	2,031,943.61	CONTRACTUAL ALLOW	1,168,173.98
NON-COVERD CHARGES	225,057.57	TOTAL MEDICAID LIAB	863,769.63
		LESS: COB	3,150.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	860,618.89

TOTAL NUMBER OF ADMISSIONS 110

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	565		14	338,211.00		207,606.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	565		14	338,211.00		207,606.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	33		0	48,147.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	48,147.00		0.00
TOTAL ACCOMODATIONS	598		14	386,358.00		207,606.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	379,472.10	0.00	OTHER LAB	9,504.78	0.00
MED/SURG SUPPLY	90,482.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	258,725.46	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,092.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	83,853.00	1,361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,784.08	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	17,802.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,131.68	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	102,770.16	3,411.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	137,005.94	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,401.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	92,611.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,488.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,765.19	0.00	INJECTABLE DRUGS	2,572.09	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	865.74	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,553.66	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	104.43	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	296,823.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,935.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,531.32	12,218.07			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	461.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	27,129.42	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,182.00	0.00			
			TOTAL ANCILLARY	1,645,585.61	17,451.57
			TOTAL ACCOMODATIONS	386,358.00	207,606.00
			TOTAL CHARGES	2,031,943.61	225,057.57

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

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

Run Date: 08/12/2016  
Run Time: 02:57:37  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000151A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



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

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

Run Date: 08/12/2016  
Run Time: 02:57:37  
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RESTORATION HEALTHCARE OF COMMERCE, LLC  
70 MEDICAL CENTER DR  
COMMERCE,GA 30529-1078

PROVIDER NUMBER  
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,975,009.31	ADJUSTMENTS	30,469.65
COVERED CHARGES	1,756,011.70	CONTRACTUAL ALLOW	1,421,451.63
NON-COVERD CHARGES	218,997.61	TOTAL MEDICAID LIAB	334,560.07
		LESS: COB	0.00
		LESS: COPAYMENT	1,695.00
		REIMBURSEMENT	332,865.07
		ALL OTHER	292,800.72
		FEE SCHEDULE-LAB	37,016.66
		INJECTABLE DRUGS	3,047.69

TOTAL NUMBER OF CLAIMS 1,501

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,129.21	20,617.51	OTHER LAB	19,587.89	0.00
MED/SURG SUPPLY	47,296.00	3,332.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	112,133.55	5,246.61	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	220,264.00	22,887.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,455.09	276.00	FEE SCHEDULE LAB	361,247.77	45,523.51
EKG/ECG	32,250.00	0.00	MRI SERVICES	88,076.00	0.00
IV THERAPY	106,990.65	737.58	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	107,456.28	19,094.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,797.59	4,244.87	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,130.00	539.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	432,029.22	900.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,896.00	11,878.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55,293.12	24,172.72
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	328.29	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,393.03	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	43,517.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,254.88	2,964.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	596.70	718.71			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,553.29	461.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,308.96	8,256.78			
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	29,265.50	910.00			
			TOTAL ANCILLARY	1,756,011.70	218,997.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,756,011.70	218,997.61

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

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

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,774.28	ADJUSTMENTS	0.00
COVERED CHARGES	4,702.30	CONTRACTUAL ALLOW	4,700.63
NON-COVERD CHARGES	71.98	TOTAL MEDICAID LIAB	1.67
		LESS: COB	0.00
		LESS: COPAYMENT	1.67
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

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

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

PROVIDER NUMBER  
 000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34.20	48.98	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	183.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	161.00	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	672.00	23.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	397.86	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	46.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,722.42	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	123.97	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,702.30	71.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,702.30	71.98

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: 08/12/2016  
Run Time: 02:57:46  
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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	206,637.06	ADJUSTMENTS	803.10
COVERED CHARGES	201,256.80	CONTRACTUAL ALLOW	184,139.16
NON-COVERD CHARGES	5,380.26	TOTAL MEDICAID LIAB	17,117.64
		LESS: COB	0.00
		LESS: COPAYMENT	622.25
		REIMBURSEMENT	16,495.39
		TOTAL NUMBER OF CLAIMS	306

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,603.86	265.34	OTHER LAB	2,133.00	0.00
MED/SURG SUPPLY	1,015.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,364.00	340.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,443.00	1,361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,100.82	2,034.58
EKG/ECG	774.00	0.00	MRI SERVICES	4,679.00	0.00
IV THERAPY	12,910.98	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,648.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	135,984.99	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,946.15	1,379.34
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	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	0.00	0.00			
			TOTAL ANCILLARY	201,256.80	5,380.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	201,256.80	5,380.26

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: 08/12/2016  
Run Time: 02:57:47  
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RESTORATION HEALTHCARE OF COMMERCE, LLC  
70 MEDICAL CENTER DR  
COMMERCE,GA 30529-1078

PROVIDER NUMBER  
000000151A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

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

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

PROVIDER NUMBER  
000000151A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



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

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

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000151A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	230,549.58	ADJUSTMENTS	20,121.57
COVERED CHARGES	205,337.58	CONTRACTUAL ALLOW	122,599.15
NON-COVERD CHARGES	25,212.00	TOTAL MEDICAID LIAB	82,738.43
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	82,738.43

TOTAL NUMBER OF ADMISSIONS 12

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	88		0	35,200.00		25,212.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	88		0	35,200.00		25,212.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,612.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	1,612.00		0.00
TOTAL ACCOMODATIONS	89		0	36,812.00		25,212.00

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,568.33	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,952.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,860.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,039.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,543.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,962.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,472.25	0.00	MRI SERVICES	1,755.50	0.00
IV THERAPY	319.50	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	2,752.50	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	8,916.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,627.25	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,395.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	361.00	0.00			
			TOTAL ANCILLARY	168,525.58	0.00
			TOTAL ACCOMODATIONS	36,812.00	25,212.00
			TOTAL CHARGES	205,337.58	25,212.00

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	881,032.89	ADJUSTMENTS	37,499.13
COVERED CHARGES	743,270.47	CONTRACTUAL ALLOW	548,546.47
NON-COVERD CHARGES	137,762.42	TOTAL MEDICAID LIAB	194,724.00
		LESS: COB	36.05
		LESS: COPAYMENT	888.00
		REIMBURSEMENT	193,799.95
		ALL OTHER	164,089.58
		FEE SCHEDULE-LAB	29,366.76
		INJECTABLE DRUGS	343.61

TOTAL NUMBER OF CLAIMS 958

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

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

Run Date: 08/12/2016  
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HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
 1221 E MCPHERSON AVE  
 NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,110.14	0.00	OTHER LAB	9,446.75	0.00
MED/SURG SUPPLY	18,935.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	79,071.75	310.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	85,617.75	71,795.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	154,534.08	33,005.42
EKG/ECG	12,156.25	1,472.25	MRI SERVICES	9,639.25	5,759.25
IV THERAPY	12,639.00	0.00	PROFESSIONAL FEES	0.00	172.75
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,989.25	7.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	167,922.75	1,035.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,354.50	20,114.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	378.00	211.50	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	413.75	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	21,965.00	1,950.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,749.25	1,249.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	98,921.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,840.75	264.75			
			TOTAL ANCILLARY	743,270.47	137,762.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	743,270.47	137,762.42

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: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,276.75	ADJUSTMENTS	0.00
COVERED CHARGES	8,773.50	CONTRACTUAL ALLOW	3,834.30
NON-COVERD CHARGES	2,503.25	TOTAL MEDICAID LIAB	4,939.20
		LESS: COB	4,933.20
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,325.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	239.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	216.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,123.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	155.00	32.25
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	88.25	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	151.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	474.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	2,471.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,773.50	2,503.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,773.50	2,503.25



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

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

Run Date: 08/12/2016  
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HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	91,010.66	ADJUSTMENTS	1,070.80
COVERED CHARGES	82,733.66	CONTRACTUAL ALLOW	71,579.44
NON-COVERD CHARGES	8,277.00	TOTAL MEDICAID LIAB	11,154.22
		LESS: COB	78.10
		LESS: COPAYMENT	432.00
		REIMBURSEMENT	10,644.12
		TOTAL NUMBER OF CLAIMS	198

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,537.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,827.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,948.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,267.50	1,316.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,737.75	2,596.75
EKG/ECG	818.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,280.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	377.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	873.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,967.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,098.00	3,826.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	537.75			
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	82,733.66	8,277.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	82,733.66	8,277.00

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

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

Run Date: 08/12/2016  
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HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
1221 E MCPHERSON AVE  
NASHVILLE,GA 31639-2326

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,365.30	ADJUSTMENTS	0.00
COVERED CHARGES	918.80	CONTRACTUAL ALLOW	686.45
NON-COVERD CHARGES	446.50	TOTAL MEDICAID LIAB	232.35
		LESS: COB	229.35
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	83.50	83.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75.50	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	651.50	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	363.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	918.80	446.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	918.80	446.50

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000173A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000173A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 01:28:09  
 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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	109,823.05	ADJUSTMENTS	0.00
COVERED CHARGES	105,427.45	CONTRACTUAL ALLOW	13,980.31
NON-COVERD CHARGES	4,395.60	TOTAL MEDICAID LIAB	91,447.14
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	91,447.14
TOTAL NUMBER OF ADMISSIONS			16

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	45		0	21,825.00		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	45		0	21,825.00		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	45		0	21,825.00		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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,064.51	0.00	OTHER LAB	440.00	0.00
MED/SURG SUPPLY	5,227.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,396.63	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,484.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,440.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	244.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,660.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,488.50	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	7,557.50	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	16,387.20	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	314.60	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,845.25	954.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,561.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	930.60	0.00			
			TOTAL ANCILLARY	83,602.45	4,395.60
			TOTAL ACCOMODATIONS	21,825.00	0.00
			TOTAL CHARGES	105,427.45	4,395.60



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

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

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	573,892.00	ADJUSTMENTS	18,851.83
COVERED CHARGES	505,217.42	CONTRACTUAL ALLOW	197,051.31
NON-COVERD CHARGES	68,674.58	TOTAL MEDICAID LIAB	308,166.11
		LESS: COB	2,408.62
		LESS: COPAYMENT	987.00
		REIMBURSEMENT	304,770.49
		ALL OTHER	270,584.49
		FEE SCHEDULE-LAB	25,378.07
		INJECTABLE DRUGS	8,807.93

TOTAL NUMBER OF CLAIMS 733

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

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

Run Date: 08/12/2016  
 Run Time: 01:28:12  
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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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,127.73	0.00	OTHER LAB	3,540.02	0.00
MED/SURG SUPPLY	14,866.14	23.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,193.25	7,411.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,386.60	10,322.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	489.52	FEE SCHEDULE LAB	167,474.79	35,055.66
EKG/ECG	10,622.10	1,740.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,224.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,399.45	1,370.90	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	112,695.19	673.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,178.50	6,044.80
RADIOLOGY THERAPEUTIC	84.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	120.75	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	475.20
OTHER IMAGING SERVICE	5,840.65	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,945.25	3,385.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	780.85	1,561.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,080.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,778.90	0.00			
			TOTAL ANCILLARY	505,217.42	68,674.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	505,217.42	68,674.58

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

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

Run Date: 08/12/2016  
Run Time: 01:28:12  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
76	2014339069422	11/26/14 - 11/26/14	12/15/14	0.00	475.20	0.00	0.00	0.00
TOTAL				0.00	475.20	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
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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	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 01:28:32  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,711.64	ADJUSTMENTS	94.00
COVERED CHARGES	40,534.19	CONTRACTUAL ALLOW	34,784.19
NON-COVERD CHARGES	2,177.45	TOTAL MEDICAID LIAB	5,750.00
		LESS: COB	0.00
		LESS: COPAYMENT	234.00
		REIMBURSEMENT	5,516.00
		TOTAL NUMBER OF CLAIMS	115

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	772.20	35.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	370.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,299.50	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	11,890.34	2,072.45
EKG/ECG	875.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	138.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,027.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,161.25	70.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	40,534.19	2,177.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,534.19	2,177.45





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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 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	110.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	110.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	110.00	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

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	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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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	04/01/14	THROUGH	03/31/15
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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	137,054.00	ADJUSTMENTS	5,812.18
COVERED CHARGES	134,840.00	CONTRACTUAL ALLOW	70,694.99
NON-COVERD CHARGES	2,214.00	TOTAL MEDICAID LIAB	64,145.01
		LESS: COB	482.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	63,662.66

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	37		0	20,919.00		1,362.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	37		0	20,919.00		1,362.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	37		0	20,919.00		1,362.00

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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,718.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,354.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	35,781.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,805.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,648.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,743.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,555.00	0.00	MRI SERVICES	6,892.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,892.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,081.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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.	3,444.00	852.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	113,921.00	852.00
			TOTAL ACCOMODATIONS	20,919.00	1,362.00
			TOTAL CHARGES	134,840.00	2,214.00

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

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

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,516,631.70	ADJUSTMENTS	24,365.35
COVERED CHARGES	1,388,731.96	CONTRACTUAL ALLOW	994,107.96
NON-COVERD CHARGES	127,899.74	TOTAL MEDICAID LIAB	394,624.00
		LESS: COB	77.66
		LESS: COPAYMENT	2,174.97
		REIMBURSEMENT	392,371.37
		ALL OTHER	329,454.37
		FEE SCHEDULE-LAB	59,054.46
		INJECTABLE DRUGS	3,862.54
		TOTAL NUMBER OF CLAIMS	1,626

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,386.80	0.00	OTHER LAB	4,438.00	0.00
MED/SURG SUPPLY	14,643.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	120,545.00	762.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	247,801.00	27,234.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,566.00	24,327.02	FEE SCHEDULE LAB	442,035.16	48,189.72
EKG/ECG	11,451.00	378.00	MRI SERVICES	6,526.00	0.00
IV THERAPY	47,494.00	722.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,034.00	2,044.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	165,897.00	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	29,836.00	4,147.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,188.00	16,293.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,450.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	53.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	442.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,129.00	1,494.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	402.00	2,106.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	17,250.00	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	1,218.00	0.00			
			TOTAL ANCILLARY	1,388,731.96	127,899.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,388,731.96	127,899.74



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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,926.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,117.00	CONTRACTUAL ALLOW	-4,269.59
NON-COVERD CHARGES	7,809.00	TOTAL MEDICAID LIAB	9,386.59
		LESS: COB	9,374.59
		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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	63.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	636.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,137.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,819.00	488.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	92.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,136.00	184.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	356.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,117.00	7,809.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,117.00	7,809.00

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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,302.00	ADJUSTMENTS	282.00
COVERED CHARGES	59,324.00	CONTRACTUAL ALLOW	53,974.00
NON-COVERD CHARGES	3,978.00	TOTAL MEDICAID LIAB	5,350.00
		LESS: COB	0.00
		LESS: COPAYMENT	159.00
		REIMBURSEMENT	5,191.00
		TOTAL NUMBER OF CLAIMS	107

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	709.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,766.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,903.00	3,000.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,579.00	968.00
EKG/ECG	756.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,240.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	716.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,607.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,953.00	10.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	59,324.00	3,978.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,324.00	3,978.00

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

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

Run Date: 08/12/2016  
Run Time: 01:29:02  
Page: 10

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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 01:29:02  
Page: 11

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,129.00	ADJUSTMENTS	0.00
COVERED CHARGES	165,742.00	CONTRACTUAL ALLOW	137,209.54
NON-COVERD CHARGES	1,387.00	TOTAL MEDICAID LIAB	28,532.46
		LESS: COB	0.00
		LESS: COPAYMENT	384.00
		REIMBURSEMENT	28,148.46

TOTAL NUMBER OF CLAIMS 6

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,153.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,896.00	1,387.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,693.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	165,742.00	1,387.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	165,742.00	1,387.00

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

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

Run Date: 08/12/2016  
Run Time: 01:29:02  
Page: 13

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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000272A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,105,008.66	ADJUSTMENTS	1,200,839.51
COVERED CHARGES	28,899,755.10	CONTRACTUAL ALLOW	23,277,443.84
NON-COVERD CHARGES	205,253.56	TOTAL MEDICAID LIAB	5,622,311.26
		LESS: COB	89,186.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,533,124.41

TOTAL NUMBER OF ADMISSIONS 747

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,325		2	684,765.00		48,722.77
ROUTINE NURSERY	241		0	117,736.88		2,598.99
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.04
TOTAL ROUTINE	1,566		2	802,501.88		51,321.80
SPECIAL CARE SERVICES						
CCU	281		0	309,184.77		0.00
ICU	1,309		0	1,241,426.69		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,590		0	1,550,611.46		0.00
TOTAL ACCOMODATIONS	3,156		2	2,353,113.34		51,321.80

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,661,827.30	0.00	OTHER LAB	92,053.12	0.00
MED/SURG SUPPLY	4,926,092.24	6,345.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,962,668.31	0.00	EDUCATION & TRAINING	18,284.32	0.00
RADIOLOGY-DIAGNOSTIC	545,937.17	22,202.58	OTHER THERAPEUTIC SVC	0.00	9,690.16
CT SCAN	1,553,805.95	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	234,118.69	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	104,170.10	0.00	MRI SERVICES	341,297.63	0.00
IV THERAPY	11,728.03	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,858,878.95	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	382,485.86	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,758,973.42	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	593,928.28	0.00	AMBULANCE	0.00	0.00
GI SERVICES	289,078.58	739.35	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,784,622.81	0.00	SPECIAL SERVICES	0.00	855.00
RECOVERY ROOM	83,881.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	151,731.19	0.00	INJECTABLE DRUGS	304,652.56	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,204.05	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	14,239.99	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	33,320.37	6,036.30	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,087.32	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,092,987.97	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	59,536.31
OTHER IMAGING SERVICE	109,981.22	1,099.12			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	160,217.34	33,083.65			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	79,744.94	14,344.26			
AUDIOLOGY	3,945.61	0.00			
CARDIOLOGY	1,277,934.02	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	65,321.85	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,441.27	0.00			
			TOTAL ANCILLARY	26,546,641.76	153,931.76
			TOTAL ACCOMODATIONS	2,353,113.34	51,321.80
			TOTAL CHARGES	28,899,755.10	205,253.56

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014308037608	10/24/14 - 10/25/14	11/10/14	0.00	2,872.71	0.00	0.00	0.00
615	2014343042047	11/28/14 - 12/01/14	12/15/14	0.00	2,872.71	0.00	0.00	0.00
615	2015023061797	01/15/15 - 01/16/15	01/26/15	0.00	2,872.71	0.00	0.00	0.00
615	2015104045462	03/23/15 - 04/02/15	04/20/15	0.00	6,410.73	0.00	0.00	0.00
615	2015106052359	04/04/15 - 04/05/15	04/20/15	0.00	2,872.71	0.00	0.00	0.00
615	2015114063129	03/27/15 - 04/04/15	04/27/15	0.00	2,872.71	0.00	0.00	0.00
615	2015121051247	04/16/15 - 04/22/15	05/04/15	0.00	3,538.02	0.00	0.00	0.00
615	2015134047562	04/25/15 - 04/28/15	05/18/15	0.00	6,410.73	0.00	0.00	0.00
615	2015142070488	05/15/15 - 05/16/15	05/25/15	0.00	2,872.71	0.00	0.00	0.00
615	4915162001277	03/31/15 - 04/03/15	06/15/15	0.00	2,872.71	0.00	0.00	0.00
615	2315192000013	12/23/14 - 12/28/14	08/10/15	0.00	2,872.71	0.00	1,849.30	0.00
615	2315282000221	01/27/15 - 02/02/15	11/02/15	0.00	2,872.71	0.00	1,543.31	0.00
615	5215362006520	07/28/15 - 08/07/15	02/22/16	0.00	5,745.42	0.00	0.00	0.00
615	5215362007816	07/28/15 - 08/09/15	02/22/16	0.00	2,872.71	0.00	0.00	0.00
615	5215362010200	08/18/15 - 08/21/15	02/22/16	0.00	2,872.71	0.00	0.00	0.00
615	5916026000474	09/27/15 - 10/12/15	02/01/16	0.00	2,958.89	0.00	0.00	0.00
615	2316057000065	03/28/15 - 04/07/15	03/28/16	0.00	2,872.71	0.00	2,279.09	0.00
TOTAL				0.00	59,536.31	0.00	5,671.70	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	409,746.18	ADJUSTMENTS	0.00
COVERED CHARGES	408,583.83	CONTRACTUAL ALLOW	269,183.49
NON-COVERD CHARGES	1,162.35	TOTAL MEDICAID LIAB	139,400.34
		LESS: COB	139,400.34
		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	4,729.00		234.23
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9		0	4,729.00		234.23
SPECIAL CARE SERVICES						
CCU	8		0	8,779.92		0.00
ICU	10		0	8,157.40		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	18		0	16,937.32		0.00
TOTAL ACCOMODATIONS	27		0	21,666.32		234.23

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,453.17	0.00	OTHER LAB	1,149.58	0.00
MED/SURG SUPPLY	82,343.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,200.09	0.00	EDUCATION & TRAINING	128.88	0.00
RADIOLOGY-DIAGNOSTIC	2,578.70	928.12	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,518.33	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	828.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	93,453.61	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,675.27	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,237.23	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,763.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,133.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,376.05	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	43,150.79	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	878.18	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	51,048.90	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	386,917.51	928.12
			TOTAL ACCOMODATIONS	21,666.32	234.23
			TOTAL CHARGES	408,583.83	1,162.35

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

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

Run Date: 08/12/2016  
Run Time: 02:01:33  
Page: 6

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

PROVIDER NUMBER  
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,411,072.45	ADJUSTMENTS	499,970.17
COVERED CHARGES	25,739,048.67	CONTRACTUAL ALLOW	23,540,213.67
NON-COVERD CHARGES	3,672,023.78	TOTAL MEDICAID LIAB	2,198,835.00
		LESS: COB	1,835.14
		LESS: COPAYMENT	6,456.42
		REIMBURSEMENT	2,190,543.44
		ALL OTHER	1,997,676.30
		FEE SCHEDULE-LAB	173,127.11
		INJECTABLE DRUGS	19,740.03
		TOTAL NUMBER OF CLAIMS	5,212

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
 000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,860.46	181,565.92	OTHER LAB	673,669.50	27,310.52
MED/SURG SUPPLY	3,577,567.44	29,170.52	RECREATIONAL THERAPY	456.99	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	292.89	128.88
RADIOLOGY-DIAGNOSTIC	992,039.30	93,907.04	OTHER THERAPEUTIC SVC	0.00	95,593.57
CT SCAN	2,471,245.06	271,894.87	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	433.80	8,420.32	FEE SCHEDULE LAB	3,190,159.65	433,179.44
EKG/ECG	105,383.35	9,521.18	MRI SERVICES	676,389.23	63,489.80
IV THERAPY	48,049.76	5,029.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,064,997.55	410,396.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	349,608.07	117,630.43	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	862,692.23	22,634.83	AMBULANCE	0.00	0.00
GI SERVICES	462,532.04	82,668.24	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,658,809.17	158,629.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	322,811.81	1,940.77	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	598,018.14	418,112.42
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	616.67	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	464.07	5,223.81	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,741.52	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	6,046.14	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	41,456.94	423,216.12
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	297.99
OTHER IMAGING SERVICE	539,261.41	98,847.89			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,980.99	3,933.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	128,516.21	37,141.39			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,358,346.24	646,039.69			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,373.06	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	497,633.31	16,695.07			
			TOTAL ANCILLARY	25,739,048.67	3,672,023.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,739,048.67	3,672,023.78

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

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

Run Date: 08/12/2016  
Run Time: 02:01:33  
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EAST GA REGIONAL MEDICAL CTR., LLC  
1499 FAIR RD  
STATESBORO,GA 30458-1683

PROVIDER NUMBER  
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
45	2215265003765	09/02/15 - 09/02/15	09/28/15	0.00	297.99	0.00	0.00	0.00
TOTAL				0.00	297.99	0.00	0.00	0.00



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

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

Run Date: 08/12/2016  
Run Time: 02:02:18  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	698,644.79	ADJUSTMENTS	0.00
COVERED CHARGES	565,196.83	CONTRACTUAL ALLOW	290,475.08
NON-COVERD CHARGES	133,447.96	TOTAL MEDICAID LIAB	274,721.75
		LESS: COB	274,638.58
		LESS: COPAYMENT	83.17
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 122

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	765.19	6,002.84	OTHER LAB	17,884.34	1,055.66
MED/SURG SUPPLY	128,479.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,776.67	3,118.65	OTHER THERAPEUTIC SVC	0.00	2,840.06
CT SCAN	22,366.13	29,624.71	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	78,259.98	4,216.92
EKG/ECG	833.12	496.89	MRI SERVICES	7,517.31	14,366.08
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,551.06	25,834.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	813.20	7,689.42	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	33,653.14	1,740.96	AMBULANCE	0.00	0.00
GI SERVICES	1,924.70	9,513.99	CAST ROOM	0.00	0.00
EMERGENCY ROOM	142,954.02	2,237.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,405.97	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,848.19	4,715.80
RADIOLOGY THERAPEUTIC	0.00	202.44	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	412.52	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	913.85	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	107.19	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	422.28	445.78
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,163.43	15,811.26			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,773.72			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,545.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,032.86	327.61			
			TOTAL ANCILLARY	565,196.83	133,447.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	565,196.83	133,447.96

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

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

Run Date: 08/12/2016  
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EAST GA REGIONAL MEDICAL CTR., LLC  
1499 FAIR RD  
STATESBORO,GA 30458-1683

PROVIDER NUMBER  
000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,059,855.82	ADJUSTMENTS	1,662.14
COVERED CHARGES	1,945,543.23	CONTRACTUAL ALLOW	1,904,315.45
NON-COVERD CHARGES	114,312.59	TOTAL MEDICAID LIAB	41,227.78
		LESS: COB	21.09
		LESS: COPAYMENT	1,366.54
		REIMBURSEMENT	39,840.15
		TOTAL NUMBER OF CLAIMS	737

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

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

Run Date: 08/12/2016  
 Run Time: 02:02:20  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	731.45	19,931.18	OTHER LAB	23,913.51	2,111.32
MED/SURG SUPPLY	61,648.20	153.58	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	88,336.32	0.00	OTHER THERAPEUTIC SVC	0.00	971.10
CT SCAN	79,988.84	30,522.64	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	233,259.23	17,276.15
EKG/ECG	7,633.89	0.00	MRI SERVICES	7,206.71	0.00
IV THERAPY	63.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,716.80	5,310.20	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	1,368,960.38	12,158.52	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	29,811.27	21,769.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,964.26	3,428.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,518.56	679.77			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,790.01	0.00			
			TOTAL ANCILLARY	1,945,543.23	114,312.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,945,543.23	114,312.59

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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,071.95	ADJUSTMENTS	0.00
COVERED CHARGES	68,435.21	CONTRACTUAL ALLOW	38,235.33
NON-COVERD CHARGES	8,636.74	TOTAL MEDICAID LIAB	30,199.88
		LESS: COB	30,175.88
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	20

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

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

Run Date: 08/12/2016  
 Run Time: 02:02:26  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	404.24	OTHER LAB	2,686.09	0.00
MED/SURG SUPPLY	2,961.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	922.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,986.22	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,241.68	1,666.39
EKG/ECG	336.23	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,431.97	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,362.24	506.92
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,492.68	2,072.97			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	68,435.21	8,636.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	68,435.21	8,636.74

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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,129,896.35	ADJUSTMENTS	21,859.03
COVERED CHARGES	2,055,364.31	CONTRACTUAL ALLOW	1,945,958.91
NON-COVERD CHARGES	74,532.04	TOTAL MEDICAID LIAB	109,405.40
		LESS: COB	0.00
		LESS: COPAYMENT	88.05
		REIMBURSEMENT	109,317.35

TOTAL NUMBER OF CLAIMS 20

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.79	9,130.01	OTHER LAB	2,111.32	0.00
MED/SURG SUPPLY	424,559.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,304.70	0.00	OTHER THERAPEUTIC SVC	0.00	304.66
CT SCAN	9,813.95	10,244.54	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,654.80	5,476.15
EKG/ECG	496.89	865.80	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	439.51	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	960,437.92	7,795.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	74,715.04	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,395.50	318.01	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,677.76	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	77,951.09	9,572.97
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	241.72	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	415,305.44	22,671.79
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,825.80	2,593.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,780.11	839.19			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,118.51	153.19			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,771.40	3,885.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,418.51	0.00			
			TOTAL ANCILLARY	2,055,364.31	74,532.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,055,364.31	74,532.04



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

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

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000272A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 01:29:09  
 Page: 1

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 06/01/14 THROUGH 05/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	339,297.42	ADJUSTMENTS	0.00
COVERED CHARGES	312,490.42	CONTRACTUAL ALLOW	158,643.88
NON-COVERD CHARGES	26,807.00	TOTAL MEDICAID LIAB	153,846.54
		LESS: COB	2,766.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	151,080.23
		TOTAL NUMBER OF ADMISSIONS	30

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	102		0	32,640.00		23,552.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	102		0	32,640.00		23,552.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	102		0	32,640.00		23,552.00

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

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

Run Date: 08/12/2016  
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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 06/01/14 THROUGH 05/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,066.93	0.00	OTHER LAB	956.50	0.00
MED/SURG SUPPLY	36,061.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	57,301.00	0.00	EDUCATION & TRAINING	201.00	0.00
RADIOLOGY-DIAGNOSTIC	7,544.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,459.02	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,498.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,841.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,431.25	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	40,132.25	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	26,359.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,377.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	921.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,181.75	3,255.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,206.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,310.00	0.00			
			TOTAL ANCILLARY	279,850.42	3,255.00
			TOTAL ACCOMODATIONS	32,640.00	23,552.00
			TOTAL CHARGES	312,490.42	26,807.00

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

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

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/14 THROUGH 05/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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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 06/01/14 THROUGH 05/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,034,866.85	ADJUSTMENTS	52,309.62
COVERED CHARGES	941,457.93	CONTRACTUAL ALLOW	574,160.84
NON-COVERD CHARGES	93,408.92	TOTAL MEDICAID LIAB	367,297.09
		LESS: COB	1,132.66
		LESS: COPAYMENT	813.00
		REIMBURSEMENT	365,351.43
		ALL OTHER	343,721.75
		FEE SCHEDULE-LAB	21,414.57
		INJECTABLE DRUGS	215.11

TOTAL NUMBER OF CLAIMS 958

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 06/01/14 THROUGH 05/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,620.50	2,119.00	OTHER LAB	3,006.50	0.00
MED/SURG SUPPLY	35,459.67	109.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	603.00
RADIOLOGY-DIAGNOSTIC	53,147.75	2,053.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	63,241.77	3,027.43	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	127,581.49	37,636.00
EKG/ECG	8,476.00	320.00	MRI SERVICES	19,897.65	0.00
IV THERAPY	47,544.00	7,000.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,273.00	3,438.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,323.59	10,547.33	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,731.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	18,794.25	3,088.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	370,107.25	11,986.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,211.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,199.50	3,502.50
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	264.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,841.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,326.51
OTHER IMAGING SERVICE	52,718.25	1,329.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,752.00	1,302.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,413.00	1,206.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,175.06	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,942.25	2,550.00			
			TOTAL ANCILLARY	941,457.93	93,408.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	941,457.93	93,408.92

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: 08/12/2016  
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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 06/01/14 THROUGH 05/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015047026555	02/09/15 - 02/09/15	02/23/15	0.00	1,326.51	0.00	0.00	0.00
TOTAL				0.00	1,326.51	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

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 06/01/14 THROUGH 05/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,063.65	ADJUSTMENTS	0.00
COVERED CHARGES	2,175.65	CONTRACTUAL ALLOW	1,159.28
NON-COVERD CHARGES	888.00	TOTAL MEDICAID LIAB	1,016.37
		LESS: COB	1,016.37
		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

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 06/01/14 THROUGH 05/31/15  
 ADMISSION DATES 00/00/00 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	20.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	438.75	352.75
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	163.50	105.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,537.50	430.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,175.65	888.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,175.65	888.00

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

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

Run Date: 08/12/2016  
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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 06/01/14 THROUGH 05/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	110,363.84	ADJUSTMENTS	0.00
COVERED CHARGES	105,693.33	CONTRACTUAL ALLOW	96,519.17
NON-COVERD CHARGES	4,670.51	TOTAL MEDICAID LIAB	9,174.16
		LESS: COB	0.00
		LESS: COPAYMENT	318.00
		REIMBURSEMENT	8,856.16
		TOTAL NUMBER OF CLAIMS	164

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 06/01/14 THROUGH 05/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,380.00	85.00	OTHER LAB	296.50	0.00
MED/SURG SUPPLY	1,778.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,048.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,608.93	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,251.75	3,224.00
EKG/ECG	320.00	0.00	MRI SERVICES	0.00	1,326.51
IV THERAPY	4,112.50	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	286.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	79,211.75	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	760.00	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	460.50	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	178.75	0.00			
			TOTAL ANCILLARY	105,693.33	4,670.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	105,693.33	4,670.51

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

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 06/01/14 THROUGH 05/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,006.45	ADJUSTMENTS	0.00
COVERED CHARGES	1,653.70	CONTRACTUAL ALLOW	897.86
NON-COVERD CHARGES	352.75	TOTAL MEDICAID LIAB	755.84
		LESS: COB	755.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/14 THROUGH 05/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10.70	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	417.00	352.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,086.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,653.70	352.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,653.70	352.75

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

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

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	06/01/14	THROUGH	05/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000283A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	06/01/14	THROUGH	05/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000294A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	80,938,965.95	ADJUSTMENTS	1,404,163.68
COVERED CHARGES	73,591,712.95	CONTRACTUAL ALLOW	51,416,838.92
NON-COVERD CHARGES	7,347,253.00	TOTAL MEDICAID LIAB	22,174,874.03
		LESS: COB	301,979.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	21,872,894.80

TOTAL NUMBER OF ADMISSIONS 3,232

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	8,158	6	8,356,108.00	6,776,319.00
ROUTINE NURSERY	2,512	6	3,531,129.00	29,268.00
SWING BED	0	1	0.00	3,785.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10,670	13	11,887,237.00	6,809,372.00
SPECIAL CARE SERVICES				
CCU	113	0	438,720.00	0.00
ICU	1,986	0	6,356,212.00	0.00
NICU	1,580	0	5,494,728.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	3,679	0	12,289,660.00	0.00
TOTAL ACCOMODATIONS	14,349	13	24,176,897.00	6,809,372.00



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,938,800.80	1,211.00	OTHER LAB	609,932.00	35,654.00
MED/SURG SUPPLY	420,623.00	35,087.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,122,200.00	2,488.00	EDUCATION & TRAINING	11,915.00	0.00
RADIOLOGY-DIAGNOSTIC	2,021,034.50	870.00	OTHER THERAPEUTIC SVC	0.00	20,557.00
CT SCAN	3,761,693.00	132,129.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	327,474.21	256.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	651,059.00	0.00	MRI SERVICES	670,667.00	0.00
IV THERAPY	578,492.00	0.00	PROFESSIONAL FEES	0.00	43.00
OPERATING ROOM	7,796,979.00	26,662.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	491,520.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,886,160.00	5,529.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,279,635.00	2,703.00	AMBULANCE	0.00	0.00
GI SERVICES	305,938.00	2,062.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,633,736.00	2,103.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,111,385.00	2,886.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	484,607.00	607.00	INJECTABLE DRUGS	4,416,674.47	14,763.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	141,424.07	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	106,140.40	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	938,434.00	53,380.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,006.00	178.00	TRAUMA RESPONSE	0.00	81,738.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,517,251.00	754.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	114,849.00
OTHER IMAGING SERVICE	431,059.00	447.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	525,866.00	363.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	493,767.00	0.00			
AUDIOLOGY	36,120.00	0.00			
CARDIOLOGY	2,301,107.50	80.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	139,496.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	261,620.00	482.00			
			TOTAL ANCILLARY	49,414,815.95	537,881.00
			TOTAL ACCOMODATIONS	24,176,897.00	6,809,372.00
			TOTAL CHARGES	73,591,712.95	7,347,253.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2314301000037	09/10/14 - 09/12/14	11/03/14	0.00	4,348.00	0.00	0.00	0.00
615	2014303004383	09/22/14 - 09/24/14	11/03/14	0.00	4,348.00	0.00	0.00	0.00
615	2214321001820	08/18/14 - 09/01/14	11/24/14	0.00	4,348.00	0.00	0.00	0.00
615	9114350003080	08/30/14 - 09/01/14	01/12/15	0.00	2,363.00	0.00	856.16	0.00
615	2015014000093	12/21/14 - 01/06/15	01/19/15	0.00	2,363.00	0.00	0.00	0.00
615	1115036000151	01/21/15 - 01/26/15	03/09/15	0.00	4,726.00	0.00	0.00	0.00
615	2015048081036	02/07/15 - 02/08/15	02/23/15	0.00	2,363.00	0.00	0.00	0.00
615	2315065000146	09/11/14 - 09/18/14	03/23/15	0.00	4,348.00	0.00	0.00	0.00
615	2015068035393	02/20/15 - 02/21/15	03/16/15	0.00	4,348.00	0.00	0.00	0.00
948	2215075000540	02/12/15 - 02/13/15	03/23/15	0.00	384.00	0.00	0.00	0.00
615	2215082007808	02/27/15 - 03/09/15	03/30/15	0.00	2,363.00	0.00	0.00	0.00
615	2015092080364	03/19/15 - 03/26/15	04/06/15	0.00	4,348.00	0.00	0.00	0.00
615	2015099084569	02/10/15 - 02/13/15	04/13/15	0.00	2,363.00	0.00	0.00	0.00
615	2215112007434	01/09/15 - 01/27/15	04/27/15	0.00	4,348.00	0.00	0.00	0.00
615	9115112000076	12/21/14 - 12/25/14	05/04/15	0.00	4,348.00	0.00	1,490.67	0.00
615	2015128077772	04/29/15 - 05/01/15	05/18/15	0.00	2,363.00	0.00	0.00	0.00
615	2315149000061	11/20/14 - 11/28/14	06/22/15	0.00	4,348.00	0.00	2,105.74	0.00
615	2315161000011	02/27/15 - 03/03/15	06/29/15	0.00	4,348.00	0.00	0.00	0.00
615	9715181957022	11/27/14 - 12/05/14	07/06/15	0.00	4,726.00	0.00	2,152.03	0.00
615	2015181058978	06/18/15 - 06/23/15	07/06/15	0.00	2,363.00	0.00	0.00	0.00
615	2015195012344	01/27/15 - 02/02/15	07/20/15	0.00	2,363.00	0.00	0.00	0.00
615	2315196000073	02/26/15 - 03/05/15	08/17/15	0.00	2,363.00	0.00	990.23	0.00
615	2215201001887	04/17/15 - 04/24/15	07/27/15	0.00	4,348.00	0.00	0.00	0.00
615	2015208029170	06/23/15 - 07/03/15	08/03/15	0.00	2,363.00	0.00	0.00	0.00
615	2315243000170	02/07/15 - 02/10/15	10/05/15	0.00	4,348.00	0.00	1,751.50	0.00
615	2015245078478	05/19/15 - 05/28/15	09/07/15	0.00	4,726.00	0.00	0.00	0.00
615	2215267000986	02/21/15 - 04/03/15	09/28/15	0.00	4,348.00	0.00	0.00	0.00
615	2315295000012	05/27/15 - 05/31/15	11/09/15	0.00	2,363.00	0.00	1,156.52	0.00
615	2315356000134	06/11/15 - 07/24/15	01/25/16	0.00	4,348.00	0.00	0.00	0.00
615	2216077003631	11/18/14 - 02/23/16	03/21/16	0.00	4,348.00	0.00	0.00	0.00
615	2316147000075	03/25/15 - 04/02/15	07/04/16	0.00	2,363.00	0.00	5,301.51	0.00
615	2216188010465	05/19/15 - 01/15/16	07/11/16	0.00	2,363.00	0.00	0.00	0.00
615	2016205005467	05/25/15 - 06/08/15	08/01/16	0.00	4,348.00	0.00	0.00	0.00
TOTAL				0.00	114,849.00	0.00	15,804.36	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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	554,370.32	ADJUSTMENTS	0.00
COVERED CHARGES	521,524.32	CONTRACTUAL ALLOW	233,788.55
NON-COVERD CHARGES	32,846.00	TOTAL MEDICAID LIAB	287,735.77
		LESS: COB	287,735.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	57		0	58,938.00		30,777.00
ROUTINE NURSERY	27		0	62,935.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	84		0	121,873.00		30,777.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	3,785.00		0.00
NICU	18		0	62,460.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	66,245.00		0.00
TOTAL ACCOMODATIONS	103		0	188,118.00		30,777.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,551.00	0.00	OTHER LAB	3,670.00	0.00
MED/SURG SUPPLY	1,573.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,671.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,225.00	0.00	OTHER THERAPEUTIC SVC	0.00	121.00
CT SCAN	9,231.00	1,948.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	824.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	796.00	0.00	MRI SERVICES	3,600.00	0.00
IV THERAPY	793.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,587.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,772.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,620.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,792.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,144.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,676.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	10,928.00	0.00	INJECTABLE DRUGS	120,390.32	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	254.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	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	1,074.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,400.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,660.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,295.00	0.00			
AUDIOLOGY	344.00	0.00			
CARDIOLOGY	2,300.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,693.00	0.00			
			TOTAL ANCILLARY	333,406.32	2,069.00
			TOTAL ACCOMODATIONS	188,118.00	30,777.00
			TOTAL CHARGES	521,524.32	32,846.00

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

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

Run Date: 08/12/2016  
Run Time: 02:23:05  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,911,311.00	ADJUSTMENTS	647,285.85
COVERED CHARGES	25,293,547.81	CONTRACTUAL ALLOW	20,559,033.12
NON-COVERD CHARGES	3,617,763.19	TOTAL MEDICAID LIAB	4,734,514.69
		LESS: COB	6,901.66
		LESS: COPAYMENT	13,133.70
		REIMBURSEMENT	4,714,479.33
		ALL OTHER	3,510,832.42
		FEE SCHEDULE-LAB	249,875.64
		INJECTABLE DRUGS	953,771.27

TOTAL NUMBER OF CLAIMS 9,394

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
 000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	484,275.00	34,990.00	OTHER LAB	381,170.00	3,799.00
MED/SURG SUPPLY	72,402.53	2,845.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,671.00	EDUCATION & TRAINING	120.00	1,120.00
RADIOLOGY-DIAGNOSTIC	1,317,328.00	24,793.00	OTHER THERAPEUTIC SVC	0.00	64,656.00
CT SCAN	2,515,228.00	578,292.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,322.00	6,485.04	FEE SCHEDULE LAB	2,498,238.30	357,157.40
EKG/ECG	467,574.00	21,164.00	MRI SERVICES	315,664.00	67,441.00
IV THERAPY	1,451,346.00	65,599.00	PROFESSIONAL FEES	0.00	242.00
OPERATING ROOM	2,064,840.84	283,696.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,720.00	0.00	REHAB THERAPY	0.00	259.00
RESPIRATORY SERVICES	103,357.00	55,081.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	558,159.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	141,386.00	33,581.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,791,105.00	23,262.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	515,728.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	503.00	INJECTABLE DRUGS	4,070,584.35	233,329.80
RADIOLOGY THERAPEUTIC	0.00	2,817.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	646.00	934.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,564.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	85,034.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	56,776.53	2,540.00	TRAUMA RESPONSE	0.00	28,114.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,021.00	905,623.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	16,901.00
OTHER IMAGING SERVICE	964,018.00	194,423.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	58,002.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	720,173.00	177,482.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,136,034.00	336,874.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,844.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	533,485.26	3,490.00			
			TOTAL ANCILLARY	25,293,547.81	3,617,763.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,293,547.81	3,617,763.19

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014308048896	10/23/14 - 10/23/14	11/10/14	0.00	2,363.00	0.00	0.00	0.00
615	2014353013440	11/25/14 - 11/25/14	12/22/14	0.00	1,985.00	0.00	0.00	0.00
615	2014353013440	11/25/14 - 11/25/14	12/22/14	0.00	2,363.00	0.00	0.00	0.00
615	2015127006708	04/03/15 - 04/03/15	05/11/15	0.00	2,363.00	0.00	0.00	0.00
615	5915133000056	11/24/14 - 11/24/14	05/18/15	0.00	2,363.00	0.00	0.00	0.00
615	5915133000056	11/24/14 - 11/24/14	05/18/15	0.00	2,610.00	0.00	0.00	0.00
615	2215133014134	03/23/15 - 03/23/15	05/18/15	0.00	1,985.00	0.00	0.00	0.00
4450	2215239001518	04/09/15 - 04/09/15	08/31/15	0.00	869.00	0.00	0.00	0.00
TOTAL				0.00	16,901.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	295,774.20	ADJUSTMENTS	0.00
COVERED CHARGES	241,266.20	CONTRACTUAL ALLOW	134,386.36
NON-COVERD CHARGES	54,508.00	TOTAL MEDICAID LIAB	106,879.84
		LESS: COB	106,768.90
		LESS: COPAYMENT	110.94
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 109



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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,189.00	556.00	OTHER LAB	10,294.00	0.00
MED/SURG SUPPLY	1,638.00	31.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	237.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,573.00	637.00	OTHER THERAPEUTIC SVC	0.00	1,089.00
CT SCAN	8,980.00	13,404.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,776.00	FEE SCHEDULE LAB	36,184.00	2,535.00
EKG/ECG	3,980.00	96.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,974.00	1,409.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,446.00	14,666.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	720.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	636.00	623.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,558.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,665.00	951.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,868.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	634.00	INJECTABLE DRUGS	34,505.20	2,802.00
RADIOLOGY THERAPEUTIC	0.00	313.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	224.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,476.00	12,525.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,580.00	0.00			
			TOTAL ANCILLARY	241,266.20	54,508.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	241,266.20	54,508.00

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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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	938,482.00	ADJUSTMENTS	868.04
COVERED CHARGES	896,781.00	CONTRACTUAL ALLOW	856,112.63
NON-COVERD CHARGES	41,701.00	TOTAL MEDICAID LIAB	40,668.37
		LESS: COB	0.00
		LESS: COPAYMENT	951.24
		REIMBURSEMENT	39,717.13
		TOTAL NUMBER OF CLAIMS	727

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,578.00	840.00	OTHER LAB	9,119.00	0.00
MED/SURG SUPPLY	1,106.00	57.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	123.00	EDUCATION & TRAINING	0.00	210.00
RADIOLOGY-DIAGNOSTIC	69,769.00	0.00	OTHER THERAPEUTIC SVC	0.00	8,228.00
CT SCAN	52,046.00	2,052.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	108,201.00	20,505.00
EKG/ECG	11,542.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	27,565.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,896.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	570,609.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,895.00	658.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	1,502.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,985.00
OTHER IMAGING SERVICE	18,401.00	5,541.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,054.00	0.00			
			TOTAL ANCILLARY	896,781.00	41,701.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	896,781.00	41,701.00

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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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015147006913	04/19/15 - 04/19/15	06/01/15	0.00	1,985.00	0.00	0.00	0.00
TOTAL				0.00	1,985.00	0.00	0.00	0.00

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

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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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,982.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,652.00	CONTRACTUAL ALLOW	6,763.35
NON-COVERD CHARGES	330.00	TOTAL MEDICAID LIAB	6,888.65
		LESS: COB	6,876.65
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13

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

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

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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	391.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	48.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,043.00	0.00	OTHER THERAPEUTIC SVC	0.00	121.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,629.00	0.00
EKG/ECG	398.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,327.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,354.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	462.00	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,652.00	330.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,652.00	330.00

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

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

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

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

PROVIDER NUMBER  
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,456,186.90	ADJUSTMENTS	91,434.63
COVERED CHARGES	2,255,663.15	CONTRACTUAL ALLOW	1,754,277.38
NON-COVERD CHARGES	200,523.75	TOTAL MEDICAID LIAB	501,385.77
		LESS: COB	0.00
		LESS: COPAYMENT	369.00
		REIMBURSEMENT	501,016.77

TOTAL NUMBER OF CLAIMS 88

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,646.00	105.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,776.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,780.00	900.00	OTHER THERAPEUTIC SVC	0.00	242.00
CT SCAN	15,279.00	9,056.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	300.00	FEE SCHEDULE LAB	32,040.00	3,603.50
EKG/ECG	9,950.00	1,194.00	MRI SERVICES	0.00	0.00
IV THERAPY	131,776.00	2,489.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	430,750.75	6,503.25	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	62,100.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,570.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,755.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,270,413.40	39,878.00
RADIOLOGY THERAPEUTIC	0.00	939.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,038.00	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	91,710.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,242.00	363.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,565.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	178,880.00	40,005.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,140.00	139.00			
			TOTAL ANCILLARY	2,255,663.15	200,523.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,255,663.15	200,523.75



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

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

Run Date: 08/12/2016  
Run Time: 02:24:07  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000316A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,564,709.52	ADJUSTMENTS	74,885.84
COVERED CHARGES	1,535,397.52	CONTRACTUAL ALLOW	1,108,072.62
NON-COVERD CHARGES	29,312.00	TOTAL MEDICAID LIAB	427,324.90
		LESS: COB	15,401.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	411,923.06

TOTAL NUMBER OF ADMISSIONS 64

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	172		0	162,311.00		21,805.00
ROUTINE NURSERY	0		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	162,311.00		21,805.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	82		0	164,902.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	164,902.00		0.00
TOTAL ACCOMODATIONS	254		0	327,213.00		21,805.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	129,028.34	0.00	OTHER LAB	1,922.00	0.00
MED/SURG SUPPLY	120,502.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	273,262.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,972.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	132,220.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,584.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	18,719.00	0.00	MRI SERVICES	3,687.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,720.00	3,328.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	144,221.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	125,063.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,669.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	22,985.00	0.00	INJECTABLE DRUGS	125,416.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	336.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	776.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	464.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,760.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,360.00	4,179.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,517.00	0.00			
			TOTAL ANCILLARY	1,208,184.52	7,507.00
			TOTAL ACCOMODATIONS	327,213.00	21,805.00
			TOTAL CHARGES	1,535,397.52	29,312.00

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

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

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 01:29:34  
Page: 4

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

PROVIDER NUMBER  
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,721,931.96	ADJUSTMENTS	52,157.42
COVERED CHARGES	2,433,008.94	CONTRACTUAL ALLOW	1,954,732.05
NON-COVERD CHARGES	288,923.02	TOTAL MEDICAID LIAB	478,276.89
		LESS: COB	620.65
		LESS: COPAYMENT	2,079.00
		REIMBURSEMENT	475,577.24
		ALL OTHER	437,425.17
		FEE SCHEDULE-LAB	35,554.16
		INJECTABLE DRUGS	2,597.91

TOTAL NUMBER OF CLAIMS 1,281

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

PROVIDER NUMBER  
 000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,627.90	10,056.75	OTHER LAB	7,956.00	447.00
MED/SURG SUPPLY	211,489.00	198.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	132,608.00	3,137.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	285,937.00	57,226.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,649.00	6,853.00	FEE SCHEDULE LAB	536,617.00	50,705.80
EKG/ECG	74,566.00	0.00	MRI SERVICES	53,366.00	12,135.00
IV THERAPY	107.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	402,025.25	93,067.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,711.00	3,895.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	423,649.00	15,644.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	140,707.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	39,481.79	14,033.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,301.00	483.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	46.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,687.00
OTHER IMAGING SERVICE	34,667.00	4,776.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,350.00	1,340.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,670.00	1,788.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,478.00	9,451.00			
			TOTAL ANCILLARY	2,433,008.94	288,923.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,433,008.94	288,923.02

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

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

Run Date: 08/12/2016  
Run Time: 01:29:34  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015303042816	10/23/15 - 10/23/15	11/02/15	0.00	3,687.00	0.00	0.00	0.00
TOTAL				0.00	3,687.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
Run Time: 01:29:58  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,287.64	ADJUSTMENTS	0.00
COVERED CHARGES	12,043.64	CONTRACTUAL ALLOW	5,625.00
NON-COVERD CHARGES	7,244.00	TOTAL MEDICAID LIAB	6,418.64
		LESS: COB	6,414.90
		LESS: COPAYMENT	3.74
		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

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

PROVIDER NUMBER  
 000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	112.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	390.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	865.00	386.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,415.00	6,760.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,937.00	84.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	212.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,338.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	131.64	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	643.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,043.64	7,244.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,043.64	7,244.00

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

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

Run Date: 08/12/2016  
Run Time: 01:29:58  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	271,074.71	ADJUSTMENTS	799.00
COVERED CHARGES	251,350.73	CONTRACTUAL ALLOW	240,400.73
NON-COVERD CHARGES	19,723.98	TOTAL MEDICAID LIAB	10,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	438.00
		REIMBURSEMENT	10,512.00
		TOTAL NUMBER OF CLAIMS	219

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,706.63	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,951.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	82.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,963.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,189.00	2,415.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	48,415.00	4,990.00
EKG/ECG	3,712.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,522.00	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	134,651.00	4,744.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,610.10	6,232.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	409.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	222.00	1,260.00			
			TOTAL ANCILLARY	251,350.73	19,723.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	251,350.73	19,723.98

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

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

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,905.89	ADJUSTMENTS	0.00
COVERED CHARGES	8,462.89	CONTRACTUAL ALLOW	7,402.10
NON-COVERD CHARGES	2,443.00	TOTAL MEDICAID LIAB	1,060.79
		LESS: COB	1,054.79
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 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	284.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	256.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,651.00	2,415.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	621.00	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	2,508.00	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	142.89	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,462.89	2,443.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,462.89	2,443.00

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

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

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,885.00	ADJUSTMENTS	0.00
COVERED CHARGES	34,740.00	CONTRACTUAL ALLOW	29,848.54
NON-COVERD CHARGES	145.00	TOTAL MEDICAID LIAB	4,891.46
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,888.46
		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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48.00	111.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	297.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	33,289.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	999.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	107.00	34.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	34,740.00	145.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,740.00	145.00

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

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

Run Date: 08/12/2016  
Run Time: 01:30:04  
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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	01/01/15	THROUGH	12/31/15
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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,969,633.64	ADJUSTMENTS	684,616.83
COVERED CHARGES	26,622,133.64	CONTRACTUAL ALLOW	20,297,465.97
NON-COVERD CHARGES	347,500.00	TOTAL MEDICAID LIAB	6,324,667.67
		LESS: COB	98,267.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,226,399.79

TOTAL NUMBER OF ADMISSIONS 639

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,563	41	2,242,625.00	35,875.00
ROUTINE NURSERY	347	0	304,770.00	39,240.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	2,910	41	2,547,395.00	75,115.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,863	0	3,592,155.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,863	0	3,592,155.00	0.00
TOTAL ACCOMODATIONS	4,773	41	6,139,550.00	75,115.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,159,251.87	0.00	OTHER LAB	77,178.00	0.00
MED/SURG SUPPLY	894,474.34	1,524.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,897,357.00	19,598.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,001,995.00	0.00	OTHER THERAPEUTIC SVC	0.00	11,109.00
CT SCAN	1,129,120.00	39,524.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	203,919.83	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	71,411.00	0.00	MRI SERVICES	255,546.00	0.00
IV THERAPY	238,066.00	2,275.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,932,059.00	14,608.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	338,843.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,659,664.00	1.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	459,085.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	78,744.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	428,507.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	253,376.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	119,641.00	0.00	INJECTABLE DRUGS	3,241,989.74	0.00
RADIOLOGY THERAPEUTIC	141,880.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	81,390.82	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	103,351.04	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	326,136.00	65,091.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	187,117.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	121,582.00	22,666.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	755,047.00	43,983.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	82,855.00	52,006.00			
AUDIOLOGY	2,493.00	0.00			
CARDIOLOGY	106,962.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	33,016.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	100,526.00	0.00			
			TOTAL ANCILLARY	20,482,583.64	272,385.00
			TOTAL ACCOMODATIONS	6,139,550.00	75,115.00
			TOTAL CHARGES	26,622,133.64	347,500.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	171,342.00	ADJUSTMENTS	0.00
COVERED CHARGES	169,042.00	CONTRACTUAL ALLOW	83,090.48
NON-COVERD CHARGES	2,300.00	TOTAL MEDICAID LIAB	85,951.52
		LESS: COB	85,951.52
		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	39		0	34,375.00		2,300.00
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	39		0	34,375.00		2,300.00
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	39		0	34,375.00		2,300.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,310.00	0.00	OTHER LAB	941.00	0.00
MED/SURG SUPPLY	5,867.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,135.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,261.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
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	11,090.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	59,966.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,147.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	485.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,591.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	888.00	0.00	INJECTABLE DRUGS	11,902.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	531.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	287.00	0.00			
			TOTAL ANCILLARY	134,667.00	0.00
			TOTAL ACCOMODATIONS	34,375.00	2,300.00
			TOTAL CHARGES	169,042.00	2,300.00

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

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

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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,966,034.54	ADJUSTMENTS	383,035.40
COVERED CHARGES	17,312,170.15	CONTRACTUAL ALLOW	14,387,713.42
NON-COVERD CHARGES	1,653,864.39	TOTAL MEDICAID LIAB	2,924,456.73
		LESS: COB	14,306.99
		LESS: COPAYMENT	13,411.09
		REIMBURSEMENT	2,896,738.65
		ALL OTHER	2,566,506.50
		FEE SCHEDULE-LAB	282,454.80
		INJECTABLE DRUGS	47,777.35

TOTAL NUMBER OF CLAIMS 8,337

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,595,446.21	5,112.93	OTHER LAB	109,573.00	2,507.00
MED/SURG SUPPLY	289,528.07	40,431.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,870.00	110.00
RADIOLOGY-DIAGNOSTIC	850,212.00	25,911.00	OTHER THERAPEUTIC SVC	0.00	55.00
CT SCAN	1,222,661.00	307,349.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	41,094.10	10,218.75	FEE SCHEDULE LAB	2,239,160.20	249,508.39
EKG/ECG	70,022.00	2,660.00	MRI SERVICES	208,488.00	44,905.00
IV THERAPY	1,371,291.00	56,266.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,912,546.77	188,766.29	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,879.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	119,231.00	32,508.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	469,212.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	65,620.00	8,492.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,748,229.00	368.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	443,320.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	226,854.79	10,148.82
RADIOLOGY THERAPEUTIC	1,606,599.00	302,091.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,146.65	11,921.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,449.00	3,468.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,669.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	167.00	1,411.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	128,231.00	11,087.00
LITHOTRIPSY	130,640.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	717,767.00	127,045.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	192,651.00	59,976.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	50,057.00	113,292.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,150.00	7,722.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,307.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	356,767.36	28,864.00			
			TOTAL ANCILLARY	17,312,170.15	1,653,864.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,312,170.15	1,653,864.39

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

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

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

CANDLER HOSPITAL  
5353 REYNOLDS ST  
SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	604,255.02	ADJUSTMENTS	0.00
COVERED CHARGES	376,715.33	CONTRACTUAL ALLOW	168,637.00
NON-COVERD CHARGES	227,539.69	TOTAL MEDICAID LIAB	208,078.33
		LESS: COB	207,928.79
		LESS: COPAYMENT	149.54
		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

CANDLER HOSPITAL  
 5353 REYNOLDS ST  
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,290.83	53.00	OTHER LAB	4,524.00	0.00
MED/SURG SUPPLY	16,986.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,870.00	0.00
RADIOLOGY-DIAGNOSTIC	4,993.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,770.00	23,541.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,017.00	2,893.00
EKG/ECG	399.00	0.00	MRI SERVICES	0.00	6,853.00
IV THERAPY	27,492.00	529.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,227.31	28,747.69	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	941.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	372.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,300.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,176.00	9,264.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,674.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,508.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,586.19	18,035.00
RADIOLOGY THERAPEUTIC	30,332.00	6,929.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	105,914.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,777.00	5,198.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,642.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,158.00	18,351.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	931.00	931.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,749.00	301.00			
			TOTAL ANCILLARY	376,715.33	227,539.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	376,715.33	227,539.69



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

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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,039,100.94	ADJUSTMENTS	1,226.62
COVERED CHARGES	995,757.32	CONTRACTUAL ALLOW	947,816.75
NON-COVERD CHARGES	43,343.62	TOTAL MEDICAID LIAB	47,940.57
		LESS: COB	27.73
		LESS: COPAYMENT	1,935.00
		REIMBURSEMENT	45,977.84
		TOTAL NUMBER OF CLAIMS	857

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,464.27	172.02	OTHER LAB	16,292.00	0.00
MED/SURG SUPPLY	1,455.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	102,917.00	1,693.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,167.00	15,380.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	121,106.00	10,263.00
EKG/ECG	7,847.00	0.00	MRI SERVICES	4,633.00	0.00
IV THERAPY	106,363.00	2,498.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,654.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	584.00	146.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,252.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	522,024.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,591.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,077.66	193.60
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	218.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	956.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,815.00	12,780.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	559.00	0.00			
			TOTAL ANCILLARY	995,757.32	43,343.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	995,757.32	43,343.62

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

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

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CANDLER HOSPITAL  
5353 REYNOLDS ST  
SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,859.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,731.00	CONTRACTUAL ALLOW	10,710.60
NON-COVERD CHARGES	3,128.00	TOTAL MEDICAID LIAB	4,020.40
		LESS: COB	4,005.40
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	267.00	106.00	OTHER LAB	498.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,548.00	1,230.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,237.00	520.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,086.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,303.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	340.00	7.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	452.00	1,265.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,731.00	3,128.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,731.00	3,128.00

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	578,652.02	ADJUSTMENTS	16,535.61
COVERED CHARGES	556,740.06	CONTRACTUAL ALLOW	490,501.62
NON-COVERD CHARGES	21,911.96	TOTAL MEDICAID LIAB	66,238.44
		LESS: COB	0.00
		LESS: COPAYMENT	60.00
		REIMBURSEMENT	66,178.44

TOTAL NUMBER OF CLAIMS 12

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,329.27	53.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,644.00	4,062.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,400.00	2,127.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,620.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	345.10	FEE SCHEDULE LAB	3,349.00	424.00
EKG/ECG	399.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,972.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,015.00	5,545.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,857.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,255.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	151,387.79	735.86
RADIOLOGY THERAPEUTIC	70,201.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	125,396.00	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.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,410.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	556,740.06	21,911.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	556,740.06	21,911.96

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

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

Run Date: 08/12/2016  
Run Time: 01:32:46  
Page: 15

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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000404A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,628,903.74	ADJUSTMENTS	828,354.00
COVERED CHARGES	39,763,186.08	CONTRACTUAL ALLOW	28,238,854.36
NON-COVERD CHARGES	1,865,717.66	TOTAL MEDICAID LIAB	11,524,331.72
		LESS: COB	182,397.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,341,934.27

TOTAL NUMBER OF ADMISSIONS 1,858

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,593		70	5,256,167.00		678,080.00
ROUTINE NURSERY	1,577		4	2,700,093.00		20,742.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7,170		74	7,956,260.00		698,822.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	566		0	1,540,652.00		0.00
NICU	552		0	1,811,999.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,118		0	3,352,651.00		0.00
TOTAL ACCOMODATIONS	8,288		74	11,308,911.00		698,822.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,083,452.42	0.00	OTHER LAB	261,946.62	0.00
MED/SURG SUPPLY	1,649,532.33	1,187.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,496,635.18	4,060.50	EDUCATION & TRAINING	70,826.65	0.00
RADIOLOGY-DIAGNOSTIC	495,641.68	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	891,879.50	425,835.91	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	150,983.47	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	235,749.15	0.00	MRI SERVICES	669,786.60	0.00
IV THERAPY	118,069.09	373.72	PROFESSIONAL FEES	0.00	66.15
OPERATING ROOM	1,880,381.18	2,576.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	999,923.40	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,298,006.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	597,063.21	0.00	AMBULANCE	0.00	0.00
GI SERVICES	351,137.85	3,416.70	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,259,255.08	223.87	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	456,699.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	238,957.95	0.00	INJECTABLE DRUGS	3,236.32	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	43,081.87	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	92,501.46	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	235,685.10	6,736.80	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	98,163.46	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	428,067.04	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	381,234.52	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	548,607.45	13,356.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	351,112.65	89,326.65			
AUDIOLOGY	3,140.55	619,735.20			
CARDIOLOGY	1,718,312.17	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,932.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	329,272.83	0.00			
			TOTAL ANCILLARY	28,454,275.08	1,166,895.66
			TOTAL ACCOMODATIONS	11,308,911.00	698,822.00
			TOTAL CHARGES	39,763,186.08	1,865,717.66

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

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

Run Date: 08/12/2016  
 Run Time: 03:18:18  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	702,092.03	ADJUSTMENTS	0.00
COVERED CHARGES	694,076.78	CONTRACTUAL ALLOW	367,070.01
NON-COVERD CHARGES	8,015.25	TOTAL MEDICAID LIAB	327,006.77
		LESS: COB	327,006.77
		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	34		0	32,096.00		3,915.00
ROUTINE NURSERY	22		0	56,980.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	56		0	89,076.00		3,915.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	60		0	196,320.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	60		0	196,320.00		0.00
TOTAL ACCOMODATIONS	116		0	285,396.00		3,915.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61,769.10	0.00	OTHER LAB	1,485.75	0.00
MED/SURG SUPPLY	34,278.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	37,079.70	0.00	EDUCATION & TRAINING	1,115.10	0.00
RADIOLOGY-DIAGNOSTIC	2,314.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,480.75	1,799.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	401.13	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,334.15	0.00	MRI SERVICES	8,029.35	0.00
IV THERAPY	2,381.93	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,265.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,769.10	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,466.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,454.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,677.61	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,325.55	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,607.90	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	258.30	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,368.49	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,337.15	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,224.80	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,540.85	1,253.70			
AUDIOLOGY	0.00	1,046.85			
CARDIOLOGY	71,559.60	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	1,155.00	0.00			
			TOTAL ANCILLARY	408,680.78	4,100.25
			TOTAL ACCOMODATIONS	285,396.00	3,915.00
			TOTAL CHARGES	694,076.78	8,015.25

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

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

Run Date: 08/12/2016  
Run Time: 03:18:20  
Page: 5

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

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,624,874.09	ADJUSTMENTS	498,565.45
COVERED CHARGES	19,753,618.17	CONTRACTUAL ALLOW	16,472,967.53
NON-COVERD CHARGES	3,871,255.92	TOTAL MEDICAID LIAB	3,280,650.64
		LESS: COB	6,946.75
		LESS: COPAYMENT	5,057.71
		REIMBURSEMENT	3,268,646.18
		ALL OTHER	2,945,671.91
		FEE SCHEDULE-LAB	278,414.08
		INJECTABLE DRUGS	44,560.19

TOTAL NUMBER OF CLAIMS 6,745

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

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	320,698.19	53,783.51	OTHER LAB	285,970.65	1,672.65
MED/SURG SUPPLY	329,683.66	75,970.37	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	319.20	EDUCATION & TRAINING	185.85	2,998.80
RADIOLOGY-DIAGNOSTIC	798,404.42	13,969.20	OTHER THERAPEUTIC SVC	0.00	4,104.06
CT SCAN	1,394,674.05	431,477.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	56,476.35	36,842.45	FEE SCHEDULE LAB	4,174,850.60	794,469.72
EKG/ECG	228,526.70	31,640.70	MRI SERVICES	429,960.30	93,692.05
IV THERAPY	264,048.85	7,669.60	PROFESSIONAL FEES	0.00	22.05
OPERATING ROOM	1,058,079.01	256,996.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	139,908.30	1,668.45	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75,484.51	95,051.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	612,416.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	466,080.39	111,781.86	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,974,855.12	122,676.15	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	379,709.44	0.00	DRUG-SPECIFIC/HOME IV	0.00	13,048.35
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	277,155.36	241,325.58
RADIOLOGY THERAPEUTIC	16,433.50	442.08	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,288.30	3,290.70	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,212.70	6,229.70	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	22,591.80	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	251,134.21	12,075.66	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,672.74	368,752.98
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,008,399.00	396,378.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	59,234.70	7,116.90			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	175,690.20	268,683.45			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	454,451.55	389,237.10			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,792.95	448.35			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	478,139.87	4,721.33			
			TOTAL ANCILLARY	19,753,618.17	3,871,147.77
			TOTAL ACCOMODATIONS	0.00	108.15
			TOTAL CHARGES	19,753,618.17	3,871,255.92

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

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

Run Date: 08/12/2016  
Run Time: 03:18:58  
Page: 7

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

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

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,810.98	ADJUSTMENTS	0.00
COVERED CHARGES	119,101.78	CONTRACTUAL ALLOW	49,594.43
NON-COVERD CHARGES	48,709.20	TOTAL MEDICAID LIAB	69,507.35
		LESS: COB	69,450.49
		LESS: COPAYMENT	56.86
		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

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

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,711.20	639.27	OTHER LAB	3,290.70	0.00
MED/SURG SUPPLY	2,168.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,078.35	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,522.75	0.00	OTHER THERAPEUTIC SVC	0.00	223.87
CT SCAN	2,110.51	12,707.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,608.23	2,883.40
EKG/ECG	518.70	259.35	MRI SERVICES	0.00	4,142.25
IV THERAPY	1,917.30	398.07	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,987.05	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,209.85	238.35	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,903.65	137.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,916.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,416.70	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,612.07	1,709.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,062.45	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	508.93	200.19
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,349.25	539.70	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,172.43	12,375.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,643.35	7,004.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	398.07	0.00			
NUCLEAR MEDICINE	847.35	63.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,642.85	693.00			
			TOTAL ANCILLARY	119,101.78	48,709.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	119,101.78	48,709.20

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

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

Run Date: 08/12/2016  
Run Time: 03:19:00  
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SOUTHERN REGIONAL MEDICAL CENTER  
11 UPPER RIVERDALE RD SW  
RIVERDALE,GA 30274-2615

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	919,608.12	ADJUSTMENTS	914.98
COVERED CHARGES	860,576.20	CONTRACTUAL ALLOW	822,984.53
NON-COVERD CHARGES	59,031.92	TOTAL MEDICAID LIAB	37,591.67
		LESS: COB	0.00
		LESS: COPAYMENT	1,287.00
		REIMBURSEMENT	36,304.67
		TOTAL NUMBER OF CLAIMS	672



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,639.45	1,857.42	OTHER LAB	5,580.75	0.00
MED/SURG SUPPLY	1,829.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,369.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,568.65	14,805.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	165,747.98	34,807.50
EKG/ECG	6,224.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,367.35	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	594.30	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,788.15	137.55	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	568,406.32	855.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,654.32	1,109.94
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,696.05	5,458.95			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,108.80	0.00			
			TOTAL ANCILLARY	860,576.20	59,031.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	860,576.20	59,031.92

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

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

Run Date: 08/12/2016  
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Page: 11

SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,212.94	ADJUSTMENTS	0.00
COVERED CHARGES	7,244.84	CONTRACTUAL ALLOW	4,746.86
NON-COVERD CHARGES	968.10	TOTAL MEDICAID LIAB	2,497.98
		LESS: COB	2,488.98
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

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

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

Run Date: 08/12/2016  
 Run Time: 03:19:05  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,820.70	63.00
EKG/ECG	259.35	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	186.86	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,087.87	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	15.71	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	784.35	905.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,244.84	968.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,244.84	968.10

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

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

Run Date: 08/12/2016  
Run Time: 03:19:07  
Page: 13

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,107,604.14	ADJUSTMENTS	32,781.73
COVERED CHARGES	959,254.34	CONTRACTUAL ALLOW	844,528.38
NON-COVERD CHARGES	148,349.80	TOTAL MEDICAID LIAB	114,725.96
		LESS: COB	0.00
		LESS: COPAYMENT	156.00
		REIMBURSEMENT	114,569.96
		TOTAL NUMBER OF CLAIMS	21

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

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

PROVIDER NUMBER  
 000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,260.37	387.02	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,454.46	5,632.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,797.60	0.00	OTHER THERAPEUTIC SVC	0.00	223.87
CT SCAN	11,412.45	4,851.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	769.65	FEE SCHEDULE LAB	53,786.25	10,185.45
EKG/ECG	518.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,574.57	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	209,377.89	7,963.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	161,354.55	16,928.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,316.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,728.74	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,099.45	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	285,590.46	12,842.53
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	25,491.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,970.45	623.70	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,450.00	61,835.26
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,458.30	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,652.30	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,025.70	615.30			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	71,425.20	0.00			
			TOTAL ANCILLARY	959,254.34	148,349.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	959,254.34	148,349.80

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

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

Run Date: 08/12/2016  
Run Time: 03:19:09  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000404A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 01:46:39  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000415A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	260,763.37	ADJUSTMENTS	0.00
COVERED CHARGES	257,280.37	CONTRACTUAL ALLOW	115,597.22
NON-COVERD CHARGES	3,483.00	TOTAL MEDICAID LIAB	141,683.15
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	141,683.15

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	71		0	20,732.00		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	71		0	20,732.00		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	71		0	20,732.00		0.00

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

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

Run Date: 08/12/2016  
 Run Time: 01:46:39  
 Page: 2

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,706.70	0.00	OTHER LAB	626.00	0.00
MED/SURG SUPPLY	35,554.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	48,928.44	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,457.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,166.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	318.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	22,378.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,250.00	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	4,322.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	360.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,152.00	3,483.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,249.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,080.00	0.00			
			TOTAL ANCILLARY	236,548.37	3,483.00
			TOTAL ACCOMODATIONS	20,732.00	0.00
			TOTAL CHARGES	257,280.37	3,483.00



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

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

Run Date: 08/12/2016  
Run Time: 01:46:40  
Page: 3

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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 01:46:40  
Page: 4

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

PROVIDER NUMBER  
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	726,523.67	ADJUSTMENTS	6,651.84
COVERED CHARGES	631,357.85	CONTRACTUAL ALLOW	285,417.64
NON-COVERD CHARGES	95,165.82	TOTAL MEDICAID LIAB	345,940.21
		LESS: COB	0.00
		LESS: COPAYMENT	1,634.38
		REIMBURSEMENT	344,305.83
		ALL OTHER	319,919.26
		FEE SCHEDULE-LAB	24,386.57
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 970

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

PROVIDER NUMBER  
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,513.88	43.10	OTHER LAB	2,570.00	0.00
MED/SURG SUPPLY	29,292.19	565.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,862.00	596.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	105,105.00	2,436.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,254.00	1,288.00	FEE SCHEDULE LAB	200,011.78	60,475.15
EKG/ECG	19,334.00	8,620.00	MRI SERVICES	7,056.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	733.00
OPERATING ROOM	11,201.00	1,300.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,655.00	1,698.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	90,303.00	10,696.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,680.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,158.00	480.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,512.00	494.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,208.00	1,548.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,166.00	1,083.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	29,510.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,966.00	3,110.00			
			TOTAL ANCILLARY	631,357.85	95,165.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	631,357.85	95,165.82

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1.47	ADJUSTMENTS	0.00
COVERED CHARGES	1.47	CONTRACTUAL ALLOW	0.38
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1.09
		LESS: COB	0.00
		LESS: COPAYMENT	1.09
		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

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

PROVIDER NUMBER  
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 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	1.47	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	1.47	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1.47	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

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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,657.01	ADJUSTMENTS	47.00
COVERED CHARGES	64,120.01	CONTRACTUAL ALLOW	55,625.01
NON-COVERD CHARGES	4,537.00	TOTAL MEDICAID LIAB	8,495.00
		LESS: COB	0.00
		LESS: COPAYMENT	339.00
		REIMBURSEMENT	8,156.00
		TOTAL NUMBER OF CLAIMS	170

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,995.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,041.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,227.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,561.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,224.12	3,210.00
EKG/ECG	1,574.00	464.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	368.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	83.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,413.00	495.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	64,120.01	4,537.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,120.01	4,537.00

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

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

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
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

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

PROVIDER NUMBER  
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,965.97	ADJUSTMENTS	0.00
COVERED CHARGES	8,601.97	CONTRACTUAL ALLOW	2,973.39
NON-COVERD CHARGES	364.00	TOTAL MEDICAID LIAB	5,628.58
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,628.58

TOTAL NUMBER OF CLAIMS 1

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

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

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

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

PROVIDER NUMBER  
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,021.12	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	338.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	202.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,829.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	834.00	30.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,147.00	334.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	230.00	0.00			
			TOTAL ANCILLARY	8,601.97	364.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,601.97	364.00

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

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

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000426A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	81,248,679.02	ADJUSTMENTS	1,935,584.39
COVERED CHARGES	76,954,879.76	CONTRACTUAL ALLOW	59,518,947.87
NON-COVERD CHARGES	4,293,799.26	TOTAL MEDICAID LIAB	17,435,931.89
		LESS: COB	135,630.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,300,301.02
		TOTAL NUMBER OF ADMISSIONS	2,336

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,227		215	6,276,135.20		3,471,960.20
ROUTINE NURSERY	1,251		16	1,979,845.20		73,682.70
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		14,545.50
TOTAL ROUTINE	7,478		231	8,255,980.40		3,560,188.40
SPECIAL CARE SERVICES						
CCU	2,886		24	6,287,158.02		74,290.00
ICU	773		2	2,400,967.74		18,732.00
NICU	539		0	1,614,790.50		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	71		0	320,435.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		85	0.00		131,919.60
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,269		111	10,623,351.26		224,941.60
TOTAL ACCOMODATIONS	11,747		342	18,879,331.66		3,785,130.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000426A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,854,669.75	35,333.50	OTHER LAB	680,124.30	1,990.00
MED/SURG SUPPLY	2,751,029.25	31,485.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,581,254.94	28,047.00	EDUCATION & TRAINING	37,952.00	0.00
RADIOLOGY-DIAGNOSTIC	1,438,771.96	5,172.00	OTHER THERAPEUTIC SVC	0.00	4,086.00
CT SCAN	3,563,344.40	9,592.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	597,008.02	27,143.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	586,774.00	388.00	MRI SERVICES	1,191,470.03	8,431.00
IV THERAPY	848,053.08	11,372.01	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,905,430.16	8,312.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,419,587.68	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,040,199.79	91,160.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,605,564.15	2,034.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,649,054.47	714.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	939,271.70	254.00	DRUG-SPECIFIC/HOME IV	0.00	577.75
LABORATORY PATHOLOGIC	258,167.79	403.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	25,417.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	384,633.02	22,192.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	186,886.00	4,208.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,698,887.65	143,712.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	83,167.06	5,679.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	467,482.20	326.00	IMPL DEV CHARGE PATIENTS	1,837,039.15	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	659.00
OTHER IMAGING SERVICE	523,475.49	1,245.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	876,838.81	45,177.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	504,724.00	15,304.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,114,106.00	3,673.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	189,100.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	236,064.25	0.00			
			TOTAL ANCILLARY	58,075,548.10	508,669.26
			TOTAL ACCOMODATIONS	18,879,331.66	3,785,130.00
			TOTAL CHARGES	76,954,879.76	4,293,799.26

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: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015070042754	02/27/15 - 03/05/15	03/16/15	0.00	659.00	0.00	0.00	0.00
TOTAL				0.00	659.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
 Run Time: 03:35:08  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	489,511.03	ADJUSTMENTS	0.00
COVERED CHARGES	477,787.53	CONTRACTUAL ALLOW	254,096.45
NON-COVERD CHARGES	11,723.50	TOTAL MEDICAID LIAB	223,691.08
		LESS: COB	223,691.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	66		1	66,924.00		11,532.50
ROUTINE NURSERY	5		0	2,550.00		191.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	71		1	69,474.00		11,723.50
SPECIAL CARE SERVICES						
CCU	3		0	6,555.00		0.00
ICU	1		0	3,122.00		0.00
NICU	3		0	8,928.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	7		0	18,605.00		0.00
TOTAL ACCOMODATIONS	78		1	88,079.00		11,723.50

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,749.75	0.00	OTHER LAB	2,751.00	0.00
MED/SURG SUPPLY	20,012.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,755.00	0.00	EDUCATION & TRAINING	2,920.00	0.00
RADIOLOGY-DIAGNOSTIC	1,266.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,722.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	776.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	554.01	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,283.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	179,370.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,144.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,577.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,810.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,631.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,904.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	333.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,410.72	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,692.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,045.92	0.00			
			TOTAL ANCILLARY	389,708.53	0.00
			TOTAL ACCOMODATIONS	88,079.00	11,723.50
			TOTAL CHARGES	477,787.53	11,723.50



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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,965,953.89	ADJUSTMENTS	679,304.51
COVERED CHARGES	25,059,849.84	CONTRACTUAL ALLOW	21,365,989.45
NON-COVERD CHARGES	3,906,104.05	TOTAL MEDICAID LIAB	3,693,860.39
		LESS: COB	48,511.12
		LESS: COPAYMENT	6,698.94
		REIMBURSEMENT	3,638,650.33
		ALL OTHER	3,136,791.88
		FEE SCHEDULE-LAB	372,340.68
		INJECTABLE DRUGS	129,517.77

TOTAL NUMBER OF CLAIMS 9,730

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	550,432.75	19,694.25	OTHER LAB	542,280.92	238.00
MED/SURG SUPPLY	758,416.78	19,887.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	486.68	EDUCATION & TRAINING	109.00	0.00
RADIOLOGY-DIAGNOSTIC	1,302,042.79	15,056.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,557,398.00	736,622.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	44,992.00	29,627.00	FEE SCHEDULE LAB	4,173,235.79	623,881.46
EKG/ECG	417,124.00	3,880.00	MRI SERVICES	488,570.13	189,455.00
IV THERAPY	1,038,889.75	14,551.24	PROFESSIONAL FEES	0.00	80.00
OPERATING ROOM	1,760,973.40	438,233.70	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	255,459.00	0.00	REHAB THERAPY	0.00	330.00
RESPIRATORY SERVICES	126,449.64	70,304.66	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	913,207.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,934.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,640,638.39	9,301.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	817,871.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,429.00
LABORATORY PATHOLOGIC	0.00	47.00	INJECTABLE DRUGS	763,511.50	582,743.50
RADIOLOGY THERAPEUTIC	27,122.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,348.00	8,123.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	678.00	6,321.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	155,687.70	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	247,732.60	24,300.36	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	177,476.00	86,365.60	IMPL DEV CHARGE PATIENTS	199,799.04	98,359.36
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	280.64
OTHER IMAGING SERVICE	794,777.89	264,280.68			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	82,007.86	1,156.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	284,362.00	235,091.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	469,874.00	267,911.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,221.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	607,914.66	1,378.50			
			TOTAL ANCILLARY	25,059,849.84	3,906,104.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,059,849.84	3,906,104.05

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

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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3021	5915008000138	12/19/14 - 12/19/14	01/12/15	0.00	61.00	0.00	0.00	0.00
8301	5915076000039	02/18/15 - 02/18/15	03/23/15	0.00	200.00	0.00	0.00	0.00
3000	5915091000149	03/10/15 - 03/10/15	04/06/15	0.00	19.64	0.00	0.00	0.00
TOTAL				0.00	280.64	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	507,231.26	ADJUSTMENTS	0.00
COVERED CHARGES	408,483.01	CONTRACTUAL ALLOW	208,240.16
NON-COVERD CHARGES	98,748.25	TOTAL MEDICAID LIAB	200,242.85
		LESS: COB	200,212.50
		LESS: COPAYMENT	30.35
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 123

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,646.75	300.00	OTHER LAB	25,965.33	0.00
MED/SURG SUPPLY	14,902.11	6,030.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,184.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,349.00	22,911.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	338.00	0.00	FEE SCHEDULE LAB	60,008.43	6,128.80
EKG/ECG	5,432.00	0.00	MRI SERVICES	0.00	8,808.00
IV THERAPY	16,086.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,805.00	19,590.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,193.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	753.00	3,693.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,945.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	81,652.68	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,326.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,392.50	913.25
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	2,387.00	222.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,429.44	6,217.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,748.36	17,077.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,294.00	6,858.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,738.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,600.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,305.96	0.00			
			TOTAL ANCILLARY	408,483.01	98,748.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	408,483.01	98,748.25

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,217,909.39	ADJUSTMENTS	809.10
COVERED CHARGES	1,147,635.28	CONTRACTUAL ALLOW	1,102,982.44
NON-COVERD CHARGES	70,274.11	TOTAL MEDICAID LIAB	44,652.84
		LESS: COB	506.65
		LESS: COPAYMENT	1,323.00
		REIMBURSEMENT	42,823.19
		TOTAL NUMBER OF CLAIMS	790

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,697.75	4.00	OTHER LAB	26,719.68	0.00
MED/SURG SUPPLY	3,653.09	124.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	69,196.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,312.60	25,799.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	217,311.79	18,601.88
EKG/ECG	12,028.00	0.00	MRI SERVICES	5,651.00	0.00
IV THERAPY	46,770.36	145.28	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,764.56	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	641,013.23	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,920.75	2,620.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,975.95	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	222.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	7,074.40	1,446.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,283.48	9,336.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	238.00	0.00			
			TOTAL ANCILLARY	1,147,635.28	70,274.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,147,635.28	70,274.11

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,252.00	ADJUSTMENTS	0.00
COVERED CHARGES	32,742.50	CONTRACTUAL ALLOW	20,670.67
NON-COVERD CHARGES	3,509.50	TOTAL MEDICAID LIAB	12,071.83
		LESS: COB	12,056.83
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11



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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120.50	0.00	OTHER LAB	5,112.00	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	603.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,954.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	446.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,804.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45.00	14.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	964.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	648.00	3,495.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,742.50	3,509.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,742.50	3,509.50

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: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,373,432.89	ADJUSTMENTS	100,981.07
COVERED CHARGES	2,280,842.25	CONTRACTUAL ALLOW	1,954,877.61
NON-COVERD CHARGES	92,590.64	TOTAL MEDICAID LIAB	325,964.64
		LESS: COB	0.00
		LESS: COPAYMENT	405.72
		REIMBURSEMENT	325,558.92
		TOTAL NUMBER OF CLAIMS	58

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,588.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	150,453.86	1,303.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,347.00	1,072.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,222.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,994.60	2,745.00
EKG/ECG	776.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,842.65	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	335,445.90	8,804.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,729.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	97,329.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,385.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	59,560.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,156,880.75	52,519.00
RADIOLOGY THERAPEUTIC	29,784.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,978.00	322.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	227,305.76	21,667.60
LITHOTRIPSY	35,961.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,690.13	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,232.00	4,158.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	61,335.70	0.00			
			TOTAL ANCILLARY	2,280,842.25	92,590.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,280,842.25	92,590.64

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

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

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 03:29:01  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000437A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 05/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	907,320.33	ADJUSTMENTS	30,122.76
COVERED CHARGES	906,092.33	CONTRACTUAL ALLOW	499,530.95
NON-COVERD CHARGES	1,228.00	TOTAL MEDICAID LIAB	406,561.38
		LESS: COB	13,012.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	393,548.97

TOTAL NUMBER OF ADMISSIONS 73

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	132		0	57,948.00		439.00
ROUTINE NURSERY	42		0	12,062.00		131.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	174		0	70,010.00		570.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	59		0	62,330.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	59		0	62,330.00		0.00
TOTAL ACCOMODATIONS	233		0	132,340.00		570.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000437A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,531.98	0.00	OTHER LAB	7,418.00	0.00
MED/SURG SUPPLY	70,169.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	127,017.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,716.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,542.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,472.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,080.00	0.00	MRI SERVICES	9,170.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,488.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,259.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	64,957.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,669.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	54,978.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,573.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	336.00	0.00	INJECTABLE DRUGS	133,360.65	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,719.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,259.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	677.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,355.00	658.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,277.00	0.00			
AUDIOLOGY	658.00	0.00			
CARDIOLOGY	15,668.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,402.00	0.00			
			TOTAL ANCILLARY	773,752.33	658.00
			TOTAL ACCOMODATIONS	132,340.00	570.00
			TOTAL CHARGES	906,092.33	1,228.00

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

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

Run Date: 08/12/2016  
Run Time: 03:29:02  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000437A

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

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 03:29:02  
Page: 4

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

PROVIDER NUMBER  
000000437A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,472,249.83	ADJUSTMENTS	89,209.93
COVERED CHARGES	1,343,861.27	CONTRACTUAL ALLOW	950,629.66
NON-COVERD CHARGES	128,388.56	TOTAL MEDICAID LIAB	393,231.61
		LESS: COB	64.83
		LESS: COPAYMENT	1,113.00
		REIMBURSEMENT	392,053.78
		ALL OTHER	357,947.98
		FEE SCHEDULE-LAB	29,806.57
		INJECTABLE DRUGS	4,299.23

TOTAL NUMBER OF CLAIMS 964



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

PROVIDER NUMBER  
 000000437A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,057.09	7,556.70	OTHER LAB	7,257.00	0.00
MED/SURG SUPPLY	70,460.04	12,132.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,049.00	1,866.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	213,466.00	9,938.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,384.00	3,543.00	FEE SCHEDULE LAB	253,191.00	23,881.00
EKG/ECG	15,680.00	320.00	MRI SERVICES	33,492.00	1,353.00
IV THERAPY	50,873.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	54,439.00	11,183.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	795.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,433.00	107.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1.00	222.00	AMBULANCE	0.00	0.00
GI SERVICES	58,057.34	13,823.66	CAST ROOM	0.00	0.00
EMERGENCY ROOM	281,046.00	320.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,355.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	204.00	INJECTABLE DRUGS	47,245.80	24,068.20
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	213.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,898.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,266.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,117.00	1,134.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,149.00	2,632.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	37,897.00	9,066.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,768.00	2,674.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	29,796.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,587.00	254.00			
			TOTAL ANCILLARY	1,343,861.27	128,388.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,343,861.27	128,388.56

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

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

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000437A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,506.88	ADJUSTMENTS	0.00
COVERED CHARGES	25,681.88	CONTRACTUAL ALLOW	6,794.60
NON-COVERD CHARGES	2,825.00	TOTAL MEDICAID LIAB	18,887.28
		LESS: COB	18,863.28
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 24

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

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

PROVIDER NUMBER  
 000000437A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	149.88	0.00	OTHER LAB	441.00	0.00
MED/SURG SUPPLY	61.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,615.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,710.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	473.00	FEE SCHEDULE LAB	6,554.00	1,146.00
EKG/ECG	320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,993.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	612.00	383.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	678.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,548.00	823.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,681.88	2,825.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,681.88	2,825.00

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

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

Run Date: 08/12/2016  
Run Time: 03:29:07  
Page: 8

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

PROVIDER NUMBER  
000000437A

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

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	121,918.96	ADJUSTMENTS	797.10
COVERED CHARGES	116,741.00	CONTRACTUAL ALLOW	106,951.50
NON-COVERD CHARGES	5,177.96	TOTAL MEDICAID LIAB	9,789.50
		LESS: COB	0.00
		LESS: COPAYMENT	372.00
		REIMBURSEMENT	9,417.50
		TOTAL NUMBER OF CLAIMS	175

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000437A

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

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,155.00	311.96	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,125.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,347.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,184.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,984.00	2,540.00
EKG/ECG	1,600.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,872.00	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	1,144.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	66,476.00	212.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,894.00	2,114.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	960.00	0.00			
			TOTAL ANCILLARY	116,741.00	5,177.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	116,741.00	5,177.96

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

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

Run Date: 08/12/2016  
Run Time: 03:29:08  
Page: 10

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

PROVIDER NUMBER 000000437A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 05/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,308.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,055.00	CONTRACTUAL ALLOW	1,650.75
NON-COVERD CHARGES	253.00	TOTAL MEDICAID LIAB	1,404.25
		LESS: COB	1,401.25
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 05/31/15  
 ADMISSION DATES 00/00/00 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	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	1,163.00	253.00
EKG/ECG	160.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,561.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,055.00	253.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,055.00	253.00

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000437A

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

\*\* NO DATA \*\*



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

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

Run Date: 08/12/2016  
Run Time: 03:29:09  
Page: 13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000437A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	05/31/15
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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,638,806.74	ADJUSTMENTS	1,086,019.05
COVERED CHARGES	12,374,211.15	CONTRACTUAL ALLOW	8,224,631.47
NON-COVERD CHARGES	264,595.59	TOTAL MEDICAID LIAB	4,149,579.68
		LESS: COB	38,709.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,110,870.27

TOTAL NUMBER OF ADMISSIONS 513

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,759		9	1,161,201.00		80,098.00
ROUTINE NURSERY	94		0	55,264.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,853		9	1,216,465.00		80,098.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	408		0	526,548.00		0.00
NICU	2		0	1,406.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	410		0	527,954.00		0.00
TOTAL ACCOMODATIONS	2,263		9	1,744,419.00		80,098.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,622,587.00	0.00	OTHER LAB	46,508.00	0.00
MED/SURG SUPPLY	558,310.00	840.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,279,523.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	286,495.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	374,892.00	15,806.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	96,725.33	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	289,340.00	0.00	MRI SERVICES	118,897.86	0.00
IV THERAPY	215,966.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,459,594.00	17,933.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,622.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	851,921.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	187,117.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	79,812.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	289,787.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,091.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	49,012.00
LABORATORY PATHOLOGIC	25,118.00	0.00	INJECTABLE DRUGS	106,375.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,440.31	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	51,575.00	2,920.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,984.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	828,484.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,498.00
OTHER IMAGING SERVICE	35,692.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,235.00	89,320.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	114,658.00	2,795.00			
AUDIOLOGY	3,397.00	0.00			
CARDIOLOGY	358,707.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,233.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	205,705.65	373.59			
			TOTAL ANCILLARY	10,629,792.15	184,497.59
			TOTAL ACCOMODATIONS	1,744,419.00	80,098.00
			TOTAL CHARGES	12,374,211.15	264,595.59

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

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

Run Date: 08/12/2016  
Run Time: 01:47:02  
Page: 3

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

PROVIDER NUMBER  
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215362002748	07/19/15 - 07/23/15	02/22/16	0.00	5,498.00	0.00	0.00	0.00
TOTAL				0.00	5,498.00	0.00	0.00	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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	267,125.04	ADJUSTMENTS	0.00
COVERED CHARGES	263,652.04	CONTRACTUAL ALLOW	217,761.49
NON-COVERD CHARGES	3,473.00	TOTAL MEDICAID LIAB	45,890.55
		LESS: COB	45,890.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	32		0	20,312.00		2,184.00
ROUTINE NURSERY	0		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	20,312.00		2,184.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	8		0	10,472.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	8		0	10,472.00		0.00
TOTAL ACCOMODATIONS	40		0	30,784.00		2,184.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,542.00	0.00	OTHER LAB	1,067.00	0.00
MED/SURG SUPPLY	11,380.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	39,170.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,598.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,964.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,279.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,206.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,031.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,975.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,724.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,462.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,867.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	147.00	0.00	INJECTABLE DRUGS	8,563.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,317.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	389.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	442.00	992.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	978.00	297.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	70,562.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	205.00	0.00			
			TOTAL ANCILLARY	232,868.04	1,289.00
			TOTAL ACCOMODATIONS	30,784.00	2,184.00
			TOTAL CHARGES	263,652.04	3,473.00

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

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

Run Date: 08/12/2016  
Run Time: 01:47:12  
Page: 6

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,847,049.14	ADJUSTMENTS	619,205.05
COVERED CHARGES	11,163,484.98	CONTRACTUAL ALLOW	9,108,996.46
NON-COVERD CHARGES	683,564.16	TOTAL MEDICAID LIAB	2,054,488.52
		LESS: COB	14,457.54
		LESS: COPAYMENT	5,578.73
		REIMBURSEMENT	2,034,452.25
		ALL OTHER	1,847,426.69
		FEE SCHEDULE-LAB	166,326.25
		INJECTABLE DRUGS	20,699.31

TOTAL NUMBER OF CLAIMS 4,984

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	445,785.98	584.00	OTHER LAB	65,163.00	0.00
MED/SURG SUPPLY	323,750.00	1,463.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	407,444.00	16,996.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,033,646.00	60,337.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,356.00	3,243.04	FEE SCHEDULE LAB	2,087,142.98	126,756.00
EKG/ECG	172,789.96	3,387.00	MRI SERVICES	274,041.00	10,547.00
IV THERAPY	690,698.00	33,596.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,817,370.00	97,169.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,084.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	126,764.00	28,401.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	344,949.00	1,657.00	AMBULANCE	0.00	0.00
GI SERVICES	260,277.00	15,064.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,471,641.07	5,583.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	79,232.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	9,996.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	112,160.99	22,946.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	564.00	846.15	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,490.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	220,414.00	249.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	69,749.00	133,977.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	162,842.00	9,984.00			
BLOOD	380.00	0.00			
BLOOD STORAGE & PRO.	2,128.00	8,968.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	322,052.00	3,977.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	206,439.00	18,201.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,469.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	386,153.00	60,146.95			
			TOTAL ANCILLARY	11,163,484.98	683,564.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,163,484.98	683,564.16



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

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

Run Date: 08/12/2016  
Run Time: 01:48:00  
Page: 8

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	91,871.04	ADJUSTMENTS	0.00
COVERED CHARGES	81,427.04	CONTRACTUAL ALLOW	33,198.20
NON-COVERD CHARGES	10,444.00	TOTAL MEDICAID LIAB	48,228.84
		LESS: COB	48,216.84
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 38

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

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,916.00	0.00	OTHER LAB	596.00	0.00
MED/SURG SUPPLY	1,842.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,100.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,854.00	1,264.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,219.00	1,291.00	FEE SCHEDULE LAB	17,302.00	817.00
EKG/ECG	370.00	0.00	MRI SERVICES	0.00	5,251.00
IV THERAPY	5,624.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,357.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	648.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,663.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,528.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,857.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	287.00	275.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	842.00	1,546.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,459.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,963.04	0.00			
			TOTAL ANCILLARY	81,427.04	10,444.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	81,427.04	10,444.00

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

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

Run Date: 08/12/2016  
Run Time: 01:48:02  
Page: 10

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	605,444.53	ADJUSTMENTS	1,873.90
COVERED CHARGES	596,362.53	CONTRACTUAL ALLOW	555,358.49
NON-COVERD CHARGES	9,082.00	TOTAL MEDICAID LIAB	41,004.04
		LESS: COB	0.00
		LESS: COPAYMENT	1,232.76
		REIMBURSEMENT	39,771.28
		TOTAL NUMBER OF CLAIMS	735

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,909.99	0.00	OTHER LAB	4,691.00	0.00
MED/SURG SUPPLY	4,124.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,135.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,643.00	1,264.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	118,821.99	6,077.00
EKG/ECG	3,330.00	0.00	MRI SERVICES	2,603.00	0.00
IV THERAPY	38,807.00	83.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,032.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,446.00	734.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,462.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	295,816.02	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	619.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,751.00	194.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	730.00	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	4,917.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,171.53	0.00			
			TOTAL ANCILLARY	596,362.53	9,082.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	596,362.53	9,082.00

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

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

Run Date: 08/12/2016  
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Page: 12

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,598.00	ADJUSTMENTS	0.00
COVERED CHARGES	11,007.00	CONTRACTUAL ALLOW	7,768.39
NON-COVERD CHARGES	591.00	TOTAL MEDICAID LIAB	3,238.61
		LESS: COB	3,232.57
		LESS: COPAYMENT	6.04
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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

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

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	175.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	197.99	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	173.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,075.97	125.00
EKG/ECG	185.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,206.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,556.04	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	17.00	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	421.00	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	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,007.00	591.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,007.00	591.00

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

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

Run Date: 08/12/2016  
Run Time: 01:48:09  
Page: 14

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,358,913.00	ADJUSTMENTS	101,767.89
COVERED CHARGES	1,269,187.00	CONTRACTUAL ALLOW	1,060,131.84
NON-COVERD CHARGES	89,726.00	TOTAL MEDICAID LIAB	209,055.16
		LESS: COB	0.00
		LESS: COPAYMENT	108.00
		REIMBURSEMENT	208,947.16

TOTAL NUMBER OF CLAIMS 37

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,392.00	0.00	OTHER LAB	625.00	0.00
MED/SURG SUPPLY	8,756.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,052.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,264.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,575.00	100.00
EKG/ECG	370.00	185.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	805,527.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,120.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	60,765.00	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	19,189.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,025.00	1,007.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	171,994.00	68,081.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	389.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	128,763.00	20,353.00			
			TOTAL ANCILLARY	1,269,187.00	89,726.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,269,187.00	89,726.00



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

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

Run Date: 08/12/2016  
Run Time: 01:48:11  
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000448A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000459A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,324,943.93	ADJUSTMENTS	889,392.59
COVERED CHARGES	35,811,669.93	CONTRACTUAL ALLOW	27,844,786.15
NON-COVERD CHARGES	2,513,274.00	TOTAL MEDICAID LIAB	7,966,883.78
		LESS: COB	63,408.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,903,475.23

TOTAL NUMBER OF ADMISSIONS 889

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,415		12	2,994,955.00		1,971,101.00
ROUTINE NURSERY	195		0	381,148.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,610		12	3,376,103.00		1,971,101.00
SPECIAL CARE SERVICES						
CCU	267		0	528,514.00		0.00
ICU	926		0	2,256,604.00		49,280.00
NICU	185		3	716,223.00		11,301.00
PED ICU	0		0	0.00		0.00
NEURO ICU	22		0	61,428.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,400		3	3,562,769.00		60,581.00
TOTAL ACCOMODATIONS	5,010		15	6,938,872.00		2,031,682.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,419,231.00	4,784.25	OTHER LAB	184,214.25	0.00
MED/SURG SUPPLY	1,160,931.25	7,495.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,784,172.75	12,765.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,065,994.25	577.00	OTHER THERAPEUTIC SVC	0.00	1,220.00
CT SCAN	1,257,409.00	291,909.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	609,093.97	1,361.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	177,056.25	0.00	MRI SERVICES	453,618.25	0.00
IV THERAPY	51,198.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,259,023.50	6,181.00	DURABLE MED. EQUIP.	0.00	144.00
LABOR/DELIVERY ROOM	267,113.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,329,577.25	49,615.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	485,664.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	119,515.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	903,243.25	967.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	378,471.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	70,150.00
LABORATORY PATHOLOGIC	115,151.25	0.00	INJECTABLE DRUGS	6,366,734.95	19,248.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	499,213.59	865.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	116,955.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	190,836.00	11,286.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,827.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,592.75	0.00	IMPL DEV CHARGE PATIENTS	354,333.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	282,460.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	231,343.50	650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	126,466.75	262.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,611,853.75	2,112.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,726.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,775.92	0.00			
			TOTAL ANCILLARY	28,872,797.93	481,592.00
			TOTAL ACCOMODATIONS	6,938,872.00	2,031,682.00
			TOTAL CHARGES	35,811,669.93	2,513,274.00

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

PROVIDER NUMBER 000000459A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	218,281.00	ADJUSTMENTS	0.00
COVERED CHARGES	216,581.00	CONTRACTUAL ALLOW	135,340.49
NON-COVERD CHARGES	1,700.00	TOTAL MEDICAID LIAB	81,240.51
		LESS: COB	81,240.51
		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	28		0	24,556.00		1,700.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	28		0	24,556.00		1,700.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	28		0	24,556.00		1,700.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,447.25	0.00	OTHER LAB	3,927.00	0.00
MED/SURG SUPPLY	2,344.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,731.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	356.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,615.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	62,301.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	315.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,106.50	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	40,035.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,759.50	0.00	INJECTABLE DRUGS	23,660.75	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	49.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,640.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	735.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	192,025.00	0.00
			TOTAL ACCOMODATIONS	24,556.00	1,700.00
			TOTAL CHARGES	216,581.00	1,700.00

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

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

Run Date: 08/12/2016  
Run Time: 01:48:31  
Page: 5

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,683,765.77	ADJUSTMENTS	62,952.07
COVERED CHARGES	11,653,206.44	CONTRACTUAL ALLOW	10,470,789.05
NON-COVERD CHARGES	2,030,559.33	TOTAL MEDICAID LIAB	1,182,417.39
		LESS: COB	107.15
		LESS: COPAYMENT	1,344.00
		REIMBURSEMENT	1,180,966.24
		ALL OTHER	1,053,246.33
		FEE SCHEDULE-LAB	118,726.10
		INJECTABLE DRUGS	8,993.81
		TOTAL NUMBER OF CLAIMS	3,656

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	245,026.75	450.00	OTHER LAB	102,649.50	0.00
MED/SURG SUPPLY	157,529.50	70,950.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	348.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	982,287.50	3,672.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,020,418.75	596,368.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,910.75	FEE SCHEDULE LAB	2,609,133.54	346,327.64
EKG/ECG	217,668.75	7,125.00	MRI SERVICES	99,574.75	35,710.25
IV THERAPY	432,770.50	18,135.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	549,403.48	103,457.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,456.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50,163.25	7,480.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	240,183.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	162,806.67	28,469.33	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,645,990.25	74,247.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	200,254.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,101.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	93,986.50	65,150.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,090.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,280.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,026.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,298.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	39,573.75	27,800.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	370,893.75	148,535.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,627.25	4,905.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	28,812.50	20,734.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	298,494.75	453,694.74			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,517.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	75,983.00	4,292.00			
			TOTAL ANCILLARY	11,653,206.44	2,030,559.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,653,206.44	2,030,559.33

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: 08/12/2016  
Run Time: 01:49:01  
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	257,122.25	ADJUSTMENTS	0.00
COVERED CHARGES	178,721.00	CONTRACTUAL ALLOW	112,793.23
NON-COVERD CHARGES	78,401.25	TOTAL MEDICAID LIAB	65,927.77
		LESS: COB	65,894.77
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 69



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

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,099.25	0.00	OTHER LAB	3,927.00	0.00
MED/SURG SUPPLY	1,531.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,206.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,279.00	24,551.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	46,638.25	3,678.25
EKG/ECG	2,137.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,308.00	310.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,633.00	10,671.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,448.00	295.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,138.00	724.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,914.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,736.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,468.00	2,395.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,902.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	506.25	25,448.25
RADIOLOGY THERAPEUTIC	800.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,220.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,443.25	7,591.25			
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	4,120.00	0.00			
			TOTAL ANCILLARY	178,721.00	78,401.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	178,721.00	78,401.25

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

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

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,186,205.75	ADJUSTMENTS	379.58
COVERED CHARGES	1,081,747.25	CONTRACTUAL ALLOW	1,044,988.71
NON-COVERD CHARGES	104,458.50	TOTAL MEDICAID LIAB	36,758.54
		LESS: COB	0.00
		LESS: COPAYMENT	1,368.00
		REIMBURSEMENT	35,390.54
		TOTAL NUMBER OF CLAIMS	658

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,762.75	0.00	OTHER LAB	12,594.00	0.00
MED/SURG SUPPLY	664.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	108,771.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	92,497.50	54,005.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	256,293.25	38,588.00
EKG/ECG	12,825.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	39,916.25	1,104.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,314.00	249.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	522,835.75	782.25	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	6,317.75	2,320.75
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	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	9,955.25	6,728.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	625.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,081,747.25	104,458.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,081,747.25	104,458.50

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

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

PROVIDER NUMBER  
000000459A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,920.50	ADJUSTMENTS	0.00
COVERED CHARGES	30,818.00	CONTRACTUAL ALLOW	25,432.78
NON-COVERD CHARGES	6,102.50	TOTAL MEDICAID LIAB	5,385.22
		LESS: COB	5,376.22
		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

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	334.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	60.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,835.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,670.00	3,977.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,665.50	2,055.25
EKG/ECG	1,068.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	383.50	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	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	9,666.25	69.75	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	60.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,818.00	6,102.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,818.00	6,102.50

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

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	630,392.00	ADJUSTMENTS	0.00
COVERED CHARGES	613,817.00	CONTRACTUAL ALLOW	574,037.80
NON-COVERD CHARGES	16,575.00	TOTAL MEDICAID LIAB	39,779.20
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	39,749.20

TOTAL NUMBER OF CLAIMS 7

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

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,066.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,512.50	8,670.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,657.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,417.00	0.00
EKG/ECG	356.25	356.25	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	382,634.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,715.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,062.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	753.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	180,117.25	5,775.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,208.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,319.00	1,773.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	613,817.00	16,575.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	613,817.00	16,575.00

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

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

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	115,306.50	ADJUSTMENTS	0.00
COVERED CHARGES	104,240.75	CONTRACTUAL ALLOW	10,671.63
NON-COVERD CHARGES	11,065.75	TOTAL MEDICAID LIAB	93,569.12
		LESS: COB	93,566.12
		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

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,142.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	119.25	1,503.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	603.25	516.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	698.00	0.00
EKG/ECG	0.00	356.25	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	57,858.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	391.00	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	41,816.25	1,050.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,612.00	7,450.75			
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	0.00	0.00			
			TOTAL ANCILLARY	104,240.75	11,065.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	104,240.75	11,065.75

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,391,326.39	ADJUSTMENTS	431,421.81
COVERED CHARGES	20,654,764.70	CONTRACTUAL ALLOW	15,171,755.59
NON-COVERD CHARGES	736,561.69	TOTAL MEDICAID LIAB	5,483,009.11
		LESS: COB	44,541.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,438,467.26

TOTAL NUMBER OF ADMISSIONS 591

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,549		9	907,680.00		478,796.00
ROUTINE NURSERY	210		1	131,218.00		87,134.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,759		10	1,038,898.00		565,930.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	848		0	1,649,412.00		3,116.00
NICU	1		0	2,903.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	849		0	1,652,315.00		3,116.00
TOTAL ACCOMODATIONS	2,608		10	2,691,213.00		569,046.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,929,279.72	14,362.35	OTHER LAB	110,949.00	0.00
MED/SURG SUPPLY	582,012.68	5,848.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,137,017.00	40,389.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	513,552.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,345,676.00	7,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	161,550.22	1,339.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	197,067.00	0.00	MRI SERVICES	221,666.00	0.00
IV THERAPY	36,368.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,629,451.00	4,666.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	247,714.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,462,697.00	9,888.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	259,375.00	0.00	AMBULANCE	0.00	3,564.00
GI SERVICES	167,326.00	2,521.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,119,806.00	6,799.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	407,641.00	2,386.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	51,713.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	75,231.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	42,186.00	1,140.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	49,240.00	2,736.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	253,044.00	7,128.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	43,316.00	4,742.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,029,567.28	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	181,146.00	5,300.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	251,820.00	36,650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	55,796.00	10,457.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	325,411.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	45,993.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,940.80	0.00			
			TOTAL ANCILLARY	17,963,551.70	167,515.69
			TOTAL ACCOMODATIONS	2,691,213.00	569,046.00
			TOTAL CHARGES	20,654,764.70	736,561.69

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,531.97	ADJUSTMENTS	0.00
COVERED CHARGES	29,987.97	CONTRACTUAL ALLOW	20,972.33
NON-COVERD CHARGES	2,544.00	TOTAL MEDICAID LIAB	9,015.64
		LESS: COB	9,015.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6		0	3,660.00		2,544.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6		0	3,660.00		2,544.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	6		0	3,660.00		2,544.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,396.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	842.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,173.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,844.00	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,648.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	860.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	221.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,093.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,327.97	0.00
			TOTAL ACCOMODATIONS	3,660.00	2,544.00
			TOTAL CHARGES	29,987.97	2,544.00

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

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

Run Date: 08/12/2016  
Run Time: 02:52:54  
Page: 5

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

PROVIDER NUMBER  
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,130,224.10	ADJUSTMENTS	478,885.24
COVERED CHARGES	15,385,049.49	CONTRACTUAL ALLOW	13,221,603.14
NON-COVERD CHARGES	2,745,174.61	TOTAL MEDICAID LIAB	2,163,446.35
		LESS: COB	45,608.61
		LESS: COPAYMENT	4,080.00
		REIMBURSEMENT	2,113,757.74
		ALL OTHER	1,928,311.68
		FEE SCHEDULE-LAB	143,816.06
		INJECTABLE DRUGS	41,630.00

TOTAL NUMBER OF CLAIMS 4,761

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	357,023.39	36,989.80	OTHER LAB	162,651.00	0.00
MED/SURG SUPPLY	275,677.80	15,829.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	841,837.00	8,662.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,219,706.00	793,520.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	8,873.18	FEE SCHEDULE LAB	2,438,210.40	365,840.40
EKG/ECG	322,765.00	9,746.00	MRI SERVICES	233,243.00	55,036.00
IV THERAPY	37,747.00	1,137.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	881,697.00	234,911.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	92,348.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95,186.00	42,357.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	189,137.00	1,536.00	AMBULANCE	0.00	0.00
GI SERVICES	270,214.00	80,333.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,154,683.00	119,870.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	343,095.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	563,533.13	296,278.00
RADIOLOGY THERAPEUTIC	229,568.00	8,340.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,721.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,833.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	37,812.00	10,387.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	37,626.31	50,348.71
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	447,038.00	250,374.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,876.00	14,660.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	202,161.00	229,765.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	352,982.00	100,167.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	215,338.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	360,894.46	4,660.00			
			TOTAL ANCILLARY	15,385,049.49	2,745,174.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,385,049.49	2,745,174.61

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	405,349.80	ADJUSTMENTS	0.00
COVERED CHARGES	285,320.82	CONTRACTUAL ALLOW	195,176.36
NON-COVERD CHARGES	120,028.98	TOTAL MEDICAID LIAB	90,144.46
		LESS: COB	89,990.89
		LESS: COPAYMENT	153.57
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 107



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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,107.77	499.20	OTHER LAB	1,901.00	0.00
MED/SURG SUPPLY	4,705.95	283.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,238.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,447.00	54,859.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,156.00	3,601.00
EKG/ECG	4,430.00	0.00	MRI SERVICES	7,976.00	12,866.00
IV THERAPY	5,080.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,647.00	20,132.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,024.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	732.00	1,026.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,946.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,528.00	333.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,091.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,879.90	2,738.33
RADIOLOGY THERAPEUTIC	1,199.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,195.00	221.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	702.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,510.00	15,325.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	4,674.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,769.00	2,769.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,758.20	0.00			
			TOTAL ANCILLARY	285,320.82	120,028.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	285,320.82	120,028.98

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: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	617,020.21	ADJUSTMENTS	850.03
COVERED CHARGES	551,008.88	CONTRACTUAL ALLOW	525,786.66
NON-COVERD CHARGES	66,011.33	TOTAL MEDICAID LIAB	25,222.22
		LESS: COB	2,342.74
		LESS: COPAYMENT	723.00
		REIMBURSEMENT	22,156.48
		TOTAL NUMBER OF CLAIMS	410

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,223.85	832.00	OTHER LAB	1,385.00	0.00
MED/SURG SUPPLY	6,562.64	274.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,998.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,945.00	31,098.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	89,597.00	14,421.00
EKG/ECG	7,088.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,937.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	902.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,404.00	212.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,409.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	344,680.00	4,154.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,547.19	3,546.71
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	442.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,872.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,116.00	8,697.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,597.00	462.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,617.20	0.00			
			TOTAL ANCILLARY	551,008.88	66,011.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	551,008.88	66,011.33

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,572.30	ADJUSTMENTS	0.00
COVERED CHARGES	12,393.90	CONTRACTUAL ALLOW	7,291.50
NON-COVERD CHARGES	1,178.40	TOTAL MEDICAID LIAB	5,102.40
		LESS: COB	5,093.40
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.90	166.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	95.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	658.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,051.00	1,012.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,617.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	947.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,393.90	1,178.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,393.90	1,178.40

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: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	738,244.73	ADJUSTMENTS	12,467.40
COVERED CHARGES	718,863.18	CONTRACTUAL ALLOW	643,785.04
NON-COVERD CHARGES	19,381.55	TOTAL MEDICAID LIAB	75,078.14
		LESS: COB	0.00
		LESS: COPAYMENT	465.00
		REIMBURSEMENT	74,613.14
		TOTAL NUMBER OF CLAIMS	12

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,607.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	630.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,864.00	5,292.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	39,231.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	256,627.58	1,527.55
RADIOLOGY THERAPEUTIC	392,514.00	10,763.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	618.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,216.00	1,466.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,555.00	333.00			
			TOTAL ANCILLARY	718,863.18	19,381.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	718,863.18	19,381.55

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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	07/01/14	THROUGH	06/30/15
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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	91,732,436.80	ADJUSTMENTS	8,110,064.95
COVERED CHARGES	87,548,276.54	CONTRACTUAL ALLOW	60,575,745.19
NON-COVERD CHARGES	4,184,160.26	TOTAL MEDICAID LIAB	26,972,531.35
		LESS: COB	214,789.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	26,757,741.84

TOTAL NUMBER OF ADMISSIONS 2,172

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,611		13	15,182,370.00		1,917,135.00
ROUTINE NURSERY	1,268		26	1,662,745.00		31,135.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13,879		39	16,845,115.00		1,948,270.00
SPECIAL CARE SERVICES						
CCU	439		0	2,030,375.00		0.00
ICU	1,586		0	7,288,375.00		46,250.00
NICU	354		0	1,071,925.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,379		0	10,390,675.00		46,250.00
TOTAL ACCOMODATIONS	16,258		39	27,235,790.00		1,994,520.00

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,978,299.88	8,455.21	OTHER LAB	509,218.00	3,644.00
MED/SURG SUPPLY	4,646,704.83	131,440.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,243,299.00	205,493.00	EDUCATION & TRAINING	159.00	0.00
RADIOLOGY-DIAGNOSTIC	1,203,512.00	8,554.00	OTHER THERAPEUTIC SVC	0.00	6,818.00
CT SCAN	2,906,148.00	56,986.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,320,727.24	65,180.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	353,834.00	690.00	MRI SERVICES	1,405,159.00	0.00
IV THERAPY	4,999.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,668,539.00	19,332.00	DURABLE MED. EQUIP.	0.00	4,923.45
LABOR/DELIVERY ROOM	949,357.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,348,444.00	124,872.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,793,824.00	4,140.00	AMBULANCE	0.00	0.00
GI SERVICES	416,685.00	4,091.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,019,092.00	8,854.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	590,862.00	2,718.00	DRUG-SPECIFIC/HOME IV	0.00	58,762.96
LABORATORY PATHOLOGIC	540,678.00	0.00	INJECTABLE DRUGS	8,370,672.44	139,386.62
RADIOLOGY THERAPEUTIC	77,596.00	2,373.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	351,771.12	5,778.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	218,648.81	2,090.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,323,721.00	328,096.00	PATIENT CONVENIENCE	0.00	257.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	126.00	2,146.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,591,988.20	29.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	541,417.00
OTHER IMAGING SERVICE	313,316.02	278,838.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,092,584.00	51,347.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	174,205.00	112,264.00			
AUDIOLOGY	16,539.00	0.00			
CARDIOLOGY	2,596,293.00	8,015.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	241,493.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,992.00	2,650.00			
			TOTAL ANCILLARY	60,312,486.54	2,189,640.26
			TOTAL ACCOMODATIONS	27,235,790.00	1,994,520.00
			TOTAL CHARGES	87,548,276.54	4,184,160.26

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014263026518	09/10/14 - 09/12/14	09/29/14	0.00	2,974.00	0.00	0.00	0.00
614	2014263026536	09/05/14 - 09/10/14	09/29/14	0.00	2,974.00	0.00	0.00	0.00
614	2014273032031	09/07/14 - 09/21/14	10/06/14	0.00	2,907.00	0.00	0.00	0.00
614	2014277025393	09/25/14 - 09/28/14	10/13/14	0.00	13,194.00	0.00	0.00	0.00
614	2014290031804	09/29/14 - 10/10/14	10/20/14	0.00	2,907.00	0.00	0.00	0.00
614	2014291033729	09/25/14 - 10/04/14	10/27/14	0.00	2,974.00	0.00	0.00	0.00
614	2014296033296	10/15/14 - 10/17/14	10/27/14	0.00	6,587.00	0.00	0.00	0.00
614	2014297039492	09/05/14 - 09/11/14	10/27/14	0.00	6,597.00	0.00	0.00	0.00
614	2014298025197	10/13/14 - 10/17/14	11/03/14	0.00	6,597.00	0.00	0.00	0.00
615	2014300015697	10/15/14 - 10/21/14	11/03/14	0.00	3,015.00	0.00	0.00	0.00
614	2014303034623	09/21/14 - 10/15/14	11/03/14	0.00	6,597.00	0.00	0.00	0.00
614	2014306000584	10/18/14 - 10/27/14	11/10/14	0.00	6,597.00	0.00	0.00	0.00
615	5914317000026	10/02/14 - 10/21/14	11/17/14	0.00	11,790.00	0.00	0.00	0.00
614	2014318027948	11/07/14 - 11/08/14	11/17/14	0.00	6,597.00	0.00	0.00	0.00
614	2214328012215	10/06/14 - 10/23/14	12/01/14	0.00	6,597.00	0.00	0.00	0.00
614	2014330016722	10/21/14 - 10/30/14	12/01/14	0.00	13,194.00	0.00	0.00	0.00
614	2014342007283	11/27/14 - 12/02/14	12/15/14	0.00	2,984.00	0.00	0.00	0.00
614	2014346011359	12/04/14 - 12/06/14	12/15/14	0.00	6,597.00	0.00	0.00	0.00
614	2214350006688	11/02/14 - 12/04/14	12/22/14	0.00	9,504.00	0.00	0.00	0.00
615	2014357027798	11/11/14 - 11/14/14	12/29/14	0.00	5,895.00	0.00	0.00	0.00
615	2014358029667	09/29/14 - 11/26/14	12/29/14	0.00	11,790.00	0.00	0.00	0.00
615	2215006005698	11/27/14 - 12/05/14	01/12/15	0.00	11,790.00	0.00	0.00	0.00
614	5915006001400	11/20/14 - 12/03/14	01/12/15	0.00	13,194.00	0.00	0.00	0.00
615	9115009002033	11/12/14 - 11/16/14	01/19/15	0.00	6,030.00	0.00	1,689.47	0.00
614	2015016010056	12/10/14 - 01/09/15	01/19/15	0.00	2,974.00	0.00	0.00	0.00
614	2015021011654	01/07/15 - 01/15/15	01/26/15	0.00	13,194.00	0.00	0.00	0.00
614	2015022024320	12/28/14 - 01/13/15	01/26/15	0.00	13,194.00	0.00	0.00	0.00
618	2015028022331	10/04/14 - 11/09/14	02/02/15	0.00	11,628.00	0.00	0.00	0.00
614	2015028022331	10/04/14 - 11/09/14	02/02/15	0.00	6,557.00	0.00	0.00	0.00
615	9115029001654	12/10/14 - 12/13/14	02/16/15	0.00	11,790.00	0.00	3,264.47	0.00
615	2015052024882	01/28/15 - 02/13/15	03/02/15	0.00	5,895.00	0.00	0.00	0.00
615	1115054002871	01/12/15 - 01/15/15	03/23/15	0.00	3,015.00	0.00	1,715.41	0.00
614	5215064000028	09/17/14 - 10/17/14	03/09/15	0.00	6,597.00	0.00	5,851.22	0.00
614	5215064000028	09/17/14 - 10/17/14	03/09/15	0.00	6,597.00	0.00	5,851.22	0.00
615	2015069026839	01/31/15 - 03/04/15	03/16/15	0.00	3,015.00	0.00	0.00	0.00
615	9115054006254	10/01/14 - 10/04/14	03/16/15	0.00	3,015.00	0.00	1,709.41	0.00
615	2015081000237	02/27/15 - 03/04/15	03/30/15	0.00	11,790.00	0.00	0.00	0.00
615	2015107028883	04/05/15 - 04/10/15	04/20/15	0.00	3,015.00	0.00	0.00	0.00
615	2015111024004	03/21/15 - 04/13/15	04/27/15	0.00	3,015.00	0.00	0.00	0.00
615	2015111024196	04/04/15 - 04/13/15	04/27/15	0.00	11,790.00	0.00	0.00	0.00
615	2015118026011	04/17/15 - 04/22/15	05/04/15	0.00	11,790.00	0.00	0.00	0.00
615	2015147008232	04/23/15 - 04/24/15	06/01/15	0.00	11,790.00	0.00	0.00	0.00

SUMMARY TYPE I  
INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN  
550 PEACHTREE ST NE  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM
615	2015148037988	04/29/15 - 05/02/15	06/01/15	0.00	11,790.00	0.00	0.00	0.00
615	2015155028959	05/06/15 - 05/17/15	06/08/15	0.00	11,790.00	0.00	0.00	0.00
615	2015159003125	05/25/15 - 06/02/15	06/15/15	0.00	11,790.00	0.00	0.00	0.00
615	2315159000099	03/20/15 - 04/03/15	07/06/15	0.00	6,030.00	0.00	3,381.68	0.00
615	2015163027353	05/16/15 - 05/17/15	06/15/15	0.00	11,790.00	0.00	0.00	0.00
615	5215168000020	03/16/15 - 04/08/15	06/22/15	0.00	11,790.00	0.00	0.00	0.00
615	2015175005184	09/27/14 - 09/30/14	06/29/15	0.00	3,015.00	0.00	0.00	0.00
615	2315176000036	03/31/15 - 04/04/15	08/03/15	0.00	11,790.00	0.00	3,601.39	0.00
615	2015181012039	06/16/15 - 06/21/15	07/06/15	0.00	6,030.00	0.00	0.00	0.00
615	2015190027751	01/26/15 - 01/31/15	07/13/15	0.00	5,895.00	0.00	0.00	0.00
615	2315197000023	05/07/15 - 05/11/15	08/17/15	0.00	3,015.00	0.00	2,292.65	0.00
615	2015244076849	05/21/15 - 05/31/15	09/07/15	0.00	11,790.00	0.00	0.00	0.00
615	5915254001640	04/28/15 - 06/11/15	09/21/15	0.00	3,015.00	0.00	0.00	0.00
615	5915254001642	02/05/15 - 05/05/15	09/21/15	0.00	11,790.00	0.00	0.00	0.00
615	2215258004469	06/25/15 - 07/26/15	09/21/15	0.00	11,790.00	0.00	0.00	0.00
615	2315265000158	01/08/15 - 01/21/15	10/19/15	0.00	3,015.00	0.00	5,083.75	0.00
615	2315300000301	02/17/15 - 02/18/15	11/23/15	0.00	11,790.00	0.00	3,083.00	0.00
615	2315302000093	07/18/15 - 07/22/15	11/30/15	0.00	11,790.00	0.00	3,337.76	0.00
615	5215362009154	08/13/15 - 08/18/15	02/22/16	0.00	11,790.00	0.00	0.00	0.00
615	5215362013293	08/10/15 - 08/30/15	02/22/16	0.00	11,790.00	0.00	0.00	0.00
615	5215362014776	08/23/15 - 09/05/15	02/22/16	0.00	6,220.00	0.00	0.00	0.00
615	5215363000296	08/27/15 - 09/01/15	02/22/16	0.00	11,790.00	0.00	0.00	0.00
615	2016007092712	06/02/15 - 06/11/15	01/11/16	0.00	11,790.00	0.00	0.00	0.00
615	2016014079302	08/30/15 - 09/02/15	02/08/16	0.00	3,015.00	0.00	0.00	0.00
615	2316040000193	04/08/15 - 04/10/15	03/21/16	0.00	11,790.00	0.00	53.02	0.00
614	2016200023929	07/11/15 - 09/11/15	07/25/16	0.00	2,984.00	0.00	0.00	0.00

TOTAL 0.00 541,417.00 0.00 40,914.45 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: 08/12/2016  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN  
 550 PEACHTREE ST NE  
 ATLANTA,GA 30308-2247

PROVIDER NUMBER  
 000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	680,891.69	ADJUSTMENTS	0.00
COVERED CHARGES	662,042.69	CONTRACTUAL ALLOW	308,112.04
NON-COVERD CHARGES	18,849.00	TOTAL MEDICAID LIAB	353,930.65
		LESS: COB	353,930.65
		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	127		0	155,575.00		15,875.00
ROUTINE NURSERY	6		0	5,160.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	133		0	160,735.00		15,875.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	4,625.00		0.00
NICU	1		0	2,980.00		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		0	7,605.00		0.00
TOTAL ACCOMODATIONS	135		0	168,340.00		15,875.00

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,439.05	0.00	OTHER LAB	993.00	0.00
MED/SURG SUPPLY	21,819.49	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	49,286.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,884.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,762.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,266.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	828.00	0.00	MRI SERVICES	2,974.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,176.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	145,699.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,105.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,743.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,633.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,278.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,699.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,217.00	0.00	INJECTABLE DRUGS	58,687.65	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,228.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,411.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,974.00
OTHER IMAGING SERVICE	2,549.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,454.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	131.00	0.00			
CARDIOLOGY	2,300.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,140.00	0.00			
			TOTAL ANCILLARY	493,702.69	2,974.00
			TOTAL ACCOMODATIONS	168,340.00	15,875.00
			TOTAL CHARGES	662,042.69	18,849.00

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

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

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN  
550 PEACHTREE ST NE  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2216005004481	02/21/15 - 03/20/15	01/11/16	0.00	2,974.00	0.00	51,913.50	0.00
TOTAL				0.00	2,974.00	0.00	51,913.50	0.00

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

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

Run Date: 08/12/2016  
Run Time: 02:05:36  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,605,568.80	ADJUSTMENTS	694,630.90
COVERED CHARGES	23,682,309.93	CONTRACTUAL ALLOW	17,897,838.44
NON-COVERD CHARGES	8,923,258.87	TOTAL MEDICAID LIAB	5,784,471.49
		LESS: COB	13,744.54
		LESS: COPAYMENT	21,115.49
		REIMBURSEMENT	5,749,611.46
		ALL OTHER	3,908,314.07
		FEE SCHEDULE-LAB	447,671.54
		INJECTABLE DRUGS	1,393,625.85

TOTAL NUMBER OF CLAIMS 10,517



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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	193,929.88	465,483.56	OTHER LAB	348,684.00	1,777.00
MED/SURG SUPPLY	646,016.38	110,446.08	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	42.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	806,176.00	75,968.00	OTHER THERAPEUTIC SVC	0.00	43,942.00
CT SCAN	1,723,826.00	1,438,166.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,542.00	17,969.02	FEE SCHEDULE LAB	4,159,648.15	454,936.60
EKG/ECG	245,128.00	10,115.00	MRI SERVICES	1,479,431.00	714,607.00
IV THERAPY	1,235,532.00	38,877.56	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,093,253.00	614,333.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,770.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108,624.00	55,034.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	555,661.00	3,546.00	AMBULANCE	0.00	0.00
GI SERVICES	107,849.00	55,259.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,433,538.00	50,481.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	496,806.00	4,428.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,636,977.16	1,630,320.05
RADIOLOGY THERAPEUTIC	191,221.00	4,581.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	7,871.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	252.00	4,537.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	308,284.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	111,057.00	11,417.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	70,635.40	409,071.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	259,223.00
OTHER IMAGING SERVICE	897,789.00	1,074,306.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	525,517.50	64,365.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	370,226.00	568,663.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	470,318.00	406,249.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,804.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	716,098.46	18,961.00			
			TOTAL ANCILLARY	23,682,309.93	8,923,258.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,682,309.93	8,923,258.87

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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014253062087	09/02/14 - 09/02/14	09/15/14	0.00	6,597.00	0.00	0.00	0.00
614	2014253062087	09/02/14 - 09/02/14	09/15/14	0.00	6,597.00	0.00	0.00	0.00
614	2014253062091	09/02/14 - 09/02/14	09/15/14	0.00	6,597.00	0.00	0.00	0.00
614	2014253062091	09/02/14 - 09/02/14	09/15/14	0.00	6,597.00	0.00	0.00	0.00
615	2014260029889	09/08/14 - 09/08/14	09/22/14	0.00	5,895.00	0.00	0.00	0.00
615	2014260029889	09/08/14 - 09/08/14	09/22/14	0.00	5,895.00	0.00	0.00	0.00
614	2014267031179	09/17/14 - 09/17/14	09/29/14	0.00	5,706.00	0.00	0.00	0.00
614	2014273032029	09/19/14 - 09/19/14	10/06/14	0.00	6,597.00	0.00	0.00	0.00
614	2014290056425	10/07/14 - 10/07/14	10/20/14	0.00	6,597.00	0.00	0.00	0.00
614	2014303034299	10/24/14 - 10/24/14	11/03/14	0.00	6,597.00	0.00	0.00	0.00
614	2014310026785	10/30/14 - 10/30/14	11/10/14	0.00	6,597.00	0.00	0.00	0.00
614	2014328011295	11/18/14 - 11/18/14	12/01/14	0.00	6,597.00	0.00	0.00	0.00
614	2014328011295	11/18/14 - 11/18/14	12/01/14	0.00	6,597.00	0.00	0.00	0.00
614	2014328011295	11/18/14 - 11/18/14	12/01/14	0.00	6,557.00	0.00	0.00	0.00
618	2014332048289	11/21/14 - 11/21/14	12/01/14	0.00	2,907.00	0.00	0.00	0.00
614	2214351011730	11/10/14 - 11/10/14	12/22/14	0.00	6,597.00	0.00	0.00	0.00
614	5914353000928	11/05/14 - 11/05/14	12/22/14	0.00	6,587.00	0.00	0.00	0.00
618	2014354024386	12/12/14 - 12/12/14	12/29/14	0.00	2,907.00	0.00	0.00	0.00
618	2014354024386	12/12/14 - 12/12/14	12/29/14	0.00	2,907.00	0.00	0.00	0.00
614	2014361004126	12/17/14 - 12/17/14	01/05/15	0.00	6,597.00	0.00	0.00	0.00
614	2014365029538	12/22/14 - 12/22/14	01/05/15	0.00	5,706.00	0.00	0.00	0.00
614	2015014019587	01/05/15 - 01/05/15	01/19/15	0.00	6,557.00	0.00	0.00	0.00
615	2015055027028	02/11/15 - 02/11/15	03/02/15	0.00	5,895.00	0.00	0.00	0.00
615	2015055027028	02/11/15 - 02/11/15	03/02/15	0.00	5,895.00	0.00	0.00	0.00
615	2015112027731	04/14/15 - 04/14/15	04/27/15	0.00	3,015.00	0.00	0.00	0.00
615	2015114039397	04/16/15 - 04/16/15	04/27/15	0.00	3,015.00	0.00	0.00	0.00
615	2015126040129	04/25/15 - 04/25/15	05/11/15	0.00	5,895.00	0.00	0.00	0.00
615	2015126040129	04/25/15 - 04/25/15	05/11/15	0.00	5,895.00	0.00	0.00	0.00
615	2015133033719	05/03/15 - 05/03/15	05/18/15	0.00	5,895.00	0.00	0.00	0.00
615	2015133033719	05/03/15 - 05/03/15	05/18/15	0.00	11,790.00	0.00	0.00	0.00
615	2015141054750	05/06/15 - 05/06/15	05/25/15	0.00	3,015.00	0.00	0.00	0.00
615	2015142048765	05/14/15 - 05/14/15	05/25/15	0.00	5,895.00	0.00	0.00	0.00
615	2015142048765	05/14/15 - 05/14/15	05/25/15	0.00	5,895.00	0.00	0.00	0.00
615	2015176049759	06/18/15 - 06/18/15	06/29/15	0.00	5,895.00	0.00	0.00	0.00
615	2015196031889	07/02/15 - 07/02/15	07/20/15	0.00	5,895.00	0.00	0.00	0.00
615	2015196031889	07/02/15 - 07/02/15	07/20/15	0.00	5,895.00	0.00	0.00	0.00
615	2015221000328	07/31/15 - 07/31/15	08/17/15	0.00	5,895.00	0.00	0.00	0.00
614	2015229028915	07/08/15 - 07/08/15	08/24/15	0.00	6,597.00	0.00	0.00	0.00
614	2015229028915	07/08/15 - 07/08/15	08/24/15	0.00	6,597.00	0.00	0.00	0.00
615	2015247070613	12/16/14 - 12/16/14	09/14/15	0.00	5,895.00	0.00	0.00	0.00
615	2015247070613	12/16/14 - 12/16/14	09/14/15	0.00	5,895.00	0.00	0.00	0.00
615	2015257027616	08/31/15 - 08/31/15	09/21/15	0.00	5,895.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
Run Time: 02:05:36  
Page: 11

EMORY UNIVERSITY HOSPITAL MIDTOWN		PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00		
550 PEACHTREE ST NE		000000503A	SERVICE DATES	09/01/14	THROUGH	08/31/15		
ATLANTA,GA 30308-2247			ADMISSION DATES	00/00/00	THROUGH	00/00/00		
615	2015257027616	08/31/15 - 08/31/15	09/21/15	0.00	5,895.00	0.00	0.00	0.00
615	5915323001237	08/29/15 - 08/29/15	11/23/15	0.00	5,895.00	0.00	0.00	0.00
1	2316092000111	05/07/15 - 05/07/15	04/11/16	0.00	86.00	0.00	0.00	0.00
TOTAL				0.00	259,223.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
Run Time: 02:06:58  
Page: 12

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

EMORY UNIVERSITY HOSPITAL MIDTOWN  
550 PEACHTREE ST NE  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	607,339.02	ADJUSTMENTS	0.00
COVERED CHARGES	335,876.46	CONTRACTUAL ALLOW	89,146.07
NON-COVERD CHARGES	271,462.56	TOTAL MEDICAID LIAB	246,730.39
		LESS: COB	246,358.76
		LESS: COPAYMENT	371.63
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 176

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

EMORY UNIVERSITY HOSPITAL MIDTOWN  
 550 PEACHTREE ST NE  
 ATLANTA,GA 30308-2247

PROVIDER NUMBER  
 000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,851.84	6,822.70	OTHER LAB	7,021.00	0.00
MED/SURG SUPPLY	12,946.50	842.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,091.00	219.00	OTHER THERAPEUTIC SVC	0.00	4,740.00
CT SCAN	10,480.00	31,728.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	111,300.00	14,415.00
EKG/ECG	2,208.00	0.00	MRI SERVICES	0.00	46,129.00
IV THERAPY	14,703.00	6,629.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,923.00	26,614.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,854.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,006.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,662.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,117.00	1,183.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,436.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,344.62	59,098.96
RADIOLOGY THERAPEUTIC	3,384.00	770.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	698.00	1,398.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	385.00	26,092.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,429.00	22,032.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,596.50	1,454.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,831.00	6,472.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,200.00	14,823.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,409.00	0.00			
			TOTAL ANCILLARY	335,876.46	271,462.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	335,876.46	271,462.56

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	903,420.25	ADJUSTMENTS	1,205.26
COVERED CHARGES	842,801.07	CONTRACTUAL ALLOW	791,839.75
NON-COVERD CHARGES	60,619.18	TOTAL MEDICAID LIAB	50,961.32
		LESS: COB	6.56
		LESS: COPAYMENT	2,535.59
		REIMBURSEMENT	48,419.17
		TOTAL NUMBER OF CLAIMS	912

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	250.02	10,816.77	OTHER LAB	22,116.00	0.00
MED/SURG SUPPLY	6,415.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,473.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,005.00	18,384.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	371.00	FEE SCHEDULE LAB	165,461.00	9,346.00
EKG/ECG	13,110.00	138.00	MRI SERVICES	12,898.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,886.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,302.00	488.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,058.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	434,725.00	2,268.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,039.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,060.05	4,230.41
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	42.00	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	14,675.00	12,021.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,164.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,328.00	1,350.00			
			TOTAL ANCILLARY	842,801.07	60,619.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	842,801.07	60,619.18

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,472.20	ADJUSTMENTS	0.00
COVERED CHARGES	5,122.20	CONTRACTUAL ALLOW	4,273.18
NON-COVERD CHARGES	350.00	TOTAL MEDICAID LIAB	849.02
		LESS: COB	843.02
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4



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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.76	0.00	OTHER LAB	993.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	237.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,305.00	32.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,544.00	318.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.44	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,122.20	350.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,122.20	350.00

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,609,212.51	ADJUSTMENTS	74,924.87
COVERED CHARGES	2,373,473.64	CONTRACTUAL ALLOW	1,720,398.03
NON-COVERD CHARGES	235,738.87	TOTAL MEDICAID LIAB	653,075.61
		LESS: COB	32,334.14
		LESS: COPAYMENT	1,254.83
		REIMBURSEMENT	619,486.64
		TOTAL NUMBER OF CLAIMS	109

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

EMORY UNIVERSITY HOSPITAL MIDTOWN PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 550 PEACHTREE ST NE 000000503A SERVICE DATES 09/01/14 THROUGH 08/31/15  
 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	25,883.76	5,672.91	OTHER LAB	874.00	0.00
MED/SURG SUPPLY	83,179.00	9,338.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,546.00	24,240.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,250.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	551.00	FEE SCHEDULE LAB	167,429.00	17,895.60
EKG/ECG	966.00	0.00	MRI SERVICES	25,796.00	0.00
IV THERAPY	335,642.00	5,231.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	287,139.00	8,330.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,069.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	57,622.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,693.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,454.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,683.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,079,461.88	88,947.36
RADIOLOGY THERAPEUTIC	51,309.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,944.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	268.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	73,198.00	39,850.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	840.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,537.00	4,570.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,493.00	2,210.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	100,180.00	21,756.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,922.00	242.00			
			TOTAL ANCILLARY	2,373,473.64	235,738.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,373,473.64	235,738.87

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

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

Run Date: 08/12/2016  
Run Time: 02:07:16  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN  
550 PEACHTREE ST NE  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,810.83	ADJUSTMENTS	0.00
COVERED CHARGES	30,831.95	CONTRACTUAL ALLOW	12,795.65
NON-COVERD CHARGES	978.88	TOTAL MEDICAID LIAB	18,036.30
		LESS: COB	18,027.30
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 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	390.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,059.00	544.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	199.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	20,876.95	44.88
RADIOLOGY THERAPEUTIC	1,308.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	389.00	0.00			
			TOTAL ANCILLARY	30,831.95	978.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,831.95	978.88

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,263,422.29	ADJUSTMENTS	55,095.80
COVERED CHARGES	5,124,274.29	CONTRACTUAL ALLOW	2,837,799.99
NON-COVERD CHARGES	139,148.00	TOTAL MEDICAID LIAB	2,286,474.30
		LESS: COB	18,415.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,268,059.10

TOTAL NUMBER OF ADMISSIONS 305

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	901		6	594,660.00		44,810.00
ROUTINE NURSERY	39		0	25,740.00		11,630.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		12.00
TOTAL ROUTINE	940		6	620,400.00		56,452.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	381		0	553,800.00		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	381		0	553,800.00		0.00
TOTAL ACCOMODATIONS	1,321		6	1,174,200.00		56,452.00

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	368,842.28	0.00	OTHER LAB	22,261.00	0.00
MED/SURG SUPPLY	324,216.26	526.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	930,574.68	0.00	EDUCATION & TRAINING	7,216.00	0.00
RADIOLOGY-DIAGNOSTIC	103,638.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	357,378.00	5,658.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	41,223.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	42,641.00	0.00	MRI SERVICES	93,356.00	0.00
IV THERAPY	62,972.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	354,919.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,971.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	112,865.33	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,240.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	156,943.00	0.00	SPECIAL SERVICES	0.00	21,390.00
RECOVERY ROOM	41,392.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,673.00	0.00	INJECTABLE DRUGS	488,851.08	0.00
RADIOLOGY THERAPEUTIC	1,712.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,885.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,928.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	38,639.35	783.47	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	931.00	8,549.53	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	105,367.31	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,368.00
OTHER IMAGING SERVICE	26,585.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	68,548.00	37,027.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,154.00	2,394.00			
AUDIOLOGY	3,486.00	0.00			
CARDIOLOGY	105,731.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,952.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,983.00	0.00			
			TOTAL ANCILLARY	3,950,074.29	82,696.00
			TOTAL ACCOMODATIONS	1,174,200.00	56,452.00
			TOTAL CHARGES	5,124,274.29	139,148.00

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015037069938	01/05/15 - 01/08/15	02/09/15	0.00	3,184.00	0.00	0.00	0.00
614	2215264005332	04/03/15 - 04/22/15	09/28/15	0.00	3,184.00	0.00	0.00	0.00
TOTAL				0.00	6,368.00	0.00	0.00	0.00



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

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

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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL  
 902 N 7TH ST  
 CORDELE,GA 31015-3234

PROVIDER NUMBER 000000514A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,549.79	ADJUSTMENTS	0.00
COVERED CHARGES	6,409.79	CONTRACTUAL ALLOW	1,155.09
NON-COVERD CHARGES	1,140.00	TOTAL MEDICAID LIAB	5,254.70
		LESS: COB	5,254.70
		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	1,320.00		1,140.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,320.00		1,140.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	2		0	1,320.00		1,140.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL  
 902 N 7TH ST  
 CORDELE,GA 31015-3234

PROVIDER NUMBER  
 000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	836.29	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	348.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	560.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	777.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,397.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	65.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	58.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,089.79	0.00
			TOTAL ACCOMODATIONS	1,320.00	1,140.00
			TOTAL CHARGES	6,409.79	1,140.00

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,817,607.60	ADJUSTMENTS	196,706.71
COVERED CHARGES	5,445,381.25	CONTRACTUAL ALLOW	4,265,120.86
NON-COVERD CHARGES	1,372,226.35	TOTAL MEDICAID LIAB	1,180,260.39
		LESS: COB	398.91
		LESS: COPAYMENT	4,796.66
		REIMBURSEMENT	1,175,064.82
		ALL OTHER	827,478.64
		FEE SCHEDULE-LAB	162,781.04
		INJECTABLE DRUGS	184,805.14
		TOTAL NUMBER OF CLAIMS	4,529

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,730.23	75,436.83	OTHER LAB	129,184.00	0.00
MED/SURG SUPPLY	198,213.35	8,130.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	114.00
RADIOLOGY-DIAGNOSTIC	289,778.00	5,858.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	521,954.00	316,366.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	31,015.00	9,892.00	FEE SCHEDULE LAB	1,456,325.32	483,319.70
EKG/ECG	65,759.00	3,425.00	MRI SERVICES	210,960.00	21,872.00
IV THERAPY	124,220.00	36,666.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	477,212.10	68,529.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	880.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,881.41	4,904.42	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	62,609.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	523,570.00	47,861.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	57,814.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	583,959.71	119,310.78
RADIOLOGY THERAPEUTIC	45,657.70	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	3,449.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	162,944.49	18,454.43	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,254.30	23,365.08
LITHOTRIPSY	11,084.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	161,637.00	19,312.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,809.00	6,224.00			
ONCOLOGY	95.00	95.00			
NUCLEAR MEDICINE	86,596.00	79,769.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	63,552.00	19,418.00			
AMBULATORY SURGERY	630.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,446.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	87,610.64	454.00			
			TOTAL ANCILLARY	5,445,381.25	1,372,226.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,445,381.25	1,372,226.35

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	140,913.45	ADJUSTMENTS	0.00
COVERED CHARGES	87,859.50	CONTRACTUAL ALLOW	18,986.65
NON-COVERD CHARGES	53,053.95	TOTAL MEDICAID LIAB	68,872.85
		LESS: COB	68,839.44
		LESS: COPAYMENT	33.41
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 106

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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,115.16	2,731.51	OTHER LAB	598.00	0.00
MED/SURG SUPPLY	4,547.41	35.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	159.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,077.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,428.00	23,650.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,593.00	FEE SCHEDULE LAB	35,789.00	9,075.00
EKG/ECG	548.00	0.00	MRI SERVICES	2,324.00	6,560.00
IV THERAPY	3,196.00	676.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,678.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	527.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	726.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,647.00	760.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,140.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,969.93	897.44
RADIOLOGY THERAPEUTIC	1,144.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,504.00	712.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	456.00	697.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,184.00
OTHER IMAGING SERVICE	7,344.00	548.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	842.00	389.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,387.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,259.00	0.00			
			TOTAL ANCILLARY	87,859.50	53,053.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	87,859.50	53,053.95

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: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014346036634	11/11/14 - 11/11/14	12/15/14	0.00	3,184.00	0.00	0.00	0.00
TOTAL				0.00	3,184.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	302,179.56	ADJUSTMENTS	800.09
COVERED CHARGES	237,325.17	CONTRACTUAL ALLOW	219,592.22
NON-COVERD CHARGES	64,854.39	TOTAL MEDICAID LIAB	17,732.95
		LESS: COB	20.92
		LESS: COPAYMENT	606.00
		REIMBURSEMENT	17,106.03
		TOTAL NUMBER OF CLAIMS	317



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,362.60	1,114.68	OTHER LAB	1,196.00	0.00
MED/SURG SUPPLY	3,253.00	314.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,888.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,674.00	23,701.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	78,296.00	31,742.00
EKG/ECG	4,932.00	137.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,675.00	1,050.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	860.42	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	85,476.00	4,449.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,292.15	1,869.71
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	258.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,741.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	421.00	389.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	237,325.17	64,854.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	237,325.17	64,854.39

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

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

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,246.55	ADJUSTMENTS	0.00
COVERED CHARGES	5,246.55	CONTRACTUAL ALLOW	1,943.13
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3,303.42
		LESS: COB	3,300.42
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL  
 902 N 7TH ST  
 CORDELE,GA 31015-3234

PROVIDER NUMBER  
 000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 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	34.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	325.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,496.00	0.00
EKG/ECG	137.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,218.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36.55	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,246.55	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,246.55	0.00

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	233,383.70	ADJUSTMENTS	10,536.00
COVERED CHARGES	228,592.80	CONTRACTUAL ALLOW	149,595.31
NON-COVERD CHARGES	4,790.90	TOTAL MEDICAID LIAB	78,997.49
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	78,946.49

TOTAL NUMBER OF CLAIMS 15

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	678.05	818.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,782.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	186.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,363.00	1,542.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,204.00	1,342.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,197.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,223.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	570.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	187,099.36	710.02
RADIOLOGY THERAPEUTIC	7,291.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	283.00	132.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	684.25	246.08
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,032.00	0.00			
			TOTAL ANCILLARY	228,592.80	4,790.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	228,592.80	4,790.90

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

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

Run Date: 08/12/2016  
Run Time: 01:52:59  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 01:54:54  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,035,413.81	ADJUSTMENTS	674,762.12
COVERED CHARGES	5,109,047.71	CONTRACTUAL ALLOW	3,181,815.88
NON-COVERD CHARGES	926,366.10	TOTAL MEDICAID LIAB	1,927,231.83
		LESS: COB	14,040.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,913,190.86

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	757		0	514,760.00		845,667.48
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	757		0	514,760.00		845,667.48
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	341		0	714,292.68		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	341		0	714,292.68		0.00
TOTAL ACCOMODATIONS	1,098		0	1,229,052.68		845,667.48

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

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

Run Date: 08/12/2016  
 Run Time: 01:54:54  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	466,950.60	7,051.20	OTHER LAB	7,404.18	0.00
MED/SURG SUPPLY	286,755.79	36,093.41	RECREATIONAL THERAPY	3,154.44	0.00
LABORATORY-GENERAL	393,567.37	14,432.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,389.64	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,527.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	73,258.44	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,500.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	87,049.96	1,721.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,784,772.06	6,518.67	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	984.09	0.00	AMBULANCE	0.00	0.00
GI SERVICES	15,854.35	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,948.34	0.00	INJECTABLE DRUGS	421,271.71	628.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	70,254.81	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	88,200.69	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	30,740.20	14,102.40	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,096.63	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,311.34	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,719.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,199.45	150.77			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,694.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,421.82	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,968.72	0.00			
			TOTAL ANCILLARY	3,879,995.03	80,698.62
			TOTAL ACCOMODATIONS	1,229,052.68	845,667.48
			TOTAL CHARGES	5,109,047.71	926,366.10



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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DECATUR HLTH RESOURCES INCHOSP  
450 N CANDLER ST  
DECATUR,GA 30030-2626

PROVIDER NUMBER  
000000525A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
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	07/01/14	THROUGH	06/30/15
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	07/01/14	THROUGH	06/30/15
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	07/01/14	THROUGH	06/30/15
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	07/01/14	THROUGH	06/30/15
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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,498,486.12	ADJUSTMENTS	1,053,658.93
COVERED CHARGES	48,766,478.82	CONTRACTUAL ALLOW	30,820,705.10
NON-COVERD CHARGES	2,732,007.30	TOTAL MEDICAID LIAB	17,945,773.72
		LESS: COB	270,674.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,675,099.22

TOTAL NUMBER OF ADMISSIONS 2,846

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,097		3	5,443,579.84		1,197,350.87
ROUTINE NURSERY	2,709		11	2,732,934.18		793,505.96
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		2,583.00
TOTAL ROUTINE	9,806		14	8,176,514.02		1,993,439.83
SPECIAL CARE SERVICES						
CCU	18		0	18,304.16		0.00
ICU	2,056		0	3,576,529.17		0.00
NICU	68		0	181,152.36		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		429	0.00		429,549.12
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,142		429	3,775,985.69		429,549.12
TOTAL ACCOMODATIONS	11,948		443	11,952,499.71		2,422,988.95



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,206,760.53	7,835.40	OTHER LAB	655,383.23	0.00
MED/SURG SUPPLY	1,217,629.24	15,224.18	RECREATIONAL THERAPY	12,654.27	0.00
LABORATORY-GENERAL	6,498,227.66	27,204.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	948,106.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,500,865.45	62,481.77	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	688,485.71	982.40	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	377,131.12	300.00	MRI SERVICES	375,969.50	0.00
IV THERAPY	716,863.25	7,412.11	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,460,357.88	11,030.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,002,285.91	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,560,335.92	18,602.39	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	605,900.78	0.00	AMBULANCE	0.00	0.00
GI SERVICES	197,383.54	1,375.41	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,111,455.98	753.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	856,667.71	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	314,430.95	0.00	INJECTABLE DRUGS	3,844,906.80	2,884.30
RADIOLOGY THERAPEUTIC	192,701.95	522.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	427,772.03	710.96	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	324,722.83	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	365,924.00	9,080.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	32,980.56	309.17	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	33,970.86	0.00	IMPL DEV CHARGE PATIENTS	1,077,785.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,232.66
OTHER IMAGING SERVICE	444,499.18	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	421,805.90	52,244.66			
ONCOLOGY	493.00	0.00			
NUCLEAR MEDICINE	300,996.16	85,855.63			
AUDIOLOGY	134,761.24	0.00			
CARDIOLOGY	1,497,216.18	562.16			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	96,864.52	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	309,683.62	2,414.69			
			TOTAL ANCILLARY	36,813,979.11	309,018.35
			TOTAL ACCOMODATIONS	11,952,499.71	2,422,988.95
			TOTAL CHARGES	48,766,478.82	2,732,007.30

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014335035882	11/23/14 - 11/25/14	12/08/14	0.00	94.82	0.00	0.00	0.00
948	2014342029804	11/22/14 - 12/01/14	12/15/14	0.00	189.64	0.00	0.00	0.00
948	2014344091242	11/30/14 - 12/05/14	12/15/14	0.00	189.64	0.00	0.00	0.00
948	2014358069722	12/16/14 - 12/21/14	12/29/14	0.00	94.82	0.00	0.00	0.00
948	2015021047816	12/23/14 - 12/26/14	01/26/15	0.00	94.82	0.00	0.00	0.00
948	2015023078928	12/31/14 - 01/02/15	02/02/15	0.00	94.82	0.00	0.00	0.00
948	2015065078175	02/20/15 - 02/27/15	03/16/15	0.00	94.82	0.00	0.00	0.00
948	2015082029050	03/16/15 - 03/18/15	03/30/15	0.00	189.64	0.00	0.00	0.00
948	2015083059881	03/17/15 - 03/18/15	03/30/15	0.00	189.64	0.00	0.00	0.00
TOTAL				0.00	1,232.66	0.00	0.00	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER  
 2701 N DECATUR RD  
 DECATUR,GA 30033-5918

PROVIDER NUMBER  
 000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	778,490.69	ADJUSTMENTS	0.00
COVERED CHARGES	761,566.45	CONTRACTUAL ALLOW	426,896.91
NON-COVERD CHARGES	16,924.24	TOTAL MEDICAID LIAB	334,669.54
		LESS: COB	334,669.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	150		0	115,350.00		16,924.24
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	150		0	115,350.00		16,924.24
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	4,368.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	4,368.00		0.00
TOTAL ACCOMODATIONS	152		0	119,718.00		16,924.24

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	122,215.60	0.00	OTHER LAB	8,643.77	0.00
MED/SURG SUPPLY	25,885.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	60,968.71	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,080.15	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,376.49	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,100.00	0.00	MRI SERVICES	1,415.00	0.00
IV THERAPY	1,779.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,848.52	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	34,335.52	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	83,881.55	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,227.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,331.26	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,894.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,401.32	0.00	INJECTABLE DRUGS	97,969.03	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	62.41	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	220.59	0.00	IMPL DEV CHARGE PATIENTS	15,521.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,827.53	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,744.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	417.66	0.00			
CARDIOLOGY	58,711.08	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	14,990.56	0.00			
			TOTAL ANCILLARY	641,848.45	0.00
			TOTAL ACCOMODATIONS	119,718.00	16,924.24
			TOTAL CHARGES	761,566.45	16,924.24

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,330,727.75	ADJUSTMENTS	764,847.61
COVERED CHARGES	18,827,882.12	CONTRACTUAL ALLOW	14,754,181.75
NON-COVERD CHARGES	2,502,845.63	TOTAL MEDICAID LIAB	4,073,700.37
		LESS: COB	9,520.21
		LESS: COPAYMENT	7,107.72
		REIMBURSEMENT	4,057,072.44
		ALL OTHER	3,663,241.21
		FEE SCHEDULE-LAB	266,061.31
		INJECTABLE DRUGS	127,769.92

TOTAL NUMBER OF CLAIMS 7,345

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	295,013.89	1,426.60	OTHER LAB	576,856.37	0.00
MED/SURG SUPPLY	321,024.41	57,966.73	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	4,037.39	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,055,001.71	6,317.79	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,449,649.30	258,529.81	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	31,193.70	33,984.79	FEE SCHEDULE LAB	3,143,794.84	662,023.31
EKG/ECG	362,700.00	1,200.00	MRI SERVICES	300,031.00	38,194.55
IV THERAPY	1,088,984.36	20,207.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,270,623.38	417,976.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,303.30	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	125,004.93	31,101.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	362,159.12	0.00	AMBULANCE	0.00	0.00
GI SERVICES	68,306.39	21,620.07	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,276,861.28	2,751.41	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	528,099.59	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,802.10
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	705,710.80	218,918.30
RADIOLOGY THERAPEUTIC	272,559.77	159,316.29	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,534.13	7,748.73	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,795.32	8,352.95	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	19,976.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36,157.12	6,135.39	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	38,505.25	99,792.92
LITHOTRIPSY	0.00	20,787.36	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,170,784.90	128,310.86			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	57,594.45	38,539.94			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	299,533.92	166,615.87			
AUDIOLOGY	14,829.47	3,022.84			
CARDIOLOGY	304,041.61	56,478.06			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,820.01	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	620,407.80	8,709.66			
			TOTAL ANCILLARY	18,827,882.12	2,502,845.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,827,882.12	2,502,845.63

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	384,090.44	ADJUSTMENTS	0.00
COVERED CHARGES	316,912.84	CONTRACTUAL ALLOW	143,599.78
NON-COVERD CHARGES	67,177.60	TOTAL MEDICAID LIAB	173,313.06
		LESS: COB	173,208.06
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 152

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,579.30	0.00	OTHER LAB	9,198.28	0.00
MED/SURG SUPPLY	3,587.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,335.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,703.40	14,838.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	73,876.45	10,302.04
EKG/ECG	4,500.00	0.00	MRI SERVICES	7,475.00	7,405.00
IV THERAPY	23,917.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,453.27	1,666.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	720.57	327.58	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,865.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,995.68	1,362.52	CAST ROOM	0.00	0.00
EMERGENCY ROOM	94,606.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,198.59	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,586.70	3,770.00
RADIOLOGY THERAPEUTIC	1,364.79	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	618.34	62.41	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	538.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,867.02	19,809.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,261.70	399.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	891.88	6,695.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,236.97	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,072.23	0.00			
			TOTAL ANCILLARY	316,912.84	67,177.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	316,912.84	67,177.60



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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,194,944.92	ADJUSTMENTS	2,085.66
COVERED CHARGES	1,130,794.94	CONTRACTUAL ALLOW	1,084,644.48
NON-COVERD CHARGES	64,149.98	TOTAL MEDICAID LIAB	46,150.46
		LESS: COB	0.00
		LESS: COPAYMENT	1,767.47
		REIMBURSEMENT	44,382.99
		TOTAL NUMBER OF CLAIMS	825

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,260.00	140.60	OTHER LAB	13,919.44	0.00
MED/SURG SUPPLY	3,638.03	639.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,893.83	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,699.38	9,807.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	217,980.21	32,653.51
EKG/ECG	12,900.00	0.00	MRI SERVICES	14,124.00	0.00
IV THERAPY	73,991.27	1,978.35	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,621.47	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	593,278.64	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	15,204.60	4,574.40
RADIOLOGY THERAPEUTIC	1,779.76	360.65	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	124.82	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	220.59	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	78,776.15	13,526.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,068.00	345.18			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,439.57	0.00			
			TOTAL ANCILLARY	1,130,794.94	64,149.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,130,794.94	64,149.98

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,331.42	ADJUSTMENTS	0.00
COVERED CHARGES	23,763.27	CONTRACTUAL ALLOW	14,357.06
NON-COVERD CHARGES	1,568.15	TOTAL MEDICAID LIAB	9,406.21
		LESS: COB	9,370.21
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	17

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	152.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	23.00	143.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,932.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,040.16	472.10
EKG/ECG	0.00	0.00	MRI SERVICES	2,395.00	0.00
IV THERAPY	1,639.23	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,067.03	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	132.30	409.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,382.30	543.95			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,763.27	1,568.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,763.27	1,568.15

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,418,119.78	ADJUSTMENTS	104,503.34
COVERED CHARGES	1,963,496.93	CONTRACTUAL ALLOW	1,677,003.33
NON-COVERD CHARGES	454,622.85	TOTAL MEDICAID LIAB	286,493.60
		LESS: COB	0.00
		LESS: COPAYMENT	711.00
		REIMBURSEMENT	285,782.60
		TOTAL NUMBER OF CLAIMS	52

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,032.80	61.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82,820.18	24,915.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,171.74	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,860.00	2,320.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,637.83	FEE SCHEDULE LAB	51,985.62	10,121.74
EKG/ECG	6,900.00	1,200.00	MRI SERVICES	8,118.00	3,524.00
IV THERAPY	26,164.31	314.14	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	499,602.71	48,326.69	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,581.79	2,200.06	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	64,030.67	1,998.85	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,057.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,428.01	1,608.73	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	126,266.40	42,030.90
RADIOLOGY THERAPEUTIC	474,308.04	55,945.90	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	309.17	124.82	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	178,553.68	218,246.10
LITHOTRIPSY	62,362.08	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,098.76	5,324.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,235.00	3,124.86			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,216.70	1,770.09			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	194,909.64	26,742.80			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,484.63	1,083.74			
			TOTAL ANCILLARY	1,963,496.93	454,622.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,963,496.93	454,622.85

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,669.03	ADJUSTMENTS	0.00
COVERED CHARGES	28,346.78	CONTRACTUAL ALLOW	7,111.88
NON-COVERD CHARGES	3,322.25	TOTAL MEDICAID LIAB	21,234.90
		LESS: COB	21,192.90
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

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

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	28,037.61	3,322.25	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	309.17	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,346.78	3,322.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,346.78	3,322.25

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE  
 2801 DEKALB MEDICAL PKWY  
 LITHONIA,GA 30058-4996

PROVIDER NUMBER 000000536U  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,808,185.30	ADJUSTMENTS	29,954.17
COVERED CHARGES	10,632,981.42	CONTRACTUAL ALLOW	6,404,453.27
NON-COVERD CHARGES	175,203.88	TOTAL MEDICAID LIAB	4,228,528.15
		LESS: COB	27,563.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,200,965.00

TOTAL NUMBER OF ADMISSIONS 546

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	566		0	414,312.00		118,599.69
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	566		0	414,312.00		118,599.69
SPECIAL CARE SERVICES						
CCU	6		0	6,269.76		0.00
ICU	1,746		2	2,088,262.00		3,045.28
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	6		0	6,269.76		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		9	0.00		9,011.52
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,758		11	2,100,801.52		12,056.80
TOTAL ACCOMODATIONS	2,324		11	2,515,113.52		130,656.49

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	689,929.43	0.00	OTHER LAB	79,486.43	0.00
MED/SURG SUPPLY	177,552.16	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,709,952.81	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	225,603.01	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	522,507.16	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	81,380.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	118,200.00	0.00	MRI SERVICES	76,044.00	0.00
IV THERAPY	478,705.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	245,735.62	8,550.92	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	953,663.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	70,437.04	0.00	AMBULANCE	0.00	0.00
GI SERVICES	56,504.15	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	789,336.03	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,814.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	31,853.48	0.00	INJECTABLE DRUGS	974,473.03	0.00
RADIOLOGY THERAPEUTIC	15,502.94	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	31,146.45	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	39,264.94	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	77,180.00	4,085.62	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,746.04	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,174.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	99,504.21	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	85,654.00	8,332.96			
ONCOLOGY	314.14	0.00			
NUCLEAR MEDICINE	88,094.28	20,795.23			
AUDIOLOGY	540.88	0.00			
CARDIOLOGY	280,823.04	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,145.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,599.10	2,782.66			
			TOTAL ANCILLARY	8,117,867.90	44,547.39
			TOTAL ACCOMODATIONS	2,515,113.52	130,656.49
			TOTAL CHARGES	10,632,981.42	175,203.88

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

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

Run Date: 08/12/2016  
 Run Time: 01:55:13  
 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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,579.00	ADJUSTMENTS	0.00
COVERED CHARGES	73,745.25	CONTRACTUAL ALLOW	13,853.02
NON-COVERD CHARGES	3,833.75	TOTAL MEDICAID LIAB	59,892.23
		LESS: COB	59,892.23
		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	8,052.00		2,824.67
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11		0	8,052.00		2,824.67
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	9		0	8,302.56		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	9		0	8,302.56		0.00
TOTAL ACCOMODATIONS	20		0	16,354.56		2,824.67

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,310.00	0.00	OTHER LAB	2,174.65	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,094.14	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,531.44	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,798.39	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	535.85	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	900.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,815.22	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,160.35	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	8,216.10	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
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	817.65	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	436.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,467.02	1,009.08			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,133.88	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	57,390.69	1,009.08
			TOTAL ACCOMODATIONS	16,354.56	2,824.67
			TOTAL CHARGES	73,745.25	3,833.75

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

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

Run Date: 08/12/2016  
Run Time: 01:55:15  
Page: 5

DEKALB MEDICAL CENTER AT HILLANDALE  
2801 DEKALB MEDICAL PKWY  
LITHONIA,GA 30058-4996

PROVIDER NUMBER  
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,269,329.32	ADJUSTMENTS	322,898.56
COVERED CHARGES	11,198,495.57	CONTRACTUAL ALLOW	9,075,447.73
NON-COVERD CHARGES	1,070,833.75	TOTAL MEDICAID LIAB	2,123,047.84
		LESS: COB	1,375.11
		LESS: COPAYMENT	3,794.59
		REIMBURSEMENT	2,117,878.14
		ALL OTHER	1,925,359.02
		FEE SCHEDULE-LAB	163,043.64
		INJECTABLE DRUGS	29,475.48

TOTAL NUMBER OF CLAIMS 5,083

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	159,096.52	3,744.90	OTHER LAB	120,454.44	811.24
MED/SURG SUPPLY	151,632.75	4,401.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	131.42	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	647,117.96	3,162.58	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	977,824.96	147,983.62	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	113,640.77	42,601.73	FEE SCHEDULE LAB	1,988,233.59	365,607.52
EKG/ECG	215,400.00	1,200.00	MRI SERVICES	189,870.00	22,185.90
IV THERAPY	960,361.23	16,789.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	420,491.75	119,524.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	98,716.85	26,851.87	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	133,041.72	0.00	AMBULANCE	0.00	0.00
GI SERVICES	29,501.77	1,856.73	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,442,695.15	871.39	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	153,329.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	542.40
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	268,364.90	79,070.50
RADIOLOGY THERAPEUTIC	2,888.67	13,627.32	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,098.60	10,029.21	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,090.57	7,590.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,988.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	607.10	4,964.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	50,619.35	21,712.26
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	625,475.47	78,042.12			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,284.00	5,208.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	109,305.71	38,315.21			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	65,722.68	29,051.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,829.53	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	233,800.29	14,968.80			
			TOTAL ANCILLARY	11,198,495.57	1,070,833.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,198,495.57	1,070,833.75

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

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

Run Date: 08/12/2016  
Run Time: 01:56:06  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER AT HILLANDALE  
2801 DEKALB MEDICAL PKWY  
LITHONIA,GA 30058-4996

PROVIDER NUMBER  
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	346,147.46	ADJUSTMENTS	0.00
COVERED CHARGES	294,587.33	CONTRACTUAL ALLOW	117,949.33
NON-COVERD CHARGES	51,560.13	TOTAL MEDICAID LIAB	176,638.00
		LESS: COB	176,599.00
		LESS: COPAYMENT	39.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 125

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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,358.90	0.00	OTHER LAB	1,622.48	0.00
MED/SURG SUPPLY	1,289.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,965.21	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,695.56	17,685.34	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,909.55	FEE SCHEDULE LAB	69,480.32	7,938.04
EKG/ECG	3,300.00	0.00	MRI SERVICES	3,863.00	0.00
IV THERAPY	50,030.88	315.64	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,084.73	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,216.20	327.58	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,491.47	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	100,796.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,741.01	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,254.10	1,691.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,191.53	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	279.51	1,694.85	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,908.00	16,806.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,209.60	0.00			
			TOTAL ANCILLARY	294,587.33	51,560.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	294,587.33	51,560.13



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

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

Run Date: 08/12/2016  
Run Time: 01:56:09  
Page: 9

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,038,808.07	ADJUSTMENTS	1,855.87
COVERED CHARGES	1,003,831.43	CONTRACTUAL ALLOW	955,611.18
NON-COVERD CHARGES	34,976.64	TOTAL MEDICAID LIAB	48,220.25
		LESS: COB	0.00
		LESS: COPAYMENT	1,608.00
		REIMBURSEMENT	46,612.25
		TOTAL NUMBER OF CLAIMS	862

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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,421.00	0.00	OTHER LAB	11,935.00	0.00
MED/SURG SUPPLY	1,833.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,549.39	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,634.98	3,647.39	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	173,986.23	20,349.51
EKG/ECG	10,500.00	0.00	MRI SERVICES	2,936.00	0.00
IV THERAPY	80,393.86	946.92	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,142.19	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	560,746.59	669.13	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,344.60	2,882.20
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	249.64	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,382.14	6,231.85			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,025.75	0.00			
			TOTAL ANCILLARY	1,003,831.43	34,976.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,003,831.43	34,976.64

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

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

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE  
2801 DEKALB MEDICAL PKWY  
LITHONIA,GA 30058-4996

PROVIDER NUMBER  
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,489.46	ADJUSTMENTS	0.00
COVERED CHARGES	17,076.60	CONTRACTUAL ALLOW	6,471.77
NON-COVERD CHARGES	3,412.86	TOTAL MEDICAID LIAB	10,604.83
		LESS: COB	10,586.83
		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

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DEKALB MEDICAL CENTER AT HILLANDALE  
 2801 DEKALB MEDICAL PKWY  
 LITHONIA,GA 30058-4996

PROVIDER NUMBER  
 000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 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	130.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,674.21	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,948.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,529.06	88.26
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	300.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,254.08	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	84.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,234.45	1,246.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,076.60	3,412.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,076.60	3,412.86

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

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

Run Date: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER AT HILLANDALE  
2801 DEKALB MEDICAL PKWY  
LITHONIA,GA 30058-4996

PROVIDER NUMBER  
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,130.21	ADJUSTMENTS	0.00
COVERED CHARGES	30,092.19	CONTRACTUAL ALLOW	23,739.54
NON-COVERD CHARGES	38.02	TOTAL MEDICAID LIAB	6,352.65
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	6,346.65
		TOTAL NUMBER OF CLAIMS	1

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,572.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	513.49	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	317.01	29.42
EKG/ECG	300.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,142.63	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,520.99	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,780.27	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11.70	8.60
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	10,830.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,092.19	38.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,092.19	38.02

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

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

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER AT HILLANDALE  
2801 DEKALB MEDICAL PKWY  
LITHONIA,GA 30058-4996

PROVIDER NUMBER  
000000536U

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER 000000558A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	94,965,256.61	ADJUSTMENTS	6,301,659.95
COVERED CHARGES	92,762,147.59	CONTRACTUAL ALLOW	79,189,318.54
NON-COVERD CHARGES	2,203,109.02	TOTAL MEDICAID LIAB	13,572,829.05
		LESS: COB	73,917.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,498,911.88

TOTAL NUMBER OF ADMISSIONS 804

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,767		12	1,727,339.00		644,298.07
ROUTINE NURSERY	218		1	317,682.00		81,879.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,985		13	2,045,021.00		726,177.07
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,751		23	4,372,696.00		201,528.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	1,320		0	9,734,329.00		108,966.00
HOSPICE	0		0	0.00		0.00
REHAB	0		22	0.00		33,220.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,071		45	14,107,025.00		343,714.00
TOTAL ACCOMODATIONS	5,056		58	16,152,046.00		1,069,891.07



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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,201,034.02	180,823.73	OTHER LAB	277,961.60	1,776.99
MED/SURG SUPPLY	13,091,689.40	210,321.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,123,292.46	46,089.93	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	995,606.96	16,563.39	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,400,443.63	354,865.02	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	360,395.70	11,507.16	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	318,079.89	0.00	MRI SERVICES	291,199.23	0.00
IV THERAPY	38,009.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,828,725.49	24,819.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	169,625.46	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,384,972.21	23,609.34	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	256,984.93	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	993,566.70	2,059.99	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,523,151.21	2,221.87	DRUG-SPECIFIC/HOME IV	0.00	774.09
LABORATORY PATHOLOGIC	254,839.45	0.00	INJECTABLE DRUGS	17,569,119.84	176,540.19
RADIOLOGY THERAPEUTIC	15,747.90	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	439,394.60	26,523.01	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	71,395.46	4,625.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	331,329.04	0.00	PATIENT CONVENIENCE	0.00	1,126.65
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,858.83	30,704.36	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	960,668.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	262,875.60	6,438.37			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	718,125.47	10,697.55			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	339,225.68	1,130.42			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,213,393.20	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	72,013.05	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	89,376.76	0.00			
			TOTAL ANCILLARY	76,610,101.59	1,133,217.95
			TOTAL ACCOMODATIONS	16,152,046.00	1,069,891.07
			TOTAL CHARGES	92,762,147.59	2,203,109.02

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	590,136.01	ADJUSTMENTS	0.00
COVERED CHARGES	536,974.01	CONTRACTUAL ALLOW	393,659.25
NON-COVERD CHARGES	53,162.00	TOTAL MEDICAID LIAB	143,314.76
		LESS: COB	143,314.76
		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	54		5	53,514.00		52,494.00
ROUTINE NURSERY	4		0	3,964.00		668.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	58		5	57,478.00		53,162.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	10,909.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	10,909.00		0.00
TOTAL ACCOMODATIONS	63		5	68,387.00		53,162.00

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,150.80	0.00	OTHER LAB	2,360.49	0.00
MED/SURG SUPPLY	23,669.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	114,894.93	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,190.47	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,761.79	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	714.51	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	61,040.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,765.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,285.19	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,750.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,611.33	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,713.39	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,465.99	0.00	INJECTABLE DRUGS	90,460.39	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	8,523.13	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	109.24	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,257.66	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,419.07	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,326.43	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,953.89	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,162.87	0.00			
			TOTAL ANCILLARY	468,587.01	0.00
			TOTAL ACCOMODATIONS	68,387.00	53,162.00
			TOTAL CHARGES	536,974.01	53,162.00

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

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

Run Date: 08/12/2016  
Run Time: 01:59:54  
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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,909,874.37	ADJUSTMENTS	123,172.45
COVERED CHARGES	16,742,110.08	CONTRACTUAL ALLOW	14,843,553.52
NON-COVERD CHARGES	2,167,764.29	TOTAL MEDICAID LIAB	1,898,556.56
		LESS: COB	2,790.02
		LESS: COPAYMENT	6,558.00
		REIMBURSEMENT	1,889,208.54
		ALL OTHER	1,749,589.89
		FEE SCHEDULE-LAB	117,163.16
		INJECTABLE DRUGS	22,455.49
		TOTAL NUMBER OF CLAIMS	5,123

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	288,448.95	3,695.98	OTHER LAB	88,167.90	0.00
MED/SURG SUPPLY	769,278.00	57,489.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	689,957.45	9,694.54	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,487,633.63	237,371.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	76,314.38	59,775.59	FEE SCHEDULE LAB	1,417,614.64	222,130.34
EKG/ECG	282,184.90	17,730.38	MRI SERVICES	141,551.97	25,555.33
IV THERAPY	557,243.63	67,914.17	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,974,965.22	721,072.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	290,420.49	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	129,741.53	9,552.33	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	831.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	447,607.88	54,019.79	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,343,608.75	82,976.89	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,177,562.18	5,290.18	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	235,862.34	55,547.45
RADIOLOGY THERAPEUTIC	518,321.80	46,757.96	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,814.11	4,816.87	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	288.51	411.26	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	192,154.28	7,462.86	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	55,664.50	27,755.00
LITHOTRIPSY	48,221.08	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	424,130.82	46,709.08			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,419.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	462,638.12	175,228.20			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	257,866.59	188,906.69			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,088.35	1,734.42			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	357,507.72	38,166.09			
			TOTAL ANCILLARY	16,742,110.08	2,167,764.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,742,110.08	2,167,764.29

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

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

Run Date: 08/12/2016  
Run Time: 02:00:52  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	882,172.43	ADJUSTMENTS	0.00
COVERED CHARGES	657,932.39	CONTRACTUAL ALLOW	477,168.67
NON-COVERD CHARGES	224,240.04	TOTAL MEDICAID LIAB	180,763.72
		LESS: COB	180,685.76
		LESS: COPAYMENT	77.96
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 171

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,074.07	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	45,170.73	2,479.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,275.18	782.64	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,643.81	14,963.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,699.56	FEE SCHEDULE LAB	49,203.35	11,334.58
EKG/ECG	8,256.54	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,332.62	1,135.56	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	167,136.49	129,586.73	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	47,053.05	4,121.47	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,646.07	4,830.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,202.11	18,966.34	CAST ROOM	0.00	0.00
EMERGENCY ROOM	128,186.36	5,008.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	75,504.55	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,775.88	1,166.03
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	6,392.36	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	761.60	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	62.36
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,869.53	218.48	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,074.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,499.43	8,568.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	438.34	438.34			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	11,326.43			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,130.59	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,734.42	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,724.77	398.20			
			TOTAL ANCILLARY	657,932.39	224,240.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	657,932.39	224,240.04

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

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

Run Date: 08/12/2016  
Run Time: 02:00:55  
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DOCTORS HOSPITAL  
3651 WHEELER RD  
AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	551,461.79	ADJUSTMENTS	105.88
COVERED CHARGES	539,265.91	CONTRACTUAL ALLOW	514,596.37
NON-COVERD CHARGES	12,195.88	TOTAL MEDICAID LIAB	24,669.54
		LESS: COB	0.00
		LESS: COPAYMENT	804.00
		REIMBURSEMENT	23,865.54
		TOTAL NUMBER OF CLAIMS	441



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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,384.23	0.00	OTHER LAB	684.06	0.00
MED/SURG SUPPLY	2,082.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,257.51	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,429.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,423.23	4,430.95
EKG/ECG	11,114.58	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	31,866.99	611.73	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,901.48	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	361,719.77	1,247.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,521.34	2,347.98
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	202.30	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,380.16	3,355.82			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	500.71	0.00			
			TOTAL ANCILLARY	539,265.91	12,195.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	539,265.91	12,195.88

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

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

Run Date: 08/12/2016  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,209.71	ADJUSTMENTS	0.00
COVERED CHARGES	16,993.19	CONTRACTUAL ALLOW	9,332.27
NON-COVERD CHARGES	216.52	TOTAL MEDICAID LIAB	7,660.92
		LESS: COB	7,642.92
		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

Run Date: 08/12/2016  
 Run Time: 02:01:00  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102.38	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	846.45	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,608.98	216.52
EKG/ECG	1,376.09	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	203.91	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,726.15	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	129.23	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,993.19	216.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,993.19	216.52

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

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

Run Date: 08/12/2016  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,669,289.72	ADJUSTMENTS	0.00
COVERED CHARGES	1,569,157.55	CONTRACTUAL ALLOW	1,394,546.45
NON-COVERD CHARGES	100,132.17	TOTAL MEDICAID LIAB	174,611.10
		LESS: COB	0.00
		LESS: COPAYMENT	396.00
		REIMBURSEMENT	174,215.10
		TOTAL NUMBER OF CLAIMS	30

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,836.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	124,978.95	22,516.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,841.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,887.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,825.15	2,160.29
EKG/ECG	3,360.83	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,140.70	368.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	461,414.75	46,058.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,962.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	109,514.54	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,494.58	242.02
RADIOLOGY THERAPEUTIC	524,343.04	1,052.52	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	763.97	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	123,492.75	1,463.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,190.08	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	126,360.48	26,269.82			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,749.18	0.00			
			TOTAL ANCILLARY	1,569,157.55	100,132.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,569,157.55	100,132.17

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

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

Run Date: 08/12/2016  
Run Time: 02:01:03  
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	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 01:56:25  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL  
 901 GRIFFIN AVE  
 EASTMAN,GA 31023-6720

PROVIDER NUMBER 000000591A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,882,704.33	ADJUSTMENTS	243,684.22
COVERED CHARGES	2,803,507.02	CONTRACTUAL ALLOW	1,403,642.42
NON-COVERD CHARGES	79,197.31	TOTAL MEDICAID LIAB	1,399,864.60
		LESS: COB	11,578.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,388,285.69

TOTAL NUMBER OF ADMISSIONS 210

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	628		0	459,150.00		40,825.00
ROUTINE NURSERY	26		0	11,310.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1,500.00
TOTAL ROUTINE	654		0	470,460.00		42,325.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	98		0	143,080.00		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	98		0	143,080.00		0.00
TOTAL ACCOMODATIONS	752		0	613,540.00		42,325.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310,128.57	0.00	OTHER LAB	11,962.84	0.00
MED/SURG SUPPLY	268,257.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	493,004.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,647.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	171,085.15	19,962.72	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,998.89	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	45,738.50	0.00	MRI SERVICES	3,300.39	0.00
IV THERAPY	68,416.35	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,846.06	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,161.79	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	160,703.57	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	56,822.32	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,442.24	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	142,647.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,824.72	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	104,921.56	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	1,434.97	83.66	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	77,445.33	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,554.36	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	38,118.85	16,529.98			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,484.19	295.95			
AUDIOLOGY	1,348.49	0.00			
CARDIOLOGY	18,044.20	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	470.44	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,155.95	0.00			
			TOTAL ANCILLARY	2,189,967.02	36,872.31
			TOTAL ACCOMODATIONS	613,540.00	42,325.00
			TOTAL CHARGES	2,803,507.02	79,197.31



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

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

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 01:56:28  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,784,511.10	ADJUSTMENTS	68,496.57
COVERED CHARGES	3,605,573.62	CONTRACTUAL ALLOW	2,892,031.62
NON-COVERD CHARGES	178,937.48	TOTAL MEDICAID LIAB	713,542.00
		LESS: COB	1,385.21
		LESS: COPAYMENT	2,985.00
		REIMBURSEMENT	709,171.79
		ALL OTHER	636,936.22
		FEE SCHEDULE-LAB	70,461.96
		INJECTABLE DRUGS	1,773.61
		TOTAL NUMBER OF CLAIMS	2,487

DODGE COUNTY HOSPITAL  
 901 GRIFFIN AVE  
 EASTMAN,GA 31023-6720

PROVIDER NUMBER  
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,430.70	5,541.98	OTHER LAB	103,472.39	0.00
MED/SURG SUPPLY	227,678.83	36.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	226,407.15	490.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	460,190.80	12,706.58	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,108.38	10,748.48	FEE SCHEDULE LAB	720,373.29	98,592.58
EKG/ECG	91,812.70	3,429.70	MRI SERVICES	116,829.70	1,503.16
IV THERAPY	176,930.80	614.36	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	122,297.54	4,747.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	69,441.12	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,974.99	1,456.22	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	116,922.09	1,311.30	AMBULANCE	0.00	0.00
GI SERVICES	30,502.68	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	779,803.13	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,449.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,255.34	20,196.29
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	1,305.19	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,145.71	526.08
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	47,674.69	4,262.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,941.53	4,508.58			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,749.29	2,224.79			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	26,577.82	1,250.18			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,881.76	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	68,722.07	3,485.98			
			TOTAL ANCILLARY	3,605,573.62	178,937.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,605,573.62	178,937.48

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: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,529.00	ADJUSTMENTS	0.00
COVERED CHARGES	13,273.39	CONTRACTUAL ALLOW	7,718.09
NON-COVERD CHARGES	3,255.61	TOTAL MEDICAID LIAB	5,555.30
		LESS: COB	5,540.30
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

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

DODGE COUNTY HOSPITAL  
 901 GRIFFIN AVE  
 EASTMAN,GA 31023-6720

PROVIDER NUMBER  
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.54	282.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	387.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	839.37	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	415.89	2,365.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,909.57	607.96
EKG/ECG	849.50	0.00	MRI SERVICES	1,503.16	0.00
IV THERAPY	150.32	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,377.57	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,785.92	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	32.18	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,273.39	3,255.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,273.39	3,255.61

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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	213,121.11	ADJUSTMENTS	432.52
COVERED CHARGES	210,081.88	CONTRACTUAL ALLOW	191,901.38
NON-COVERD CHARGES	3,039.23	TOTAL MEDICAID LIAB	18,180.50
		LESS: COB	0.00
		LESS: COPAYMENT	735.00
		REIMBURSEMENT	17,445.50
		TOTAL NUMBER OF CLAIMS	325

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,523.32	12.70	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,144.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,269.26	151.56	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,476.84	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,545.88	2,788.43
EKG/ECG	4,117.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,763.70	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	318.27	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	159,551.69	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,371.45	86.54
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	210,081.88	3,039.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	210,081.88	3,039.23

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

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

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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,921.37	ADJUSTMENTS	0.00
COVERED CHARGES	1,895.22	CONTRACTUAL ALLOW	1,090.22
NON-COVERD CHARGES	26.15	TOTAL MEDICAID LIAB	805.00
		LESS: COB	799.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	196.06	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	224.56	26.15
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,389.96	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,895.22	26.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,895.22	26.15

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

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

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

DODGE COUNTY HOSPITAL  
901 GRIFFIN AVE  
EASTMAN,GA 31023-6720

PROVIDER NUMBER  
000000591A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DODGE COUNTY HOSPITAL  
901 GRIFFIN AVE  
EASTMAN,GA 31023-6720

PROVIDER NUMBER  
000000591A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER  
 200 PERRY HOUSE RD  
 FITZGERALD,GA 31750-8857

PROVIDER NUMBER 000000613A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,773,027.94	ADJUSTMENTS	44,265.68
COVERED CHARGES	1,720,994.44	CONTRACTUAL ALLOW	904,592.77
NON-COVERD CHARGES	52,033.50	TOTAL MEDICAID LIAB	816,401.67
		LESS: COB	6,408.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	809,993.15

TOTAL NUMBER OF ADMISSIONS 130

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	258		6	116,515.00		19,150.00
ROUTINE NURSERY	15		0	3,900.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	273		6	120,415.00		19,150.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	101		0	121,200.00		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	101		0	121,200.00		0.00
TOTAL ACCOMODATIONS	374		6	241,615.00		19,150.00

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

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	214,514.50	21,425.00	OTHER LAB	8,376.00	0.00
MED/SURG SUPPLY	116,847.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	300,231.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,214.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	189,605.25	616.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,359.81	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	34,456.00	0.00	MRI SERVICES	7,212.25	0.00
IV THERAPY	5,175.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	73,503.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,386.00	3,028.75	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	119,066.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,428.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	120,844.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,334.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,100.00	0.00	INJECTABLE DRUGS	111,694.75	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	1,403.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,897.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,192.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,772.25	6,387.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,427.75	0.00			
AUDIOLOGY	213.50	0.00			
CARDIOLOGY	40,013.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,111.00	1,426.00			
			TOTAL ANCILLARY	1,479,379.44	32,883.50
			TOTAL ACCOMODATIONS	241,615.00	19,150.00
			TOTAL CHARGES	1,720,994.44	52,033.50

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

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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 01:57:34  
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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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,745,551.71	ADJUSTMENTS	66,539.79
COVERED CHARGES	3,157,952.27	CONTRACTUAL ALLOW	2,193,996.94
NON-COVERD CHARGES	587,599.44	TOTAL MEDICAID LIAB	963,955.33
		LESS: COB	974.43
		LESS: COPAYMENT	1,751.07
		REIMBURSEMENT	961,229.83
		ALL OTHER	870,170.76
		FEE SCHEDULE-LAB	74,433.68
		INJECTABLE DRUGS	16,625.39

TOTAL NUMBER OF CLAIMS 2,237

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,315.50	120,953.00	OTHER LAB	37,657.75	0.00
MED/SURG SUPPLY	79,425.98	334.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	278.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	178,457.75	3,109.00	OTHER THERAPEUTIC SVC	0.00	2,507.75
CT SCAN	522,882.75	44,051.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,464.25	4,343.07	FEE SCHEDULE LAB	743,604.54	147,451.48
EKG/ECG	61,249.75	7,331.50	MRI SERVICES	64,187.25	10,626.75
IV THERAPY	147,377.25	5,319.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	87,268.25	7,161.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,349.75	201.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28,271.75	24,676.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,275.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	595,322.50	11,161.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,630.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	179,964.25	104,711.00
RADIOLOGY THERAPEUTIC	15,938.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,261.25	2,527.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	556.25	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	7,219.50	1,413.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,708.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	58,812.75	12,689.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,581.50	5,324.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	34,611.25	29,471.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	24,896.00	36,655.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	100,135.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	69,791.25	3,036.25			
			TOTAL ANCILLARY	3,157,952.27	587,599.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,157,952.27	587,599.44



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

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

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,466.07	ADJUSTMENTS	0.00
COVERED CHARGES	22,691.07	CONTRACTUAL ALLOW	7,668.55
NON-COVERD CHARGES	5,775.00	TOTAL MEDICAID LIAB	15,022.52
		LESS: COB	14,998.52
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 19

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

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95.00	458.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,432.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,874.00	642.25	FEE SCHEDULE LAB	6,932.25	500.50
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	3,448.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	689.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,921.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,567.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	74.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,598.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	526.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,140.50	1,049.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	516.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,691.07	5,775.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,691.07	5,775.00

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

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

Run Date: 08/12/2016  
Run Time: 01:57:47  
Page: 8

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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	365,091.63	ADJUSTMENTS	747.16
COVERED CHARGES	331,741.38	CONTRACTUAL ALLOW	306,904.94
NON-COVERD CHARGES	33,350.25	TOTAL MEDICAID LIAB	24,836.44
		LESS: COB	39.75
		LESS: COPAYMENT	810.00
		REIMBURSEMENT	23,986.69
		TOTAL NUMBER OF CLAIMS	444

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,694.75	11,093.00	OTHER LAB	706.00	0.00
MED/SURG SUPPLY	2,977.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,872.75	207.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,970.50	3,872.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	68,140.75	13,433.50
EKG/ECG	5,802.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,482.00	255.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87.50	1,429.50	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	156,918.00	138.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,748.25	480.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,022.75	1,003.25			
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	1,438.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	319.00	0.00			
			TOTAL ANCILLARY	331,741.38	33,350.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	331,741.38	33,350.25

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

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

Run Date: 08/12/2016  
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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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,263.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,233.00	CONTRACTUAL ALLOW	3,307.47
NON-COVERD CHARGES	30.00	TOTAL MEDICAID LIAB	925.53
		LESS: COB	925.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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

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

Run Date: 08/12/2016  
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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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	30.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	468.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,242.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	1,433.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	89.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,233.00	30.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,233.00	30.00

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

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

Run Date: 08/12/2016  
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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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	632,270.15	ADJUSTMENTS	11,250.28
COVERED CHARGES	610,547.40	CONTRACTUAL ALLOW	497,804.60
NON-COVERD CHARGES	21,722.75	TOTAL MEDICAID LIAB	112,742.80
		LESS: COB	0.00
		LESS: COPAYMENT	336.00
		REIMBURSEMENT	112,406.80

TOTAL NUMBER OF CLAIMS 20

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,699.00	1,525.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,292.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,345.50	0.00	OTHER THERAPEUTIC SVC	0.00	4,343.25
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,479.25	2,114.25
EKG/ECG	0.00	309.50	MRI SERVICES	0.00	0.00
IV THERAPY	2,404.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,414.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,105.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,567.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	510,197.00	11,458.25
RADIOLOGY THERAPEUTIC	35,665.75	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	5,376.75	1,843.75	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	128.75
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	610,547.40	21,722.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	610,547.40	21,722.75



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

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

Run Date: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DORMINY MEDICAL CENTER  
200 PERRY HOUSE RD  
FITZGERALD,GA 31750-8857

PROVIDER NUMBER  
000000613A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8500	2215134015933	04/20/15 - 04/20/15	05/18/15	0.00	46.00	0.00	0.00	0.00
8561	2215134015933	04/13/15 - 04/13/15	05/18/15	0.00	82.75	0.00	0.00	0.00
TOTAL				0.00	128.75	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
Run Time: 01:57:50  
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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	08/01/14	THROUGH	07/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 01:57:56  
 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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,279,223.38	ADJUSTMENTS	297,342.74
COVERED CHARGES	21,016,089.62	CONTRACTUAL ALLOW	15,944,541.06
NON-COVERD CHARGES	263,133.76	TOTAL MEDICAID LIAB	5,071,548.56
		LESS: COB	44,329.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,027,219.16

TOTAL NUMBER OF ADMISSIONS 635

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	1,278	12	1,295,892.00	215,148.50
ROUTINE NURSERY	153	2	58,772.60	768.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,431	14	1,354,664.60	215,916.50
SPECIAL CARE SERVICES				
CCU	719	2	1,571,790.10	4,370.00
ICU	410	0	1,280,013.07	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,129	2	2,851,803.17	4,370.00
TOTAL ACCOMODATIONS	2,560	16	4,206,467.77	220,286.50

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,617,487.50	506.25	OTHER LAB	170,051.58	0.00
MED/SURG SUPPLY	837,776.55	3,084.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,954,329.46	0.00	EDUCATION & TRAINING	3,709.00	0.00
RADIOLOGY-DIAGNOSTIC	432,818.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,269,053.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,472.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	188,568.00	0.00	MRI SERVICES	242,889.00	0.00
IV THERAPY	408,347.02	8,910.01	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	679,166.92	4,897.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	559,093.39	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,347,481.00	194.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	302,582.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,156,639.36	1,602.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	137,486.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	76,457.60	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	1,116.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	31,117.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	532,931.90	11,976.00	PATIENT CONVENIENCE	0.00	420.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25,054.34	546.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	21,643.60	0.00	IMPL DEV CHARGE PATIENTS	183,114.38	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	141,159.76	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	199,002.79	7,078.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	219,763.00	2,270.00			
AUDIOLOGY	30,161.00	0.00			
CARDIOLOGY	902,593.00	1,364.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,356.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	59,200.62	0.00			
			TOTAL ANCILLARY	16,809,621.85	42,847.26
			TOTAL ACCOMODATIONS	4,206,467.77	220,286.50
			TOTAL CHARGES	21,016,089.62	263,133.76

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

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

Run Date: 08/12/2016  
 Run Time: 01:58:10  
 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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	169,284.52	ADJUSTMENTS	0.00
COVERED CHARGES	166,556.52	CONTRACTUAL ALLOW	72,730.26
NON-COVERD CHARGES	2,728.00	TOTAL MEDICAID LIAB	93,826.26
		LESS: COB	93,826.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	17		0	17,238.00		2,728.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	17		0	17,238.00		2,728.00
SPECIAL CARE SERVICES						
CCU	6		0	13,110.00		0.00
ICU	2		0	6,244.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	8		0	19,354.00		0.00
TOTAL ACCOMODATIONS	25		0	36,592.00		2,728.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,575.50	0.00	OTHER LAB	1,276.00	0.00
MED/SURG SUPPLY	2,666.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,160.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,794.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,958.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,620.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	388.00	0.00	MRI SERVICES	6,133.00	0.00
IV THERAPY	2,398.02	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,313.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,940.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,105.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	484.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,813.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	111.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	482.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	675.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,168.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,999.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,668.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	238.00	0.00			
			TOTAL ANCILLARY	129,964.52	0.00
			TOTAL ACCOMODATIONS	36,592.00	2,728.00
			TOTAL CHARGES	166,556.52	2,728.00

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

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

Run Date: 08/12/2016  
Run Time: 01:58:11  
Page: 5

WELLSTAR DOUGLAS HOSPITAL  
8954 HOSPITAL DR  
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,043,828.49	ADJUSTMENTS	269,095.18
COVERED CHARGES	13,828,228.39	CONTRACTUAL ALLOW	11,968,142.27
NON-COVERD CHARGES	1,215,600.10	TOTAL MEDICAID LIAB	1,860,086.12
		LESS: COB	18,687.79
		LESS: COPAYMENT	2,769.00
		REIMBURSEMENT	1,838,629.33
		ALL OTHER	1,578,173.46
		FEE SCHEDULE-LAB	174,279.90
		INJECTABLE DRUGS	86,175.97

TOTAL NUMBER OF CLAIMS 5,328

WELLSTAR DOUGLAS HOSPITAL  
 8954 HOSPITAL DR  
 DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	319,054.18	13,856.68	OTHER LAB	144,422.44	0.00
MED/SURG SUPPLY	208,190.73	15,349.99	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	918,085.09	8,156.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,181,302.20	248,509.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,719.00	12,807.00	FEE SCHEDULE LAB	2,074,841.78	290,699.19
EKG/ECG	223,704.00	1,940.00	MRI SERVICES	356,806.59	42,230.00
IV THERAPY	619,076.36	7,444.68	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	486,780.11	120,284.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	81,286.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	79,275.60	62,304.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	305,848.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,982.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,669,687.86	1.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	163,803.55	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,155.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	443,923.58	210,872.75
RADIOLOGY THERAPEUTIC	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	1,482.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,975.95	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,039.00	7,073.04	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	62,166.80	20,580.00	IMPL DEV CHARGE PATIENTS	14,404.72	12,407.00
LITHOTRIPSY	71,922.00	0.00	NO CC/INVALID REV CODE	0.00	50.00
OTHER IMAGING SERVICE	434,034.04	46,882.92			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,505.93	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	282,074.00	22,687.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	246,940.00	55,646.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	186,244.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	211,109.98	1,205.00			
			TOTAL ANCILLARY	13,828,228.39	1,215,600.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,828,228.39	1,215,600.10



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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215172011098	08/27/14 - 08/27/14	08/24/15	0.00	0.00	0.00	0.00	0.00
3021	5215172011099	08/27/14 - 08/27/14	08/24/15	0.00	50.00	0.00	0.00	0.00
TOTAL				0.00	50.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	249,539.89	ADJUSTMENTS	0.00
COVERED CHARGES	210,778.06	CONTRACTUAL ALLOW	110,191.51
NON-COVERD CHARGES	38,761.83	TOTAL MEDICAID LIAB	100,586.55
		LESS: COB	100,552.99
		LESS: COPAYMENT	33.56
		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

WELLSTAR DOUGLAS HOSPITAL  
 8954 HOSPITAL DR  
 DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,217.75	870.00	OTHER LAB	7,106.30	0.00
MED/SURG SUPPLY	1,812.80	180.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,483.09	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,908.00	14,684.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,410.10	3,863.64
EKG/ECG	1,940.00	0.00	MRI SERVICES	6,133.00	4,233.00
IV THERAPY	8,047.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,021.00	3,917.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,140.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	650.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,176.00	2,034.00	AMBULANCE	0.00	0.00
GI SERVICES	4,200.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,783.53	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,390.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,656.25	231.75
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	482.00	0.00	IMPL DEV CHARGE PATIENTS	111.04	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,170.00	2,172.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,948.00	6,576.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	870.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,122.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	210,778.06	38,761.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	210,778.06	38,761.83

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	899,521.44	ADJUSTMENTS	1,229.60
COVERED CHARGES	869,387.44	CONTRACTUAL ALLOW	834,334.02
NON-COVERD CHARGES	30,134.00	TOTAL MEDICAID LIAB	35,053.42
		LESS: COB	35.00
		LESS: COPAYMENT	1,131.00
		REIMBURSEMENT	33,887.42
		TOTAL NUMBER OF CLAIMS	626

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,656.75	5.00	OTHER LAB	6,387.27	0.00
MED/SURG SUPPLY	2,193.00	406.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,004.88	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	57,008.60	11,115.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	791.00	FEE SCHEDULE LAB	134,966.42	10,848.00
EKG/ECG	9,312.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	37,590.85	290.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,662.00	837.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	504,832.27	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	4,640.00	2,275.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	11,114.40	2,892.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,019.00	675.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	869,387.44	30,134.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	869,387.44	30,134.00

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,816.50	ADJUSTMENTS	0.00
COVERED CHARGES	6,816.50	CONTRACTUAL ALLOW	4,588.26
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,228.24
		LESS: COB	2,222.24
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,417.00	0.00
EKG/ECG	388.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	585.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,696.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	73.50	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	648.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,816.50	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,816.50	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: 08/12/2016  
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Page: 14

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	745,220.42	ADJUSTMENTS	17,310.63
COVERED CHARGES	739,093.42	CONTRACTUAL ALLOW	629,636.96
NON-COVERD CHARGES	6,127.00	TOTAL MEDICAID LIAB	109,456.46
		LESS: COB	0.00
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	109,360.46

TOTAL NUMBER OF CLAIMS 19



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,948.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,594.16	4,911.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,147.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	140.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,890.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,593.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	643,237.25	530.00
RADIOLOGY THERAPEUTIC	10,262.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	546.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,440.00	686.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,296.01	0.00			
			TOTAL ANCILLARY	739,093.42	6,127.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	739,093.42	6,127.00

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

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

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 02:01:10  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
 11740 COLUMBIA ST  
 BLAKELY, GA 39823-2574

PROVIDER NUMBER  
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	478,047.20	ADJUSTMENTS	49,399.77
COVERED CHARGES	431,582.20	CONTRACTUAL ALLOW	252,077.25
NON-COVERD CHARGES	46,465.00	TOTAL MEDICAID LIAB	179,504.95
		LESS: COB	4,711.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	174,793.33

TOTAL NUMBER OF ADMISSIONS 38

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	207		5	111,780.00		43,585.00
ROUTINE NURSERY	0		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		5	111,780.00		43,585.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	207		5	111,780.00		43,585.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
 11740 COLUMBIA ST  
 BLAKELY, GA 39823-2574

PROVIDER NUMBER  
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,918.00	0.00	OTHER LAB	2,070.00	0.00
MED/SURG SUPPLY	24,022.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	66,458.00	0.00	EDUCATION & TRAINING	126.00	0.00
RADIOLOGY-DIAGNOSTIC	6,869.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,731.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,702.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	720.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,322.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,894.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,049.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,848.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,462.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	880.00	0.00			
BLOOD	2,712.00	0.00			
BLOOD STORAGE & PRO.	2,712.00	2,880.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,307.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	319,802.20	2,880.00
			TOTAL ACCOMODATIONS	111,780.00	43,585.00
			TOTAL CHARGES	431,582.20	46,465.00

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

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

Run Date: 08/12/2016  
Run Time: 02:01:10  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 02:01:10  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	696,448.80	ADJUSTMENTS	7,551.56
COVERED CHARGES	617,100.40	CONTRACTUAL ALLOW	420,962.18
NON-COVERD CHARGES	79,348.40	TOTAL MEDICAID LIAB	196,138.22
		LESS: COB	0.00
		LESS: COPAYMENT	924.84
		REIMBURSEMENT	195,213.38
		ALL OTHER	169,056.62
		FEE SCHEDULE-LAB	15,236.57
		INJECTABLE DRUGS	10,920.19

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: 08/12/2016  
 Run Time: 02:01:10  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,002.00	4,883.20	OTHER LAB	4,609.00	0.00
MED/SURG SUPPLY	4,853.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	4,486.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,675.00	716.00	OTHER THERAPEUTIC SVC	0.00	315.00
CT SCAN	100,710.00	20,315.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,118.00	2,262.00	FEE SCHEDULE LAB	186,694.00	27,703.00
EKG/ECG	3,280.00	114.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,586.00	380.00	PROFESSIONAL FEES	0.00	1,363.00
OPERATING ROOM	10,470.00	1,775.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,813.00	812.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	255.00	577.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	178,964.00	2,049.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	360.00	360.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,544.40	7,992.20
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	194.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,396.00	852.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,200.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,316.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,455.00	0.00			
			TOTAL ANCILLARY	617,100.40	79,348.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	617,100.40	79,348.40

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

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

Run Date: 08/12/2016  
Run Time: 02:01:13  
Page: 6

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	570.00	ADJUSTMENTS	0.00
COVERED CHARGES	551.00	CONTRACTUAL ALLOW	197.14
NON-COVERD CHARGES	19.00	TOTAL MEDICAID LIAB	353.86
		LESS: COB	350.88
		LESS: COPAYMENT	2.98
		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: 08/12/2016  
 Run Time: 02:01:13  
 Page: 7

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	291.00	19.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	260.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	551.00	19.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	551.00	19.00

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

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

Run Date: 08/12/2016  
Run Time: 02:01:13  
Page: 8

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	79,116.00	ADJUSTMENTS	47.00
COVERED CHARGES	67,901.00	CONTRACTUAL ALLOW	62,901.00
NON-COVERD CHARGES	11,215.00	TOTAL MEDICAID LIAB	5,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	192.00
		REIMBURSEMENT	4,808.00
		TOTAL NUMBER OF CLAIMS	100

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,080.00	255.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	251.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,611.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,722.00	7,146.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	198.00	FEE SCHEDULE LAB	12,630.00	3,545.00
EKG/ECG	400.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	48,235.00	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	945.00	71.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	67,901.00	11,215.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,901.00	11,215.00

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

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

Run Date: 08/12/2016  
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Page: 10

SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
11740 COLUMBIA ST  
BLAKELY,GA 39823-2574

PROVIDER NUMBER  
000000635A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,630.00	ADJUSTMENTS	4,862.05
COVERED CHARGES	48,836.00	CONTRACTUAL ALLOW	34,249.01
NON-COVERD CHARGES	8,794.00	TOTAL MEDICAID LIAB	14,586.99
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	14,523.99

TOTAL NUMBER OF CLAIMS 3

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,115.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	105.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	5,174.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	895.00	0.00	OTHER THERAPEUTIC SVC	0.00	315.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,849.00	1,701.00
EKG/ECG	57.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,844.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	390.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	971.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,103.00	164.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	2,712.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,440.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,795.00	0.00			
			TOTAL ANCILLARY	48,836.00	8,794.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,836.00	8,794.00

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

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

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EFFINGHAM COUNTY HOSPITAL  
 459 GA HIGHWAY 119 S  
 SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER 000000657A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	308,733.89	ADJUSTMENTS	19,309.52
COVERED CHARGES	223,748.53	CONTRACTUAL ALLOW	128,731.79
NON-COVERD CHARGES	84,985.36	TOTAL MEDICAID LIAB	95,016.74
		LESS: COB	7,877.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	87,139.07

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	55		0	45,375.00		84,618.00
ROUTINE NURSERY	0		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	45,375.00		84,618.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	45,375.00		84,618.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EFFINGHAM COUNTY HOSPITAL  
 459 GA HIGHWAY 119 S  
 SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER  
 000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,315.32	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22,065.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	23,187.10	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,170.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,448.44	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,306.17	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,081.63	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,711.00	0.00	PROFESSIONAL FEES	0.00	265.36
OPERATING ROOM	12,333.08	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,034.74	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,552.31	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,751.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,539.26	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,445.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,077.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,260.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	102.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,095.00	0.00			
			TOTAL ANCILLARY	178,373.53	367.36
			TOTAL ACCOMODATIONS	45,375.00	84,618.00
			TOTAL CHARGES	223,748.53	84,985.36

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

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

Run Date: 08/12/2016  
Run Time: 02:03:18  
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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 02:03:18  
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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,094,637.60	ADJUSTMENTS	131,824.32
COVERED CHARGES	2,789,945.11	CONTRACTUAL ALLOW	1,965,651.16
NON-COVERD CHARGES	304,692.49	TOTAL MEDICAID LIAB	824,293.95
		LESS: COB	3,873.52
		LESS: COPAYMENT	2,058.00
		REIMBURSEMENT	818,362.43
		ALL OTHER	768,129.71
		FEE SCHEDULE-LAB	44,199.81
		INJECTABLE DRUGS	6,032.91
		TOTAL NUMBER OF CLAIMS	1,694

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,806.75	211.00	OTHER LAB	43,652.86	0.00
MED/SURG SUPPLY	63,409.75	504.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	376.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	268,972.70	5,116.59	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	500,037.55	120,598.94	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,536.19	1,177.65	FEE SCHEDULE LAB	452,090.27	85,669.41
EKG/ECG	36,222.56	2,059.42	MRI SERVICES	109,552.09	3,545.98
IV THERAPY	318.50	818.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	80,626.48	7,002.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,231.58	2,651.66	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,409.85	1,698.00	AMBULANCE	0.00	0.00
GI SERVICES	42,002.29	7,168.57	CAST ROOM	0.00	0.00
EMERGENCY ROOM	768,766.41	1,234.78	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,816.47	3,900.15	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,272.03	19,522.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,526.81	1,421.15	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	966.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	9,095.47
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	97,136.95	21,410.31			
BLOOD	2,804.25	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,685.00	4,584.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,373.72	3,961.14			
AMBULATORY SURGERY	4,241.95	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,452.10	0.00			
			TOTAL ANCILLARY	2,789,945.11	304,692.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,789,945.11	304,692.49

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

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

Run Date: 08/12/2016  
Run Time: 02:03:36  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,173.40	ADJUSTMENTS	0.00
COVERED CHARGES	37,039.16	CONTRACTUAL ALLOW	18,600.48
NON-COVERD CHARGES	13,134.24	TOTAL MEDICAID LIAB	18,438.68
		LESS: COB	18,410.66
		LESS: COPAYMENT	28.02
		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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,249.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	383.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,152.88	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,899.00	8,138.42	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,805.38	979.71
EKG/ECG	728.08	0.00	MRI SERVICES	0.00	3,221.77
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	66.34
OPERATING ROOM	1,663.85	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,881.14	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	508.00	174.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	452.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	718.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	102.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	37,039.16	13,134.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,039.16	13,134.24

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

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

Run Date: 08/12/2016  
Run Time: 02:03:37  
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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	163,375.85	ADJUSTMENTS	291.00
COVERED CHARGES	158,982.82	CONTRACTUAL ALLOW	150,432.82
NON-COVERD CHARGES	4,393.03	TOTAL MEDICAID LIAB	8,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	312.00
		REIMBURSEMENT	8,238.00
		TOTAL NUMBER OF CLAIMS	171

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,984.50	0.00	OTHER LAB	3,040.80	0.00
MED/SURG SUPPLY	571.74	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,658.75	387.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,243.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,542.51	1,325.03
EKG/ECG	1,318.13	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	600.76	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	113,747.85	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	1,623.78	438.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,894.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	158,982.82	4,393.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	158,982.82	4,393.03



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

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

Run Date: 08/12/2016  
Run Time: 02:03:39  
Page: 10

EFFINGHAM COUNTY HOSPITAL  
459 GA HIGHWAY 119 S  
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER  
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,615.70	ADJUSTMENTS	0.00
COVERED CHARGES	9,363.60	CONTRACTUAL ALLOW	6,130.27
NON-COVERD CHARGES	252.10	TOTAL MEDICAID LIAB	3,233.33
		LESS: COB	3,221.33
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

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

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

Run Date: 08/12/2016  
 Run Time: 02:03:39  
 Page: 11

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	233.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	82.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	943.74	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	1,877.84	208.10
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,843.67	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	382.50	44.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,363.60	252.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,363.60	252.10

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

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

Run Date: 08/12/2016  
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Page: 12

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	74,269.84	ADJUSTMENTS	0.00
COVERED CHARGES	61,812.40	CONTRACTUAL ALLOW	44,410.21
NON-COVERD CHARGES	12,457.44	TOTAL MEDICAID LIAB	17,402.19
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,402.19

TOTAL NUMBER OF CLAIMS 3

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,010.67	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,713.21	97.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	437.63	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	9,846.99	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,458.11	338.30
EKG/ECG	270.71	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,311.42	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	250.38	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,615.62	428.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,833.94	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,537.12	405.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,393.59	1,138.15
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,336.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	204.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,644.00	0.00			
			TOTAL ANCILLARY	61,812.40	12,457.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	61,812.40	12,457.44

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

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

Run Date: 08/12/2016  
Run Time: 02:03:40  
Page: 14

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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 02:03:46  
 Page: 1

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	613,422.06	ADJUSTMENTS	17,449.12
COVERED CHARGES	590,130.25	CONTRACTUAL ALLOW	209,142.71
NON-COVERD CHARGES	23,291.81	TOTAL MEDICAID LIAB	380,987.54
		LESS: COB	3,906.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	377,081.22

TOTAL NUMBER OF ADMISSIONS 65

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	191		8	116,128.00		15,992.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	191		8	116,128.00		15,992.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	13		0	15,665.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	15,665.00		0.00
TOTAL ACCOMODATIONS	204		8	131,793.00		15,992.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,508.80	0.00	OTHER LAB	5,440.08	0.00
MED/SURG SUPPLY	26,909.00	184.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	101,626.35	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,448.09	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,359.27	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,481.99	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,169.00	0.00	MRI SERVICES	1,878.00	0.00
IV THERAPY	14,895.45	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,500.00	0.00	DURABLE MED. EQUIP.	0.00	34.50
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,899.63	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	981.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,960.42	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,975.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	130.00	0.00	INJECTABLE DRUGS	39,505.57	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,175.80
OTHER IMAGING SERVICE	5,045.73	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,325.75	2,780.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,554.57	125.51			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,564.65	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	2,178.90	0.00			
			TOTAL ANCILLARY	458,337.25	7,299.81
			TOTAL ACCOMODATIONS	131,793.00	15,992.00
			TOTAL CHARGES	590,130.25	23,291.81

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

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

Run Date: 08/12/2016  
Run Time: 02:03:46  
Page: 3

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

PROVIDER NUMBER  
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215013000099	12/29/14 - 12/31/14	01/19/15	0.00	2,002.00	0.00	0.00	0.00
615	2015021037648	01/13/15 - 01/16/15	01/26/15	0.00	2,173.80	0.00	0.00	0.00
TOTAL				0.00	4,175.80	0.00	0.00	0.00



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

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

Run Date: 08/12/2016  
Run Time: 02:03:47  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000668A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 02:03:47  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,191,627.70	ADJUSTMENTS	28,453.07
COVERED CHARGES	1,095,664.86	CONTRACTUAL ALLOW	816,645.66
NON-COVERD CHARGES	95,962.84	TOTAL MEDICAID LIAB	279,019.20
		LESS: COB	0.00
		LESS: COPAYMENT	1,094.37
		REIMBURSEMENT	277,924.83
		ALL OTHER	254,387.28
		FEE SCHEDULE-LAB	23,318.87
		INJECTABLE DRUGS	218.68

TOTAL NUMBER OF CLAIMS 974

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
 000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,579.55	12,017.26	OTHER LAB	12,680.69	0.00
MED/SURG SUPPLY	11,151.71	288.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	635.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,733.60	1,172.49	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	152,635.49	17,167.64	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,889.64	3,634.46	FEE SCHEDULE LAB	206,661.54	20,632.88
EKG/ECG	21,156.00	821.00	MRI SERVICES	33,093.71	2,113.00
IV THERAPY	51,617.84	2,810.08	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	66,673.33	23,166.67	DURABLE MED. EQUIP.	0.00	103.50
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,440.44	449.82	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,306.00	150.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	302,423.42	2,600.36	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,951.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,630.00	2,902.30
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	43,184.26	531.21			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,816.57	608.48			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,590.51	1,512.93			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	781.84	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,667.72	2,645.76			
			TOTAL ANCILLARY	1,095,664.86	95,962.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,095,664.86	95,962.84

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

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

PROVIDER NUMBER  
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	797.47	ADJUSTMENTS	0.00
COVERED CHARGES	797.47	CONTRACTUAL ALLOW	259.49
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	537.98
		LESS: COB	537.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	253.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	89.92	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	454.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	797.47	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	797.47	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: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	67,041.03	ADJUSTMENTS	52.94
COVERED CHARGES	64,318.95	CONTRACTUAL ALLOW	58,557.13
NON-COVERD CHARGES	2,722.08	TOTAL MEDICAID LIAB	5,761.82
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	5,542.82
		TOTAL NUMBER OF CLAIMS	103

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,532.69	111.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	38.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,495.86	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,586.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,518.83	2,611.08
EKG/ECG	933.13	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,071.88	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,760.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	282.20	0.00			
			TOTAL ANCILLARY	64,318.95	2,722.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,318.95	2,722.08

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

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

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



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

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

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMANUEL MEDICAL CENTER  
 117 KITE RD  
 SWAINSBORO,GA 30401-3231

PROVIDER NUMBER 000000701A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,955,505.68	ADJUSTMENTS	16,152.39
COVERED CHARGES	2,930,104.18	CONTRACTUAL ALLOW	1,905,141.76
NON-COVERD CHARGES	25,401.50	TOTAL MEDICAID LIAB	1,024,962.42
		LESS: COB	16,269.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,008,693.30

TOTAL NUMBER OF ADMISSIONS 163

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	487		0	240,548.00		8,667.00
ROUTINE NURSERY	28		0	13,916.00		2,154.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	515		0	254,464.00		10,821.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	89		0	98,078.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	89		0	98,078.00		0.00
TOTAL ACCOMODATIONS	604		0	352,542.00		10,821.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	928,785.30	2,829.50	OTHER LAB	9,651.00	0.00
MED/SURG SUPPLY	89,412.79	201.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	498,579.43	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,733.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	253,062.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,580.70	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	24,564.00	0.00	MRI SERVICES	28,134.00	0.00
IV THERAPY	8,913.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,206.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,983.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	269,672.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,848.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	179,182.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,110.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,979.81	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,311.70	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	2,785.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,731.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,594.00	11,550.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,121.00	0.00			
AUDIOLOGY	5,217.55	0.00			
CARDIOLOGY	25,575.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,830.00	0.00			
			TOTAL ANCILLARY	2,577,562.18	14,580.50
			TOTAL ACCOMODATIONS	352,542.00	10,821.00
			TOTAL CHARGES	2,930,104.18	25,401.50

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,936,807.44	ADJUSTMENTS	52,833.97
COVERED CHARGES	5,484,273.24	CONTRACTUAL ALLOW	4,616,094.39
NON-COVERD CHARGES	452,534.20	TOTAL MEDICAID LIAB	868,178.85
		LESS: COB	3,642.20
		LESS: COPAYMENT	1,552.53
		REIMBURSEMENT	862,984.12
		ALL OTHER	782,476.28
		FEE SCHEDULE-LAB	80,507.84
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	2,328

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	456,160.22	3,292.25	OTHER LAB	40,887.00	0.00
MED/SURG SUPPLY	172,941.47	3,333.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	287,572.00	588.00	OTHER THERAPEUTIC SVC	0.00	456.00
CT SCAN	607,874.00	91,754.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	182.25	158.40	FEE SCHEDULE LAB	1,080,478.14	231,272.88
EKG/ECG	52,272.00	0.00	MRI SERVICES	145,711.00	4,012.00
IV THERAPY	296,993.00	3,278.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	93,920.00	34,702.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,187.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,395.35	1,432.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,289.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,604,091.01	16,778.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	56,730.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	81.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,310.40	655.20	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,620.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	7,197.85
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	186,473.00	17,828.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,780.00	4,725.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	32,043.00	9,293.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	30,086.80	5,115.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,486.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	259,790.00	16,582.02			
			TOTAL ANCILLARY	5,484,273.24	452,534.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,484,273.24	452,534.20

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

EMANUEL MEDICAL CENTER  
117 KITE RD  
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,064.12	ADJUSTMENTS	0.00
COVERED CHARGES	55,367.52	CONTRACTUAL ALLOW	32,060.37
NON-COVERD CHARGES	10,696.60	TOTAL MEDICAID LIAB	23,307.15
		LESS: COB	23,292.95
		LESS: COPAYMENT	14.20
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27



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

EMANUEL MEDICAL CENTER  
 117 KITE RD  
 SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
 000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,892.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,183.85	72.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,431.00	334.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,169.00	5,332.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,242.37	1,575.60
EKG/ECG	828.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,568.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	1,756.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,194.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,220.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	372.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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	1,085.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	332.00	542.00			
			TOTAL ANCILLARY	55,367.52	10,696.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	55,367.52	10,696.60

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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EMANUEL MEDICAL CENTER  
117 KITE RD  
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	687,209.08	ADJUSTMENTS	164.82
COVERED CHARGES	673,186.28	CONTRACTUAL ALLOW	652,991.94
NON-COVERD CHARGES	14,022.80	TOTAL MEDICAID LIAB	20,194.34
		LESS: COB	55.81
		LESS: COPAYMENT	648.00
		REIMBURSEMENT	19,490.53
		TOTAL NUMBER OF CLAIMS	361

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,309.75	152.00	OTHER LAB	3,162.00	0.00
MED/SURG SUPPLY	4,935.47	243.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,152.00	0.00	OTHER THERAPEUTIC SVC	0.00	114.00
CT SCAN	29,603.00	2,482.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	114,204.26	10,278.30
EKG/ECG	4,416.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	34,963.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	671.80	104.50	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	396,745.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	124.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,683.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,078.00	525.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,096.00	0.00			
			TOTAL ANCILLARY	673,186.28	14,022.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	673,186.28	14,022.80

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,325.19	ADJUSTMENTS	0.00
COVERED CHARGES	14,272.09	CONTRACTUAL ALLOW	6,590.23
NON-COVERD CHARGES	53.10	TOTAL MEDICAID LIAB	7,681.86
		LESS: COB	7,672.86
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	568.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	74.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,738.19	53.10
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	627.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,126.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,138.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,272.09	53.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,272.09	53.10

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

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

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV  
 1364 CLIFTON RD NE DEPT RM  
 ATLANTA,GA 30322-1059

PROVIDER NUMBER 000000712A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	114,822,981.47	ADJUSTMENTS	10,453,417.19
COVERED CHARGES	110,807,260.85	CONTRACTUAL ALLOW	76,708,030.79
NON-COVERD CHARGES	4,015,720.62	TOTAL MEDICAID LIAB	34,099,230.06
		LESS: COB	189,534.21
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	33,909,695.85

TOTAL NUMBER OF ADMISSIONS 1,581

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,394		41	8,984,120.00		1,217,745.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7,394		41	8,984,120.00		1,217,745.00
SPECIAL CARE SERVICES						
CCU	371		0	1,614,000.00		117,625.00
ICU	6,223		3	19,726,170.00		114,395.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		65	0.00		116,605.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6,594		68	21,340,170.00		348,625.00
TOTAL ACCOMODATIONS	13,988		109	30,324,290.00		1,566,370.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV  
 1364 CLIFTON RD NE DEPT RM  
 ATLANTA,GA 30322-1059

PROVIDER NUMBER  
 000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,209,888.55	48,382.87	OTHER LAB	772,562.00	3,304.00
MED/SURG SUPPLY	5,120,842.41	180,141.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,416,091.00	222,409.00	EDUCATION & TRAINING	106.00	0.00
RADIOLOGY-DIAGNOSTIC	1,421,772.00	7,830.00	OTHER THERAPEUTIC SVC	0.00	61,696.00
CT SCAN	3,650,008.00	23,167.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	838,916.91	5,977.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	312,351.00	2,898.00	MRI SERVICES	2,598,868.00	6,597.00
IV THERAPY	279.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,260,973.00	25,292.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,150,837.00	41,078.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,041,569.00	8,460.00	AMBULANCE	0.00	0.00
GI SERVICES	400,224.00	7,622.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,190,716.00	7,834.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	669,058.00	3,870.00	DRUG-SPECIFIC/HOME IV	0.00	263,604.08
LABORATORY PATHOLOGIC	1,024,520.00	5,555.00	INJECTABLE DRUGS	17,923,021.18	123,509.45
RADIOLOGY THERAPEUTIC	74,073.00	3,051.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	532,530.75	7,387.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	251,180.62	5,429.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	417,332.00	134,782.00	PATIENT CONVENIENCE	0.00	83.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,464,461.68	5,912.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	757,904.00
OTHER IMAGING SERVICE	259,193.00	152,118.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,670,023.50	216,034.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	80,179.00	71,596.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,971,207.00	3,668.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,648,448.00	800.00			
ORGAN ACQUISITION	2,078,089.25	41,197.00			
TREATMENT/OBSERV. RM	33,650.00	163.00			
			TOTAL ANCILLARY	80,482,970.85	2,449,350.62
			TOTAL ACCOMODATIONS	30,324,290.00	1,566,370.00
			TOTAL CHARGES	110,807,260.85	4,015,720.62

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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014259010219	09/02/14 - 09/08/14	09/22/14	0.00	13,194.00	0.00	0.00	0.00
615	2014266030251	09/13/14 - 09/17/14	09/29/14	0.00	11,790.00	0.00	0.00	0.00
614	2014274032157	09/19/14 - 09/25/14	10/06/14	0.00	6,597.00	0.00	0.00	0.00
614	2014277025512	09/05/14 - 09/28/14	10/13/14	0.00	6,597.00	0.00	0.00	0.00
614	2014283025793	10/02/14 - 10/04/14	10/13/14	0.00	6,597.00	0.00	0.00	0.00
618	2014294025800	09/18/14 - 10/15/14	10/27/14	0.00	8,721.00	0.00	0.00	0.00
614	2014304027790	10/15/14 - 10/25/14	11/03/14	0.00	6,597.00	0.00	0.00	0.00
614	2014310027068	09/17/14 - 10/30/14	11/10/14	0.00	13,194.00	0.00	0.00	0.00
614	2214314008968	10/08/14 - 10/12/14	11/17/14	0.00	2,907.00	0.00	0.00	0.00
614	2214317003430	09/23/14 - 10/03/14	11/24/14	0.00	6,597.00	0.00	0.00	0.00
615	2014320000451	10/12/14 - 11/10/14	11/24/14	0.00	5,895.00	0.00	0.00	0.00
614	5914322000024	10/14/14 - 10/21/14	11/24/14	0.00	6,597.00	0.00	0.00	0.00
614	5914322000026	10/04/14 - 10/17/14	11/24/14	0.00	6,597.00	0.00	0.00	0.00
614	2014324073210	11/12/14 - 11/14/14	11/24/14	0.00	6,597.00	0.00	0.00	0.00
614	5214324000035	10/06/14 - 10/20/14	11/24/14	0.00	6,597.00	0.00	0.00	0.00
614	2014326027003	11/07/14 - 11/14/14	12/01/14	0.00	1,575.00	0.00	0.00	0.00
614	2014328011204	11/12/14 - 11/18/14	12/22/14	0.00	13,194.00	0.00	0.00	0.00
615	2014330017531	11/16/14 - 11/18/14	12/01/14	0.00	11,790.00	0.00	0.00	0.00
614	2214335007930	10/20/14 - 10/24/14	12/08/14	0.00	6,587.00	0.00	0.01	0.00
614	2014339051095	11/13/14 - 11/26/14	12/08/14	0.00	2,468.00	0.00	0.00	0.00
615	2014344030339	10/26/14 - 11/02/14	12/15/14	0.00	3,015.00	0.00	0.00	0.00
614	2014345024631	11/29/14 - 12/02/14	12/15/14	0.00	6,597.00	0.00	0.00	0.00
614	2014345024744	11/28/14 - 12/05/14	12/15/14	0.00	6,597.00	0.00	0.00	0.00
615	2014346011902	11/17/14 - 12/02/14	12/15/14	0.00	11,790.00	0.00	0.00	0.00
614	2014349004357	12/01/14 - 12/05/14	12/22/14	0.00	6,597.00	0.00	0.00	0.00
615	2014351031500	12/06/14 - 12/10/14	12/22/14	0.00	11,790.00	0.00	0.00	0.00
615	2014352029562	09/16/14 - 09/20/14	12/22/14	0.00	8,910.00	0.00	0.00	0.00
614	2014352029566	09/24/14 - 10/03/14	12/22/14	0.00	13,194.00	0.00	0.00	0.00
615	5214356000011	10/23/14 - 11/04/14	12/29/14	0.00	3,015.00	0.00	0.00	0.00
615	2014360051567	12/17/14 - 12/20/14	12/29/14	0.00	11,790.00	0.00	0.00	0.00
615	2014365030401	11/02/14 - 11/07/14	01/05/15	0.00	5,895.00	0.00	0.00	0.00
615	9114350003076	10/01/14 - 10/19/14	01/05/15	0.00	11,790.00	0.00	6,373.31	0.00
614	22150060000615	10/21/14 - 12/12/14	01/12/15	0.00	2,795.00	0.00	0.00	0.00
614	2015009010345	12/31/14 - 01/03/15	01/12/15	0.00	6,597.00	0.00	0.00	0.00
615	2015009010355	12/29/14 - 01/03/15	01/12/15	0.00	3,015.00	0.00	0.00	0.00
615	2015013019274	01/05/15 - 01/07/15	01/19/15	0.00	11,790.00	0.00	0.00	0.00
615	2015021011811	01/10/15 - 01/15/15	01/26/15	0.00	5,895.00	0.00	0.00	0.00
615	2215023011601	10/15/14 - 11/14/14	01/26/15	0.00	3,015.00	0.00	0.00	0.00
615	2015028023036	01/18/15 - 01/20/15	02/02/15	0.00	11,790.00	0.00	0.00	0.00
614	2015030026740	01/04/15 - 01/23/15	02/02/15	0.00	6,597.00	0.00	0.00	0.00
615	2015035017326	01/22/15 - 01/27/15	02/09/15	0.00	11,790.00	0.00	0.00	0.00
614	5215041000031	09/12/14 - 11/06/14	02/16/15	0.00	6,597.00	0.00	0.00	0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV  
 1364 CLIFTON RD NE DEPT RM  
 ATLANTA,GA 30322-1059

PROVIDER NUMBER  
 000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM
614	2015045027866	01/06/15 - 01/23/15	02/23/15	0.00	13,194.00	0.00	0.00	0.00	0.00
615	5215047000014	10/31/14 - 12/05/14	02/23/15	0.00	11,790.00	0.00	0.00	0.00	0.00
615	2015049010737	01/26/15 - 02/03/15	02/23/15	0.00	11,790.00	0.00	0.00	0.00	0.00
615	2215058007828	10/13/14 - 11/18/14	03/02/15	0.00	3,015.00	0.00	0.00	0.00	0.00
615	2215061000805	12/25/14 - 01/13/15	03/09/15	0.00	3,015.00	0.00	0.00	0.00	0.00
615	2015062014947	02/07/15 - 02/12/15	03/09/15	0.00	5,895.00	0.00	0.00	0.00	0.00
615	2015067000391	01/23/15 - 01/28/15	03/16/15	0.00	11,790.00	0.00	0.00	0.00	0.00
614	2015073024815	01/05/15 - 02/03/15	03/23/15	0.00	13,194.00	0.00	0.00	0.00	0.00
615	2015073024943	02/10/15 - 03/07/15	03/23/15	0.00	5,895.00	0.00	0.00	0.00	0.00
615	2015075004780	03/02/15 - 03/05/15	03/23/15	0.00	11,790.00	0.00	0.00	0.00	0.00
614	5215091003470	10/08/14 - 12/10/14	04/06/15	0.00	6,597.00	0.00	0.00	0.00	0.00
615	2215096000425	02/28/15 - 03/04/15	04/13/15	0.00	3,015.00	0.00	0.00	0.00	0.00
615	2215097005134	02/14/15 - 03/06/15	04/13/15	0.00	5,895.00	0.00	0.00	0.00	0.00
615	2315098000147	09/27/14 - 10/31/14	04/20/15	0.00	8,910.00	0.00	9,342.83	0.00	0.00
615	2015100038921	09/06/14 - 09/11/14	04/13/15	0.00	3,015.00	0.00	0.00	0.00	0.00
614	5215105000015	09/19/14 - 12/08/14	04/20/15	0.00	6,597.00	0.00	0.00	0.00	0.00
614	2215111011468	12/22/14 - 12/31/14	04/27/15	0.00	6,597.00	0.00	0.00	0.00	0.00
614	5215114000016	11/10/14 - 12/24/14	05/04/15	0.00	2,974.00	0.00	0.00	0.00	0.00
614	9815125000041	10/30/14 - 11/19/14	05/11/15	0.00	13,194.00	0.00	0.00	0.00	0.00
615	2315127000043	03/05/15 - 03/07/15	05/18/15	0.00	11,790.00	0.00	3,101.63	0.00	0.00
615	2215128022619	02/01/15 - 02/18/15	05/11/15	0.00	5,895.00	0.00	0.00	0.00	0.00
615	2015145005932	05/13/15 - 05/15/15	06/01/15	0.00	11,790.00	0.00	0.00	0.00	0.00
615	2015149006600	05/14/15 - 05/21/15	06/01/15	0.00	6,030.00	0.00	0.00	0.00	0.00
615	2015150031764	05/05/15 - 05/21/15	06/08/15	0.00	11,790.00	0.00	0.00	0.00	0.00
615	2315154000220	03/29/15 - 04/12/15	07/06/15	0.00	11,790.00	0.00	4,249.47	0.00	0.00
615	2315156000294	02/01/15 - 04/20/15	06/22/15	0.00	3,015.00	0.00	0.00	0.00	0.00
615	2215162006440	12/24/14 - 12/29/14	06/15/15	0.00	5,895.00	0.00	0.00	0.00	0.00
614	2315162000137	04/13/15 - 04/16/15	07/06/15	0.00	2,907.00	0.00	923.19	0.00	0.00
615	2015182077696	06/10/15 - 06/24/15	07/06/15	0.00	3,015.00	0.00	0.00	0.00	0.00
614	2015183012866	06/05/15 - 06/26/15	07/06/15	0.00	13,194.00	0.00	0.00	0.00	0.00
615	2015193000552	06/09/15 - 07/03/15	07/20/15	0.00	11,790.00	0.00	0.00	0.00	0.00
614	2215223004951	11/04/14 - 11/05/14	08/17/15	0.00	6,597.00	0.00	0.00	0.00	0.00
615	2215244001876	06/16/15 - 07/01/15	09/07/15	0.00	3,015.00	0.00	0.00	0.00	0.00
615	2215273005685	01/02/15 - 01/05/15	10/05/15	0.00	11,790.00	0.00	0.00	0.00	0.00
614	2215286004069	05/25/15 - 06/23/15	10/19/15	0.00	13,194.00	0.00	0.00	0.00	0.00
615	2315300000198	08/06/15 - 08/13/15	11/23/15	0.00	11,790.00	0.00	3,808.98	0.00	0.00
615	5215344000184	06/16/15 - 07/04/15	12/14/15	0.00	3,015.00	0.00	0.00	0.00	0.00
615	2015350088324	11/06/14 - 11/14/14	12/21/15	0.00	11,790.00	0.00	0.00	0.00	0.00
615	5215356000147	07/31/15 - 11/07/15	12/28/15	0.00	3,181.00	0.00	0.00	0.00	0.00
614	5215362009926	07/30/15 - 08/21/15	02/22/16	0.00	6,597.00	0.00	0.00	0.00	0.00
614	5215363002092	07/23/15 - 08/18/15	02/22/16	0.00	13,194.00	0.00	0.00	0.00	0.00
615	2016013001414	11/18/14 - 11/20/14	01/18/16	0.00	5,895.00	0.00	0.00	0.00	0.00
614	5216028000165	06/08/15 - 06/27/15	02/01/16	0.00	13,194.00	0.00	0.00	0.00	0.00
614	2016029080361	06/03/15 - 06/30/15	02/08/16	0.00	19,791.00	0.00	0.00	0.00	0.00
615	5016054981005	12/22/14 - 02/04/15	03/07/16	0.00	11,790.00	0.00	0.00	0.00	0.00
614	5016054981005	12/22/14 - 02/04/15	03/07/16	0.00	13,194.00	0.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
Run Time: 02:07:25  
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SUMMARY TYPE I  
INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV  
1364 CLIFTON RD NE DEPT RM  
ATLANTA,GA 30322-1059

PROVIDER NUMBER  
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

615	2016126089876	01/09/15 - 01/17/15	05/09/16	0.00	5,895.00	0.00	0.00	0.00
615	2216137010845	07/06/15 - 07/29/15	05/23/16	0.00	11,790.00	0.00	0.00	0.00
615	2216182010179	08/08/15 - 10/02/15	07/04/16	0.00	11,790.00	0.00	0.00	0.00
615	9716189981051	11/02/14 - 11/14/14	07/11/16	0.00	11,790.00	0.00	0.00	0.00
TOTAL				0.00	757,904.00	0.00	27,799.42	0.00

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

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

Run Date: 08/12/2016  
 Run Time: 02:07:43  
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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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,787,380.87	ADJUSTMENTS	0.00
COVERED CHARGES	1,753,313.45	CONTRACTUAL ALLOW	727,621.38
NON-COVERD CHARGES	34,067.42	TOTAL MEDICAID LIAB	1,025,692.07
		LESS: COB	1,025,692.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 38

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	174		0	214,405.00		21,210.00
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	174		0	214,405.00		21,210.00
SPECIAL CARE SERVICES						
CCU	8		0	37,000.00		0.00
ICU	36		0	138,340.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	175,340.00		0.00
TOTAL ACCOMODATIONS	218		0	389,745.00		21,210.00

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,616.71	0.00	OTHER LAB	2,668.00	0.00
MED/SURG SUPPLY	147,306.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	197,800.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,761.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,359.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,601.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,968.00	0.00	MRI SERVICES	35,375.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	248,911.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,518.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	56,952.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,834.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,730.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,956.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	276.42
LABORATORY PATHOLOGIC	9,674.00	0.00	INJECTABLE DRUGS	197,326.65	0.00
RADIOLOGY THERAPEUTIC	730.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,557.05	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,873.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	9,888.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	48,763.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	12,492.00
OTHER IMAGING SERVICE	6,510.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,610.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,178.00	89.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,018.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	138,698.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,387.00	0.00			
			TOTAL ANCILLARY	1,363,568.45	12,857.42
			TOTAL ACCOMODATIONS	389,745.00	21,210.00
			TOTAL CHARGES	1,753,313.45	34,067.42

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

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

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014303034941	10/01/14 - 10/15/14	11/03/14	0.00	6,597.00	0.00	20,835.79	0.00
615	2015121021159	02/28/15 - 03/03/15	05/04/15	0.00	5,895.00	0.00	34,145.92	0.00
TOTAL				0.00	12,492.00	0.00	54,981.71	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

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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,182,190.47	ADJUSTMENTS	786,823.17
COVERED CHARGES	18,262,088.00	CONTRACTUAL ALLOW	14,207,563.95
NON-COVERD CHARGES	9,920,102.47	TOTAL MEDICAID LIAB	4,054,524.05
		LESS: COB	18,152.87
		LESS: COPAYMENT	13,312.95
		REIMBURSEMENT	4,023,058.23
		ALL OTHER	3,196,343.08
		FEE SCHEDULE-LAB	753,955.83
		INJECTABLE DRUGS	72,759.32
		TOTAL NUMBER OF CLAIMS	12,054



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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	264,822.23	372,992.24	OTHER LAB	157,065.00	1,168.00
MED/SURG SUPPLY	566,737.00	117,538.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	161.00	EDUCATION & TRAINING	0.00	3,763.00
RADIOLOGY-DIAGNOSTIC	594,420.00	236,204.00	OTHER THERAPEUTIC SVC	27,280.00	131,330.00
CT SCAN	1,627,077.00	1,053,495.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,814.00	22,233.11	FEE SCHEDULE LAB	4,490,437.39	1,038,545.55
EKG/ECG	113,988.00	5,188.00	MRI SERVICES	3,434,440.00	1,749,051.00
IV THERAPY	191.00	225.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,858,620.00	756,894.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,981.00	8,201.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	296,913.00	1,602.00	AMBULANCE	0.00	0.00
GI SERVICES	105,943.00	45,208.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,446,932.00	28,512.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	271,196.00	1,404.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	386,470.56	1,295,050.40
RADIOLOGY THERAPEUTIC	5,411.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	10,682.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	850.00	8,312.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	128,388.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	3,238.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	110,382.04	802,892.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	301,887.00
OTHER IMAGING SERVICE	696,441.00	543,403.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	442,464.78	1,528.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	215,423.00	362,892.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	805,603.00	827,340.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,592.00	1,336.00			
ORGAN ACQUISITION	0.00	36,356.25			
TREATMENT/OBSERV. RM	271,594.00	23,082.00			
			TOTAL ANCILLARY	18,262,088.00	9,920,102.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,262,088.00	9,920,102.47

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014254027546	09/05/14 - 09/05/14	09/15/14	0.00	6,597.00	0.00	0.00	0.00
615	2014256022782	09/03/14 - 09/03/14	09/22/14	0.00	5,895.00	0.00	0.00	0.00
615	2014256022782	09/03/14 - 09/03/14	09/22/14	0.00	5,895.00	0.00	0.00	0.00
618	5914279000839	09/03/14 - 09/03/14	10/13/14	0.00	2,907.00	0.00	0.00	0.00
615	2014281032157	09/29/14 - 09/29/14	10/13/14	0.00	5,895.00	0.00	0.00	0.00
614	2014281032159	09/29/14 - 09/29/14	10/13/14	0.00	6,597.00	0.00	0.00	0.00
618	2014281032203	09/16/14 - 09/16/14	10/13/14	0.00	2,907.00	0.00	0.00	0.00
614	2014282025202	09/29/14 - 09/29/14	10/13/14	0.00	6,597.00	0.00	0.00	0.00
614	2014283026108	10/02/14 - 10/02/14	10/13/14	0.00	6,597.00	0.00	0.00	0.00
614	2014287038077	10/01/14 - 10/01/14	10/20/14	0.00	6,597.00	0.00	0.00	0.00
614	2014289067346	10/09/14 - 10/09/14	10/20/14	0.00	6,597.00	0.00	0.00	0.00
614	2214296016132	09/09/14 - 09/09/14	10/27/14	0.00	6,597.00	0.00	0.00	0.00
614	2014312025526	10/28/14 - 10/28/14	11/17/14	0.00	6,597.00	0.00	0.00	0.00
615	2014323030982	10/20/14 - 10/20/14	11/24/14	0.00	5,895.00	0.00	0.00	0.00
615	2014323030982	10/20/14 - 10/20/14	11/24/14	0.00	5,895.00	0.00	0.00	0.00
614	2014325029726	11/14/14 - 11/14/14	11/24/14	0.00	6,597.00	0.00	0.00	0.00
614	2014347017983	12/01/14 - 12/01/14	12/22/14	0.00	6,597.00	0.00	0.00	0.00
614	2014357029768	12/15/14 - 12/15/14	12/29/14	0.00	6,597.00	0.00	0.00	0.00
614	2014363003450	12/19/14 - 12/19/14	01/05/15	0.00	6,597.00	0.00	0.00	0.00
614	2015006022568	12/26/14 - 12/26/14	01/12/15	0.00	5,706.00	0.00	0.00	0.00
614	2015008019685	12/20/14 - 12/20/14	01/12/15	0.00	6,597.00	0.00	0.00	0.00
614	2015008019696	12/26/14 - 12/26/14	01/12/15	0.00	6,597.00	0.00	0.00	0.00
614	2015008019696	12/26/14 - 12/26/14	01/12/15	0.00	6,597.00	0.00	0.00	0.00
614	2015013020201	12/29/14 - 12/29/14	01/19/15	0.00	6,597.00	0.00	0.00	0.00
614	2015016011341	01/07/15 - 01/07/15	01/19/15	0.00	6,597.00	0.00	0.00	0.00
614	2015016011342	01/05/15 - 01/05/15	01/19/15	0.00	6,597.00	0.00	0.00	0.00
614	2015020018566	01/07/15 - 01/07/15	01/26/15	0.00	6,597.00	0.00	0.00	0.00
614	2015023021836	12/19/14 - 12/19/14	01/26/15	0.00	6,597.00	0.00	0.00	0.00
618	2015023022053	01/14/15 - 01/14/15	01/26/15	0.00	2,907.00	0.00	0.00	0.00
618	2015023022053	01/14/15 - 01/14/15	01/26/15	0.00	2,907.00	0.00	0.00	0.00
614	2015023022053	01/14/15 - 01/14/15	01/26/15	0.00	6,597.00	0.00	0.00	0.00
614	2015023022053	01/14/15 - 01/14/15	01/26/15	0.00	6,597.00	0.00	0.00	0.00
614	2015028023476	11/26/14 - 11/26/14	02/02/15	0.00	6,597.00	0.00	0.00	0.00
614	2015028023476	11/26/14 - 11/26/14	02/02/15	0.00	6,597.00	0.00	0.00	0.00
618	2015028023476	11/26/14 - 11/26/14	02/02/15	0.00	2,907.00	0.00	0.00	0.00
618	2015028023476	11/26/14 - 11/26/14	02/02/15	0.00	2,907.00	0.00	0.00	0.00
615	2015083028081	12/12/14 - 12/12/14	03/30/15	0.00	5,895.00	0.00	0.00	0.00
614	5215090002894	01/07/15 - 01/07/15	04/13/15	0.00	6,597.00	0.00	0.00	0.00
614	5215091001762	01/06/15 - 01/06/15	04/13/15	0.00	6,597.00	0.00	0.00	0.00
614	5215091001762	01/06/15 - 01/06/15	04/13/15	0.00	6,597.00	0.00	0.00	0.00
615	2015122032672	04/22/15 - 04/22/15	05/11/15	0.00	3,015.00	0.00	0.00	0.00
615	5915163000561	04/10/15 - 04/10/15	06/15/15	0.00	5,895.00	0.00	0.00	0.00

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

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

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EMORY UNIV HOSPPT FINANCIALSERV  
1364 CLIFTON RD NE DEPT RM  
ATLANTA,GA 30322-1059

PROVIDER NUMBER  
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

615	2015184004586	06/26/15 - 06/26/15	07/06/15	0.00	5,895.00	0.00	0.00	0.00
615	2015196032863	07/07/15 - 07/07/15	07/20/15	0.00	5,895.00	0.00	0.00	0.00
615	2015208000007	07/19/15 - 07/19/15	08/03/15	0.00	3,015.00	0.00	0.00	0.00
615	2015208000007	07/19/15 - 07/19/15	08/03/15	0.00	3,015.00	0.00	0.00	0.00
615	2015217011479	03/31/15 - 03/31/15	08/10/15	0.00	3,015.00	0.00	0.00	0.00
615	2015225000001	08/03/15 - 08/03/15	08/17/15	0.00	5,895.00	0.00	0.00	0.00
615	2015225000001	08/03/15 - 08/03/15	08/17/15	0.00	5,895.00	0.00	0.00	0.00
615	2015232000667	08/13/15 - 08/13/15	08/24/15	0.00	5,895.00	0.00	0.00	0.00
615	2015247074813	08/24/15 - 08/24/15	09/14/15	0.00	3,015.00	0.00	0.00	0.00
615	2015247074813	08/24/15 - 08/24/15	09/14/15	0.00	3,015.00	0.00	0.00	0.00
615	2015254098547	07/30/15 - 07/30/15	09/21/15	0.00	5,895.00	0.00	0.00	0.00
615	2015272066083	04/09/15 - 04/09/15	10/05/15	0.00	5,895.00	0.00	0.00	0.00
TOTAL				0.00	301,887.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV  
1364 CLIFTON RD NE DEPT RM  
ATLANTA,GA 30322-1059

PROVIDER NUMBER  
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,293,618.39	ADJUSTMENTS	0.00
COVERED CHARGES	457,103.98	CONTRACTUAL ALLOW	-65,279.01
NON-COVERD CHARGES	836,514.41	TOTAL MEDICAID LIAB	522,382.99
		LESS: COB	521,970.84
		LESS: COPAYMENT	412.15
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 202

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,663.16	13,949.26	OTHER LAB	9,085.00	66.00
MED/SURG SUPPLY	28,504.00	1,745.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	53.00
RADIOLOGY-DIAGNOSTIC	14,720.00	11,461.00	OTHER THERAPEUTIC SVC	0.00	102,300.00
CT SCAN	21,634.00	57,056.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	79,838.80	26,672.20
EKG/ECG	3,312.00	138.00	MRI SERVICES	12,898.00	172,066.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	103,024.00	61,224.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,759.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,043.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,978.00	3,195.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,874.00	433.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,598.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,875.02	31,634.95
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	274.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	819.00	201,183.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	22,104.00
OTHER IMAGING SERVICE	7,112.00	57,931.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,770.00	11,298.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,251.00	56,850.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,004.00	668.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,342.00	4,213.00			
			TOTAL ANCILLARY	457,103.98	836,514.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	457,103.98	836,514.41

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

Run Date: 08/12/2016  
Run Time: 02:08:51  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV  
1364 CLIFTON RD NE DEPT RM  
ATLANTA,GA 30322-1059

PROVIDER NUMBER  
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014283026125	09/19/14 - 09/19/14	10/13/14	0.00	6,597.00	0.00	4,193.51	0.00
614	2014318029175	10/02/14 - 10/02/14	11/17/14	0.00	6,597.00	0.00	356.31	0.00
615	2014331051239	10/31/14 - 10/31/14	12/01/14	0.00	3,015.00	0.00	2,643.30	0.00
615	2015230000719	07/09/15 - 07/09/15	08/24/15	0.00	5,895.00	0.00	4,746.21	0.00
TOTAL				0.00	22,104.00	0.00	11,939.33	0.00

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	245,301.00	ADJUSTMENTS	205.76
COVERED CHARGES	180,354.96	CONTRACTUAL ALLOW	172,355.53
NON-COVERD CHARGES	64,946.04	TOTAL MEDICAID LIAB	7,999.43
		LESS: COB	30.60
		LESS: COPAYMENT	435.06
		REIMBURSEMENT	7,533.77
		TOTAL NUMBER OF CLAIMS	144

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	323.01	0.00	OTHER LAB	2,897.00	0.00
MED/SURG SUPPLY	582.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,435.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,951.00	19,263.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	551.00	FEE SCHEDULE LAB	39,553.00	1,833.00
EKG/ECG	4,002.00	0.00	MRI SERVICES	11,790.00	15,810.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	649.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	91,232.00	1,707.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,824.95	17,486.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	430.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	425.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,030.00
OTHER IMAGING SERVICE	1,765.00	247.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	480.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,164.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	800.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,071.00	0.00			
			TOTAL ANCILLARY	180,354.96	64,946.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	180,354.96	64,946.04



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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014318029152	11/06/14 - 11/06/14	11/17/14	0.00	3,015.00	0.00	0.00	0.00
615	2014318029152	11/06/14 - 11/06/14	11/17/14	0.00	3,015.00	0.00	0.00	0.00
TOTAL				0.00	6,030.00	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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,238.22	ADJUSTMENTS	0.00
COVERED CHARGES	6,163.79	CONTRACTUAL ALLOW	4,415.07
NON-COVERD CHARGES	74.43	TOTAL MEDICAID LIAB	1,748.72
		LESS: COB	1,733.72
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2.79	74.43	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	730.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,853.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,578.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,163.79	74.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,163.79	74.43

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,967,544.30	ADJUSTMENTS	123,727.48
COVERED CHARGES	1,650,448.46	CONTRACTUAL ALLOW	1,360,350.34
NON-COVERD CHARGES	317,095.84	TOTAL MEDICAID LIAB	290,098.12
		LESS: COB	0.00
		LESS: COPAYMENT	213.00
		REIMBURSEMENT	289,885.12

TOTAL NUMBER OF CLAIMS 42

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,578.67	2,239.80	OTHER LAB	841.00	77.00
MED/SURG SUPPLY	138,966.00	38,736.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	136,226.00	60,086.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,865.00	644.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	371.02	FEE SCHEDULE LAB	25,044.00	6,205.20
EKG/ECG	552.00	690.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	601,908.00	69,729.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,069.00	244.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	66,636.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,589.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,115.39	28,093.82
RADIOLOGY THERAPEUTIC	6,485.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	610.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	302,696.40	64,024.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	558.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,451.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,885.00	4,509.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	213,633.00	40,837.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,350.00	0.00			
			TOTAL ANCILLARY	1,650,448.46	317,095.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,650,448.46	317,095.84

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

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

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	72,235.42	ADJUSTMENTS	0.00
COVERED CHARGES	64,908.97	CONTRACTUAL ALLOW	18,112.27
NON-COVERD CHARGES	7,326.45	TOTAL MEDICAID LIAB	46,796.70
		LESS: COB	46,781.70
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	313.58	329.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,242.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	551.00	FEE SCHEDULE LAB	710.00	194.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,249.00	4,485.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	201.00	122.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,148.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,276.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	179.39	719.25
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	33,240.00	926.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,350.00	0.00			
			TOTAL ANCILLARY	64,908.97	7,326.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,908.97	7,326.45

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

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

Run Date: 08/12/2016  
 Run Time: 02:41:09  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER 000000723A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	141,701,107.05	ADJUSTMENTS	8,646,683.81
COVERED CHARGES	137,194,777.36	CONTRACTUAL ALLOW	100,230,430.35
NON-COVERD CHARGES	4,506,329.69	TOTAL MEDICAID LIAB	36,964,347.01
		LESS: COB	208,505.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	36,755,841.09

TOTAL NUMBER OF ADMISSIONS 2,572

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	12,014	15	8,361,296.00	2,251,913.00
ROUTINE NURSERY	681	2	1,064,636.00	110,239.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	271.38
TOTAL ROUTINE	12,695	17	9,425,932.00	2,362,423.38
SPECIAL CARE SERVICES				
CCU	152	0	262,618.00	0.00
ICU	2,416	0	4,699,882.00	182,710.00
NICU	1,587	0	5,888,125.00	174,710.00
PED ICU	1,028	0	3,816,727.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	351	0	1,180,337.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,534	0	15,847,689.00	357,420.00
TOTAL ACCOMODATIONS	18,229	17	25,273,621.00	2,719,843.38



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,929,700.44	271,681.68	OTHER LAB	415,117.95	17,098.98
MED/SURG SUPPLY	13,370,042.00	248,371.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,511,676.82	464,836.97	EDUCATION & TRAINING	2,740.00	0.00
RADIOLOGY-DIAGNOSTIC	2,559,180.00	13,808.00	OTHER THERAPEUTIC SVC	0.00	12,906.00
CT SCAN	3,173,753.00	90,108.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	738,947.54	32,474.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	218,341.89	948.00	MRI SERVICES	898,721.00	3,400.00
IV THERAPY	748,571.00	20,633.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,150,344.00	63,953.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	364,041.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,339,247.00	152,683.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,415,340.00	3,668.00	AMBULANCE	0.00	0.00
GI SERVICES	340,592.00	0.00	CAST ROOM	266.00	0.00
EMERGENCY ROOM	2,630,291.99	2,235.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	713,640.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	408.60
LABORATORY PATHOLOGIC	984,780.19	9,242.00	INJECTABLE DRUGS	4,324,545.14	29,786.06
RADIOLOGY THERAPEUTIC	158,095.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	306,516.18	2,776.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	248,733.18	1,391.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	344,140.99	42,446.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	248.05	12,381.00	TRAUMA RESPONSE	0.00	176,431.00
PSYCHIATRIC SERVICES	26,796.00	0.00	IMPL DEV CHARGE PATIENTS	9,911,143.00	874.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	464,392.00	11,224.00			
BLOOD	13,656.00	569.00			
BLOOD STORAGE & PRO.	1,079,117.00	95,841.00			
ONCOLOGY	745.00	0.00			
NUCLEAR MEDICINE	94,934.00	1,017.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,303,984.00	2,040.00			
AMBULATORY SURGERY	4,294.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,879,208.00	1,255.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	255,275.00	0.00			
			TOTAL ANCILLARY	111,921,156.36	1,786,486.31
			TOTAL ACCOMODATIONS	25,273,621.00	2,719,843.38
			TOTAL CHARGES	137,194,777.36	4,506,329.69

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

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

Run Date: 08/12/2016  
 Run Time: 02:41:44  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,488,066.07	ADJUSTMENTS	0.00
COVERED CHARGES	1,369,817.46	CONTRACTUAL ALLOW	698,240.02
NON-COVERD CHARGES	118,248.61	TOTAL MEDICAID LIAB	671,577.44
		LESS: COB	671,577.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 35

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	130		5	85,426.00		46,632.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	130		5	85,426.00		46,632.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	6,496.00		0.00
NICU	0		0	0.00		0.00
PED ICU	14		0	51,934.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	58,430.00		0.00
TOTAL ACCOMODATIONS	148		5	143,856.00		46,632.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,696.45	10,211.53	OTHER LAB	899.00	1,168.00
MED/SURG SUPPLY	112,404.00	9,309.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	138,122.45	10,300.00	EDUCATION & TRAINING	274.00	0.00
RADIOLOGY-DIAGNOSTIC	18,027.00	1,796.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,100.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,546.06	1,445.06	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,046.00	148.00	MRI SERVICES	27,028.00	5,014.00
IV THERAPY	9,803.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	94,938.00	10,270.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	65,685.00	1,112.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,918.00	6,906.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,820.00	1,160.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,402.00	1,334.00	DRUG-SPECIFIC/HOME IV	0.00	2,724.00
LABORATORY PATHOLOGIC	4,475.00	2,114.00	INJECTABLE DRUGS	133,457.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	992.04	289.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,816.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	694.00	TRAUMA RESPONSE	0.00	4,179.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	227,168.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,798.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,469.00	478.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	73,823.00	965.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	42,403.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	851.00	0.00			
			TOTAL ANCILLARY	1,225,961.46	71,616.61
			TOTAL ACCOMODATIONS	143,856.00	46,632.00
			TOTAL CHARGES	1,369,817.46	118,248.61

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,249,629.45	ADJUSTMENTS	1,400,674.36
COVERED CHARGES	50,607,532.95	CONTRACTUAL ALLOW	39,405,763.42
NON-COVERD CHARGES	6,642,096.50	TOTAL MEDICAID LIAB	11,201,769.53
		LESS: COB	49,767.95
		LESS: COPAYMENT	57,653.29
		REIMBURSEMENT	11,094,348.29
		ALL OTHER	9,343,827.72
		FEE SCHEDULE-LAB	695,827.38
		INJECTABLE DRUGS	1,054,693.19

TOTAL NUMBER OF CLAIMS 35,176

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,079,118.48	33,379.33	OTHER LAB	747,693.00	23,725.00
MED/SURG SUPPLY	1,739,208.00	71,319.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,198.00	EDUCATION & TRAINING	274.00	2,603.00
RADIOLOGY-DIAGNOSTIC	1,953,106.00	72,482.00	OTHER THERAPEUTIC SVC	32.00	26,312.00
CT SCAN	3,018,048.00	282,915.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	54,829.00	41,220.00	FEE SCHEDULE LAB	7,813,353.93	1,627,420.71
EKG/ECG	236,119.00	9,526.00	MRI SERVICES	1,812,213.00	200,043.00
IV THERAPY	959,941.00	21,371.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,972,112.23	551,449.53	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,154.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	880,972.00	149,696.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,741,554.00	1,151.00	AMBULANCE	0.00	0.00
GI SERVICES	518,147.79	42,640.16	CAST ROOM	27,568.00	2,637.00
EMERGENCY ROOM	3,839,167.00	9,581.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,166,076.00	1,422.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,925,559.04	2,363,951.43
RADIOLOGY THERAPEUTIC	2,134,742.00	144,235.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,951.00	15,098.59	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,435.00	18,791.18	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	21,628.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,143,445.00	37,496.73	TRAUMA RESPONSE	0.00	160,368.00
PSYCHIATRIC SERVICES	69,413.00	17,598.00	IMPL DEV CHARGE PATIENTS	410,723.00	69,745.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,054,939.00	145,508.00			
BLOOD	7,966.00	0.00			
BLOOD STORAGE & PRO.	350,890.00	1,377.00			
ONCOLOGY	70,564.00	0.00			
NUCLEAR MEDICINE	443,930.00	80,157.00			
AUDIOLOGY	10,683.00	4,378.00			
CARDIOLOGY	1,057,803.16	343,352.84			
AMBULATORY SURGERY	4,294.00	0.00			
OSTEOPATHIC SERVICES	0.00	56.00			
E E G	760,243.00	6,490.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	576,266.32	38,775.00			
			TOTAL ANCILLARY	50,607,532.95	6,642,096.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,607,532.95	6,642,096.50

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
1170	5915033000721	10/31/14 - 10/31/14	02/09/15	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
Run Time: 02:44:14  
Page: 8

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,151,110.64	ADJUSTMENTS	0.00
COVERED CHARGES	790,404.87	CONTRACTUAL ALLOW	363,404.01
NON-COVERD CHARGES	360,705.77	TOTAL MEDICAID LIAB	427,000.86
		LESS: COB	426,538.58
		LESS: COPAYMENT	462.28
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 569

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,371.80	395.51	OTHER LAB	31,798.00	3,112.00
MED/SURG SUPPLY	28,996.00	11,062.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,613.00	470.00	OTHER THERAPEUTIC SVC	330.00	0.00
CT SCAN	7,872.00	21,038.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	118,530.14	14,781.42
EKG/ECG	5,765.00	158.00	MRI SERVICES	9,688.00	34,688.00
IV THERAPY	12,634.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	139,235.07	37,734.93	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,039.00	1,076.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	67,157.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,045.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	66,524.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,720.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,688.98	85,284.08
RADIOLOGY THERAPEUTIC	6,586.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	402.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	191.00	614.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	28,649.00	956.81	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	70.00	IMPL DEV CHARGE PATIENTS	1,687.00	109,536.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,489.00	6,363.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	840.00	0.00			
NUCLEAR MEDICINE	3,783.00	3,566.00			
AUDIOLOGY	955.00	0.00			
CARDIOLOGY	14,799.00	28,862.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	85,671.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,747.88	536.00			
			TOTAL ANCILLARY	790,404.87	360,705.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	790,404.87	360,705.77



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: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,669,992.29	ADJUSTMENTS	993.00
COVERED CHARGES	1,612,424.13	CONTRACTUAL ALLOW	1,513,024.13
NON-COVERD CHARGES	57,568.16	TOTAL MEDICAID LIAB	99,400.00
		LESS: COB	0.00
		LESS: COPAYMENT	3,588.00
		REIMBURSEMENT	95,812.00
		TOTAL NUMBER OF CLAIMS	1,988

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	61,810.42	0.00	OTHER LAB	11,272.00	0.00
MED/SURG SUPPLY	1,550.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	111,399.00	926.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	127,981.00	9,778.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	217,190.00	17,267.16
EKG/ECG	11,184.00	148.00	MRI SERVICES	19,883.00	5,280.00
IV THERAPY	65,768.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,164.00	258.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,792.00	2,242.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,720.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	898,907.00	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	28,094.71	448.00
RADIOLOGY THERAPEUTIC	1,509.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,844.00	0.00	TRAUMA RESPONSE	0.00	14,937.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,956.00	3,969.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	918.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,517.00	595.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,685.00	0.00			
			TOTAL ANCILLARY	1,612,424.13	57,568.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,612,424.13	57,568.16

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,320.15	ADJUSTMENTS	0.00
COVERED CHARGES	41,454.15	CONTRACTUAL ALLOW	25,645.79
NON-COVERD CHARGES	2,866.00	TOTAL MEDICAID LIAB	15,808.36
		LESS: COB	15,760.36
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	30

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,051.15	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	3,476.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,821.00	255.00
EKG/ECG	770.00	148.00	MRI SERVICES	0.00	2,190.00
IV THERAPY	2,447.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	825.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,176.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	170.00	62.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	255.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	484.00	211.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	814.00	0.00			
			TOTAL ANCILLARY	41,454.15	2,866.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	41,454.15	2,866.00

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,395,829.42	ADJUSTMENTS	573,750.18
COVERED CHARGES	11,614,557.36	CONTRACTUAL ALLOW	10,271,484.94
NON-COVERD CHARGES	781,272.06	TOTAL MEDICAID LIAB	1,343,072.42
		LESS: COB	4,603.51
		LESS: COPAYMENT	974.06
		REIMBURSEMENT	1,337,494.85

TOTAL NUMBER OF CLAIMS 213

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	673,683.68	0.00	OTHER LAB	764.00	0.00
MED/SURG SUPPLY	1,115,314.00	20,405.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	191,406.00	8,419.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	80,055.00	8,467.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	5,540.00	FEE SCHEDULE LAB	159,481.00	76,548.00
EKG/ECG	1,836.00	0.00	MRI SERVICES	2,515.00	19,620.00
IV THERAPY	13,538.00	41.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,343,033.34	67,032.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,408.00	574.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	350,448.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,220.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	113,470.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,740,092.06	94,996.63
RADIOLOGY THERAPEUTIC	864,122.00	2,547.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,120.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,192.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,363.00	50.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,233,159.00	75,311.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,814.00	7,098.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,867.00	0.00			
ONCOLOGY	4,984.00	0.00			
NUCLEAR MEDICINE	8,302.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,569,732.28	391,126.72			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	72,410.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,540.00	184.00			
			TOTAL ANCILLARY	11,614,557.36	781,272.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,614,557.36	781,272.06

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	300,742.72	ADJUSTMENTS	0.00
COVERED CHARGES	242,189.04	CONTRACTUAL ALLOW	156,962.57
NON-COVERD CHARGES	58,553.68	TOTAL MEDICAID LIAB	85,226.47
		LESS: COB	85,217.47
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,975.72	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27,954.00	12,448.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,886.00	2,816.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,312.00	708.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,147.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,022.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,353.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	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	111,180.00	19,418.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	456.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	44,903.32	22,967.68			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	242,189.04	58,553.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	242,189.04	58,553.68



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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL  
 200 N RIVER ST  
 CLAXTON,GA 30417-1659

PROVIDER NUMBER 000000734A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	523,597.00	ADJUSTMENTS	57,587.33
COVERED CHARGES	496,157.00	CONTRACTUAL ALLOW	229,171.82
NON-COVERD CHARGES	27,440.00	TOTAL MEDICAID LIAB	266,985.18
		LESS: COB	1,482.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	265,502.53

TOTAL NUMBER OF ADMISSIONS 37

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	73		0	71,057.00		18,298.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	73		0	71,057.00		18,298.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	27		0	42,525.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	27		0	42,525.00		0.00
TOTAL ACCOMODATIONS	100		0	113,582.00		18,298.00

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL  
 200 N RIVER ST  
 CLAXTON,GA 30417-1659

PROVIDER NUMBER  
 000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,301.00	0.00	OTHER LAB	1,813.00	0.00
MED/SURG SUPPLY	40,808.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	132,988.00	0.00	EDUCATION & TRAINING	316.00	0.00
RADIOLOGY-DIAGNOSTIC	14,998.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,046.00	2,389.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,555.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,347.00	0.00	MRI SERVICES	3,077.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,895.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,596.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,121.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	347.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	426.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,473.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,580.00	6,174.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,949.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	939.00	579.00			
			TOTAL ANCILLARY	382,575.00	9,142.00
			TOTAL ACCOMODATIONS	113,582.00	18,298.00
			TOTAL CHARGES	496,157.00	27,440.00

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

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

Run Date: 08/12/2016  
Run Time: 02:09:11  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL  
200 N RIVER ST  
CLAXTON,GA 30417-1659

PROVIDER NUMBER  
000000734A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 02:09:11  
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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,687,948.55	ADJUSTMENTS	30,388.40
COVERED CHARGES	1,479,703.45	CONTRACTUAL ALLOW	1,193,699.97
NON-COVERD CHARGES	208,245.10	TOTAL MEDICAID LIAB	286,003.48
		LESS: COB	108.13
		LESS: COPAYMENT	1,818.00
		REIMBURSEMENT	284,077.35
		ALL OTHER	257,426.25
		FEE SCHEDULE-LAB	25,129.70
		INJECTABLE DRUGS	1,521.40
		TOTAL NUMBER OF CLAIMS	1,136

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

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

Run Date: 08/12/2016  
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EVANS MEMORIAL HOSPITAL  
 200 N RIVER ST  
 CLAXTON,GA 30417-1659

PROVIDER NUMBER  
 000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,959.15	2,232.00	OTHER LAB	7,497.00	0.00
MED/SURG SUPPLY	57,899.00	98.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	179.00	EDUCATION & TRAINING	0.00	316.00
RADIOLOGY-DIAGNOSTIC	105,334.00	2,046.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	176,617.00	72,417.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,494.00	7,259.00	FEE SCHEDULE LAB	334,502.30	42,390.10
EKG/ECG	17,299.00	1,134.00	MRI SERVICES	86,229.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,654.00	17,614.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,264.00	2,513.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	42,160.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	326,437.00	17,319.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,264.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,608.00	7,582.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	568.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,665.00	1,176.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	25,699.00	4,248.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,480.00	3,087.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,575.00	326.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,949.00	3,414.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	80,118.00	22,327.00			
			TOTAL ANCILLARY	1,479,703.45	208,245.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,479,703.45	208,245.10

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

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,347.00	ADJUSTMENTS	0.00
COVERED CHARGES	21,401.00	CONTRACTUAL ALLOW	9,431.94
NON-COVERD CHARGES	6,946.00	TOTAL MEDICAID LIAB	11,969.06
		LESS: COB	11,948.06
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	421.00	25.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	327.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,954.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,552.00	129.00
EKG/ECG	378.00	0.00	MRI SERVICES	0.00	6,154.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,038.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,142.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	316.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	726.00	165.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	68.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,487.00	405.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,401.00	6,946.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,401.00	6,946.00

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

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

Run Date: 08/12/2016  
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EVANS MEMORIAL HOSPITAL  
200 N RIVER ST  
CLAXTON,GA 30417-1659

PROVIDER NUMBER  
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	124,869.00	ADJUSTMENTS	323.64
COVERED CHARGES	113,464.00	CONTRACTUAL ALLOW	105,688.34
NON-COVERD CHARGES	11,405.00	TOTAL MEDICAID LIAB	7,775.66
		LESS: COB	0.00
		LESS: COPAYMENT	246.00
		REIMBURSEMENT	7,529.66
		TOTAL NUMBER OF CLAIMS	139



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,935.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,512.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,415.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,648.00	7,772.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,770.00	2,584.00
EKG/ECG	567.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	168.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	70,441.00	447.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,008.00	602.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	113,464.00	11,405.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	113,464.00	11,405.00

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL  
200 N RIVER ST  
CLAXTON,GA 30417-1659

PROVIDER NUMBER  
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	548.00	ADJUSTMENTS	0.00
COVERED CHARGES	548.00	CONTRACTUAL ALLOW	361.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	187.00
		LESS: COB	187.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EVANS MEMORIAL HOSPITAL  
 200 N RIVER ST  
 CLAXTON,GA 30417-1659

PROVIDER NUMBER  
 000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	510.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	548.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	548.00	0.00

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

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

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 02:09:25  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 01:19:59  
 Page: 1

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,358,902.45	ADJUSTMENTS	2,370,715.10
COVERED CHARGES	52,832,419.20	CONTRACTUAL ALLOW	39,135,270.70
NON-COVERD CHARGES	1,526,483.25	TOTAL MEDICAID LIAB	13,697,148.50
		LESS: COB	151,197.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,545,951.16

TOTAL NUMBER OF ADMISSIONS 1,919

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,471		13	3,559,050.00		926,695.00
ROUTINE NURSERY	1,154		6	1,097,300.00		9,548.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		71,209.50
TOTAL ROUTINE	7,625		19	4,656,350.00		1,007,452.50
SPECIAL CARE SERVICES						
CCU	1,064		0	915,750.00		0.00
ICU	931		0	1,183,384.00		0.00
NICU	488		0	1,053,403.00		0.00
PED ICU	24		0	29,040.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,507		0	3,181,577.00		0.00
TOTAL ACCOMODATIONS	10,132		19	7,837,927.00		1,007,452.50

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,898,852.67	1,901.50	OTHER LAB	266,147.00	0.00
MED/SURG SUPPLY	4,162,585.84	65,508.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,144,899.00	6,779.00	EDUCATION & TRAINING	10,380.00	216.00
RADIOLOGY-DIAGNOSTIC	710,174.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,271,049.00	13,750.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	101,376.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	794,956.00	0.00	MRI SERVICES	338,403.00	0.00
IV THERAPY	373,558.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,556,777.62	21,444.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	994,299.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,774,575.50	6,895.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	673,588.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,784,205.00	7,658.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	477,219.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	87,430.00
LABORATORY PATHOLOGIC	169,855.00	0.00	INJECTABLE DRUGS	3,203,055.06	571.75
RADIOLOGY THERAPEUTIC	140.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	50,322.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	42,763.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	190,578.00	18,026.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,590.00	8,024.50	TRAUMA RESPONSE	0.00	31,968.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,451,046.26	811.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	211,523.00	27,300.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	404,928.00	172,906.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	188,097.00	44,792.00			
AUDIOLOGY	11,200.00	0.00			
CARDIOLOGY	1,547,397.00	1,400.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,682.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	158,271.00	1,650.00			
			TOTAL ANCILLARY	44,994,492.20	519,030.75
			TOTAL ACCOMODATIONS	7,837,927.00	1,007,452.50
			TOTAL CHARGES	52,832,419.20	1,526,483.25

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

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

Run Date: 08/12/2016  
 Run Time: 01:21:00  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,447,475.89	ADJUSTMENTS	0.00
COVERED CHARGES	1,432,887.89	CONTRACTUAL ALLOW	692,444.45
NON-COVERD CHARGES	14,588.00	TOTAL MEDICAID LIAB	740,443.44
		LESS: COB	740,443.44
		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	62		0	34,100.00		2,970.00
ROUTINE NURSERY	60		0	85,200.00		1,562.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	122		0	119,300.00		4,532.00
SPECIAL CARE SERVICES						
CCU	14		0	12,045.00		0.00
ICU	19		0	15,675.00		0.00
NICU	132		0	284,064.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	165		0	311,784.00		0.00
TOTAL ACCOMODATIONS	287		0	431,084.00		4,532.00



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	236,093.30	0.00	OTHER LAB	6,441.00	0.00
MED/SURG SUPPLY	152,029.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	163,270.00	0.00	EDUCATION & TRAINING	72.00	0.00
RADIOLOGY-DIAGNOSTIC	17,973.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,587.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,292.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,689.00	0.00	MRI SERVICES	3,430.00	0.00
IV THERAPY	26,284.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,648.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	68,190.00	1,200.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134,879.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,239.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,041.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,783.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	394.00	0.00	INJECTABLE DRUGS	27,102.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,109.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	769.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	199.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,972.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,251.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,348.00	8,856.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	840.00	0.00			
CARDIOLOGY	43,797.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,082.00	0.00			
			TOTAL ANCILLARY	1,001,803.89	10,056.00
			TOTAL ACCOMODATIONS	431,084.00	4,532.00
			TOTAL CHARGES	1,432,887.89	14,588.00

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,582,119.78	ADJUSTMENTS	1,613,235.00
COVERED CHARGES	36,002,556.43	CONTRACTUAL ALLOW	30,064,680.74
NON-COVERD CHARGES	3,579,563.35	TOTAL MEDICAID LIAB	5,937,875.69
		LESS: COB	15,391.74
		LESS: COPAYMENT	14,878.09
		REIMBURSEMENT	5,907,605.86
		ALL OTHER	5,167,281.49
		FEE SCHEDULE-LAB	514,918.35
		INJECTABLE DRUGS	225,406.02

TOTAL NUMBER OF CLAIMS 13,965

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	623,080.70	8,340.00	OTHER LAB	142,260.00	1,875.00
MED/SURG SUPPLY	1,845,891.98	44,784.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,078.00	EDUCATION & TRAINING	7,443.00	1,692.00
RADIOLOGY-DIAGNOSTIC	1,104,172.00	24,726.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,344,806.00	114,376.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	140,864.00	24,715.00	FEE SCHEDULE LAB	6,597,407.84	960,066.30
EKG/ECG	542,990.00	18,187.00	MRI SERVICES	651,829.00	77,493.00
IV THERAPY	2,132,585.00	175,462.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,986,825.94	416,278.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	179,030.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	321,616.00	31,985.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	517,017.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,984.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,781,576.00	649,353.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	614,635.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,600.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,673,955.65	574,138.05
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,648.00	384.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,253.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	15,191.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	250.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	523,319.00	29,535.00	TRAUMA RESPONSE	0.00	57,024.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	294,529.32	0.00
LITHOTRIPSY	28,144.00	0.00	NO CC/INVALID REV CODE	0.00	2,880.00
OTHER IMAGING SERVICE	415,479.00	45,826.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,072.00	13,118.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	534,737.00	106,509.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	569,167.00	147,324.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	205,419.00	626.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,199,823.00	28,745.00			
			TOTAL ANCILLARY	36,002,556.43	3,579,563.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,002,556.43	3,579,563.35

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

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

Run Date: 08/12/2016  
Run Time: 01:21:03  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5914290004073	08/29/14 - 08/29/14	10/20/14	0.00	2,800.00	0.00	0.00	0.00
-1	9715098965002	10/14/14 - 10/14/14	04/13/15	0.00	40.00	0.00	0.00	0.00
614	5915110001188	02/03/15 - 02/03/15	04/27/15	0.00	40.00	0.00	0.00	0.00
TOTAL				0.00	2,880.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
Run Time: 01:23:47  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,040,704.00	ADJUSTMENTS	0.00
COVERED CHARGES	819,806.75	CONTRACTUAL ALLOW	319,525.58
NON-COVERD CHARGES	220,897.25	TOTAL MEDICAID LIAB	500,281.17
		LESS: COB	500,131.92
		LESS: COPAYMENT	149.25
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 292

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,801.50	0.00	OTHER LAB	5,083.00	0.00
MED/SURG SUPPLY	45,366.00	2,312.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	226.00	EDUCATION & TRAINING	196.00	0.00
RADIOLOGY-DIAGNOSTIC	24,423.00	222.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,476.00	35,302.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	304.00	76.00	FEE SCHEDULE LAB	159,603.00	18,518.00
EKG/ECG	10,575.00	0.00	MRI SERVICES	3,380.00	11,737.00
IV THERAPY	30,484.00	2,926.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,632.00	85,509.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,376.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	973.00	365.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,478.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	224,160.00	27,397.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,959.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,818.25	12,736.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	152.00	76.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	304.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,381.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	22,983.00	221.00	TRAUMA RESPONSE	0.00	11,232.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,498.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,351.00	6,194.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,155.00	463.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,751.00	3,546.00			
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	10,577.00	154.00			
			TOTAL ANCILLARY	819,806.75	220,897.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	819,806.75	220,897.25

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

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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,026,204.00	ADJUSTMENTS	7,201.03
COVERED CHARGES	969,618.75	CONTRACTUAL ALLOW	934,974.33
NON-COVERD CHARGES	56,585.25	TOTAL MEDICAID LIAB	34,644.42
		LESS: COB	0.00
		LESS: COPAYMENT	1,345.00
		REIMBURSEMENT	33,299.42
		TOTAL NUMBER OF CLAIMS	691

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,227.75	0.00	OTHER LAB	1,437.00	0.00
MED/SURG SUPPLY	13,732.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,772.00	222.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,108.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	384.00	0.00	FEE SCHEDULE LAB	122,787.00	8,337.00
EKG/ECG	4,350.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,000.00	154.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	906.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	708,974.00	35,634.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46,472.00	11,678.25
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	750.00	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	6,719.00	310.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	969,618.75	56,585.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	969,618.75	56,585.25



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

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

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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	256,870.75	ADJUSTMENTS	0.00
COVERED CHARGES	240,839.75	CONTRACTUAL ALLOW	210,627.44
NON-COVERD CHARGES	16,031.00	TOTAL MEDICAID LIAB	30,212.31
		LESS: COB	30,041.31
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	183

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

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

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FLOYD MEDICAL CENTER  
 304 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER  
 000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	141.00	0.00	OTHER LAB	479.00	0.00
MED/SURG SUPPLY	3,365.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,714.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,380.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	40,344.00	4,508.00
EKG/ECG	1,450.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,104.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	175,517.00	10,491.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,015.75	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	2,272.00	1,032.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	240,839.75	16,031.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	240,839.75	16,031.00

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,493,712.55	ADJUSTMENTS	225,057.97
COVERED CHARGES	4,226,503.50	CONTRACTUAL ALLOW	3,659,236.66
NON-COVERD CHARGES	267,209.05	TOTAL MEDICAID LIAB	567,266.84
		LESS: COB	0.00
		LESS: COPAYMENT	348.00
		REIMBURSEMENT	566,918.84

TOTAL NUMBER OF CLAIMS 101

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	173,859.00	1,117.00	OTHER LAB	5,900.00	0.00
MED/SURG SUPPLY	329,874.00	76.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	468.00	36.00
RADIOLOGY-DIAGNOSTIC	19,551.00	6,649.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,412.00	6,317.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	532.00	FEE SCHEDULE LAB	147,934.70	22,877.30
EKG/ECG	16,855.00	4,373.00	MRI SERVICES	6,526.00	3,096.00
IV THERAPY	264,096.00	15,806.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,168,793.25	56,296.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,356.00	3,666.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	135,526.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,827.00	434.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	114,399.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	572,827.55	92,867.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	777.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	872,497.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,004.00	1,136.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,873.00	452.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	174,610.00	46,550.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	626.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	99,912.00	4,928.00			
			TOTAL ANCILLARY	4,226,503.50	267,209.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,226,503.50	267,209.05

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	149,760.00	ADJUSTMENTS	0.00
COVERED CHARGES	129,681.00	CONTRACTUAL ALLOW	62,507.81
NON-COVERD CHARGES	20,079.00	TOTAL MEDICAID LIAB	67,173.19
		LESS: COB	67,146.19
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,407.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,915.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	390.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,673.00	246.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,008.00	770.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,817.00	18,758.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,639.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,062.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,493.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,506.50	305.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	44,844.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	826.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,100.00	0.00			
			TOTAL ANCILLARY	129,681.00	20,079.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	129,681.00	20,079.00

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,813,843.64	ADJUSTMENTS	3,911,831.17
COVERED CHARGES	43,657,936.64	CONTRACTUAL ALLOW	33,813,568.09
NON-COVERD CHARGES	2,155,907.00	TOTAL MEDICAID LIAB	9,844,368.55
		LESS: COB	73,396.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,770,972.15

TOTAL NUMBER OF ADMISSIONS 1,288

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,191		0	4,282,530.00		809,090.00
ROUTINE NURSERY	1,692		51	2,682,306.00		527,368.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,883		51	6,964,836.00		1,336,458.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	559		0	2,050,094.00		0.00
NICU	179		0	990,499.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	738		0	3,040,593.00		0.00
TOTAL ACCOMODATIONS	6,621		51	10,005,429.00		1,336,458.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,740,820.63	64,044.00	OTHER LAB	82,562.00	0.00
MED/SURG SUPPLY	2,277,520.50	53,501.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,323,786.88	199,058.00	EDUCATION & TRAINING	3,230.00	71.00
RADIOLOGY-DIAGNOSTIC	675,020.00	1,389.00	OTHER THERAPEUTIC SVC	0.00	37,452.00
CT SCAN	1,167,159.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	264,882.00	1,334.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	176,696.00	0.00	MRI SERVICES	368,882.00	0.00
IV THERAPY	48,218.00	3,562.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,177,288.00	88,008.00	DURABLE MED. EQUIP.	0.00	1,327.00
LABOR/DELIVERY ROOM	1,269,345.00	2,823.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,820,189.50	2,168.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	454,390.00	4,933.00	AMBULANCE	0.00	0.00
GI SERVICES	7,940.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	795,739.00	4,219.00	SPECIAL SERVICES	0.00	51,241.00
RECOVERY ROOM	374,384.00	1,455.00	DRUG-SPECIFIC/HOME IV	0.00	31,919.50
LABORATORY PATHOLOGIC	304,599.00	0.00	INJECTABLE DRUGS	7,579,979.14	47,806.50
RADIOLOGY THERAPEUTIC	308,320.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	180,634.00	954.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	52,105.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	194,644.00	43,828.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	863,853.99	0.00
LITHOTRIPSY	20,172.00	0.00	NO CC/INVALID REV CODE	0.00	3,965.00
OTHER IMAGING SERVICE	319,114.00	76,296.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	573,514.00	72,685.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	150,914.00	25,410.00			
AUDIOLOGY	149,262.00	0.00			
CARDIOLOGY	891,502.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,171.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,635.00	0.00			
			TOTAL ANCILLARY	33,652,507.64	819,449.00
			TOTAL ACCOMODATIONS	10,005,429.00	1,336,458.00
			TOTAL CHARGES	43,657,936.64	2,155,907.00



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

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

Run Date: 08/12/2016  
Run Time: 03:02:03  
Page: 3

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2315174000303	05/05/15 - 05/12/15	07/20/15	0.00	3,965.00	0.00	5,409.02	0.00
TOTAL				0.00	3,965.00	0.00	5,409.02	0.00

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

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

Run Date: 08/12/2016  
 Run Time: 03:02:14  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	396,703.00	ADJUSTMENTS	0.00
COVERED CHARGES	368,321.00	CONTRACTUAL ALLOW	222,722.62
NON-COVERD CHARGES	28,382.00	TOTAL MEDICAID LIAB	145,598.38
		LESS: COB	145,598.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	51		0	52,683.00		3,468.00
ROUTINE NURSERY	22		3	53,931.00		18,761.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	73		3	106,614.00		22,229.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	73		3	106,614.00		22,229.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,132.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,267.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,417.00	0.00	EDUCATION & TRAINING	217.00	0.00
RADIOLOGY-DIAGNOSTIC	1,840.00	0.00	OTHER THERAPEUTIC SVC	0.00	765.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	27,231.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	63,540.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,880.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,975.00	0.00	SPECIAL SERVICES	0.00	5,388.00
RECOVERY ROOM	9,369.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,740.00	0.00	INJECTABLE DRUGS	45,546.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,518.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,062.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,607.00	0.00			
CARDIOLOGY	2,365.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	261,707.00	6,153.00
			TOTAL ACCOMODATIONS	106,614.00	22,229.00
			TOTAL CHARGES	368,321.00	28,382.00

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

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

Run Date: 08/12/2016  
Run Time: 03:02:16  
Page: 6

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,205,506.59	ADJUSTMENTS	589,358.64
COVERED CHARGES	13,449,419.71	CONTRACTUAL ALLOW	11,378,243.10
NON-COVERD CHARGES	1,756,086.88	TOTAL MEDICAID LIAB	2,071,176.61
		LESS: COB	2,676.11
		LESS: COPAYMENT	6,106.30
		REIMBURSEMENT	2,062,394.20
		ALL OTHER	1,787,102.63
		FEE SCHEDULE-LAB	107,899.73
		INJECTABLE DRUGS	167,391.84

TOTAL NUMBER OF CLAIMS 3,711

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	434,009.44	2,447.00	OTHER LAB	180,601.00	111.00
MED/SURG SUPPLY	560,770.00	8,561.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	735.00	EDUCATION & TRAINING	1,239.00	727.00
RADIOLOGY-DIAGNOSTIC	519,745.00	2,624.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,413,918.00	301,501.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	63,280.00	22,562.00	FEE SCHEDULE LAB	1,800,157.27	249,545.26
EKG/ECG	108,016.00	1,570.00	MRI SERVICES	476,766.00	64,831.00
IV THERAPY	378,072.00	1,530.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,189,039.00	181,185.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,850.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	39,540.00	3,751.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	202,812.00	5,219.00	AMBULANCE	0.00	0.00
GI SERVICES	3,970.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,538,264.00	18,694.00	SPECIAL SERVICES	0.00	669.00
RECOVERY ROOM	221,356.00	3,826.00	DRUG-SPECIFIC/HOME IV	0.00	306.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,393,755.44	433,448.12
RADIOLOGY THERAPEUTIC	631,670.00	159,291.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,161.00	6,291.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,382.00	691.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,222.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	326.00	864.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	104,374.00	1,410.00
LITHOTRIPSY	20,172.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	534,509.00	150,671.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	151,864.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	95,908.00	67,433.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	145,364.00	60,468.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	186,529.56	2,903.00			
			TOTAL ANCILLARY	13,449,419.71	1,756,086.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,449,419.71	1,756,086.88

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

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

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	438,077.50	ADJUSTMENTS	0.00
COVERED CHARGES	303,521.50	CONTRACTUAL ALLOW	182,323.16
NON-COVERD CHARGES	134,556.00	TOTAL MEDICAID LIAB	121,198.34
		LESS: COB	121,034.57
		LESS: COPAYMENT	163.77
		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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,576.50	0.00	OTHER LAB	2,556.00	0.00
MED/SURG SUPPLY	23,158.00	60.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,790.00	1,200.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,853.00	20,235.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,250.00	4,892.00	FEE SCHEDULE LAB	47,664.00	4,181.00
EKG/ECG	1,884.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,789.00	338.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,363.00	48,929.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,280.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	822.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,786.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	76,154.00	2,972.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,949.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,106.00	27,124.00
RADIOLOGY THERAPEUTIC	4,863.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	2,889.00	15,382.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,042.00	9,207.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,208.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,539.00	0.00			
			TOTAL ANCILLARY	303,521.50	134,556.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	303,521.50	134,556.00

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

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

Run Date: 08/12/2016  
Run Time: 03:02:40  
Page: 10

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	525,083.70	ADJUSTMENTS	1,107.46
COVERED CHARGES	489,497.20	CONTRACTUAL ALLOW	473,442.44
NON-COVERD CHARGES	35,586.50	TOTAL MEDICAID LIAB	16,054.76
		LESS: COB	46.00
		LESS: COPAYMENT	510.29
		REIMBURSEMENT	15,498.47
		TOTAL NUMBER OF CLAIMS	287



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,106.00	6,805.00	OTHER LAB	3,820.00	0.00
MED/SURG SUPPLY	15,500.00	60.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	31,003.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,088.00	10,399.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	75,801.00	5,019.00
EKG/ECG	6,908.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,666.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	908.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,408.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	274,374.00	535.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,370.00	8,296.50
RADIOLOGY THERAPEUTIC	1,112.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,561.00	4,472.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,995.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	877.20	0.00			
			TOTAL ANCILLARY	489,497.20	35,586.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	489,497.20	35,586.50

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,897.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,564.00	CONTRACTUAL ALLOW	4,175.20
NON-COVERD CHARGES	1,333.00	TOTAL MEDICAID LIAB	4,388.80
		LESS: COB	4,388.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	168.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	298.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,972.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,126.00	26.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	494.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	813.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,564.00	1,333.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,564.00	1,333.00

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

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,722,470.54	ADJUSTMENTS	24,184.28
COVERED CHARGES	1,577,505.34	CONTRACTUAL ALLOW	1,450,295.77
NON-COVERD CHARGES	144,965.20	TOTAL MEDICAID LIAB	127,209.57
		LESS: COB	0.00
		LESS: COPAYMENT	126.00
		REIMBURSEMENT	127,083.57
		TOTAL NUMBER OF CLAIMS	21

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,281.50	0.00	OTHER LAB	1,206.00	0.00
MED/SURG SUPPLY	73,448.00	7,234.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	616.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,212.00	1,110.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,206.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,312.00	FEE SCHEDULE LAB	25,657.80	5,747.20
EKG/ECG	5,966.00	1,256.00	MRI SERVICES	11,637.00	0.00
IV THERAPY	25,002.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	308,711.00	93,229.00	DURABLE MED. EQUIP.	0.00	154.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,162.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,300.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,574.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	206,202.00	13,689.00
RADIOLOGY THERAPEUTIC	60,512.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	740,230.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,067.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	4,991.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,213.00	15,627.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	699.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,219.04	0.00			
			TOTAL ANCILLARY	1,577,505.34	144,965.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,577,505.34	144,965.20

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

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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY  
 6135 ROOSEVELT HWY  
 WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
 000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,234,480.65	ADJUSTMENTS	233,307.54
COVERED CHARGES	4,479,184.05	CONTRACTUAL ALLOW	2,296,737.03
NON-COVERD CHARGES	755,296.60	TOTAL MEDICAID LIAB	2,182,447.02
		LESS: COB	8,252.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,174,194.18

TOTAL NUMBER OF ADMISSIONS 134

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,374		0	2,091,225.00		710,925.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,374		0	2,091,225.00		710,925.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	2,374		0	2,091,225.00		710,925.00

Report : CLM-0800-0  
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 Location: CLMP8000

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

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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY  
 6135 ROOSEVELT HWY  
 WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
 000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	454,382.10	9,925.00	OTHER LAB	9,406.80	0.00
MED/SURG SUPPLY	138,937.25	9,496.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	176,614.21	540.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,326.00	0.00	OTHER THERAPEUTIC SVC	0.00	203.00
CT SCAN	21,188.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	548,653.36	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,753.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	59,288.00	2,091.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	18,186.60
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,174.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,586.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	615,773.24	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	309,603.04	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	14,742.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,412.80	0.00			
BLOOD	1,919.00	0.00			
BLOOD STORAGE & PRO.	0.00	3,530.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	400.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	2,387,959.05	44,371.60
			TOTAL ACCOMODATIONS	2,091,225.00	710,925.00
			TOTAL CHARGES	4,479,184.05	755,296.60



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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

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ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

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

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
Run Time: 03:13:15  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS REHABILITATION & SPECIALTY	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
6135 ROOSEVELT HWY	000000778A	SERVICE DATES	07/01/14	THROUGH	06/30/15
WARM SPRINGS,GA 31830-2757		ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC  
 303 PARKWAY DRIVE, NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER 000000789A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	226,545,123.64	ADJUSTMENTS	12,022,036.50
COVERED CHARGES	220,467,848.19	CONTRACTUAL ALLOW	187,730,230.04
NON-COVERD CHARGES	6,077,275.45	TOTAL MEDICAID LIAB	32,737,618.15
		LESS: COB	220,658.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	32,516,960.11

TOTAL NUMBER OF ADMISSIONS 4,220

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	13,231		14	19,364,186.00		1,505,944.00
ROUTINE NURSERY	1,897		11	2,711,126.00		22,349.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		300.00
TOTAL ROUTINE	15,128		25	22,075,312.00		1,528,593.00
SPECIAL CARE SERVICES						
CCU	142		0	576,644.00		0.00
ICU	7,868		1	24,127,171.00		133,817.00
NICU	48		0	181,872.00		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	8,058		1	24,885,687.00		133,817.00
TOTAL ACCOMODATIONS	23,186		26	46,960,999.00		1,662,410.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC  
 303 PARKWAY DRIVE, NE  
 ATLANTA, GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,855,042.80	529,244.11	OTHER LAB	587,166.34	5,894.71
MED/SURG SUPPLY	13,902,779.47	258,948.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	27,180,238.82	132,389.44	EDUCATION & TRAINING	8,642.00	0.00
RADIOLOGY-DIAGNOSTIC	4,065,514.91	4,955.83	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,358,954.81	240,700.51	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,040,414.49	6,163.41	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	762,195.82	1,115.12	MRI SERVICES	2,774,116.56	0.00
IV THERAPY	3,747.84	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,042,806.03	42,957.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,015,774.34	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,856,218.46	53,250.24	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,606,595.28	0.00	AMBULANCE	0.00	0.00
GI SERVICES	456,926.56	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,132,111.73	31,133.48	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,523,851.42	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	851,653.57	4,724.41	INJECTABLE DRUGS	123,362.05	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	577,186.70	7,622.66	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	352,450.23	1,218.09	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	894,903.54	27,946.51	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	58,527.84	954.25	TRAUMA RESPONSE	0.00	1,241,651.74
PSYCHIATRIC SERVICES	1,032,953.86	0.00	IMPL DEV CHARGE PATIENTS	6,436,934.77	0.00
LITHOTRIPSY	193,852.62	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	973,795.28	32,660.65			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,779,576.79			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,977,753.45	8,451.69			
AUDIOLOGY	104,857.93	0.00			
CARDIOLOGY	3,461,222.32	1,618.36			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	188,131.03	1,608.52			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	106,166.32	78.97			
			TOTAL ANCILLARY	173,506,849.19	4,414,865.45
			TOTAL ACCOMODATIONS	46,960,999.00	1,662,410.00
			TOTAL CHARGES	220,467,848.19	6,077,275.45

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

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

Run Date: 08/12/2016  
 Run Time: 01:16:19  
 Page: 3

WELLSTAR ATLANTA MEDICAL CENTER, INC  
 303 PARKWAY DRIVE, NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	206,279.00	ADJUSTMENTS	0.00
COVERED CHARGES	187,088.05	CONTRACTUAL ALLOW	153,590.45
NON-COVERD CHARGES	19,190.95	TOTAL MEDICAID LIAB	33,497.60
		LESS: COB	33,497.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	0		0	0.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	0		0	0.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	7		0	22,867.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	7		0	22,867.00		0.00
TOTAL ACCOMODATIONS	7		0	22,867.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR ATLANTA MEDICAL CENTER, INC  
 303 PARKWAY DRIVE, NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,844.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27,578.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,615.18	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,024.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	957.76	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	378.21	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	45,069.68	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,700.56	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,902.81	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,404.07	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,933.37	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,269.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	19,190.95			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,541.89	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	164,221.05	19,190.95
			TOTAL ACCOMODATIONS	22,867.00	0.00
			TOTAL CHARGES	187,088.05	19,190.95

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

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

Run Date: 08/12/2016  
Run Time: 01:16:24  
Page: 5

WELLSTAR ATLANTA MEDICAL CENTER, INC  
303 PARKWAY DRIVE, NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,921,705.86	ADJUSTMENTS	702,458.83
COVERED CHARGES	67,065,316.87	CONTRACTUAL ALLOW	62,137,175.93
NON-COVERD CHARGES	4,856,388.99	TOTAL MEDICAID LIAB	4,928,140.94
		LESS: COB	1,950.94
		LESS: COPAYMENT	8,597.63
		REIMBURSEMENT	4,917,592.37
		ALL OTHER	4,481,074.90
		FEE SCHEDULE-LAB	385,917.79
		INJECTABLE DRUGS	50,599.68

TOTAL NUMBER OF CLAIMS 15,996

WELLSTAR ATLANTA MEDICAL CENTER, INC  
 303 PARKWAY DRIVE, NE  
 ATLANTA, GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,164,031.93	12,444.40	OTHER LAB	267,390.79	2,458.67
MED/SURG SUPPLY	3,091,868.85	1,272.33	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,903.36	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,984,983.97	50,727.16	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,083,342.85	1,124,127.77	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	13,028.83	FEE SCHEDULE LAB	12,469,502.43	512,263.82
EKG/ECG	818,383.35	11,353.82	MRI SERVICES	960,212.57	112,706.19
IV THERAPY	3,215,105.63	37,231.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,289,840.46	865,400.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	243,234.79	142,726.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,291,784.66	0.00	AMBULANCE	0.00	0.00
GI SERVICES	84,986.54	10,611.51	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,209,334.60	82,570.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	678,250.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	8,599.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,855,604.59	771,162.54
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	6,779.23	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	620.34	1,697.87	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	16,994.78	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	112,230.00	15,382.20	TRAUMA RESPONSE	0.00	367,505.16
PSYCHIATRIC SERVICES	433,204.27	957.77	IMPL DEV CHARGE PATIENTS	426,002.61	0.00
LITHOTRIPSY	1,037,375.56	16,729.82	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,746,710.09	427,242.02			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	50,203.56			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	483,727.12	92,507.22			
AUDIOLOGY	7,616.54	2,698.41			
CARDIOLOGY	260,895.82	52,630.68			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	383,094.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	465,980.97	43,471.47			
			TOTAL ANCILLARY	67,065,316.87	4,856,388.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,065,316.87	4,856,388.99

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

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

Run Date: 08/12/2016  
Run Time: 01:18:40  
Page: 7

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

WELLSTAR ATLANTA MEDICAL CENTER, INC  
303 PARKWAY DRIVE, NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,229.87	ADJUSTMENTS	0.00
COVERED CHARGES	28,548.26	CONTRACTUAL ALLOW	28,548.26
NON-COVERD CHARGES	681.61	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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

WELLSTAR ATLANTA MEDICAL CENTER, INC  
 303 PARKWAY DRIVE, NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,285.41	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,063.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,486.07	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	0.00	FEE SCHEDULE LAB	3,671.31	0.00
EKG/ECG	1,813.01	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,381.14	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	144.61	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,726.32	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,444.80	681.61
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	2,532.00	0.00			
			TOTAL ANCILLARY	28,548.26	681.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,548.26	681.61

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

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

Run Date: 08/12/2016  
Run Time: 01:18:45  
Page: 9

WELLSTAR ATLANTA MEDICAL CENTER, INC  
303 PARKWAY DRIVE, NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,996,768.89	ADJUSTMENTS	2,994.63
COVERED CHARGES	3,869,889.37	CONTRACTUAL ALLOW	3,744,527.84
NON-COVERD CHARGES	126,879.52	TOTAL MEDICAID LIAB	125,361.53
		LESS: COB	0.00
		LESS: COPAYMENT	4,926.44
		REIMBURSEMENT	120,435.09
		TOTAL NUMBER OF CLAIMS	2,241



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR ATLANTA MEDICAL CENTER, INC  
 303 PARKWAY DRIVE, NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	158,597.01	1,432.00	OTHER LAB	9,771.41	0.00
MED/SURG SUPPLY	57,183.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	174,144.74	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	269,221.94	39,606.91	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	658,561.69	13,045.79
EKG/ECG	32,595.16	358.70	MRI SERVICES	9,343.62	7,490.50
IV THERAPY	221,162.88	3,127.99	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,271.58	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,435.32	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,066,017.61	2,233.52	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	111,879.79	10,406.44
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	224.70	TRAUMA RESPONSE	0.00	19,833.95
PSYCHIATRIC SERVICES	18,167.20	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	77,140.79	29,119.02			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,394.70	0.00			
			TOTAL ANCILLARY	3,869,889.37	126,879.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,869,889.37	126,879.52

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

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

Run Date: 08/12/2016  
Run Time: 01:18:58  
Page: 11

WELLSTAR ATLANTA MEDICAL CENTER, INC  
303 PARKWAY DRIVE, NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR ATLANTA MEDICAL CENTER, INC  
303 PARKWAY DRIVE, NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,040,365.61	ADJUSTMENTS	24,314.92
COVERED CHARGES	941,965.22	CONTRACTUAL ALLOW	880,955.82
NON-COVERD CHARGES	98,400.39	TOTAL MEDICAID LIAB	61,009.40
		LESS: COB	0.00
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	60,946.40
		TOTAL NUMBER OF CLAIMS	10

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

WELLSTAR ATLANTA MEDICAL CENTER, INC  
 303 PARKWAY DRIVE, NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,288.95	0.00	OTHER LAB	1,571.95	0.00
MED/SURG SUPPLY	89,820.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,152.66	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,830.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,833.19	FEE SCHEDULE LAB	22,553.44	358.70
EKG/ECG	1,095.61	736.91	MRI SERVICES	0.00	4,548.10
IV THERAPY	76,594.06	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	240,036.47	72,157.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,219.58	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,760.18	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,710.16	3,398.16	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,020.26	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,358.07	14,597.84
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	710.81	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	58.96	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	250,752.65	0.00
LITHOTRIPSY	63,466.68	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.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,054.63	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,678.56	0.00			
			TOTAL ANCILLARY	941,965.22	98,400.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	941,965.22	98,400.39

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

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

Run Date: 08/12/2016  
Run Time: 01:19:02  
Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR ATLANTA MEDICAL CENTER, INC  
303 PARKWAY DRIVE, NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 08/12/2016  
 Run Time: 03:14:49  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER 000000811A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,646,428.48	ADJUSTMENTS	30,060.34
COVERED CHARGES	1,614,141.48	CONTRACTUAL ALLOW	983,033.53
NON-COVERD CHARGES	32,287.00	TOTAL MEDICAID LIAB	631,107.95
		LESS: COB	12,101.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	619,006.15

TOTAL NUMBER OF ADMISSIONS 103

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	291		2	283,725.00		21,378.00
ROUTINE NURSERY	54		0	49,140.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	345		2	332,865.00		21,378.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	31		0	62,731.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	31		0	62,731.00		0.00
TOTAL ACCOMODATIONS	376		2	395,596.00		21,378.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	336,213.79	0.00	OTHER LAB	4,251.00	0.00
MED/SURG SUPPLY	135,550.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	169,417.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,552.00	0.00	OTHER THERAPEUTIC SVC	0.00	119.00
CT SCAN	79,759.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,424.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,784.00	0.00	MRI SERVICES	17,400.00	0.00
IV THERAPY	26,627.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	135,815.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,266.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	59,711.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,914.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,766.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,708.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,022.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,069.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,599.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,048.00	10,790.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,599.00	0.00			
AUDIOLOGY	4,743.00	0.00			
CARDIOLOGY	18,473.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	539.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,295.00	0.00			
			TOTAL ANCILLARY	1,218,545.48	10,909.00
			TOTAL ACCOMODATIONS	395,596.00	21,378.00
			TOTAL CHARGES	1,614,141.48	32,287.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	208,126.09	ADJUSTMENTS	0.00
COVERED CHARGES	202,931.09	CONTRACTUAL ALLOW	55,447.76
NON-COVERD CHARGES	5,195.00	TOTAL MEDICAID LIAB	147,483.33
		LESS: COB	147,483.33
		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	47		0	45,825.00		5,195.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	47		0	45,825.00		5,195.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	4,042.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	4,042.00		0.00
TOTAL ACCOMODATIONS	49		0	49,867.00		5,195.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,184.04	0.00	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	10,900.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,843.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,682.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,666.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	973.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,396.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,952.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,671.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,406.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,800.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,824.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,930.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	590.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	882.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,307.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,096.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,500.00	0.00			
			TOTAL ANCILLARY	153,064.09	0.00
			TOTAL ACCOMODATIONS	49,867.00	5,195.00
			TOTAL CHARGES	202,931.09	5,195.00

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

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

Run Date: 08/12/2016  
Run Time: 03:14:52  
Page: 5

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,726,915.53	ADJUSTMENTS	134,011.89
COVERED CHARGES	2,558,928.39	CONTRACTUAL ALLOW	1,903,701.94
NON-COVERD CHARGES	167,987.14	TOTAL MEDICAID LIAB	655,226.45
		LESS: COB	2,175.46
		LESS: COPAYMENT	2,502.00
		REIMBURSEMENT	650,548.99
		ALL OTHER	520,860.57
		FEE SCHEDULE-LAB	76,047.26
		INJECTABLE DRUGS	53,641.16

TOTAL NUMBER OF CLAIMS 2,384

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108,581.40	2,425.10	OTHER LAB	32,195.00	0.00
MED/SURG SUPPLY	65,870.05	4,704.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	67.00	EDUCATION & TRAINING	110.00	0.00
RADIOLOGY-DIAGNOSTIC	149,383.00	1,451.00	OTHER THERAPEUTIC SVC	0.00	2,142.00
CT SCAN	273,522.00	21,815.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,819.00	7,381.00	FEE SCHEDULE LAB	411,135.57	46,852.30
EKG/ECG	27,285.00	2,363.00	MRI SERVICES	108,724.00	4,314.00
IV THERAPY	90,068.00	8,812.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	85,484.00	5,146.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,022.00	1,879.00	REHAB THERAPY	952.00	0.00
RESPIRATORY SERVICES	26,874.00	2,030.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,857.00	957.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	650,539.00	9,542.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,989.00	204.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	183,673.87	36,535.49
RADIOLOGY THERAPEUTIC	109,684.00	500.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	205.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,866.00	126.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	328.00	524.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	45.00
OTHER IMAGING SERVICE	75,982.00	2,856.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,421.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	25,030.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,319.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,696.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	46,518.50	5,110.50			
			TOTAL ANCILLARY	2,558,928.39	167,987.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,558,928.39	167,987.14

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: 08/12/2016  
Run Time: 03:14:52  
Page: 7

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2214317020061	07/16/14 - 07/16/14	11/17/14	0.00	45.00	0.00	0.00	0.00
TOTAL				0.00	45.00	0.00	0.00	0.00

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

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

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	94,752.60	ADJUSTMENTS	0.00
COVERED CHARGES	70,428.68	CONTRACTUAL ALLOW	25,326.09
NON-COVERD CHARGES	24,323.92	TOTAL MEDICAID LIAB	45,102.59
		LESS: COB	45,081.59
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 83

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

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,118.56	60.50	OTHER LAB	420.00	1,029.00
MED/SURG SUPPLY	905.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,333.00	426.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,450.00	7,048.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,460.00	2,944.00
EKG/ECG	1,112.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,520.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,497.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,701.00	324.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	426.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	341.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,186.00	2,610.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	296.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,884.18	3,792.42
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	183.00
OTHER IMAGING SERVICE	1,959.00	3,392.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	880.00	2,515.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	701.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	238.00	0.00			
			TOTAL ANCILLARY	70,428.68	24,323.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	70,428.68	24,323.92

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

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

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3014	2214237002109	07/31/14 - 08/01/14	09/01/14	0.00	183.00	0.00	1,099.16	0.00
TOTAL				0.00	183.00	0.00	1,099.16	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	194,874.83	ADJUSTMENTS	585.34
COVERED CHARGES	189,270.78	CONTRACTUAL ALLOW	172,600.66
NON-COVERD CHARGES	5,604.05	TOTAL MEDICAID LIAB	16,670.12
		LESS: COB	0.00
		LESS: COPAYMENT	504.00
		REIMBURSEMENT	16,166.12
		TOTAL NUMBER OF CLAIMS	298



Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,490.43	0.00	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	1,124.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,978.00	213.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,718.00	975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,719.00	2,264.00
EKG/ECG	1,112.00	139.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,004.00	238.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	294.00	757.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	117,902.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,933.35	1,018.05
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	8,534.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	189,270.78	5,604.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	189,270.78	5,604.05

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,363.83	ADJUSTMENTS	0.00
COVERED CHARGES	7,657.43	CONTRACTUAL ALLOW	3,142.79
NON-COVERD CHARGES	706.40	TOTAL MEDICAID LIAB	4,514.64
		LESS: COB	4,490.64
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	204.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	184.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,911.00	341.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	201.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,085.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	72.40	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	0.00	293.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,657.43	706.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,657.43	706.40

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: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,084.63	ADJUSTMENTS	0.00
COVERED CHARGES	23,557.23	CONTRACTUAL ALLOW	17,760.69
NON-COVERD CHARGES	6,527.40	TOTAL MEDICAID LIAB	5,796.54
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,796.54

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	983.33	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,572.50	6,262.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	137.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,131.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,228.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	593.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	912.40	265.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,557.23	6,527.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,557.23	6,527.40

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SYSTEM, INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/14	THROUGH	04/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
 2415 PARKWOOD DRIVE  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER 000000822A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,057,978.83	ADJUSTMENTS	584,238.11
COVERED CHARGES	23,505,816.98	CONTRACTUAL ALLOW	15,858,790.71
NON-COVERD CHARGES	552,161.85	TOTAL MEDICAID LIAB	7,647,026.27
		LESS: COB	75,623.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,571,402.38

TOTAL NUMBER OF ADMISSIONS 862

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,942		0	2,758,173.00		296,942.00
ROUTINE NURSERY	291		0	265,720.00		1,204.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,233		0	3,023,893.00		298,146.00
SPECIAL CARE SERVICES						
CCU	406		0	820,526.00		0.00
ICU	1,571		7	2,607,291.00		10,647.00
NICU	10		0	16,480.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,987		7	3,444,297.00		10,647.00
TOTAL ACCOMODATIONS	5,220		7	6,468,190.00		308,793.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
 2415 PARKWOOD DRIVE  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,888,905.01	13,872.37	OTHER LAB	83,872.00	0.00
MED/SURG SUPPLY	1,760,246.77	6,660.48	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,895,882.91	7,537.00	EDUCATION & TRAINING	1,680.00	0.00
RADIOLOGY-DIAGNOSTIC	390,084.00	426.00	OTHER THERAPEUTIC SVC	0.00	946.00
CT SCAN	371,964.00	120,848.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	149,014.22	10,661.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	80,032.00	0.00	MRI SERVICES	177,550.00	1,860.00
IV THERAPY	378,377.00	201.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,232,983.00	3,244.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	147,657.00	0.00	REHAB THERAPY	61.00	0.00
RESPIRATORY SERVICES	1,445,708.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	418,286.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	334,519.00	809.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	151,151.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	560.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	138,040.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	111,781.09	9,779.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,019.08	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	190,860.00	12,947.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,483.90	0.00
LITHOTRIPSY	9,500.00	0.00	NO CC/INVALID REV CODE	0.00	7,873.00
OTHER IMAGING SERVICE	61,918.00	6,960.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	491,613.00	33,585.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	71,310.00	5,160.00			
AUDIOLOGY	32,364.00	0.00			
CARDIOLOGY	858,852.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,584.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	86,769.00	0.00			
			TOTAL ANCILLARY	17,037,626.98	243,368.85
			TOTAL ACCOMODATIONS	6,468,190.00	308,793.00
			TOTAL CHARGES	23,505,816.98	552,161.85



Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
Run Time: 03:13:22  
Page: 3

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
2415 PARKWOOD DRIVE  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2215008004712	12/25/14 - 12/30/14	01/12/15	0.00	2,700.00	0.00	0.00	0.00
615	2215107007387	02/04/15 - 02/26/15	04/20/15	0.00	2,700.00	0.00	0.00	0.00
3521	2215124004050	03/10/15 - 03/19/15	05/11/15	0.00	2,473.00	0.00	0.00	0.00
TOTAL				0.00	7,873.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:13:35  
 Page: 4

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
 2415 PARKWOOD DRIVE  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	344,439.78	ADJUSTMENTS	0.00
COVERED CHARGES	338,845.15	CONTRACTUAL ALLOW	59,656.39
NON-COVERD CHARGES	5,594.63	TOTAL MEDICAID LIAB	279,188.76
		LESS: COB	279,188.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	28		0	27,300.00		2,897.00
ROUTINE NURSERY	6		0	5,460.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	34		0	32,760.00		2,897.00
SPECIAL CARE SERVICES						
CCU	17		0	34,357.00		0.00
ICU	2		0	3,042.00		0.00
NICU	2		0	3,296.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	21		0	40,695.00		0.00
TOTAL ACCOMODATIONS	55		0	73,455.00		2,897.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
 2415 PARKWOOD DRIVE  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,463.69	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41,045.46	2,697.63	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	25,219.00	0.00	EDUCATION & TRAINING	112.00	0.00
RADIOLOGY-DIAGNOSTIC	5,956.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,958.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	854.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	417.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	759.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	54,083.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,935.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,913.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,328.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,133.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,372.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	681.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	888.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	466.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	13,596.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	641.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	664.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	744.00	0.00			
CARDIOLOGY	10,162.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	265,390.15	2,697.63
			TOTAL ACCOMODATIONS	73,455.00	2,897.00
			TOTAL CHARGES	338,845.15	5,594.63

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: 08/12/2016  
Run Time: 03:13:37  
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SOUTHEAST GEORGIA HEALTH SYSTEM INC  
2415 PARKWOOD DRIVE  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,013,840.62	ADJUSTMENTS	682,992.00
COVERED CHARGES	10,015,210.96	CONTRACTUAL ALLOW	7,553,082.79
NON-COVERD CHARGES	998,629.66	TOTAL MEDICAID LIAB	2,462,128.17
		LESS: COB	5,449.07
		LESS: COPAYMENT	12,513.79
		REIMBURSEMENT	2,444,165.31
		ALL OTHER	1,923,771.06
		FEE SCHEDULE-LAB	241,421.42
		INJECTABLE DRUGS	278,972.83

TOTAL NUMBER OF CLAIMS 7,047

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
 2415 PARKWOOD DRIVE  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	494,039.66	8,179.98	OTHER LAB	142,888.00	0.00
MED/SURG SUPPLY	467,384.86	6,153.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	623.00	EDUCATION & TRAINING	220.00	0.00
RADIOLOGY-DIAGNOSTIC	387,564.00	10,827.00	OTHER THERAPEUTIC SVC	0.00	4,982.00
CT SCAN	652,483.00	57,882.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	93,846.00	28,965.14	FEE SCHEDULE LAB	1,243,022.80	170,735.21
EKG/ECG	78,414.00	2,780.00	MRI SERVICES	338,413.00	20,126.00
IV THERAPY	488,704.00	24,962.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	715,337.30	133,090.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	36,053.00	6,646.00	REHAB THERAPY	5,287.00	0.00
RESPIRATORY SERVICES	174,971.00	3,131.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	150,988.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	25,288.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,295,686.00	22,483.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	107,476.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	907,966.34	241,265.41
RADIOLOGY THERAPEUTIC	999,151.00	122,039.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,113.00	6,134.09	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,528.00	2,327.11	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,068.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,140.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	105,010.00	0.00	NO CC/INVALID REV CODE	0.00	191.40
OTHER IMAGING SERVICE	390,290.50	44,845.45			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	143,430.00	4,169.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	76,211.00	11,940.00			
AUDIOLOGY	0.00	858.00			
CARDIOLOGY	142,520.00	47,648.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,904.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	288,881.50	13,578.50			
			TOTAL ANCILLARY	10,015,210.96	998,629.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,015,210.96	998,629.66

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:13:37  
Page: 8

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
2415 PARKWOOD DRIVE  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
2510	2215152010413	03/01/15 - 03/01/15	06/08/15	0.00	72.40	0.00	0.00	0.00
1045	2216169010105	11/05/14 - 11/05/14	06/20/16	0.00	119.00	0.00	0.00	0.00
TOTAL				0.00	191.40	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:14:30  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
2415 PARKWOOD DRIVE  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	301,615.25	ADJUSTMENTS	0.00
COVERED CHARGES	198,078.10	CONTRACTUAL ALLOW	65,980.26
NON-COVERD CHARGES	103,537.15	TOTAL MEDICAID LIAB	132,097.84
		LESS: COB	131,950.84
		LESS: COPAYMENT	147.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 146

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
 2415 PARKWOOD DRIVE  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,679.01	658.85	OTHER LAB	633.00	0.00
MED/SURG SUPPLY	9,304.69	1,319.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,034.00	2,250.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,896.00	10,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,299.00	4,603.50
EKG/ECG	695.00	278.00	MRI SERVICES	0.00	4,908.00
IV THERAPY	21,486.00	439.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,350.25	21,862.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,010.00	387.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	441.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,667.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,727.00	455.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,136.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,845.15	15,512.65
RADIOLOGY THERAPEUTIC	3,543.00	29,032.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	410.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	408.40
OTHER IMAGING SERVICE	14,070.00	6,408.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,787.00	2,430.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	528.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,947.00	1,352.00			
			TOTAL ANCILLARY	198,078.10	103,537.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	198,078.10	103,537.15



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 03:14:30  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
2415 PARKWOOD DRIVE  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2215153015790	04/01/15 - 04/01/15	06/08/15	0.00	72.40	0.00	661.06	0.00
4500	2215188012079	07/06/14 - 07/06/14	07/13/15	0.00	336.00	0.00	429.50	0.00
TOTAL				0.00	408.40	0.00	1,090.56	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:14:33  
Page: 12

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
2415 PARKWOOD DRIVE  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	414,617.91	ADJUSTMENTS	2,120.60
COVERED CHARGES	401,316.43	CONTRACTUAL ALLOW	371,500.41
NON-COVERD CHARGES	13,301.48	TOTAL MEDICAID LIAB	29,816.02
		LESS: COB	0.00
		LESS: COPAYMENT	1,053.00
		REIMBURSEMENT	28,763.02
		TOTAL NUMBER OF CLAIMS	533

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
 2415 PARKWOOD DRIVE  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,765.38	337.68	OTHER LAB	2,526.00	0.00
MED/SURG SUPPLY	1,549.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,578.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,528.00	975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	68,459.00	6,154.00
EKG/ECG	4,246.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,379.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	540.00	225.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,323.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	214,693.00	119.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,734.45	2,223.80
RADIOLOGY THERAPEUTIC	12,781.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	243.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,971.00	3,099.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	168.00			
			TOTAL ANCILLARY	401,316.43	13,301.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	401,316.43	13,301.48

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:14:37  
Page: 14

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
2415 PARKWOOD DRIVE  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,231.24	ADJUSTMENTS	0.00
COVERED CHARGES	13,260.99	CONTRACTUAL ALLOW	7,097.73
NON-COVERD CHARGES	2,970.25	TOTAL MEDICAID LIAB	6,163.26
		LESS: COB	6,142.26
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:14:37  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
 2415 PARKWOOD DRIVE  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	353.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,502.00	150.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	402.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,200.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	108.60	458.25
RADIOLOGY THERAPEUTIC	3,647.00	1,607.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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	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	13,260.99	2,970.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,260.99	2,970.25

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:14:39  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
2415 PARKWOOD DRIVE  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,342,088.30	ADJUSTMENTS	142,567.02
COVERED CHARGES	1,290,193.10	CONTRACTUAL ALLOW	1,044,443.36
NON-COVERD CHARGES	51,895.20	TOTAL MEDICAID LIAB	245,749.74
		LESS: COB	0.00
		LESS: COPAYMENT	360.00
		REIMBURSEMENT	245,389.74

TOTAL NUMBER OF CLAIMS 43

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
 2415 PARKWOOD DRIVE  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,253.19	49.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	309,786.21	1,017.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	56.00
RADIOLOGY-DIAGNOSTIC	3,506.00	193.00	OTHER THERAPEUTIC SVC	0.00	710.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,035.50	136.50
EKG/ECG	1,390.00	417.00	MRI SERVICES	0.00	0.00
IV THERAPY	42,385.00	119.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	382,859.00	1,996.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	119.00	0.00
RESPIRATORY SERVICES	24,204.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,508.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,868.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	334,986.20	11,250.60
RADIOLOGY THERAPEUTIC	88,201.00	629.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,367.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	51,245.00	35,322.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,480.00	0.00			
			TOTAL ANCILLARY	1,290,193.10	51,895.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,290,193.10	51,895.20

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:14:41  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHEAST GEORGIA HEALTH SYSTEM INC  
2415 PARKWOOD DRIVE  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/14	THROUGH	04/30/15
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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,634,894.43	ADJUSTMENTS	812,880.56
COVERED CHARGES	13,080,119.94	CONTRACTUAL ALLOW	9,982,317.22
NON-COVERD CHARGES	554,774.49	TOTAL MEDICAID LIAB	3,097,802.72
		LESS: COB	18,761.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,079,041.08

TOTAL NUMBER OF ADMISSIONS 422

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	736		3	456,053.00		32,503.08
ROUTINE NURSERY	104		0	59,318.43		164.46
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	840		3	515,371.43		32,667.54
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	680		2	1,204,347.98		6,328.40
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	680		2	1,204,347.98		6,328.40
TOTAL ACCOMODATIONS	1,520		5	1,719,719.41		38,995.94

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	510,728.40	0.00	OTHER LAB	28,588.96	0.00
MED/SURG SUPPLY	180,634.57	324.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,672,949.52	1,591.86	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	298,133.32	0.00	OTHER THERAPEUTIC SVC	0.00	7,683.14
CT SCAN	304,779.68	492,789.02	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	152,860.51	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	179,458.51	0.00	MRI SERVICES	121,154.43	0.00
IV THERAPY	110,458.18	689.98	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,487,751.35	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	131,705.76	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	929,943.70	432.99	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	285,612.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	52,395.40	2,991.84	CAST ROOM	0.00	0.00
EMERGENCY ROOM	540,966.77	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	67,367.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	77,379.30	0.00	INJECTABLE DRUGS	2,326,080.49	9.16
RADIOLOGY THERAPEUTIC	85,205.32	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,579.30	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,236,083.45	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	61,104.14	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	32,463.75	3,059.92			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	55,934.03	6,205.76			
AUDIOLOGY	8,167.50	0.00			
CARDIOLOGY	404,762.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,184.76	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,966.72	0.00			
			TOTAL ANCILLARY	11,360,400.53	515,778.55
			TOTAL ACCOMODATIONS	1,719,719.41	38,995.94
			TOTAL CHARGES	13,080,119.94	554,774.49

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:24:36  
 Page: 3

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,665.87	ADJUSTMENTS	0.00
COVERED CHARGES	49,252.85	CONTRACTUAL ALLOW	19,513.44
NON-COVERD CHARGES	10,413.02	TOTAL MEDICAID LIAB	29,739.41
		LESS: COB	29,739.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	2,860.00		436.60
ROUTINE NURSERY	0		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	2,860.00		436.60
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	3,495.21		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	3,495.21		0.00
TOTAL ACCOMODATIONS	8		0	6,355.21		436.60

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,103.43	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,933.12	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	514.11	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,303.38	9,976.42	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,067.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,533.01	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,208.18	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,224.34	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	757.56	0.00	INJECTABLE DRUGS	12,142.31	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,053.77	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	57.28	0.00			
			TOTAL ANCILLARY	42,897.64	9,976.42
			TOTAL ACCOMODATIONS	6,355.21	436.60
			TOTAL CHARGES	49,252.85	10,413.02

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,254,591.12	ADJUSTMENTS	185,569.48
COVERED CHARGES	15,337,985.24	CONTRACTUAL ALLOW	13,688,158.60
NON-COVERD CHARGES	1,916,605.88	TOTAL MEDICAID LIAB	1,649,826.64
		LESS: COB	1,753.13
		LESS: COPAYMENT	5,900.64
		REIMBURSEMENT	1,642,172.87
		ALL OTHER	1,383,764.25
		FEE SCHEDULE-LAB	168,041.08
		INJECTABLE DRUGS	90,367.54

TOTAL NUMBER OF CLAIMS 5,346

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82,826.97	55,976.16	OTHER LAB	57,774.66	0.00
MED/SURG SUPPLY	192,895.10	700.38	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	760,544.06	13,361.65	OTHER THERAPEUTIC SVC	0.00	82,880.05
CT SCAN	2,508,391.84	322,124.47	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	322,507.10	22,358.28	FEE SCHEDULE LAB	2,347,784.55	291,209.70
EKG/ECG	217,167.27	2,172.42	MRI SERVICES	381,930.01	42,260.39
IV THERAPY	429,961.37	1,589.33	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,356,835.30	164,935.08	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,685.30	444.29	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,349.26	3,230.04	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	318,403.05	4,918.97	AMBULANCE	0.00	0.00
GI SERVICES	121,795.48	25,098.53	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,233,316.30	6,522.59	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	114,550.73	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,103,074.67	131,615.67
RADIOLOGY THERAPEUTIC	495,828.22	374,298.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	859.80	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	84,228.11	3,342.06	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	61,947.98	167,765.41
LITHOTRIPSY	29,098.83	0.00	NO CC/INVALID REV CODE	0.00	3,341.29
OTHER IMAGING SERVICE	329,597.62	54,256.89			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,087.86	10,709.72			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	315,010.35	63,845.62			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	150,481.51	66,789.09			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	166,582.91	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	96,328.83	0.00			
			TOTAL ANCILLARY	15,337,985.24	1,916,605.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,337,985.24	1,916,605.88

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015364019188	12/09/15 - 12/09/15	01/04/16	0.00	3,341.29	0.00	0.00	0.00
TOTAL				0.00	3,341.29	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GORDON HOSPITAL  
1035 RED BUD RD NE  
CALHOUN,GA 30701-2082

PROVIDER NUMBER  
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	257,793.98	ADJUSTMENTS	0.00
COVERED CHARGES	210,148.64	CONTRACTUAL ALLOW	128,934.53
NON-COVERD CHARGES	47,645.34	TOTAL MEDICAID LIAB	81,214.11
		LESS: COB	81,160.29
		LESS: COPAYMENT	53.82
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 80



Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,892.57	1,715.46	OTHER LAB	2,698.32	0.00
MED/SURG SUPPLY	3,968.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,555.00	648.35	OTHER THERAPEUTIC SVC	0.00	611.07
CT SCAN	17,699.86	18,860.64	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,520.06	2,482.80
EKG/ECG	2,172.42	0.00	MRI SERVICES	0.00	7,536.78
IV THERAPY	8,448.95	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,447.02	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,698.74	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.66	298.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,982.29	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,113.76	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,840.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,126.92	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,608.55	3,092.03
RADIOLOGY THERAPEUTIC	1,443.66	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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,366.96	7,285.82			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	210,148.64	47,645.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	210,148.64	47,645.34

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: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	646,353.37	ADJUSTMENTS	794.10
COVERED CHARGES	628,097.77	CONTRACTUAL ALLOW	600,015.89
NON-COVERD CHARGES	18,255.60	TOTAL MEDICAID LIAB	28,081.88
		LESS: COB	0.00
		LESS: COPAYMENT	1,000.93
		REIMBURSEMENT	27,080.95
		TOTAL NUMBER OF CLAIMS	502

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	507.64	1,364.31	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,862.45	0.00	OTHER THERAPEUTIC SVC	0.00	552.45
CT SCAN	6,606.76	3,303.38	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	79,234.59	7,759.04
EKG/ECG	6,517.26	0.00	MRI SERVICES	4,832.34	0.00
IV THERAPY	32,129.89	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678.66	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	429,059.51	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,044.61	2,306.30
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	5,624.06	2,970.12			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	628,097.77	18,255.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	628,097.77	18,255.60

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,499.37	ADJUSTMENTS	0.00
COVERED CHARGES	24,935.59	CONTRACTUAL ALLOW	16,093.94
NON-COVERD CHARGES	1,563.78	TOTAL MEDICAID LIAB	8,841.65
		LESS: COB	8,820.65
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,082.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,990.58	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,110.12	187.72
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,135.46	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	949.90	386.02
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	1,591.20	990.04			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,935.59	1,563.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,935.59	1,563.78

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,801,210.41	ADJUSTMENTS	39,139.59
COVERED CHARGES	1,558,379.93	CONTRACTUAL ALLOW	1,420,352.73
NON-COVERD CHARGES	242,830.48	TOTAL MEDICAID LIAB	138,027.20
		LESS: COB	0.00
		LESS: COPAYMENT	513.00
		REIMBURSEMENT	137,514.20
		TOTAL NUMBER OF CLAIMS	25

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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Run Date: 08/12/2016  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GORDON HOSPITAL  
 1035 RED BUD RD NE  
 CALHOUN,GA 30701-2082

PROVIDER NUMBER  
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,478.69	4,293.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,577.45	144.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	967.09	1,156.46	OTHER THERAPEUTIC SVC	0.00	26,262.89
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,039.13	1,062.54
EKG/ECG	362.07	0.00	MRI SERVICES	3,502.26	0.00
IV THERAPY	61,192.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,741.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,863.30	638.15	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	615.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,229,573.14	94,884.95
RADIOLOGY THERAPEUTIC	206,080.24	111,833.34	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,880.98	1,024.04
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	506.68	1,529.96			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,558,379.93	242,830.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,558,379.93	242,830.48

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:26:16  
 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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,958,169.87	ADJUSTMENTS	323,312.91
COVERED CHARGES	1,934,833.87	CONTRACTUAL ALLOW	958,640.23
NON-COVERD CHARGES	23,336.00	TOTAL MEDICAID LIAB	976,193.64
		LESS: COB	743.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	975,450.39

TOTAL NUMBER OF ADMISSIONS 191

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	391		0	224,481.00		22,126.00
ROUTINE NURSERY	123		0	59,901.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	514		0	284,382.00		22,126.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	50		0	72,434.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	72,434.00		0.00
TOTAL ACCOMODATIONS	564		0	356,816.00		22,126.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GRADY GENERAL HOSPITAL  
 1155 5TH ST SE  
 CAIRO,GA 39828-3142

PROVIDER NUMBER  
 000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	327,057.71	0.00	OTHER LAB	3,936.00	0.00
MED/SURG SUPPLY	172,685.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	349,780.14	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,537.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	95,770.00	1,118.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,922.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,954.00	0.00	MRI SERVICES	26,155.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	163,916.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	151,823.00	92.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56,141.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,874.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,352.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,182.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,719.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,275.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	2,264.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,315.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,779.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,326.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,837.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,878.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	4,698.00	0.00			
CARDIOLOGY	15,768.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,074.00	0.00			
			TOTAL ANCILLARY	1,578,017.87	1,210.00
			TOTAL ACCOMODATIONS	356,816.00	22,126.00
			TOTAL CHARGES	1,934,833.87	23,336.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

GRADY GENERAL HOSPITAL  
1155 5TH ST SE  
CAIRO,GA 39828-3142

PROVIDER NUMBER  
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 01:26:20  
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GRADY GENERAL HOSPITAL  
1155 5TH ST SE  
CAIRO,GA 39828-3142

PROVIDER NUMBER  
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,603,548.94	ADJUSTMENTS	70,047.69
COVERED CHARGES	2,330,255.87	CONTRACTUAL ALLOW	1,737,992.43
NON-COVERD CHARGES	273,293.07	TOTAL MEDICAID LIAB	592,263.44
		LESS: COB	187.22
		LESS: COPAYMENT	2,763.00
		REIMBURSEMENT	589,313.22
		ALL OTHER	502,694.93
		FEE SCHEDULE-LAB	74,469.07
		INJECTABLE DRUGS	12,149.22
		TOTAL NUMBER OF CLAIMS	2,248

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,197.60	55.00	OTHER LAB	7,676.00	0.00
MED/SURG SUPPLY	129,802.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	85.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	169,709.00	229.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	225,969.00	66,897.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	65,889.00	31,280.00	FEE SCHEDULE LAB	493,597.76	54,455.50
EKG/ECG	23,966.00	189.00	MRI SERVICES	53,481.00	5,896.00
IV THERAPY	132,193.00	644.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	285,373.78	37,122.22	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,149.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,370.00	3,440.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,466.00	241.00	AMBULANCE	0.00	0.00
GI SERVICES	44,866.67	12,234.33	CAST ROOM	0.00	0.00
EMERGENCY ROOM	278,641.00	825.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	59,947.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	95,369.00	31,483.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,470.00	10,313.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,796.00	1,832.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	424.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,057.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	51,844.00	11,695.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,576.06	233.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,386.00	3,144.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	52,464.00	576.00			
			TOTAL ANCILLARY	2,330,255.87	273,293.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,330,255.87	273,293.07

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 01:26:43  
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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,665.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,867.00	CONTRACTUAL ALLOW	4,763.14
NON-COVERD CHARGES	6,798.00	TOTAL MEDICAID LIAB	10,103.86
		LESS: COB	10,103.67
		LESS: COPAYMENT	0.19
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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: 08/12/2016  
 Run Time: 01:26:43  
 Page: 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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	865.00	0.00
MED/SURG SUPPLY	265.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	455.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,299.00	6,513.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,689.00	285.00
EKG/ECG	189.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	814.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,204.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	812.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,275.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,867.00	6,798.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,867.00	6,798.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:26:44  
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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	83,298.00	ADJUSTMENTS	653.28
COVERED CHARGES	79,589.00	CONTRACTUAL ALLOW	71,198.00
NON-COVERD CHARGES	3,709.00	TOTAL MEDICAID LIAB	8,391.00
		LESS: COB	0.00
		LESS: COPAYMENT	219.00
		REIMBURSEMENT	8,172.00
		TOTAL NUMBER OF CLAIMS	150



Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:26:44  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

GRADY GENERAL HOSPITAL  
 1155 5TH ST SE  
 CAIRO,GA 39828-3142

PROVIDER NUMBER  
 000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100.00	0.00	OTHER LAB	528.00	0.00
MED/SURG SUPPLY	1,548.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,477.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,179.00	689.00
EKG/ECG	900.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,743.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	552.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,478.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,802.00	1,238.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	282.00	282.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	79,589.00	3,709.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	79,589.00	3,709.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:26:46  
Page: 10

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	599.00	ADJUSTMENTS	0.00
COVERED CHARGES	599.00	CONTRACTUAL ALLOW	292.64
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	306.36
		LESS: COB	303.36
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:26:46  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	301.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	271.00	0.00	SPECIAL SERVICES	0.00	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	599.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	599.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 01:26:46  
Page: 12

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,018.00	ADJUSTMENTS	5,534.23
COVERED CHARGES	19,783.00	CONTRACTUAL ALLOW	14,242.77
NON-COVERD CHARGES	235.00	TOTAL MEDICAID LIAB	5,540.23
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	5,534.23

TOTAL NUMBER OF CLAIMS 1

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	398.00	55.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,617.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,564.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	538.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,702.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	245.00	180.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,698.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,783.00	235.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,783.00	235.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 01:26:47  
Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GENERAL HOSPITAL  
1155 5TH ST SE  
CAIRO,GA 39828-3142

PROVIDER NUMBER  
000000844A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:10:57  
 Page: 1

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	522,262,795.41	ADJUSTMENTS	36,848,791.77
COVERED CHARGES	483,973,702.84	CONTRACTUAL ALLOW	376,106,405.30
NON-COVERD CHARGES	38,289,092.57	TOTAL MEDICAID LIAB	107,867,297.54
		LESS: COB	402,636.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	107,464,661.05

TOTAL NUMBER OF ADMISSIONS 7,732

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	32,384		237	43,623,969.84		15,408,304.18
ROUTINE NURSERY	5,713		4	10,821,805.00		2,340,729.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		161,678.10
TOTAL ROUTINE	38,097		241	54,445,774.84		17,910,711.28
SPECIAL CARE SERVICES						
CCU	24		0	75,000.00		0.00
ICU	14,436		9	57,618,490.00		1,596,500.00
NICU	476		0	2,507,568.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	859		0	6,633,368.00		23,051.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	15,795		9	66,834,426.00		1,619,551.00
TOTAL ACCOMODATIONS	53,892		250	121,280,200.84		19,530,262.28

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,059,771.37	611,718.88	OTHER LAB	2,330,551.00	43,664.00
MED/SURG SUPPLY	17,897,717.22	1,799,406.86	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	55,278,684.00	1,352,449.00	EDUCATION & TRAINING	950.00	0.00
RADIOLOGY-DIAGNOSTIC	12,118,219.00	338,013.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,807,504.00	2,291,387.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,447,798.98	993,580.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,590,341.07	12,224.00	MRI SERVICES	6,055,891.00	6,599.00
IV THERAPY	435,068.56	18,865.00	PROFESSIONAL FEES	0.00	192.00
OPERATING ROOM	78,548,043.00	1,867,243.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,652,803.00	4,450.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38,878,617.00	2,380,016.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,276,243.00	381,095.00	AMBULANCE	0.00	0.00
GI SERVICES	1,023,261.00	14,817.00	CAST ROOM	13,744.00	0.00
EMERGENCY ROOM	15,119,307.00	131,093.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,550,351.00	61,561.00	DRUG-SPECIFIC/HOME IV	0.00	254,499.55
LABORATORY PATHOLOGIC	1,156,992.00	19,658.00	INJECTABLE DRUGS	16,838,930.68	730,826.09
RADIOLOGY THERAPEUTIC	1,266,303.00	9,028.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,942,079.05	995,222.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,718,597.42	24,397.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,066,192.00	426,510.00	PATIENT CONVENIENCE	0.00	5,133.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,944.00	323,022.00	TRAUMA RESPONSE	0.00	1,431,218.00
PSYCHIATRIC SERVICES	153,042.00	0.00	IMPL DEV CHARGE PATIENTS	6,590,819.65	28,944.91
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	293,184.00
OTHER IMAGING SERVICE	2,157,091.00	413,561.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,254,059.00	997,317.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	981,178.00	366,430.00			
AUDIOLOGY	473,368.00	0.00			
CARDIOLOGY	7,143,370.00	98,960.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,906,091.00	32,546.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,955,580.00	0.00			
			TOTAL ANCILLARY	362,693,502.00	18,758,830.29
			TOTAL ACCOMODATIONS	121,280,200.84	19,530,262.28
			TOTAL CHARGES	483,973,702.84	38,289,092.57



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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015183000563	04/11/15 - 04/22/15	07/06/15	0.00	4,581.00	0.00	0.00	0.00
615	2015183115803	06/16/15 - 06/24/15	07/06/15	0.00	4,581.00	0.00	0.00	0.00
615	2015189093380	04/11/15 - 04/20/15	07/13/15	0.00	4,581.00	0.00	0.00	0.00
615	2015196074692	06/08/15 - 07/01/15	07/20/15	0.00	4,581.00	0.00	0.00	0.00
615	2015197080930	04/18/15 - 05/05/15	07/20/15	0.00	4,581.00	0.00	0.00	0.00
615	2015198061161	06/13/15 - 07/10/15	07/27/15	0.00	4,581.00	0.00	0.00	0.00
615	2215212002931	02/19/15 - 02/25/15	08/03/15	0.00	4,581.00	0.00	0.00	0.00
615	2015231010703	06/24/15 - 08/11/15	08/24/15	0.00	4,581.00	0.00	0.00	0.00
615	2215231000984	02/26/15 - 03/05/15	08/24/15	0.00	4,581.00	0.00	0.00	0.00
615	2015244015638	01/07/15 - 01/08/15	09/07/15	0.00	4,581.00	0.00	0.00	0.00
615	2315259000089	02/27/15 - 03/12/15	10/12/15	0.00	4,581.00	0.00	3,520.13	0.00
615	2015259090031	03/11/15 - 05/11/15	09/21/15	0.00	4,581.00	0.00	0.00	0.00
615	2015283003040	01/16/15 - 01/21/15	10/19/15	0.00	4,581.00	0.00	0.00	0.00
615	2315309000021	02/19/15 - 03/01/15	11/30/15	0.00	4,581.00	0.00	4,292.15	0.00
615	2015311008874	10/26/15 - 10/29/15	11/16/15	0.00	4,581.00	0.00	0.00	0.00
615	2015315009203	09/04/15 - 10/23/15	11/16/15	0.00	9,162.00	0.00	0.00	0.00
615	2015320046696	10/27/15 - 10/30/15	11/23/15	0.00	4,581.00	0.00	0.00	0.00
615	2015321064194	04/28/15 - 05/14/15	11/23/15	0.00	4,581.00	0.00	0.00	0.00
615	2015322081503	04/08/15 - 04/14/15	11/23/15	0.00	4,581.00	0.00	0.00	0.00
615	2315328000129	04/21/15 - 04/25/15	01/04/16	0.00	4,581.00	0.00	0.00	0.00
615	2015328083447	11/04/15 - 11/14/15	11/30/15	0.00	4,581.00	0.00	0.00	0.00
615	2215334005500	10/29/15 - 11/03/15	12/07/15	0.00	4,581.00	0.00	0.00	0.00
615	2015335074909	11/12/15 - 11/14/15	12/21/15	0.00	4,581.00	0.00	0.00	0.00
615	2015350003290	09/10/15 - 09/12/15	12/21/15	0.00	4,581.00	0.00	0.00	0.00
615	5215362000203	07/02/15 - 07/05/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362001452	07/12/15 - 07/17/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362001453	07/12/15 - 07/18/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362002047	07/05/15 - 07/20/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362003927	07/12/15 - 07/27/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362006800	07/02/15 - 07/17/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362008149	07/13/15 - 07/31/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362010014	08/16/15 - 08/21/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362010026	08/16/15 - 08/20/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362010863	08/20/15 - 08/24/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362011799	08/23/15 - 08/27/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362014593	07/16/15 - 07/29/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362016105	08/22/15 - 09/02/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362022436	09/01/15 - 09/28/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362022441	09/19/15 - 09/27/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215362022450	09/25/15 - 09/28/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215363000199	09/16/15 - 09/26/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215363003557	09/29/15 - 10/06/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL  
 80 JESSE HILL JR DR SE  
 ATLANTA,GA 30303-3031

PROVIDER NUMBER  
 000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM
615	5215363005800	09/06/15 - 10/08/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	5215363007155	09/14/15 - 09/16/15	02/22/16	0.00	4,581.00	0.00	0.00	0.00
615	2015364024888	12/05/15 - 12/13/15	01/04/16	0.00	4,581.00	0.00	0.00	0.00
615	2215365002799	01/16/15 - 01/31/15	01/04/16	0.00	4,581.00	0.00	0.00	0.00
615	2016001005504	12/02/15 - 12/15/15	01/04/16	0.00	4,581.00	0.00	0.00	0.00
615	2016015010881	12/27/15 - 12/30/15	02/08/16	0.00	4,581.00	0.00	0.00	0.00
615	9816015000026	06/30/15 - 07/22/15	01/25/16	0.00	4,581.00	0.00	0.00	0.00
615	2016020008055	12/29/15 - 01/06/16	01/25/16	0.00	4,581.00	0.00	0.00	0.00
615	2016021003783	01/01/15 - 01/06/15	01/25/16	0.00	4,581.00	0.00	0.00	0.00
615	2016022003931	12/22/15 - 01/01/16	01/25/16	0.00	4,581.00	0.00	0.00	0.00
615	5916022000088	10/20/15 - 10/23/15	01/25/16	0.00	4,581.00	0.00	0.00	0.00
615	22160280000532	10/28/15 - 12/31/15	02/01/16	0.00	4,581.00	0.00	0.00	0.00
615	23160360000055	11/25/15 - 11/25/15	03/14/16	0.00	4,581.00	0.00	835.78	0.00
615	2016040010679	11/22/15 - 01/20/16	02/15/16	0.00	4,581.00	0.00	0.00	0.00
615	2016043007330	11/04/15 - 11/05/15	02/15/16	0.00	4,581.00	0.00	0.00	0.00
615	2016051004173	06/30/15 - 07/17/15	02/29/16	0.00	4,581.00	0.00	0.00	0.00
615	2016061061603	08/14/15 - 08/17/15	03/07/16	0.00	4,581.00	0.00	0.00	0.00
615	5016068981001	07/07/15 - 08/18/15	03/14/16	0.00	4,581.00	0.00	0.00	0.00
615	23160890000204	05/31/15 - 06/02/15	05/23/16	0.00	4,581.00	0.00	2,557.07	0.00
615	2216105005418	10/16/15 - 12/31/15	04/18/16	0.00	4,581.00	0.00	0.00	0.00
615	2016210006267	03/13/15 - 03/19/15	08/01/16	0.00	4,581.00	0.00	0.00	0.00
TOTAL				0.00	293,184.00	0.00	11,205.13	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:12:58  
 Page: 5

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,954,455.54	ADJUSTMENTS	0.00
COVERED CHARGES	1,897,148.54	CONTRACTUAL ALLOW	1,045,194.98
NON-COVERD CHARGES	57,307.00	TOTAL MEDICAID LIAB	851,953.56
		LESS: COB	851,953.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	92		0	117,386.00		42,414.00
ROUTINE NURSERY	2		0	1,774.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	94		0	119,160.00		42,414.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	41		0	205,150.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	41		0	205,150.00		0.00
TOTAL ACCOMODATIONS	135		0	324,310.00		42,414.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,313.92	0.00	OTHER LAB	12,186.00	0.00
MED/SURG SUPPLY	44,195.36	727.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	177,938.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,961.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,874.00	13,674.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,622.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,292.00	0.00	MRI SERVICES	2,461.00	0.00
IV THERAPY	3,379.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	596,245.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,777.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	182,969.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	123,591.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,916.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,562.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	320.00	0.00	INJECTABLE DRUGS	54,670.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,719.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,149.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	492.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	64,938.64	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,084.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	21,094.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	65,894.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	687.00	0.00			
			TOTAL ANCILLARY	1,572,838.54	14,893.00
			TOTAL ACCOMODATIONS	324,310.00	42,414.00
			TOTAL CHARGES	1,897,148.54	57,307.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:13:09  
Page: 7

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	131,999,778.74	ADJUSTMENTS	2,036,528.33
COVERED CHARGES	114,948,274.73	CONTRACTUAL ALLOW	92,105,387.70
NON-COVERD CHARGES	17,051,504.01	TOTAL MEDICAID LIAB	22,842,887.03
		LESS: COB	45,494.29
		LESS: COPAYMENT	152,060.34
		REIMBURSEMENT	22,645,332.40
		ALL OTHER	18,845,087.94
		FEE SCHEDULE-LAB	2,208,944.17
		INJECTABLE DRUGS	1,591,300.29

TOTAL NUMBER OF CLAIMS 72,265

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	558,119.26	8,485.82	OTHER LAB	1,665,256.00	39,172.00
MED/SURG SUPPLY	441,476.11	128,009.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,281.00	EDUCATION & TRAINING	0.00	31,262.00
RADIOLOGY-DIAGNOSTIC	6,000,204.00	249,954.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,124,630.00	1,729,630.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	416,242.00	60,792.05	FEE SCHEDULE LAB	25,142,687.20	2,929,759.50
EKG/ECG	939,725.00	86,714.00	MRI SERVICES	3,056,865.00	366,262.00
IV THERAPY	2,543,452.00	21,094.00	PROFESSIONAL FEES	0.00	110.00
OPERATING ROOM	8,413,590.52	906,938.73	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	148,816.00	2,298.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	782,937.00	69,351.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,149,588.00	32,975.00	AMBULANCE	0.00	0.00
GI SERVICES	871,038.50	276,485.50	CAST ROOM	8,700.00	0.00
EMERGENCY ROOM	20,741,460.00	102,603.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	602,439.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	103,299.98
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,108,670.70	2,257,733.45
RADIOLOGY THERAPEUTIC	1,844,743.00	3,036,377.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	130,380.00	34,702.11	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,755.00	12,001.06	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	912,282.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,887,317.00	167,957.00	TRAUMA RESPONSE	0.00	387,664.00
PSYCHIATRIC SERVICES	554,489.00	272,086.00	IMPL DEV CHARGE PATIENTS	73,645.08	259,012.20
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	46,992.00
OTHER IMAGING SERVICE	4,166,907.00	464,403.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	759,112.00	2,357.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,150,065.00	1,764,905.00			
AUDIOLOGY	49,453.00	8,150.00			
CARDIOLOGY	2,318,172.00	272,073.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	71,125.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,190,215.36	6,332.00			
			TOTAL ANCILLARY	114,948,274.73	17,051,504.01
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	114,948,274.73	17,051,504.01

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL  
 80 JESSE HILL JR DR SE  
 ATLANTA,GA 30303-3031

PROVIDER NUMBER  
 000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015205067149	07/08/15 - 07/08/15	08/03/15	0.00	4,581.00	0.00	0.00	0.00
615	2015218009329	07/16/15 - 07/16/15	08/10/15	0.00	4,581.00	0.00	0.00	0.00
614	2015218007782	07/30/15 - 07/30/15	08/10/15	0.00	1,724.00	0.00	0.00	0.00
615	2015240031124	06/21/15 - 06/21/15	08/31/15	0.00	4,581.00	0.00	0.00	0.00
614	5915265001450	09/03/15 - 09/03/15	09/28/15	0.00	1,724.00	0.00	0.00	0.00
615	5915314000073	04/28/15 - 04/28/15	11/16/15	0.00	4,581.00	0.00	0.00	0.00
-1	5015323957002	05/24/15 - 01/01/00	11/30/15	0.00	0.00	0.00	0.00	0.00
-1	5015323957002	05/24/15 - 01/01/00	11/30/15	0.00	0.00	0.00	0.00	0.00
-1	5015323957002	05/24/15 - 01/01/00	11/30/15	0.00	0.00	0.00	0.00	0.00
-1	5015323957002	05/24/15 - 01/01/00	11/30/15	0.00	0.00	0.00	0.00	0.00
-1	5015323957002	05/24/15 - 01/01/00	11/30/15	0.00	0.00	0.00	0.00	0.00
-1	5015323957002	05/24/15 - 01/01/00	11/30/15	0.00	0.00	0.00	0.00	0.00
615	5915342000047	10/16/15 - 10/16/15	12/14/15	0.00	4,581.00	0.00	0.00	0.00
614	2015345015079	11/11/15 - 11/11/15	12/14/15	0.00	1,724.00	0.00	0.00	0.00
615	2015349026146	12/08/15 - 12/08/15	12/21/15	0.00	4,581.00	0.00	0.00	0.00
614	2016005008619	12/29/15 - 12/29/15	01/11/16	0.00	1,724.00	0.00	0.00	0.00
615	2216019005930	10/30/15 - 10/30/15	01/25/16	0.00	4,581.00	0.00	0.00	0.00
615	2216019005930	10/29/15 - 10/29/15	01/25/16	0.00	4,581.00	0.00	0.00	0.00
614	5916022000130	12/14/15 - 12/14/15	01/25/16	0.00	1,724.00	0.00	0.00	0.00
614	2216043005691	11/10/15 - 11/10/15	02/15/16	0.00	1,724.00	0.00	0.00	0.00
TOTAL				0.00	46,992.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:18:19  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL  
80 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3031

PROVIDER NUMBER  
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	400,047.66	ADJUSTMENTS	0.00
COVERED CHARGES	299,047.71	CONTRACTUAL ALLOW	180,100.10
NON-COVERD CHARGES	100,999.95	TOTAL MEDICAID LIAB	118,947.61
		LESS: COB	118,741.48
		LESS: COPAYMENT	206.13
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 138



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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	648.84	0.00	OTHER LAB	1,917.00	0.00
MED/SURG SUPPLY	131.00	203.14	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	34.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,735.00	552.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	75,034.00	17,135.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	823.00	FEE SCHEDULE LAB	56,493.00	7,910.00
EKG/ECG	2,101.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	22,141.00	215.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,915.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	492.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	301.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,372.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	31,703.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,249.00	867.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,505.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,719.87	17,593.81
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,498.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,863.00	280.00	TRAUMA RESPONSE	0.00	5,848.00
PSYCHIATRIC SERVICES	0.00	6,760.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,445.00	742.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,452.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	6,836.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,533.00	0.00			
			TOTAL ANCILLARY	299,047.71	100,999.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	299,047.71	100,999.95

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:18:31  
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GRADY MEMORIAL HOSPITAL  
80 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3031

PROVIDER NUMBER  
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,866,532.21	ADJUSTMENTS	2,061.55
COVERED CHARGES	1,767,097.43	CONTRACTUAL ALLOW	1,713,896.04
NON-COVERD CHARGES	99,434.78	TOTAL MEDICAID LIAB	53,201.39
		LESS: COB	450.00
		LESS: COPAYMENT	2,912.92
		REIMBURSEMENT	49,838.47
		TOTAL NUMBER OF CLAIMS	943

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,327.63	9.05	OTHER LAB	13,213.00	0.00
MED/SURG SUPPLY	1,550.72	549.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	200,405.00	5,561.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	160,103.00	37,833.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	256,419.00	20,506.00
EKG/ECG	13,752.00	382.00	MRI SERVICES	0.00	0.00
IV THERAPY	28,859.00	430.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,932.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,505.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,746.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	499.00	0.00
EMERGENCY ROOM	1,003,000.00	950.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,901.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,625.63
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,105.08	3,676.10
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	16,716.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,506.00	629.00	TRAUMA RESPONSE	0.00	5,848.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,592.00	3,720.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,357.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	29,325.00	0.00			
			TOTAL ANCILLARY	1,767,097.43	99,434.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,767,097.43	99,434.78

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

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,720.91	ADJUSTMENTS	0.00
COVERED CHARGES	13,412.91	CONTRACTUAL ALLOW	7,441.62
NON-COVERD CHARGES	308.00	TOTAL MEDICAID LIAB	5,971.29
		LESS: COB	5,959.29
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7.91	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,037.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,116.00	308.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,950.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	302.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,412.91	308.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,412.91	308.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL  
80 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3031

PROVIDER NUMBER  
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,622,691.27	ADJUSTMENTS	622,620.63
COVERED CHARGES	11,915,352.92	CONTRACTUAL ALLOW	9,952,936.81
NON-COVERD CHARGES	707,338.35	TOTAL MEDICAID LIAB	1,962,416.11
		LESS: COB	0.00
		LESS: COPAYMENT	1,347.00
		REIMBURSEMENT	1,961,069.11

TOTAL NUMBER OF CLAIMS 250

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,845.16	30.00	OTHER LAB	9,086.00	0.00
MED/SURG SUPPLY	178,434.59	46,884.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,947.00	41,881.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	75,605.00	11,732.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	786.00	2,056.00	FEE SCHEDULE LAB	144,802.00	8,752.00
EKG/ECG	2,674.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	92,610.00	477.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,946,195.63	163,391.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,207.00	5,216.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,336,619.00	18,078.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,702.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	437,675.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	388.97
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	956,182.49	125,663.50
RADIOLOGY THERAPEUTIC	412,241.00	33,840.00	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	11,940.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,883.00	0.00	TRAUMA RESPONSE	0.00	5,848.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	660,681.05	194,576.55
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,188.00	2,165.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	25,436.00	2,561.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	129,089.00	31,857.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	296,464.00	0.00			
			TOTAL ANCILLARY	11,915,352.92	707,338.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,915,352.92	707,338.35

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 02:19:10  
Page: 18

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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:19:29  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER 000000866A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,808,520.77	ADJUSTMENTS	2,436,731.35
COVERED CHARGES	40,571,514.42	CONTRACTUAL ALLOW	33,674,685.98
NON-COVERD CHARGES	1,237,006.35	TOTAL MEDICAID LIAB	6,896,828.44
		LESS: COB	63,308.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,833,519.55

TOTAL NUMBER OF ADMISSIONS 839

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,307		84	3,726,060.00		522,986.00
ROUTINE NURSERY	175		0	154,754.50		8,775.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,482		84	3,880,814.50		531,761.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	662		1	1,467,409.50		2,190.00
NICU	1		0	2,085.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	663		1	1,469,494.50		2,190.00
TOTAL ACCOMODATIONS	4,145		85	5,350,309.00		533,951.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,206,272.82	219,062.50	OTHER LAB	142,794.00	0.00
MED/SURG SUPPLY	4,119,981.31	39,171.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,251,585.31	38,705.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	773,936.60	1,165.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,849,176.75	21,855.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	204,058.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	291,057.00	780.00	MRI SERVICES	472,701.12	2,900.00
IV THERAPY	3,465.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,885,362.40	2,350.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	224,529.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,543,492.25	3,384.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	841,442.25	0.00	AMBULANCE	0.00	1,333.50
GI SERVICES	145,316.00	1,425.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,776,748.75	755.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	236,399.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	135,137.50	340.00	INJECTABLE DRUGS	3,123.00	0.00
RADIOLOGY THERAPEUTIC	20,636.40	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	32,478.83	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	84,165.16	200.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	160,627.25	0.00	PATIENT CONVENIENCE	0.00	175.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	22,799.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	512,716.07	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	176,491.00	14,010.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	350,674.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	250,668.00	160.00			
AUDIOLOGY	9,184.90	0.00			
CARDIOLOGY	1,522,524.50	4,610.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	47,476.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	274,858.00	0.00			
			TOTAL ANCILLARY	35,221,205.42	703,055.35
			TOTAL ACCOMODATIONS	5,350,309.00	533,951.00
			TOTAL CHARGES	40,571,514.42	1,237,006.35

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER 000000866A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,420.12	ADJUSTMENTS	0.00
COVERED CHARGES	56,636.12	CONTRACTUAL ALLOW	33,653.73
NON-COVERD CHARGES	784.00	TOTAL MEDICAID LIAB	22,982.39
		LESS: COB	22,982.39
		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	6,780.00		784.00
ROUTINE NURSERY	2		0	1,500.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	8,280.00		784.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	8,280.00		784.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,022.62	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,095.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,352.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,935.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,010.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	732.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,693.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,900.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,307.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	810.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	241.25	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	256.25	0.00			
			TOTAL ANCILLARY	48,356.12	0.00
			TOTAL ACCOMODATIONS	8,280.00	784.00
			TOTAL CHARGES	56,636.12	784.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:19:40  
Page: 5

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,086,396.54	ADJUSTMENTS	436,675.31
COVERED CHARGES	23,855,717.24	CONTRACTUAL ALLOW	21,285,402.65
NON-COVERD CHARGES	2,230,679.30	TOTAL MEDICAID LIAB	2,570,314.59
		LESS: COB	5,348.66
		LESS: COPAYMENT	6,140.37
		REIMBURSEMENT	2,558,825.56
		ALL OTHER	2,248,412.80
		FEE SCHEDULE-LAB	243,699.61
		INJECTABLE DRUGS	66,713.15
		TOTAL NUMBER OF CLAIMS	6,786

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	912,539.99	73,512.01	OTHER LAB	228,895.00	790.00
MED/SURG SUPPLY	1,640,165.38	185.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,040.00	EDUCATION & TRAINING	0.00	90.00
RADIOLOGY-DIAGNOSTIC	1,449,236.75	18,897.50	OTHER THERAPEUTIC SVC	0.00	170.00
CT SCAN	2,676,763.50	392,188.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	66,604.95	25,754.32	FEE SCHEDULE LAB	3,715,002.35	277,979.00
EKG/ECG	420,420.00	13,416.00	MRI SERVICES	232,938.65	39,624.00
IV THERAPY	551,025.25	27,161.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,530,798.36	245,831.54	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	341,659.25	29,112.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	717,993.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	58,793.75	10,891.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,760,561.25	32,954.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	178,524.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,085,385.94	486,322.68
RADIOLOGY THERAPEUTIC	19,600.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,073.00	4,403.33	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,497.75	6,473.28	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,745.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34,565.05	16,091.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	137,082.38	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	448,964.69	110,575.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	71,553.94			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	274,451.00	64,741.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	453,488.25	245,699.50			
AMBULATORY SURGERY	10,580.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	403,601.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	498,505.00	32,476.25			
			TOTAL ANCILLARY	23,855,717.24	2,230,679.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,855,717.24	2,230,679.30

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:20:24  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,221.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,996.00	CONTRACTUAL ALLOW	3,500.15
NON-COVERD CHARGES	4,225.00	TOTAL MEDICAID LIAB	495.85
		LESS: COB	486.08
		LESS: COPAYMENT	9.77
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:20:24  
 Page: 8

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41.00	0.00	OTHER LAB	0.00	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	870.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,280.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	190.00	4,225.00
RADIOLOGY THERAPEUTIC	160.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	960.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	220.00	0.00			
			TOTAL ANCILLARY	3,996.00	4,225.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,996.00	4,225.00



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:20:26  
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WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,312,287.27	ADJUSTMENTS	1,739.51
COVERED CHARGES	1,242,030.44	CONTRACTUAL ALLOW	1,197,561.59
NON-COVERD CHARGES	70,256.83	TOTAL MEDICAID LIAB	44,468.85
		LESS: COB	0.00
		LESS: COPAYMENT	1,616.42
		REIMBURSEMENT	42,852.43
		TOTAL NUMBER OF CLAIMS	795

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,472.19	3,741.25	OTHER LAB	4,010.00	0.00
MED/SURG SUPPLY	12,099.75	152.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	106,282.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	86,424.50	37,135.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	585.02	FEE SCHEDULE LAB	167,241.25	10,021.00
EKG/ECG	12,519.00	390.00	MRI SERVICES	11,810.00	0.00
IV THERAPY	51,444.75	459.50	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	3,925.50	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	670,213.75	52.50	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	51,692.25	7,071.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	345.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	670.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,750.50	9,633.25			
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	6,145.00	0.00			
			TOTAL ANCILLARY	1,242,030.44	70,256.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,242,030.44	70,256.83

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:20:30  
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WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,805.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,805.00	CONTRACTUAL ALLOW	1,625.23
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	179.77
		LESS: COB	179.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 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	525.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,280.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,805.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,805.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 03:20:32  
Page: 13

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	605,805.09	ADJUSTMENTS	22,155.32
COVERED CHARGES	575,706.83	CONTRACTUAL ALLOW	515,026.39
NON-COVERD CHARGES	30,098.26	TOTAL MEDICAID LIAB	60,680.44
		LESS: COB	0.00
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	60,626.44
		TOTAL NUMBER OF CLAIMS	11

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,774.28	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	83,552.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,897.50	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	17,052.25	660.00
EKG/ECG	799.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,720.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	98,890.49	14,882.51	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	891.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,001.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,690.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,188.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	86,110.32	14,299.50
RADIOLOGY THERAPEUTIC	8,280.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	256.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	45,473.99	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	74,505.75	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	4,880.00	0.00			
			TOTAL ANCILLARY	575,706.83	30,098.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	575,706.83	30,098.26

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:20:33  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SPALDING REGIONAL HOSPITAL, INC  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR  
 541 HISTORIC HWY, 441N  
 DEMOREST,GA 30535-0000

PROVIDER NUMBER 000000877A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,101,975.57	ADJUSTMENTS	474,767.28
COVERED CHARGES	3,080,971.13	CONTRACTUAL ALLOW	1,485,894.38
NON-COVERD CHARGES	21,004.44	TOTAL MEDICAID LIAB	1,595,076.75
		LESS: COB	27,658.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,567,418.53

TOTAL NUMBER OF ADMISSIONS 253

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	563		2	258,520.00		920.00
ROUTINE NURSERY	154		6	46,500.00		1,800.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	717		8	305,020.00		2,720.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	151		0	166,100.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	151		0	166,100.00		0.00
TOTAL ACCOMODATIONS	868		8	471,120.00		2,720.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR  
 541 HISTORIC HWY, 441N  
 DEMOREST,GA 30535-0000

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	288,159.64	0.00	OTHER LAB	5,238.00	0.00
MED/SURG SUPPLY	285,928.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	307,863.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,968.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	106,252.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,455.56	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,994.50	0.00	MRI SERVICES	18,367.75	0.00
IV THERAPY	435,614.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	150,602.50	193.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	236,955.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	97,572.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54,823.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	108,773.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	70,372.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,935.00	0.00	INJECTABLE DRUGS	2,346.26	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	673.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,890.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	215.94
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,415.00	423.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	272,583.52	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,431.75
OTHER IMAGING SERVICE	6,202.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,581.50	15,225.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,437.25	795.00			
AUDIOLOGY	15,431.25	0.00			
CARDIOLOGY	16,198.25	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	25,215.00	0.00			
			TOTAL ANCILLARY	2,609,851.13	18,284.44
			TOTAL ACCOMODATIONS	471,120.00	2,720.00
			TOTAL CHARGES	3,080,971.13	21,004.44

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
Run Time: 02:24:13  
Page: 3

HABERSHAM COUNTY MEDICAL CTR  
541 HISTORIC HWY, 441N  
DEMOREST,GA 30535-0000

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015309027321	01/07/15 - 01/21/15	11/09/15	0.00	1,431.75	0.00	0.00	0.00
TOTAL				0.00	1,431.75	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:24:17  
 Page: 4

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR  
 541 HISTORIC HWY, 441N  
 DEMOREST,GA 30535-0000

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,327.22	ADJUSTMENTS	0.00
COVERED CHARGES	29,326.20	CONTRACTUAL ALLOW	11,547.75
NON-COVERD CHARGES	1.02	TOTAL MEDICAID LIAB	17,778.45
		LESS: COB	17,778.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	3,680.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	3,680.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,100.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	1,100.00		0.00
TOTAL ACCOMODATIONS	9		0	4,780.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR  
 541 HISTORIC HWY, 441N  
 DEMOREST,GA 30535-0000

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,004.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,706.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,871.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	347.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,278.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	226.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,049.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	808.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,929.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	198.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,291.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,010.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	1.02
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	289.75	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	535.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,546.20	1.02
			TOTAL ACCOMODATIONS	4,780.00	0.00
			TOTAL CHARGES	29,326.20	1.02

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:24:18  
Page: 6

HABERSHAM COUNTY MEDICAL CTR  
541 HISTORIC HWY, 441N  
DEMOREST,GA 30535-0000

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,105,914.52	ADJUSTMENTS	46,626.15
COVERED CHARGES	2,903,866.62	CONTRACTUAL ALLOW	2,199,868.64
NON-COVERD CHARGES	202,047.90	TOTAL MEDICAID LIAB	703,997.98
		LESS: COB	832.92
		LESS: COPAYMENT	1,635.00
		REIMBURSEMENT	701,530.06
		ALL OTHER	628,235.38
		FEE SCHEDULE-LAB	64,537.47
		INJECTABLE DRUGS	8,757.21
		TOTAL NUMBER OF CLAIMS	2,507

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MEDICAL CTR  
 541 HISTORIC HWY, 441N  
 DEMOREST,GA 30535-0000

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,646.53	470.09	OTHER LAB	67,705.25	0.00
MED/SURG SUPPLY	117,752.49	77.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	32.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	138,358.25	2,679.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	483,240.25	51,192.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,256.00	3,610.50	FEE SCHEDULE LAB	468,965.50	62,605.50
EKG/ECG	32,480.00	3,842.00	MRI SERVICES	61,469.50	1,366.25
IV THERAPY	31,599.00	3,141.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	96,892.21	17,458.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,568.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,510.00	1,726.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,717.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,014,685.38	8,350.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,004.50	584.25	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54,503.46	11,136.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,992.75	1,381.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	309.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	7.86
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,420.00	4,795.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,267.55	2,133.89
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,364.00	4,393.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,145.25	3,165.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	19,088.25	6,119.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,066.00	10,770.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,169.00	699.00			
			TOTAL ANCILLARY	2,903,866.62	202,047.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,903,866.62	202,047.90

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MEDICAL CTR  
541 HISTORIC HWY, 441N  
DEMOREST,GA 30535-0000

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,577.66	ADJUSTMENTS	0.00
COVERED CHARGES	33,744.64	CONTRACTUAL ALLOW	14,692.37
NON-COVERD CHARGES	10,833.02	TOTAL MEDICAID LIAB	19,052.27
		LESS: COB	19,046.62
		LESS: COPAYMENT	5.65
		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

HABERSHAM COUNTY MEDICAL CTR  
 541 HISTORIC HWY, 441N  
 DEMOREST,GA 30535-0000

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	434.09	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	696.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,139.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,411.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,640.50	301.00
EKG/ECG	339.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	362.00	362.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,640.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	211.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	151.54	9,634.52
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	82.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	324.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	453.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	394.25	0.00			
			TOTAL ANCILLARY	33,744.64	10,833.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,744.64	10,833.02



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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HABERSHAM COUNTY MEDICAL CTR  
541 HISTORIC HWY, 441N  
DEMOREST,GA 30535-0000

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	218,741.96	ADJUSTMENTS	161.82
COVERED CHARGES	213,679.06	CONTRACTUAL ALLOW	196,337.66
NON-COVERD CHARGES	5,062.90	TOTAL MEDICAID LIAB	17,341.40
		LESS: COB	0.00
		LESS: COPAYMENT	738.00
		REIMBURSEMENT	16,603.40
		TOTAL NUMBER OF CLAIMS	310

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR  
 541 HISTORIC HWY, 441N  
 DEMOREST,GA 30535-0000

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,505.37	0.00	OTHER LAB	3,258.75	0.00
MED/SURG SUPPLY	1,200.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,838.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,177.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	199.25	0.00	FEE SCHEDULE LAB	28,219.50	3,028.00
EKG/ECG	1,469.00	113.00	MRI SERVICES	1,366.25	0.00
IV THERAPY	1,852.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	994.38	994.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	695.25	148.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	981.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	137,218.75	329.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	369.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,806.93	159.78
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	486.00	289.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,039.50	0.00			
			TOTAL ANCILLARY	213,679.06	5,062.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	213,679.06	5,062.90

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR  
541 HISTORIC HWY, 441N  
DEMOREST,GA 30535-0000

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,977.60	ADJUSTMENTS	0.00
COVERED CHARGES	4,937.60	CONTRACTUAL ALLOW	2,018.93
NON-COVERD CHARGES	40.00	TOTAL MEDICAID LIAB	2,918.67
		LESS: COB	2,909.67
		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  
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 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR  
 541 HISTORIC HWY, 441N  
 DEMOREST,GA 30535-0000

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	818.75	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	591.00	40.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,448.75	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	54.10	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	4,937.60	40.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,937.60	40.00

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 HISTORIC HWY, 441N  
DEMOREST,GA 30535-0000

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,297.31	ADJUSTMENTS	0.00
COVERED CHARGES	25,295.81	CONTRACTUAL ALLOW	19,657.92
NON-COVERD CHARGES	1.50	TOTAL MEDICAID LIAB	5,637.89
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,637.89

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR  
 541 HISTORIC HWY, 441N  
 DEMOREST,GA 30535-0000

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	223.47	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	132.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	161.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	805.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	345.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,825.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,342.08	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	1.50
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	462.00	0.00			
			TOTAL ANCILLARY	25,295.81	1.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,295.81	1.50

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR  
541 HISTORIC HWY, 441N  
DEMOREST,GA 30535-0000

PROVIDER NUMBER  
000000877A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN  
 743 SPRING ST NE  
 GAINESVILLE,GA 30501-3715

PROVIDER NUMBER 000000888A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	116,516,280.96	ADJUSTMENTS	8,184,303.70
COVERED CHARGES	112,236,303.02	CONTRACTUAL ALLOW	85,539,259.10
NON-COVERD CHARGES	4,279,977.94	TOTAL MEDICAID LIAB	26,697,043.92
		LESS: COB	278,889.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	26,418,154.61

TOTAL NUMBER OF ADMISSIONS 3,265

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11,305		10	9,597,280.00		2,951,825.00
ROUTINE NURSERY	2,186		1,202	1,568,022.50		8,477.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13,491		1,212	11,165,302.50		2,960,302.00
SPECIAL CARE SERVICES						
CCU	698		0	1,449,853.00		10,505.00
ICU	1,298		0	2,701,495.00		18,909.00
NICU	800		0	1,399,812.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		304	0.00		298,265.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,796		304	5,551,160.00		327,679.00
TOTAL ACCOMODATIONS	16,287		1,516	16,716,462.50		3,287,981.00



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,082,925.84	41,321.60	OTHER LAB	512,067.50	6,907.00
MED/SURG SUPPLY	8,129,812.66	172,730.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,286,960.44	64,235.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,163,022.00	3,544.00	OTHER THERAPEUTIC SVC	40,890.00	0.00
CT SCAN	4,402,102.00	1,696.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	503,042.00	4,417.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	580,848.00	578.00	MRI SERVICES	1,189,298.00	0.00
IV THERAPY	1,382,189.00	21,109.00	PROFESSIONAL FEES	0.00	100.00
OPERATING ROOM	9,478,173.00	57,453.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,129,842.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,316,858.50	43,051.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,389,347.00	21,971.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,518,988.00	7,073.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,593,768.50	9,508.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	321,249.00	978.00	INJECTABLE DRUGS	9,995,090.08	64,747.00
RADIOLOGY THERAPEUTIC	298,631.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	239,180.00	1,518.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	225,353.00	600.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	706,168.00	222,777.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,695.00	371.00	TRAUMA RESPONSE	0.00	43,000.00
PSYCHIATRIC SERVICES	0.00	2,004.00	IMPL DEV CHARGE PATIENTS	5,703,150.00	5,789.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,417.00
OTHER IMAGING SERVICE	591,532.50	27,986.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	833,939.00	72,430.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	392,299.00	91,716.00			
AUDIOLOGY	30,483.00	0.00			
CARDIOLOGY	2,907,623.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	233,892.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	317,421.00	970.00			
			TOTAL ANCILLARY	95,519,840.52	991,996.94
			TOTAL ACCOMODATIONS	16,716,462.50	3,287,981.00
			TOTAL CHARGES	112,236,303.02	4,279,977.94

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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NORTHEAST GEORGIA MEDICAL CENTER IN PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
743 SPRING ST NE 000000888A SERVICE DATES 10/01/14 THROUGH 09/30/15  
GAINESVILLE,GA 30501-3715 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2315260000041	06/15/15 - 06/30/15	11/02/15	0.00	1,417.00	0.00	3,106.01	0.00
TOTAL				0.00	1,417.00	0.00	3,106.01	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN  
 743 SPRING ST NE  
 GAINESVILLE,GA 30501-3715

PROVIDER NUMBER  
 000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,172,746.02	ADJUSTMENTS	0.00
COVERED CHARGES	2,131,910.02	CONTRACTUAL ALLOW	1,076,249.74
NON-COVERD CHARGES	40,836.00	TOTAL MEDICAID LIAB	1,055,660.28
		LESS: COB	1,055,660.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 75

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	206		0	179,882.00		39,106.00
ROUTINE NURSERY	47		0	39,099.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	253		0	218,981.00		39,106.00
SPECIAL CARE SERVICES						
CCU	10		0	21,010.00		0.00
ICU	19		0	39,919.00		0.00
NICU	22		0	35,706.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	51		0	96,635.00		0.00
TOTAL ACCOMODATIONS	304		0	315,616.00		39,106.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	266,898.02	0.00	OTHER LAB	4,080.00	0.00
MED/SURG SUPPLY	128,375.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	121,878.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,926.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,789.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,871.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,624.00	0.00	MRI SERVICES	17,476.00	0.00
IV THERAPY	22,457.00	0.00	PROFESSIONAL FEES	0.00	150.00
OPERATING ROOM	222,869.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	189,385.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	80,350.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	137,912.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,710.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	115,119.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,988.00	0.00	INJECTABLE DRUGS	129,632.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	828.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,479.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	267.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	192,258.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,441.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,928.00	1,580.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	211.00	0.00			
CARDIOLOGY	79,623.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,920.00	0.00			
			TOTAL ANCILLARY	1,816,294.02	1,730.00
			TOTAL ACCOMODATIONS	315,616.00	39,106.00
			TOTAL CHARGES	2,131,910.02	40,836.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,016,996.82	ADJUSTMENTS	988,316.85
COVERED CHARGES	41,662,110.64	CONTRACTUAL ALLOW	35,134,246.01
NON-COVERD CHARGES	7,354,886.18	TOTAL MEDICAID LIAB	6,527,864.63
		LESS: COB	3,868.02
		LESS: COPAYMENT	19,020.12
		REIMBURSEMENT	6,504,976.49
		ALL OTHER	5,348,211.44
		FEE SCHEDULE-LAB	597,910.61
		INJECTABLE DRUGS	558,854.44

TOTAL NUMBER OF CLAIMS 13,804

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN  
 743 SPRING ST NE  
 GAINESVILLE,GA 30501-3715

PROVIDER NUMBER  
 000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,521,377.94	6,061.00	OTHER LAB	548,682.00	2,559.00
MED/SURG SUPPLY	1,037,775.00	457,567.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	292.00	EDUCATION & TRAINING	0.00	328.00
RADIOLOGY-DIAGNOSTIC	1,576,942.00	34,638.00	OTHER THERAPEUTIC SVC	16,356.00	0.00
CT SCAN	4,838,245.00	367,938.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	140,063.00	30,016.06	FEE SCHEDULE LAB	6,604,317.10	962,378.12
EKG/ECG	506,569.00	27,166.00	MRI SERVICES	1,451,426.00	164,788.00
IV THERAPY	1,952,886.00	109,919.00	PROFESSIONAL FEES	0.00	150.00
OPERATING ROOM	3,057,670.00	669,246.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	59,289.00	2,482.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	223,160.00	39,879.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	931,660.00	5,246.00	AMBULANCE	0.00	0.00
GI SERVICES	12,430.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,665,600.00	13,533.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,120,917.00	6,904.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,860,282.60	1,336,885.00
RADIOLOGY THERAPEUTIC	2,448,015.00	471,899.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	29,005.00	12,397.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,275.00	4,393.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	16,407.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	8,858.00	TRAUMA RESPONSE	0.00	21,000.00
PSYCHIATRIC SERVICES	48,307.00	3,817.00	IMPL DEV CHARGE PATIENTS	54,042.00	1,420,185.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	14.00	10,098.00
OTHER IMAGING SERVICE	1,517,335.00	95,126.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	97,859.00	60,040.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	771,732.00	337,958.00			
AUDIOLOGY	3,564.00	0.00			
CARDIOLOGY	1,369,730.00	650,682.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	472,293.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	718,292.00	3,939.00			
			TOTAL ANCILLARY	41,662,110.64	7,354,774.18
			TOTAL ACCOMODATIONS	0.00	112.00
			TOTAL CHARGES	41,662,110.64	7,354,886.18

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
 Run Time: 02:54:51  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015226043557	08/07/15 - 08/07/15	08/17/15	0.00	561.00	0.00	0.00	0.00
905	2015226043557	08/06/15 - 08/06/15	08/17/15	0.00	561.00	0.00	0.00	0.00
905	2015226043557	08/05/15 - 08/05/15	08/17/15	0.00	561.00	0.00	0.00	0.00
905	2015226043557	08/04/15 - 08/04/15	08/17/15	0.00	561.00	0.00	0.00	0.00
905	2015226043557	08/03/15 - 08/03/15	08/17/15	0.00	561.00	0.00	0.00	0.00
905	2015226043557	07/31/15 - 07/31/15	08/17/15	0.00	561.00	0.00	0.00	0.00
905	2015226043557	07/30/15 - 07/30/15	08/17/15	0.00	561.00	0.00	0.00	0.00
2550	9815274000067	04/05/15 - 04/05/15	10/05/15	14.00	0.00	0.00	0.00	0.00
905	2015275079823	09/18/15 - 09/18/15	10/12/15	0.00	561.00	0.00	0.00	0.00
905	2015275079823	09/17/15 - 09/17/15	10/12/15	0.00	561.00	0.00	0.00	0.00
905	2015275079823	09/16/15 - 09/16/15	10/12/15	0.00	561.00	0.00	0.00	0.00
905	2015275079823	09/14/15 - 09/14/15	10/12/15	0.00	561.00	0.00	0.00	0.00
905	2015275079823	09/11/15 - 09/11/15	10/12/15	0.00	561.00	0.00	0.00	0.00
905	2015275079823	09/10/15 - 09/10/15	10/12/15	0.00	561.00	0.00	0.00	0.00
905	2015275079823	09/09/15 - 09/09/15	10/12/15	0.00	561.00	0.00	0.00	0.00
905	2015275079823	09/08/15 - 09/08/15	10/12/15	0.00	561.00	0.00	0.00	0.00
905	2015275079823	09/04/15 - 09/04/15	10/12/15	0.00	561.00	0.00	0.00	0.00
905	2015275079823	09/03/15 - 09/03/15	10/12/15	0.00	561.00	0.00	0.00	0.00
905	2015275079823	09/01/15 - 09/01/15	10/12/15	0.00	561.00	0.00	0.00	0.00
TOTAL				14.00	10,098.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHEAST GEORGIA MEDICAL CENTER IN  
743 SPRING ST NE  
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER  
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,090,500.02	ADJUSTMENTS	0.00
COVERED CHARGES	811,528.02	CONTRACTUAL ALLOW	364,176.22
NON-COVERD CHARGES	278,972.00	TOTAL MEDICAID LIAB	447,351.80
		LESS: COB	447,180.15
		LESS: COPAYMENT	171.65
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 223



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,802.01	80.00	OTHER LAB	3,275.00	0.00
MED/SURG SUPPLY	44,416.00	2,831.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,130.00	678.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,216.00	46,065.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	118,113.00	13,993.00
EKG/ECG	9,316.00	0.00	MRI SERVICES	15,917.00	3,067.00
IV THERAPY	42,104.00	2,921.00	PROFESSIONAL FEES	0.00	500.00
OPERATING ROOM	59,539.00	52,211.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,135.00	493.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	727.00	282.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	47,574.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	136,587.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	52,902.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	41,172.01	5,302.00
RADIOLOGY THERAPEUTIC	14,686.00	63,154.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,666.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	320.00	66,031.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,689.00	10,765.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,232.00	1,580.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,377.00	2,851.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,360.00	4,416.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,306.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,633.00	0.00			
			TOTAL ANCILLARY	811,528.02	278,972.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	811,528.02	278,972.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,697,306.01	ADJUSTMENTS	1,220.62
COVERED CHARGES	1,629,709.01	CONTRACTUAL ALLOW	1,561,126.57
NON-COVERD CHARGES	67,597.00	TOTAL MEDICAID LIAB	68,582.44
		LESS: COB	48.06
		LESS: COPAYMENT	2,060.56
		REIMBURSEMENT	66,473.82
		TOTAL NUMBER OF CLAIMS	1,226

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,254.01	320.00	OTHER LAB	6,402.00	0.00
MED/SURG SUPPLY	10,504.00	5,642.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	134,330.00	1,369.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,731.00	1,696.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	264,879.00	29,032.00
EKG/ECG	24,565.00	0.00	MRI SERVICES	7,209.00	0.00
IV THERAPY	75,866.00	176.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	721.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,219.00	282.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,009,136.00	826.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,811.00	1,435.00
RADIOLOGY THERAPEUTIC	987.00	16,485.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,292.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	172.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,825.00	2,870.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,270.00	0.00			
			TOTAL ANCILLARY	1,629,709.01	67,597.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,629,709.01	67,597.00

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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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	92,781.00	ADJUSTMENTS	0.00
COVERED CHARGES	82,921.00	CONTRACTUAL ALLOW	42,305.95
NON-COVERD CHARGES	9,860.00	TOTAL MEDICAID LIAB	40,615.05
		LESS: COB	40,582.05
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	32

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHEAST GEORGIA MEDICAL CENTER IN  
 743 SPRING ST NE  
 GAINESVILLE,GA 30501-3715

PROVIDER NUMBER  
 000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,793.00	0.00	OTHER LAB	1,067.00	0.00
MED/SURG SUPPLY	1,391.00	444.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,650.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,696.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,913.00	2,434.00
EKG/ECG	1,734.00	0.00	MRI SERVICES	0.00	2,019.00
IV THERAPY	5,057.00	0.00	PROFESSIONAL FEES	0.00	100.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,018.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,613.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	291.00	447.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,146.00	1,140.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,848.00	1,580.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	400.00	0.00			
			TOTAL ANCILLARY	82,921.00	9,860.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	82,921.00	9,860.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN  
743 SPRING ST NE  
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER  
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,849,790.66	ADJUSTMENTS	119,341.82
COVERED CHARGES	4,434,799.66	CONTRACTUAL ALLOW	3,802,222.40
NON-COVERD CHARGES	414,991.00	TOTAL MEDICAID LIAB	632,577.26
		LESS: COB	18,765.45
		LESS: COPAYMENT	924.00
		REIMBURSEMENT	612,887.81
		TOTAL NUMBER OF CLAIMS	110

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139,587.16	2,450.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	265,057.00	106,837.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,233.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,455.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	379.00	FEE SCHEDULE LAB	70,998.00	9,668.00
EKG/ECG	7,514.00	289.00	MRI SERVICES	7,097.00	0.00
IV THERAPY	193,696.00	2,286.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	587,087.00	40,162.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,200.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	164,476.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,827.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	127,603.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,257,326.50	91,148.00
RADIOLOGY THERAPEUTIC	293,359.00	28,384.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	122,707.00	127,778.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,993.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,848.00	1,580.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,015.00	2,175.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	32,149.00	1,855.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	57,572.00	0.00			
			TOTAL ANCILLARY	4,434,799.66	414,991.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,434,799.66	414,991.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN  
743 SPRING ST NE  
GAINESVILLE,GA 30501-3715

PROVIDER NUMBER  
000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	84,461.00	ADJUSTMENTS	0.00
COVERED CHARGES	48,026.00	CONTRACTUAL ALLOW	39,475.00
NON-COVERD CHARGES	36,435.00	TOTAL MEDICAID LIAB	8,551.00
		LESS: COB	8,500.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1



Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHEAST GEORGIA MEDICAL CENTER IN  
 743 SPRING ST NE  
 GAINESVILLE,GA 30501-3715

PROVIDER NUMBER  
 000000888A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	539.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	46,942.00	36,435.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	545.00	0.00			
			TOTAL ANCILLARY	48,026.00	36,435.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,026.00	36,435.00

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER  
 1200 MEMORIAL DR  
 DALTON,GA 30720-2529

PROVIDER NUMBER 000000899A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,091,620.52	ADJUSTMENTS	1,963,944.11
COVERED CHARGES	30,398,679.74	CONTRACTUAL ALLOW	22,309,134.87
NON-COVERD CHARGES	692,940.78	TOTAL MEDICAID LIAB	8,089,544.87
		LESS: COB	80,770.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,008,773.95

TOTAL NUMBER OF ADMISSIONS 1,317

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,572		10	3,887,952.00		370,426.00
ROUTINE NURSERY	1,403		0	1,494,911.50		17,963.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,975		10	5,382,863.50		388,389.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	493		0	1,320,164.00		0.00
NICU	130		0	462,104.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	623		0	1,782,268.00		0.00
TOTAL ACCOMODATIONS	5,598		10	7,165,131.50		388,389.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER  
 1200 MEMORIAL DR  
 DALTON,GA 30720-2529

PROVIDER NUMBER  
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,702,723.35	179.80	OTHER LAB	127,618.00	0.00
MED/SURG SUPPLY	1,333,047.98	28,616.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,983,807.17	48,750.66	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	626,731.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,028,066.00	11,219.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	146,967.66	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	254,003.00	0.00	MRI SERVICES	446,463.00	0.00
IV THERAPY	474,296.00	2,044.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,337,157.50	21,814.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,447,875.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,803,651.50	9,951.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	106,215.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	821,236.00	107.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	228,932.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	106,460.05	0.00	INJECTABLE DRUGS	420,861.01	0.00
RADIOLOGY THERAPEUTIC	220,445.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	38,165.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	82,667.76	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	155,838.00	6,687.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,480.00	6,814.00	TRAUMA RESPONSE	0.00	15,729.00
PSYCHIATRIC SERVICES	233,085.00	90,636.00	IMPL DEV CHARGE PATIENTS	556,845.76	720.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	16,299.00
OTHER IMAGING SERVICE	204,034.50	5,462.00			
BLOOD	180,298.00	14,157.00			
BLOOD STORAGE & PRO.	118,974.50	24,949.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	120,375.00	417.00			
AUDIOLOGY	46,750.00	0.00			
CARDIOLOGY	779,163.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,348.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,966.00	0.00			
			TOTAL ANCILLARY	23,233,548.24	304,551.78
			TOTAL ACCOMODATIONS	7,165,131.50	388,389.00
			TOTAL CHARGES	30,398,679.74	692,940.78

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014300030312	10/14/14 - 10/20/14	11/03/14	0.00	2,629.00	0.00	0.00	0.00
614	2014349030623	11/26/14 - 12/01/14	12/22/14	0.00	2,629.00	0.00	0.00	0.00
614	2015023079369	01/09/15 - 01/17/15	02/02/15	0.00	2,629.00	0.00	0.00	0.00
614	5915078002789	02/15/15 - 02/20/15	03/23/15	0.00	2,629.00	0.00	0.00	0.00
614	2215127014281	04/15/15 - 04/20/15	05/11/15	0.00	5,783.00	0.00	0.00	0.00
TOTAL				0.00	16,299.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	278,632.07	ADJUSTMENTS	0.00
COVERED CHARGES	275,727.07	CONTRACTUAL ALLOW	80,199.10
NON-COVERD CHARGES	2,905.00	TOTAL MEDICAID LIAB	195,527.97
		LESS: COB	195,527.97
		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	18		0	19,568.00		1,261.00
ROUTINE NURSERY	48		0	77,759.00		825.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	66		0	97,327.00		2,086.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,756.00		0.00
NICU	2		0	6,380.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	9,136.00		0.00
TOTAL ACCOMODATIONS	69		0	106,463.00		2,086.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER  
 1200 MEMORIAL DR  
 DALTON,GA 30720-2529

PROVIDER NUMBER  
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,961.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,974.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,371.26	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,272.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,074.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	873.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,026.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,191.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,874.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	36,023.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,820.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,193.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,650.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	530.00	0.00	INJECTABLE DRUGS	470.90	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	827.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	168.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,361.00	819.00	IMPL DEV CHARGE PATIENTS	423.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,260.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	125.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,796.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	169,264.07	819.00
			TOTAL ACCOMODATIONS	106,463.00	2,086.00
			TOTAL CHARGES	275,727.07	2,905.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:25:05  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,780,359.66	ADJUSTMENTS	497,863.80
COVERED CHARGES	23,284,682.17	CONTRACTUAL ALLOW	19,620,757.83
NON-COVERD CHARGES	1,495,677.49	TOTAL MEDICAID LIAB	3,663,924.34
		LESS: COB	9,596.85
		LESS: COPAYMENT	9,048.46
		REIMBURSEMENT	3,645,279.03
		ALL OTHER	3,076,791.02
		FEE SCHEDULE-LAB	337,797.75
		INJECTABLE DRUGS	230,690.26

TOTAL NUMBER OF CLAIMS 8,817

HAMILTON MEDICAL CENTER  
 1200 MEMORIAL DR  
 DALTON,GA 30720-2529

PROVIDER NUMBER  
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	599,121.92	10,949.78	OTHER LAB	514,574.00	2,808.00
MED/SURG SUPPLY	751,917.90	10,957.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	75.00	EDUCATION & TRAINING	4,363.00	100.00
RADIOLOGY-DIAGNOSTIC	1,269,921.00	5,900.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,945,153.00	176,574.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	45,950.00	13,774.04	FEE SCHEDULE LAB	5,598,603.34	623,917.64
EKG/ECG	419,154.00	4,446.00	MRI SERVICES	827,776.00	83,510.00
IV THERAPY	1,609,544.00	10,783.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,433,225.83	164,702.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,799.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	302,422.00	34,647.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	149,041.00	341.00	AMBULANCE	0.00	0.00
GI SERVICES	7,812.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,332,881.00	12,567.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	136,505.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	818,858.17	61,452.70
RADIOLOGY THERAPEUTIC	574,612.00	16,327.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,225.00	490.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	459.00	462.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,084.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	136,053.00	588.00	TRAUMA RESPONSE	0.00	32,050.00
PSYCHIATRIC SERVICES	1,059.00	4,719.00	IMPL DEV CHARGE PATIENTS	75,271.34	2,962.62
LITHOTRIPSY	47,888.00	0.00	NO CC/INVALID REV CODE	0.00	1,968.00
OTHER IMAGING SERVICE	812,577.00	112,683.00			
BLOOD	76,953.00	0.00			
BLOOD STORAGE & PRO.	39,292.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	223,511.00	36,390.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	668,546.00	48,305.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	441,951.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	400,662.67	12,144.33			
			TOTAL ANCILLARY	23,284,682.17	1,495,677.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,284,682.17	1,495,677.49



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5915028000401	12/12/14 - 12/12/14	02/02/15	0.00	1,968.00	0.00	0.00	0.00
TOTAL				0.00	1,968.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	508,506.81	ADJUSTMENTS	0.00
COVERED CHARGES	391,621.24	CONTRACTUAL ALLOW	156,768.28
NON-COVERD CHARGES	116,885.57	TOTAL MEDICAID LIAB	234,852.96
		LESS: COB	234,795.96
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 155

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER  
 1200 MEMORIAL DR  
 DALTON,GA 30720-2529

PROVIDER NUMBER  
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,785.05	108.40	OTHER LAB	4,534.00	0.00
MED/SURG SUPPLY	21,301.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	572.00	0.00
RADIOLOGY-DIAGNOSTIC	20,179.00	831.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,040.00	17,060.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	112,460.23	7,055.15
EKG/ECG	11,384.00	0.00	MRI SERVICES	6,420.00	0.00
IV THERAPY	26,732.00	511.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,363.00	18,410.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,322.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,179.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,648.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	71,645.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,808.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,104.65	208.40
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	1,206.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	363.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	46,335.62
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,651.00	25,618.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,747.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,293.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,699.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,184.92	748.00			
			TOTAL ANCILLARY	391,621.24	116,885.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	391,621.24	116,885.57

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:25:46  
Page: 11

HAMILTON MEDICAL CENTER  
1200 MEMORIAL DR  
DALTON,GA 30720-2529

PROVIDER NUMBER  
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	942,577.40	ADJUSTMENTS	741.16
COVERED CHARGES	912,160.09	CONTRACTUAL ALLOW	872,218.93
NON-COVERD CHARGES	30,417.31	TOTAL MEDICAID LIAB	39,941.16
		LESS: COB	0.00
		LESS: COPAYMENT	1,803.00
		REIMBURSEMENT	38,138.16
		TOTAL NUMBER OF CLAIMS	714

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,567.74	859.35	OTHER LAB	7,204.00	0.00
MED/SURG SUPPLY	6,659.35	455.06	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,416.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,972.00	3,788.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	208,325.00	16,581.00
EKG/ECG	9,576.00	0.00	MRI SERVICES	9,434.00	0.00
IV THERAPY	80,969.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	345.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,179.00	277.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	426,640.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	2,861.90
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	336.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,452.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,097.00	4,143.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,440.00	0.00			
			TOTAL ANCILLARY	912,160.09	30,417.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	912,160.09	30,417.31

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: 08/12/2016  
Run Time: 02:25:50  
Page: 13

HAMILTON MEDICAL CENTER  
1200 MEMORIAL DR  
DALTON,GA 30720-2529

PROVIDER NUMBER  
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,354.50	ADJUSTMENTS	0.00
COVERED CHARGES	16,005.60	CONTRACTUAL ALLOW	8,623.74
NON-COVERD CHARGES	348.90	TOTAL MEDICAID LIAB	7,381.86
		LESS: COB	7,369.86
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	200.75	185.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	85.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	905.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,105.00	79.00
EKG/ECG	342.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	982.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,385.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	84.00	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	16,005.60	348.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,005.60	348.90

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HAMILTON MEDICAL CENTER  
1200 MEMORIAL DR  
DALTON,GA 30720-2529

PROVIDER NUMBER  
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,747,417.68	ADJUSTMENTS	94,990.19
COVERED CHARGES	3,668,872.73	CONTRACTUAL ALLOW	3,148,983.38
NON-COVERD CHARGES	78,544.95	TOTAL MEDICAID LIAB	519,889.35
		LESS: COB	0.00
		LESS: COPAYMENT	501.00
		REIMBURSEMENT	519,388.35
		TOTAL NUMBER OF CLAIMS	93



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,809.87	497.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	111,107.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,969.00	9,434.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,626.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	58,097.00	9,609.00
EKG/ECG	10,602.00	684.00	MRI SERVICES	3,877.00	5,503.00
IV THERAPY	76,809.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	726,324.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,614.00	991.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,837.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,656.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,396.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,636,833.80	23,486.70
RADIOLOGY THERAPEUTIC	382,687.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	888.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	314,985.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,301.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,566.00	1,252.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	170,496.00	27,088.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,392.00	0.00			
			TOTAL ANCILLARY	3,668,872.73	78,544.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,668,872.73	78,544.95

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:34:50  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER 000000943A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	253,419,215.32	ADJUSTMENTS	41,787,565.96
COVERED CHARGES	243,953,716.62	CONTRACTUAL ALLOW	160,449,999.55
NON-COVERD CHARGES	9,465,498.70	TOTAL MEDICAID LIAB	83,503,717.07
		LESS: COB	206,360.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	83,297,356.29

TOTAL NUMBER OF ADMISSIONS 3,089

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14,859		43	15,034,086.00		7,177,466.50
ROUTINE NURSERY	453		0	912,742.00		52,786.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	15,312		43	15,946,828.00		7,230,253.00
SPECIAL CARE SERVICES						
CCU	1,706		0	6,898,197.00		0.00
ICU	0		0	0.00		0.00
NICU	1,212		0	6,537,564.00		0.00
PED ICU	4,058		0	16,510,700.00		16,118.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6,976		0	29,946,461.00		16,118.00
TOTAL ACCOMODATIONS	22,288		43	45,893,289.00		7,246,371.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER  
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,688,174.20	118,238.55	OTHER LAB	718,246.50	0.00
MED/SURG SUPPLY	13,518,003.99	130,573.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	35,933,424.76	615,250.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,456,116.50	893.00	OTHER THERAPEUTIC SVC	20,597.00	149,436.50
CT SCAN	1,419,871.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,053,031.50	1,892.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	282,469.50	0.00	MRI SERVICES	1,422,542.00	0.00
IV THERAPY	87,919.50	3,178.00	PROFESSIONAL FEES	0.00	16,902.00
OPERATING ROOM	24,526,991.00	17,322.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,892,531.60	105,450.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,977,606.50	2,799.00	AMBULANCE	0.00	0.00
GI SERVICES	27,741.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,896,183.00	33,786.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,419,097.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,403,690.80	168.00	INJECTABLE DRUGS	42,311.75	0.00
RADIOLOGY THERAPEUTIC	205,777.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	552,153.00	1,560.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	491,514.00	220.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	113,102.00	50,657.50	PATIENT CONVENIENCE	0.00	198.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	276.00	43,994.50	TRAUMA RESPONSE	0.00	111,574.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,421,677.22	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	557,902.00	137,124.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,033,469.00	651,253.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	214,739.00	4,058.50			
AUDIOLOGY	51,345.00	0.00			
CARDIOLOGY	5,517,112.00	2,284.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,717,647.90	0.00			
ORGAN ACQUISITION	3,173,045.50	19,581.00			
TREATMENT/OBSERV. RM	224,118.00	733.50			
			TOTAL ANCILLARY	198,060,427.62	2,219,127.70
			TOTAL ACCOMODATIONS	45,893,289.00	7,246,371.00
			TOTAL CHARGES	243,953,716.62	9,465,498.70

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:35:55  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER 000000943A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,108,024.45	ADJUSTMENTS	0.00
COVERED CHARGES	10,799,706.45	CONTRACTUAL ALLOW	1,185,895.07
NON-COVERD CHARGES	308,318.00	TOTAL MEDICAID LIAB	9,613,811.38
		LESS: COB	9,613,811.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 117

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	409		5	329,840.00		260,524.00
ROUTINE NURSERY	43		0	96,682.50		1,684.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	452		5	426,522.50		262,208.00
SPECIAL CARE SERVICES						
CCU	121		0	487,569.50		0.00
ICU	0		0	0.00		0.00
NICU	121		0	652,929.00		0.00
PED ICU	87		0	351,526.50		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	329		0	1,492,025.00		0.00
TOTAL ACCOMODATIONS	781		5	1,918,547.50		262,208.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER  
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,635,035.75	0.00	OTHER LAB	49,729.00	0.00
MED/SURG SUPPLY	727,949.50	259.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,495,721.74	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	176,703.50	0.00	OTHER THERAPEUTIC SVC	884.50	3,222.50
CT SCAN	35,450.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,364.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,871.00	0.00	MRI SERVICES	28,458.00	0.00
IV THERAPY	1,600.00	0.00	PROFESSIONAL FEES	0.00	39,602.00
OPERATING ROOM	1,267,824.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	755,651.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	486,610.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	119,759.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	58,041.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	193,876.50	0.00	INJECTABLE DRUGS	15.00	0.00
RADIOLOGY THERAPEUTIC	1,979.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	20,902.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,115.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,166.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	92.00	942.50	TRAUMA RESPONSE	0.00	2,084.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	940,564.16	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,746.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	198,496.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	19,069.50	0.00			
AUDIOLOGY	1,701.00	0.00			
CARDIOLOGY	444,670.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	128,410.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,700.00	0.00			
			TOTAL ANCILLARY	8,881,158.95	46,110.00
			TOTAL ACCOMODATIONS	1,918,547.50	262,208.00
			TOTAL CHARGES	10,799,706.45	308,318.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 01:36:03  
Page: 5

CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1062

PROVIDER NUMBER  
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	70,378,925.92	ADJUSTMENTS	4,624,623.85
COVERED CHARGES	64,934,678.95	CONTRACTUAL ALLOW	48,564,299.93
NON-COVERD CHARGES	5,444,246.97	TOTAL MEDICAID LIAB	16,370,379.02
		LESS: COB	12,222.81
		LESS: COPAYMENT	267.00
		REIMBURSEMENT	16,357,889.21
		ALL OTHER	13,182,335.68
		FEE SCHEDULE-LAB	851,579.39
		INJECTABLE DRUGS	2,323,974.14

TOTAL NUMBER OF CLAIMS 20,491

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER  
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,264,286.25	14,673.00	OTHER LAB	507,378.50	2,315.00
MED/SURG SUPPLY	3,461,682.26	247.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	205.50	EDUCATION & TRAINING	1,587.00	0.00
RADIOLOGY-DIAGNOSTIC	1,505,673.50	47,188.50	OTHER THERAPEUTIC SVC	641.00	2,406.00
CT SCAN	1,417,633.00	59,351.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	97,852.00	26,431.00	FEE SCHEDULE LAB	13,308,188.43	2,243,959.08
EKG/ECG	128,687.00	17,375.00	MRI SERVICES	3,056,997.00	235,396.00
IV THERAPY	1,263,154.00	42,205.50	PROFESSIONAL FEES	0.00	18,794.50
OPERATING ROOM	7,867,733.86	692,375.14	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	927,535.00	40,858.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,566,474.50	1,963.50	AMBULANCE	0.00	0.00
GI SERVICES	190,718.50	51,731.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,649,177.50	69,862.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,619,865.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	614.25
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,439,706.75	849,667.00
RADIOLOGY THERAPEUTIC	276,658.50	2,272.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,082.00	5,380.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	394,202.00	14,304.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,498.00	PATIENT CONVENIENCE	0.00	1,930.50
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,439,016.00	171,850.00	TRAUMA RESPONSE	0.00	119,218.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	531,447.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	732,454.50	69,108.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	863,990.50	6,878.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	348,179.50	22,306.50			
AUDIOLOGY	177,939.50	4,844.50			
CARDIOLOGY	2,937,997.00	510,358.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,852,103.80	23,954.00			
ORGAN ACQUISITION	0.00	66,379.50			
TREATMENT/OBSERV. RM	1,078,637.50	4,345.50			
			TOTAL ANCILLARY	64,934,678.95	5,444,246.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,934,678.95	5,444,246.97



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 01:39:34  
Page: 7

SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1062

PROVIDER NUMBER  
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,785,660.45	ADJUSTMENTS	0.00
COVERED CHARGES	2,342,173.70	CONTRACTUAL ALLOW	33,993.14
NON-COVERD CHARGES	443,486.75	TOTAL MEDICAID LIAB	2,308,180.56
		LESS: COB	2,308,168.56
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 268

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER  
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,182.75	0.00	OTHER LAB	7,186.50	967.00
MED/SURG SUPPLY	228,418.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,085.50	1,213.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	50,760.00	5,521.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	202,006.50	45,352.00
EKG/ECG	1,710.00	570.00	MRI SERVICES	208,454.00	41,033.00
IV THERAPY	10,405.00	2,750.00	PROFESSIONAL FEES	0.00	12,009.50
OPERATING ROOM	423,357.50	90,134.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,841.00	4,752.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	345,731.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	11,856.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,293.50	172.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	112,449.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	336,803.75	53,742.75
RADIOLOGY THERAPEUTIC	33,176.50	1,277.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,926.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,886.50	2,255.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	25,877.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,942.50	23,223.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,049.00	5,427.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,802.50	2,295.00			
AUDIOLOGY	0.00	1,929.50			
CARDIOLOGY	89,008.00	134,201.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	31,830.50	879.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,916.00	0.00			
			TOTAL ANCILLARY	2,342,173.70	443,486.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,342,173.70	443,486.75

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:39:41  
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CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1062

PROVIDER NUMBER  
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,430,175.42	ADJUSTMENTS	1,846.03
COVERED CHARGES	1,352,613.17	CONTRACTUAL ALLOW	1,279,555.52
NON-COVERD CHARGES	77,562.25	TOTAL MEDICAID LIAB	73,057.65
		LESS: COB	42.63
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	73,003.02
		TOTAL NUMBER OF CLAIMS	1,307

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER  
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,786.25	1,575.00	OTHER LAB	11,886.00	0.00
MED/SURG SUPPLY	18,759.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	36.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,543.00	247.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,983.50	5,070.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	721.50	907.50	FEE SCHEDULE LAB	273,036.92	57,012.00
EKG/ECG	4,845.00	0.00	MRI SERVICES	4,432.50	4,326.00
IV THERAPY	1,008.00	0.00	PROFESSIONAL FEES	0.00	4,998.50
OPERATING ROOM	4,868.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,839.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,024.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	853,857.00	1,121.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	391.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,210.00	99.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	630.50	903.50	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	17,829.50	1,128.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,031.50	138.00			
AUDIOLOGY	1,929.50	0.00			
CARDIOLOGY	3,031.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,970.00	0.00			
			TOTAL ANCILLARY	1,352,613.17	77,562.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,352,613.17	77,562.25

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:39:53  
Page: 11

CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1062

PROVIDER NUMBER  
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,390.75	ADJUSTMENTS	0.00
COVERED CHARGES	10,499.25	CONTRACTUAL ALLOW	4,078.67
NON-COVERD CHARGES	1,891.50	TOTAL MEDICAID LIAB	6,420.58
		LESS: COB	6,420.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER  
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,077.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,690.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,917.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	1,891.50
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	3,750.50	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	10,499.25	1,891.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,499.25	1,891.50

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: 08/12/2016  
Run Time: 01:39:58  
Page: 13

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1062

PROVIDER NUMBER  
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,198,832.77	ADJUSTMENTS	803,472.26
COVERED CHARGES	11,163,548.67	CONTRACTUAL ALLOW	9,301,025.88
NON-COVERD CHARGES	1,035,284.10	TOTAL MEDICAID LIAB	1,862,522.79
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,862,522.79

TOTAL NUMBER OF CLAIMS 186

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER  
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	203,347.50	2,265.25	OTHER LAB	6,526.50	1,215.00
MED/SURG SUPPLY	1,826,959.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	265,229.50	44,593.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,894.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	4,010.00	FEE SCHEDULE LAB	363,649.07	128,776.60
EKG/ECG	756.00	5,217.00	MRI SERVICES	13,998.00	0.00
IV THERAPY	25,753.00	14,320.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,242,019.50	116,114.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,896.00	5,397.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,081,621.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	36,516.00	1,936.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,158.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	159,785.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	817,320.25	27,158.75
RADIOLOGY THERAPEUTIC	10,530.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	273.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,706.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,166.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,390.50	3,788.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,103,624.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,531.50	5,076.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,629.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,849,519.50	671,380.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	86,894.50	891.00			
			TOTAL ANCILLARY	11,163,548.67	1,035,284.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,163,548.67	1,035,284.10



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 01:40:07  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1062

PROVIDER NUMBER  
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	535,397.48	ADJUSTMENTS	0.00
COVERED CHARGES	530,233.98	CONTRACTUAL ALLOW	6,482.19
NON-COVERD CHARGES	5,163.50	TOTAL MEDICAID LIAB	523,751.79
		LESS: COB	523,751.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER  
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,445.00	0.00	OTHER LAB	562.00	0.00
MED/SURG SUPPLY	48,385.00	330.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	832.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,223.50	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	163.00	304.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	135,464.00	3,873.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	62.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	59,496.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,500.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47,486.75	501.50
RADIOLOGY THERAPEUTIC	1,008.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	92.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	215,757.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,910.50	0.00			
			TOTAL ANCILLARY	530,233.98	5,163.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	530,233.98	5,163.50

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:26:09  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	516,653.09	ADJUSTMENTS	7,280.72
COVERED CHARGES	510,213.09	CONTRACTUAL ALLOW	306,474.27
NON-COVERD CHARGES	6,440.00	TOTAL MEDICAID LIAB	203,738.82
		LESS: COB	2,869.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	200,869.00

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	70		0	69,160.00		6,440.00
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	70		0	69,160.00		6,440.00
SPECIAL CARE SERVICES						
CCU	19		0	32,015.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	32,015.00		0.00
TOTAL ACCOMODATIONS	89		0	101,175.00		6,440.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,430.05	0.00	OTHER LAB	5,440.00	0.00
MED/SURG SUPPLY	22,160.96	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	93,770.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,703.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	32,696.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,795.12	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,856.00	0.00	MRI SERVICES	3,236.00	0.00
IV THERAPY	14,675.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,885.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76,831.95	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,758.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,018.00	0.00	INJECTABLE DRUGS	7,999.01	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	910.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,278.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,696.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,456.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,625.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	819.00	0.00			
			TOTAL ANCILLARY	409,038.09	0.00
			TOTAL ACCOMODATIONS	101,175.00	6,440.00
			TOTAL CHARGES	510,213.09	6,440.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:26:10  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,300,870.78	ADJUSTMENTS	114,661.41
COVERED CHARGES	5,014,916.51	CONTRACTUAL ALLOW	3,949,266.90
NON-COVERD CHARGES	285,954.27	TOTAL MEDICAID LIAB	1,065,649.61
		LESS: COB	150.01
		LESS: COPAYMENT	3,381.00
		REIMBURSEMENT	1,062,118.60
		ALL OTHER	1,001,771.07
		FEE SCHEDULE-LAB	55,860.55
		INJECTABLE DRUGS	4,486.98
		TOTAL NUMBER OF CLAIMS	2,091

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	169,004.90	514.70	OTHER LAB	27,558.00	0.00
MED/SURG SUPPLY	103,361.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	270,450.00	668.00	OTHER THERAPEUTIC SVC	0.00	436.00
CT SCAN	806,153.00	62,658.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	174,290.00	16,427.00	FEE SCHEDULE LAB	747,720.00	130,672.80
EKG/ECG	64,647.00	1,687.00	MRI SERVICES	190,822.00	0.00
IV THERAPY	336,640.00	15,245.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	275,407.00	12,220.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73,486.15	1,570.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	76,947.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	56,026.60	2,145.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,165,009.00	6,210.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,216.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	52,991.99	7,564.77
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,520.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,848.48	756.00
LITHOTRIPSY	119,043.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	78,963.00	5,130.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,153.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	69,952.00	14,355.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	33,752.00	5,175.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	80,475.00	0.00			
			TOTAL ANCILLARY	5,014,916.51	285,954.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,014,916.51	285,954.27

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: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,444.75	ADJUSTMENTS	0.00
COVERED CHARGES	3,952.75	CONTRACTUAL ALLOW	2,256.37
NON-COVERD CHARGES	5,492.00	TOTAL MEDICAID LIAB	1,696.38
		LESS: COB	1,690.60
		LESS: COPAYMENT	5.78
		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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5.50	96.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,329.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,603.00	1,067.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	355.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,515.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	474.25	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	3,952.75	5,492.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,952.75	5,492.00

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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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	273,258.88	ADJUSTMENTS	97.00
COVERED CHARGES	262,846.88	CONTRACTUAL ALLOW	250,246.88
NON-COVERD CHARGES	10,412.00	TOTAL MEDICAID LIAB	12,600.00
		LESS: COB	0.00
		LESS: COPAYMENT	516.00
		REIMBURSEMENT	12,084.00
		TOTAL NUMBER OF CLAIMS	252

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,791.73	0.00	OTHER LAB	3,239.00	0.00
MED/SURG SUPPLY	559.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,693.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,532.00	6,152.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,119.00	4,106.00
EKG/ECG	1,928.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	22,330.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	700.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	154,340.00	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	2,739.80	84.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	70.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,875.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	262,846.88	10,412.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	262,846.88	10,412.00

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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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HIGGINS GENERAL HOSPITAL  
200 ALLEN MEMORIAL DR  
BREMEN,GA 30110-2012

PROVIDER NUMBER  
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	133,429.76	ADJUSTMENTS	9,832.29
COVERED CHARGES	111,787.62	CONTRACTUAL ALLOW	92,016.53
NON-COVERD CHARGES	21,642.14	TOTAL MEDICAID LIAB	19,771.09
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,771.09

TOTAL NUMBER OF CLAIMS 4

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,241.72	0.00	OTHER LAB	1,414.00	0.00
MED/SURG SUPPLY	5,170.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	750.00	250.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,721.00	3,646.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	295.00	FEE SCHEDULE LAB	14,724.00	7,331.00
EKG/ECG	1,928.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,250.00	2,395.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	631.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,938.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,149.02	583.44
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,785.00	4,785.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	29,857.00	1,725.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,859.00	0.00			
			TOTAL ANCILLARY	111,787.62	21,642.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	111,787.62	21,642.14

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:26:41  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,233,778.34	ADJUSTMENTS	2,510,042.31
COVERED CHARGES	23,451,323.85	CONTRACTUAL ALLOW	14,511,517.10
NON-COVERD CHARGES	1,782,454.49	TOTAL MEDICAID LIAB	8,939,806.75
		LESS: COB	108,742.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,831,063.85

TOTAL NUMBER OF ADMISSIONS 1,335

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,940		11	3,156,660.00		1,727,700.00
ROUTINE NURSERY	549		4	334,916.00		33,205.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,489		15	3,491,576.00		1,760,905.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	964		0	1,609,980.00		0.00
NICU	38		0	80,504.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,002		0	1,690,484.00		0.00
TOTAL ACCOMODATIONS	6,491		15	5,182,060.00		1,760,905.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER  
 1601 WATSON BLVD  
 WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER  
 000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,771,218.55	0.00	OTHER LAB	128,997.43	0.00
MED/SURG SUPPLY	409,303.43	2,526.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,439,653.81	0.00	EDUCATION & TRAINING	254.00	0.00
RADIOLOGY-DIAGNOSTIC	497,363.74	0.00	OTHER THERAPEUTIC SVC	0.00	99.60
CT SCAN	1,263,672.00	11,753.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	302,254.87	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	432,100.00	0.00	MRI SERVICES	262,358.00	0.00
IV THERAPY	21,363.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,908,223.44	581.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	816,795.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,129,117.37	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	325,393.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,726,379.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	206,490.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	77,080.20	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	46,171.35	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	201,286.50	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,008.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	364,152.92	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	146,367.04	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	196,389.42	3,777.48			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	108,786.82	2,812.20			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,225,951.58	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	104,171.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	153,959.63	0.00			
			TOTAL ANCILLARY	18,269,263.85	21,549.49
			TOTAL ACCOMODATIONS	5,182,060.00	1,760,905.00
			TOTAL CHARGES	23,451,323.85	1,782,454.49

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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 Page: 3

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	317,179.02	ADJUSTMENTS	0.00
COVERED CHARGES	260,862.02	CONTRACTUAL ALLOW	98,747.08
NON-COVERD CHARGES	56,317.00	TOTAL MEDICAID LIAB	162,114.94
		LESS: COB	162,114.94
		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	74		0	47,286.00		56,317.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	74		0	47,286.00		56,317.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	4,200.00		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	3		0	4,200.00		0.00
TOTAL ACCOMODATIONS	77		0	51,486.00		56,317.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:26:59  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,937.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,910.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,997.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,756.16	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	894.00	0.00	MRI SERVICES	2,788.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,316.27	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	63,568.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,320.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,228.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,532.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,745.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	668.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	84.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	234.82	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	373.78	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,136.22	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	37,643.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	822.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,421.00	0.00			
			TOTAL ANCILLARY	209,376.02	0.00
			TOTAL ACCOMODATIONS	51,486.00	56,317.00
			TOTAL CHARGES	260,862.02	56,317.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:27:01  
Page: 5

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,232,925.90	ADJUSTMENTS	500,552.00
COVERED CHARGES	15,063,572.53	CONTRACTUAL ALLOW	11,738,845.80
NON-COVERD CHARGES	1,169,353.37	TOTAL MEDICAID LIAB	3,324,726.73
		LESS: COB	18,663.16
		LESS: COPAYMENT	11,477.89
		REIMBURSEMENT	3,294,585.68
		ALL OTHER	2,768,229.32
		FEE SCHEDULE-LAB	270,299.75
		INJECTABLE DRUGS	256,056.61

TOTAL NUMBER OF CLAIMS 7,539

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133,008.71	8,606.72	OTHER LAB	192,370.53	1,051.18
MED/SURG SUPPLY	168,794.27	8,864.31	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,099.00	EDUCATION & TRAINING	3,694.00	0.00
RADIOLOGY-DIAGNOSTIC	690,295.74	1,553.08	OTHER THERAPEUTIC SVC	0.00	1,543.80
CT SCAN	1,601,017.93	124,358.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	67,368.32	47,828.35	FEE SCHEDULE LAB	2,026,949.31	217,466.96
EKG/ECG	344,786.00	6,258.00	MRI SERVICES	203,050.00	25,442.00
IV THERAPY	765,426.70	6,657.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,597,634.55	212,550.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,652.00	0.00	REHAB THERAPY	0.00	2,288.00
RESPIRATORY SERVICES	93,053.99	11,506.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	215,245.00	1,350.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,134,435.97	3,131.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	390,605.00	2,100.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	778,548.42	164,862.02
RADIOLOGY THERAPEUTIC	35,256.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	54,063.84	25,738.77	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,034.70	1,055.19	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	34,938.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,536.48	5,524.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	68,463.97	31,284.82
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	432,093.09	51,371.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	39,788.85	1,068.85			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	96,807.74	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	555,602.40	162,853.21			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	38,435.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	306,554.02	7,001.80			
			TOTAL ANCILLARY	15,063,572.53	1,169,353.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,063,572.53	1,169,353.37

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

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	357,620.71	ADJUSTMENTS	0.00
COVERED CHARGES	263,358.50	CONTRACTUAL ALLOW	129,774.88
NON-COVERD CHARGES	94,262.21	TOTAL MEDICAID LIAB	133,583.62
		LESS: COB	133,418.10
		LESS: COPAYMENT	165.52
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 167

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,581.54	0.00	OTHER LAB	1,743.59	0.00
MED/SURG SUPPLY	2,263.81	523.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,557.12	728.00	OTHER THERAPEUTIC SVC	0.00	747.00
CT SCAN	6,455.00	31,601.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,666.00	491.78	FEE SCHEDULE LAB	41,475.32	2,086.03
EKG/ECG	4,768.00	0.00	MRI SERVICES	0.00	8,817.00
IV THERAPY	14,435.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,857.77	11,000.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	905.63	129.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,562.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	90,216.00	489.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,618.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,217.50	3,678.69
RADIOLOGY THERAPEUTIC	312.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	155.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	866.56	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,000.00
OTHER IMAGING SERVICE	5,517.45	12,424.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,876.02	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	20,391.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	822.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,641.69	0.00			
			TOTAL ANCILLARY	263,358.50	94,262.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	263,358.50	94,262.21

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: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015308007591	10/14/15 - 10/14/15	11/09/15	0.00	1,000.00	0.00	1,796.21	0.00
TOTAL				0.00	1,000.00	0.00	1,796.21	0.00



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	320,551.48	ADJUSTMENTS	647.28
COVERED CHARGES	316,887.17	CONTRACTUAL ALLOW	297,308.17
NON-COVERD CHARGES	3,664.31	TOTAL MEDICAID LIAB	19,579.00
		LESS: COB	0.00
		LESS: COPAYMENT	552.00
		REIMBURSEMENT	19,027.00
		TOTAL NUMBER OF CLAIMS	350

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	987.43	0.00	OTHER LAB	2,451.78	0.00
MED/SURG SUPPLY	72.38	117.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,361.38	383.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,812.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,169.67	1,786.00
EKG/ECG	3,576.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,132.00	74.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	518.00	129.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	230,802.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,901.41	427.49
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,736.12	747.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	367.00	0.00			
			TOTAL ANCILLARY	316,887.17	3,664.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	316,887.17	3,664.31

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,481.21	ADJUSTMENTS	0.00
COVERED CHARGES	21,392.21	CONTRACTUAL ALLOW	15,606.92
NON-COVERD CHARGES	89.00	TOTAL MEDICAID LIAB	5,785.29
		LESS: COB	5,776.29
		LESS: COPAYMENT	9.00
		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: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	195.83	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,281.54	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,950.18	89.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	655.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	241.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,422.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	82.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,563.56	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,392.21	89.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,392.21	89.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOUSTON MEDICAL CENTER  
1601 WATSON BLVD  
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER  
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	764,420.38	ADJUSTMENTS	11,143.34
COVERED CHARGES	696,933.50	CONTRACTUAL ALLOW	551,829.32
NON-COVERD CHARGES	67,486.88	TOTAL MEDICAID LIAB	145,104.18
		LESS: COB	0.00
		LESS: COPAYMENT	182.43
		REIMBURSEMENT	144,921.75
		TOTAL NUMBER OF CLAIMS	26

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,446.38	0.00	OTHER LAB	860.00	0.00
MED/SURG SUPPLY	31,226.51	1,562.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,111.48	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,824.65	512.48
EKG/ECG	4,470.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	27,553.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	207,885.72	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	646.45	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,850.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,388.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,642.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	183,641.96	10,164.95
RADIOLOGY THERAPEUTIC	1,300.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,409.83	48,255.75
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.	462.80	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	137,637.18	6,991.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,576.74	0.00			
			TOTAL ANCILLARY	696,933.50	67,486.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	696,933.50	67,486.88

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:29:07  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL  
 710 N IRWIN AVE  
 OCILLA,GA 31774-5011

PROVIDER NUMBER 000000987A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,542,936.24	ADJUSTMENTS	392,440.05
COVERED CHARGES	1,440,645.96	CONTRACTUAL ALLOW	669,328.48
NON-COVERD CHARGES	102,290.28	TOTAL MEDICAID LIAB	771,317.48
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	771,317.48

TOTAL NUMBER OF ADMISSIONS 233

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	392		0	193,400.00		63,575.00
ROUTINE NURSERY	205		0	102,045.00		20,600.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	597		0	295,445.00		84,175.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	597		0	295,445.00		84,175.00



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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	175,528.13	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	107,773.52	121.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	119,657.42	0.00	EDUCATION & TRAINING	1,402.38	0.00
RADIOLOGY-DIAGNOSTIC	9,850.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,061.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,893.00	0.00	MRI SERVICES	2,238.00	0.00
IV THERAPY	2,394.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	315,396.00	6,704.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	168,476.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	70,295.39	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,321.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,555.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,205.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	9,362.63	219.06	INJECTABLE DRUGS	63,957.87	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,946.00	0.00			
BLOOD	713.62	3,681.72			
BLOOD STORAGE & PRO.	0.00	3,150.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	4,239.00			
CARDIOLOGY	8,175.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,145,200.96	18,115.28
			TOTAL ACCOMODATIONS	295,445.00	84,175.00
			TOTAL CHARGES	1,440,645.96	102,290.28

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 02:29:10  
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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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,133.94	ADJUSTMENTS	0.00
COVERED CHARGES	30,463.94	CONTRACTUAL ALLOW	10,185.76
NON-COVERD CHARGES	1,670.00	TOTAL MEDICAID LIAB	20,278.18
		LESS: COB	20,278.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	4,000.00		1,275.00
ROUTINE NURSERY	2		0	1,000.00		350.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	5,000.00		1,625.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	10		0	5,000.00		1,625.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL  
 710 N IRWIN AVE  
 OCILLA,GA 31774-5011

PROVIDER NUMBER  
 000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,424.37	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,689.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,711.61	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	6,704.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,705.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	320.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	650.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	412.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	219.06	0.00	INJECTABLE DRUGS	627.98	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	45.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,463.94	45.00
			TOTAL ACCOMODATIONS	5,000.00	1,625.00
			TOTAL CHARGES	30,463.94	1,670.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:29:10  
Page: 5

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 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,944,587.10	ADJUSTMENTS	143,975.70
COVERED CHARGES	1,739,053.46	CONTRACTUAL ALLOW	1,280,489.37
NON-COVERD CHARGES	205,533.64	TOTAL MEDICAID LIAB	458,564.09
		LESS: COB	6,708.41
		LESS: COPAYMENT	1,137.00
		REIMBURSEMENT	450,718.68
		ALL OTHER	403,269.41
		FEE SCHEDULE-LAB	44,967.87
		INJECTABLE DRUGS	2,481.40

TOTAL NUMBER OF CLAIMS 890

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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121,433.67	1,720.79	OTHER LAB	3,102.00	0.00
MED/SURG SUPPLY	56,331.86	561.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	231.98	EDUCATION & TRAINING	0.00	1,383.17
RADIOLOGY-DIAGNOSTIC	56,814.00	252.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	68,497.00	22,103.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	240,738.02	22,603.07
EKG/ECG	26,028.00	159.00	MRI SERVICES	7,257.00	2,223.00
IV THERAPY	84,746.00	950.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	634,800.00	118,400.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,854.41	2,459.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	31,615.00	4,753.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	167,975.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,294.00	969.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,095.74	140.80
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	786.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	5.00	0.00
OTHER IMAGING SERVICE	44,115.60	17,868.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	600.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,640.00	3,270.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,775.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	90,936.16	4,100.00			
			TOTAL ANCILLARY	1,739,053.46	205,533.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,739,053.46	205,533.64

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:29:10  
Page: 7

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 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9815245000021	05/04/15 - 05/05/15	09/07/15	5.00	0.00	0.00	0.00	0.00
TOTAL				5.00	0.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 02:29:19  
Page: 8

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 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,634.23	ADJUSTMENTS	0.00
COVERED CHARGES	41,326.73	CONTRACTUAL ALLOW	8,965.59
NON-COVERD CHARGES	17,307.50	TOTAL MEDICAID LIAB	32,361.14
		LESS: COB	32,358.14
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,661.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,140.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	561.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,650.55	97.50
EKG/ECG	795.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,326.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,097.00	16,397.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,300.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,648.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	146.10	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	802.00	663.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,159.00	150.00			
			TOTAL ANCILLARY	41,326.73	17,307.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	41,326.73	17,307.50



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:29:20  
Page: 10

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 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,732.74	ADJUSTMENTS	211.76
COVERED CHARGES	97,151.09	CONTRACTUAL ALLOW	88,480.39
NON-COVERD CHARGES	5,581.65	TOTAL MEDICAID LIAB	8,670.70
		LESS: COB	0.00
		LESS: COPAYMENT	297.00
		REIMBURSEMENT	8,373.70

TOTAL NUMBER OF CLAIMS 155

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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,158.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	445.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,064.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,386.00	3,516.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,830.53	1,084.65
EKG/ECG	1,281.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,268.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,826.00	580.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,332.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	544.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,236.00	401.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,780.00	0.00			
			TOTAL ANCILLARY	97,151.09	5,581.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	97,151.09	5,581.65

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:29:21  
Page: 12

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 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,159.10	ADJUSTMENTS	0.00
COVERED CHARGES	1,159.10	CONTRACTUAL ALLOW	611.70
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	547.40
		LESS: COB	547.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

IRWIN COUNTY HOSPITAL  
 710 N IRWIN AVE  
 OCILLA,GA 31774-5011

PROVIDER NUMBER  
 000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	85.10	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	900.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	100.00	0.00			
			TOTAL ANCILLARY	1,159.10	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,159.10	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 02:29:22  
Page: 14

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 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,312.03	ADJUSTMENTS	0.00
COVERED CHARGES	60,260.55	CONTRACTUAL ALLOW	48,751.57
NON-COVERD CHARGES	51.48	TOTAL MEDICAID LIAB	11,508.98
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	11,505.98

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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,939.47	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,946.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,090.98	51.48
EKG/ECG	215.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,799.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	878.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,114.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	227.10	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	417.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	580.00	0.00			
			TOTAL ANCILLARY	60,260.55	51.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	60,260.55	51.48

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 02:29:22  
Page: 16

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	12/01/14	THROUGH	11/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:29:28  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP  
 898 COLLEGE ST  
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER 000000998A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,885.96	ADJUSTMENTS	6,720.34
COVERED CHARGES	26,858.96	CONTRACTUAL ALLOW	9,018.80
NON-COVERD CHARGES	27.00	TOTAL MEDICAID LIAB	17,840.16
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,840.16

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	3,291.75		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9		0	3,291.75		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	9		0	3,291.75		0.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

JASPER MEMORIAL HOSP  
 898 COLLEGE ST  
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
 000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,496.01	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,123.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,686.05	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	208.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,533.13	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	100.97	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	451.65	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	606.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	27.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	361.39	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,567.21	27.00
			TOTAL ACCOMODATIONS	3,291.75	0.00
			TOTAL CHARGES	26,858.96	27.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	292,374.63	ADJUSTMENTS	17,709.26
COVERED CHARGES	258,101.36	CONTRACTUAL ALLOW	121,689.17
NON-COVERD CHARGES	34,273.27	TOTAL MEDICAID LIAB	136,412.19
		LESS: COB	0.00
		LESS: COPAYMENT	804.00
		REIMBURSEMENT	135,608.19
		ALL OTHER	121,864.92
		FEE SCHEDULE-LAB	12,007.21
		INJECTABLE DRUGS	1,736.06

TOTAL NUMBER OF CLAIMS 584

JASPER MEMORIAL HOSP  
 898 COLLEGE ST  
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
 000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,285.95	0.00	OTHER LAB	1,445.55	0.00
MED/SURG SUPPLY	5,831.78	212.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	18.76	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,466.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,637.88	8,057.49	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	387.67	387.67	FEE SCHEDULE LAB	88,226.50	20,091.64
EKG/ECG	3,314.78	100.97	MRI SERVICES	5,372.66	0.00
IV THERAPY	9,273.82	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	851.93	42.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,201.30	483.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,620.73	3,459.88
RADIOLOGY THERAPEUTIC	121.60	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,380.72	588.24	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,997.65	829.70			
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	8,766.30	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	918.14	0.00			
			TOTAL ANCILLARY	258,101.36	34,273.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	258,101.36	34,273.27

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,340.96	ADJUSTMENTS	47.00
COVERED CHARGES	13,928.42	CONTRACTUAL ALLOW	11,978.42
NON-COVERD CHARGES	412.54	TOTAL MEDICAID LIAB	1,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	1,881.00
		TOTAL NUMBER OF CLAIMS	39

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	108.38	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	653.99	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,084.16	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,205.64	253.01
EKG/ECG	201.94	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	49.16	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,134.39	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	442.11	96.60
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	62.93	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,928.42	412.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,928.42	412.54

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,053,510.25	ADJUSTMENTS	55,269.38
COVERED CHARGES	1,035,195.25	CONTRACTUAL ALLOW	610,656.18
NON-COVERD CHARGES	18,315.00	TOTAL MEDICAID LIAB	424,539.07
		LESS: COB	1,769.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	422,769.89

TOTAL NUMBER OF ADMISSIONS 72

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	205		0	92,250.00		11,350.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	205		0	92,250.00		11,350.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	49		0	49,000.00		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	49		0	49,000.00		0.00
TOTAL ACCOMODATIONS	254		0	141,250.00		11,350.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	321,011.25	0.00	OTHER LAB	3,870.00	0.00
MED/SURG SUPPLY	138,113.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	162,672.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,047.00	1,575.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	69,696.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,408.00	0.00	MRI SERVICES	3,800.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,934.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87,020.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,382.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,742.00	0.00	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	3,793.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,400.00
OTHER IMAGING SERVICE	1,080.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,835.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,200.00	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	352.00	990.00			
			TOTAL ANCILLARY	893,945.25	6,965.00
			TOTAL ACCOMODATIONS	141,250.00	11,350.00
			TOTAL CHARGES	1,035,195.25	18,315.00

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215362008615	08/11/15 - 08/13/15	02/22/16	0.00	4,400.00	0.00	0.00	0.00
TOTAL				0.00	4,400.00	0.00	0.00	0.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

JEFF DAVIS HOSPITAL  
163 S TALLAHASSEE ST  
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER  
000001009A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:29:40  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,281,918.45	ADJUSTMENTS	20,152.99
COVERED CHARGES	1,080,638.05	CONTRACTUAL ALLOW	750,842.30
NON-COVERD CHARGES	201,280.40	TOTAL MEDICAID LIAB	329,795.75
		LESS: COB	295.01
		LESS: COPAYMENT	1,374.00
		REIMBURSEMENT	328,126.74
		ALL OTHER	292,210.62
		FEE SCHEDULE-LAB	34,307.13
		INJECTABLE DRUGS	1,608.99

TOTAL NUMBER OF CLAIMS 1,175

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	45,728.30	1,049.60	OTHER LAB	20,486.00	0.00
MED/SURG SUPPLY	75,679.00	10.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	30.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	91,901.00	5,522.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	243,669.20	25,551.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	261,732.00	38,014.00
EKG/ECG	13,888.00	1,680.00	MRI SERVICES	71,600.00	1,800.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,934.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,098.00	8,331.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	16,887.00	2,558.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	157,698.00	26,168.00	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	25,757.55	47,790.80
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	700.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,850.00
OTHER IMAGING SERVICE	23,595.00	2,810.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,090.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,600.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,000.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,205.00	27,016.00			
			TOTAL ANCILLARY	1,080,638.05	200,780.40
			TOTAL ACCOMODATIONS	0.00	500.00
			TOTAL CHARGES	1,080,638.05	201,280.40



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:29:40  
Page: 7

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014364035415	12/19/14 - 12/19/14	01/05/15	0.00	50.00	0.00	0.00	0.00
615	2015019014863	01/14/15 - 01/14/15	01/26/15	0.00	4,400.00	0.00	0.00	0.00
615	2015222020077	08/05/15 - 08/05/15	08/17/15	0.00	4,400.00	0.00	0.00	0.00
TOTAL				0.00	8,850.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 02:29:48  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL  
163 S TALLAHASSEE ST  
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER  
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,017.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,017.00	CONTRACTUAL ALLOW	1,255.06
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	761.94
		LESS: COB	761.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:29:48  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL  
 163 S TALLAHASSEE ST  
 HAZLEHURST,GA 31539-6465

PROVIDER NUMBER  
 000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	15.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,402.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	600.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,017.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,017.00	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:29:48  
Page: 10

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	104,852.25	ADJUSTMENTS	188.00
COVERED CHARGES	94,361.75	CONTRACTUAL ALLOW	88,241.69
NON-COVERD CHARGES	10,490.50	TOTAL MEDICAID LIAB	6,120.06
		LESS: COB	0.00
		LESS: COPAYMENT	297.00
		REIMBURSEMENT	5,823.06
		TOTAL NUMBER OF CLAIMS	123

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,076.00	65.00	OTHER LAB	926.00	0.00
MED/SURG SUPPLY	3,409.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,753.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,800.00	1,403.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,240.00	2,500.00
EKG/ECG	1,120.00	0.00	MRI SERVICES	0.00	3,600.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	444.00	201.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,483.00	1,112.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,015.75	663.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	95.00	946.00			
			TOTAL ANCILLARY	94,361.75	10,490.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	94,361.75	10,490.50

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

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,720.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,466.00	CONTRACTUAL ALLOW	908.61
NON-COVERD CHARGES	254.00	TOTAL MEDICAID LIAB	557.39
		LESS: COB	551.39
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	234.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	295.00	168.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	847.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	68.00	86.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,466.00	254.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,466.00	254.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:29:56  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

JEFFERSON HOSPITAL  
 1067 PEACHTREE ST  
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER 000001031A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	209,045.60	ADJUSTMENTS	16,974.31
COVERED CHARGES	203,956.60	CONTRACTUAL ALLOW	35,600.67
NON-COVERD CHARGES	5,089.00	TOTAL MEDICAID LIAB	168,355.93
		LESS: COB	1,976.61
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	166,379.32

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	83		0	33,200.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	83		0	33,200.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	83		0	33,200.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

JEFFERSON HOSPITAL  
 1067 PEACHTREE ST  
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	78,275.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,619.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	188.85	0.00
RADIOLOGY-DIAGNOSTIC	5,103.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,614.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,096.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,536.50	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	12,386.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	132.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,199.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,455.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,184.00
OTHER IMAGING SERVICE	298.00	0.00			
BLOOD	5,427.00	0.00			
BLOOD STORAGE & PRO.	5,427.00	3,905.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	170,756.60	5,089.00
			TOTAL ACCOMODATIONS	33,200.00	0.00
			TOTAL CHARGES	203,956.60	5,089.00

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
Run Time: 02:29:56  
Page: 3

JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2316172000223	06/10/15 - 06/15/15	07/18/16	0.00	1,184.00	0.00	842.75	0.00
TOTAL				0.00	1,184.00	0.00	842.75	0.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:29:57  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:29:57  
Page: 5

JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	779,222.87	ADJUSTMENTS	6,538.53
COVERED CHARGES	673,616.47	CONTRACTUAL ALLOW	427,540.20
NON-COVERD CHARGES	105,606.40	TOTAL MEDICAID LIAB	246,076.27
		LESS: COB	881.31
		LESS: COPAYMENT	765.00
		REIMBURSEMENT	244,429.96
		ALL OTHER	206,568.98
		FEE SCHEDULE-LAB	36,158.91
		INJECTABLE DRUGS	1,702.07
		TOTAL NUMBER OF CLAIMS	1,134

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
 Run Time: 02:29:57  
 Page: 6

JEFFERSON HOSPITAL  
 1067 PEACHTREE ST  
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,245.00	2,149.00	OTHER LAB	17,198.00	0.00
MED/SURG SUPPLY	10,148.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	125.90
RADIOLOGY-DIAGNOSTIC	48,416.00	966.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,835.00	44,409.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,395.00	3,293.00	FEE SCHEDULE LAB	185,968.00	24,555.00
EKG/ECG	11,580.00	1,690.50	MRI SERVICES	1,179.00	0.00
IV THERAPY	3,618.00	2,428.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,521.00	395.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,578.75	2,146.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,364.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	207,810.00	6,399.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,944.00	4,335.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,928.00	399.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25,506.00	3,078.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	35,290.00	4,551.00			
BLOOD	4,824.00	0.00			
BLOOD STORAGE & PRO.	4,824.00	4,686.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,300.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,144.00	0.00			
			TOTAL ANCILLARY	673,616.47	105,606.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	673,616.47	105,606.40

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: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,413.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,124.00	CONTRACTUAL ALLOW	1,477.56
NON-COVERD CHARGES	1,289.00	TOTAL MEDICAID LIAB	2,646.44
		LESS: COB	2,646.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSPITAL  
 1067 PEACHTREE ST  
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 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	94.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	276.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	694.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,460.00	75.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,515.00	439.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	118.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	407.00	81.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	194.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,124.00	1,289.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,124.00	1,289.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:30:08  
Page: 9

JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	62,586.00	ADJUSTMENTS	273.70
COVERED CHARGES	58,669.50	CONTRACTUAL ALLOW	53,243.32
NON-COVERD CHARGES	3,916.50	TOTAL MEDICAID LIAB	5,426.18
		LESS: COB	0.00
		LESS: COPAYMENT	166.09
		REIMBURSEMENT	5,260.09
		TOTAL NUMBER OF CLAIMS	97

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	842.00	446.00	OTHER LAB	298.00	0.00
MED/SURG SUPPLY	151.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,575.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,306.00	1,918.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,535.00	1,220.00
EKG/ECG	563.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	113.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	861.00	16.50	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	37,049.00	117.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,078.00	199.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	298.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	58,669.50	3,916.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,669.50	3,916.50

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:30:09  
Page: 11

JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:30:09  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 02:30:09  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:04:20  
 Page: 1

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	210,933.02	ADJUSTMENTS	9,124.88
COVERED CHARGES	120,888.64	CONTRACTUAL ALLOW	47,696.68
NON-COVERD CHARGES	90,044.38	TOTAL MEDICAID LIAB	73,191.96
		LESS: COB	2,230.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	70,961.49

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	37		0	28,238.00		88,851.68
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	37		0	28,238.00		88,851.68
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	37		0	28,238.00		88,851.68

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,249.95	0.00	OTHER LAB	826.80	0.00
MED/SURG SUPPLY	7,724.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,809.06	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,087.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,804.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,724.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,114.63	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,392.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,307.50	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	504.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	915.20	1,192.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,918.20	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,272.00	0.00			
			TOTAL ANCILLARY	92,650.64	1,192.70
			TOTAL ACCOMODATIONS	28,238.00	88,851.68
			TOTAL CHARGES	120,888.64	90,044.38



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

JENKINS COUNTY HOSPITAL  
931 E WINTHROPE AVE  
MILLEN,GA 30442-1839

PROVIDER NUMBER  
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,610,901.52	ADJUSTMENTS	37,557.58
COVERED CHARGES	1,527,104.22	CONTRACTUAL ALLOW	1,111,292.34
NON-COVERD CHARGES	83,797.30	TOTAL MEDICAID LIAB	415,811.88
		LESS: COB	6,030.46
		LESS: COPAYMENT	1,056.00
		REIMBURSEMENT	408,725.42
		ALL OTHER	280,247.39
		FEE SCHEDULE-LAB	128,478.03
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	2,078

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,634.26	169.00	OTHER LAB	10,660.40	0.00
MED/SURG SUPPLY	7,902.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	39.04	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,725.85	3,045.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,831.85	18,733.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,599.37	13,539.09	FEE SCHEDULE LAB	621,351.60	20,834.16
EKG/ECG	13,248.85	344.90	MRI SERVICES	0.00	0.00
IV THERAPY	41,050.44	3,524.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	419,980.10	11,817.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,860.75	392.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	175,727.05	5,681.80	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	593.37	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	150.00
OTHER IMAGING SERVICE	9,522.45	1,008.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,830.40	985.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,276.20	2,938.65			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,901.95	0.00			
			TOTAL ANCILLARY	1,527,104.22	83,797.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,527,104.22	83,797.30

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2215057011140	02/13/15 - 02/13/15	03/02/15	0.00	150.00	0.00	0.00	0.00
TOTAL				0.00	150.00	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

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,522.21	ADJUSTMENTS	0.00
COVERED CHARGES	3,587.79	CONTRACTUAL ALLOW	1,795.19
NON-COVERD CHARGES	1,934.42	TOTAL MEDICAID LIAB	1,792.60
		LESS: COB	1,789.60
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	22.50	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	843.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,396.71	1,091.07
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	216.93	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	861.65	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	3,587.79	1,934.42
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,587.79	1,934.42

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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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	91,306.50	ADJUSTMENTS	97.00
COVERED CHARGES	88,224.46	CONTRACTUAL ALLOW	79,774.46
NON-COVERD CHARGES	3,082.04	TOTAL MEDICAID LIAB	8,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	357.00
		REIMBURSEMENT	8,093.00
		TOTAL NUMBER OF CLAIMS	169

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,160.78	0.00	OTHER LAB	846.65	0.00
MED/SURG SUPPLY	431.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,600.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,986.35	1,638.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,090.24	749.20
EKG/ECG	1,207.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,348.70	152.34	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	707.09	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	48,068.00	542.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,767.80	0.00			
			TOTAL ANCILLARY	88,224.46	3,082.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	88,224.46	3,082.04



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	377.83	ADJUSTMENTS	0.00
COVERED CHARGES	377.83	CONTRACTUAL ALLOW	185.81
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	192.02
		LESS: COB	192.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	54.28	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	319.55	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	377.83	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	377.83	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:04:44  
Page: 13

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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:04:44  
Page: 14

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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 02:28:21  
 Page: 1

HUTCHESON MEDICAL CENTER  
 100 GROSS CRESCENT CIR  
 FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
 000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,738,482.24	ADJUSTMENTS	290,391.94
COVERED CHARGES	4,561,261.39	CONTRACTUAL ALLOW	3,200,128.98
NON-COVERD CHARGES	177,220.85	TOTAL MEDICAID LIAB	1,361,132.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,361,132.41

TOTAL NUMBER OF ADMISSIONS 175

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	614		0	504,987.00		129,114.00
ROUTINE NURSERY	29		0	18,299.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	643		0	523,286.00		129,114.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	121		1	229,208.00		1,916.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	121		1	229,208.00		1,916.00
TOTAL ACCOMODATIONS	764		1	752,494.00		131,030.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	910,727.96	506.85	OTHER LAB	18,801.00	0.00
MED/SURG SUPPLY	128,915.14	440.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	939,559.02	7,779.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	125,791.00	10,203.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	191,443.00	5,204.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,173.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	59,844.00	0.00	MRI SERVICES	12,933.00	0.00
IV THERAPY	143,338.00	1,980.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	187,592.00	17,245.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	45,772.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	374,467.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,545.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	19,272.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	276,763.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	40,064.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,719.16	0.00
RADIOLOGY THERAPEUTIC	0.00	335.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,091.00	0.00	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	200.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	34,721.09	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,417.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,096.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	27,287.00	1,994.00			
AUDIOLOGY	710.00	0.00			
CARDIOLOGY	92,808.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	70,718.00	0.00			
			TOTAL ANCILLARY	3,808,767.39	46,190.85
			TOTAL ACCOMODATIONS	752,494.00	131,030.00
			TOTAL CHARGES	4,561,261.39	177,220.85

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:28:23  
 Page: 3

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,294.37	ADJUSTMENTS	0.00
COVERED CHARGES	13,784.37	CONTRACTUAL ALLOW	8,471.17
NON-COVERD CHARGES	510.00	TOTAL MEDICAID LIAB	5,313.20
		LESS: COB	5,313.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		0	1,566.00		510.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,566.00		510.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	2		0	1,566.00		510.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,872.37	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,000.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,408.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,227.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	890.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	821.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,218.37	0.00
			TOTAL ACCOMODATIONS	1,566.00	510.00
			TOTAL CHARGES	13,784.37	510.00



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:28:24  
Page: 5

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,837,605.88	ADJUSTMENTS	328,075.88
COVERED CHARGES	8,320,681.30	CONTRACTUAL ALLOW	6,636,017.55
NON-COVERD CHARGES	516,924.58	TOTAL MEDICAID LIAB	1,684,663.75
		LESS: COB	7,418.48
		LESS: COPAYMENT	3,630.00
		REIMBURSEMENT	1,673,615.27
		ALL OTHER	1,362,595.72
		FEE SCHEDULE-LAB	108,648.03
		INJECTABLE DRUGS	202,371.52

TOTAL NUMBER OF CLAIMS 3,587

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	233,237.99	6,651.53	OTHER LAB	35,816.00	283.00
MED/SURG SUPPLY	84,463.36	167.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	295,568.00	13,073.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	728,511.00	70,410.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	56,197.00	32,320.05	FEE SCHEDULE LAB	1,310,894.90	188,160.80
EKG/ECG	166,562.00	5,105.00	MRI SERVICES	23,621.00	0.00
IV THERAPY	635,064.00	8,300.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	274,005.00	15,730.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	130,708.00	3,895.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	63,431.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	178,083.00	14,748.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,951,885.00	1,002.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	140,038.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,030,212.04	73,270.20
RADIOLOGY THERAPEUTIC	418,031.00	24,976.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,093.00	2,464.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,009.00	1,186.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,544.00	10,516.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	45,209.32	6,298.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	70,126.00	7,511.00			
BLOOD	1,428.00	1,682.00			
BLOOD STORAGE & PRO.	32,602.00	5,526.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	121,481.00	8,493.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	137,432.00	2,630.00			
AMBULATORY SURGERY	72,326.69	9,802.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	64,102.00	2,725.00			
			TOTAL ANCILLARY	8,320,681.30	516,924.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,320,681.30	516,924.58

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: 08/12/2016  
Run Time: 02:28:54  
Page: 7

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,213.12	ADJUSTMENTS	0.00
COVERED CHARGES	64,387.80	CONTRACTUAL ALLOW	47,366.39
NON-COVERD CHARGES	11,825.32	TOTAL MEDICAID LIAB	17,021.41
		LESS: COB	16,973.41
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 24

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,726.60	2,026.50	OTHER LAB	761.00	0.00
MED/SURG SUPPLY	955.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,241.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,447.00	3,030.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,176.18	2,771.00
EKG/ECG	710.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,807.00	200.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,881.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	378.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,058.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,280.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,819.02	916.82
RADIOLOGY THERAPEUTIC	5,142.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	860.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,225.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,744.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	64,387.80	11,825.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,387.80	11,825.32

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	641,705.92	ADJUSTMENTS	1,388.44
COVERED CHARGES	633,309.52	CONTRACTUAL ALLOW	604,388.54
NON-COVERD CHARGES	8,396.40	TOTAL MEDICAID LIAB	28,920.98
		LESS: COB	0.00
		LESS: COPAYMENT	1,033.18
		REIMBURSEMENT	27,887.80
		TOTAL NUMBER OF CLAIMS	517

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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,245.04	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	163.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	54.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,386.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,005.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	79,944.16	4,645.00
EKG/ECG	8,737.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	55,191.00	1,120.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,761.00	788.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	222.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,262.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	410,009.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	821.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,140.32	1,127.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,423.00	662.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	633,309.52	8,396.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	633,309.52	8,396.40

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

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,211.95	ADJUSTMENTS	0.00
COVERED CHARGES	12,157.95	CONTRACTUAL ALLOW	9,880.98
NON-COVERD CHARGES	54.00	TOTAL MEDICAID LIAB	2,276.97
		LESS: COB	2,273.97
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 7

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	325.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,956.00	54.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,460.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,349.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,157.95	54.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,157.95	54.00



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

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,531,586.65	ADJUSTMENTS	47,241.52
COVERED CHARGES	1,459,772.12	CONTRACTUAL ALLOW	1,228,550.61
NON-COVERD CHARGES	71,814.53	TOTAL MEDICAID LIAB	231,221.51
		LESS: COB	5,854.19
		LESS: COPAYMENT	618.00
		REIMBURSEMENT	224,749.32
		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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,940.55	0.00	OTHER LAB	1,698.00	1,132.00
MED/SURG SUPPLY	3,711.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,351.16	2,315.56
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,777.00	1,150.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	970,892.41	64,993.97
RADIOLOGY THERAPEUTIC	418,402.00	2,136.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	87.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,459,772.12	71,814.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,459,772.12	71,814.53

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

HUTCHESON MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
100 GROSS CRESCENT CIR	000001075A	SERVICE DATES	10/01/14	THROUGH	09/30/15
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
2602	2215162003510	03/30/15 - 03/30/15	06/15/15	0.00	87.00	0.00	0.00	0.00
TOTAL				0.00	87.00	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

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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,084,652.11	ADJUSTMENTS	422,858.69
COVERED CHARGES	13,929,890.51	CONTRACTUAL ALLOW	9,742,064.96
NON-COVERD CHARGES	154,761.60	TOTAL MEDICAID LIAB	4,187,825.55
		LESS: COB	9,682.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,178,143.30

TOTAL NUMBER OF ADMISSIONS 652

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,306		0	1,074,130.00		4,100.00
ROUTINE NURSERY	308		0	242,704.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,614		0	1,316,834.00		4,100.00
SPECIAL CARE SERVICES						
CCU	315		0	473,000.00		0.00
ICU	162		2	324,162.00		4,002.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	477		2	797,162.00		4,002.00
TOTAL ACCOMODATIONS	2,091		2	2,113,996.00		8,102.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	625,653.00	60.00	OTHER LAB	79,892.25	0.00
MED/SURG SUPPLY	589,199.72	1,101.35	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,091,413.10	4,051.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	255,428.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	749,974.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,819.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	292,174.25	0.00	MRI SERVICES	123,161.50	0.00
IV THERAPY	20,476.50	0.00	PROFESSIONAL FEES	0.00	968.00
OPERATING ROOM	2,301,259.50	46,248.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	456,252.83	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	500,420.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	319,211.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	798,276.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	163,711.34	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	67,771.25	0.00	INJECTABLE DRUGS	1,096,238.82	0.00
RADIOLOGY THERAPEUTIC	1,157.54	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,768.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,423.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	155,088.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,861.50	14,790.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	180,210.91	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,948.00
OTHER IMAGING SERVICE	75,039.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	82,143.75	63,050.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	65,114.75	11,441.50			
AUDIOLOGY	46,241.00	0.00			
CARDIOLOGY	579,513.50	0.00			
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	33,588.25	0.00			
			TOTAL ANCILLARY	11,815,894.51	146,659.60
			TOTAL ACCOMODATIONS	2,113,996.00	8,102.00
			TOTAL CHARGES	13,929,890.51	154,761.60

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
Run Time: 02:39:54  
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MEADOWS REGIONAL MEDICAL CENTER  
1 MEADOWS PKWY  
VIDALIA,GA 30474-8759

PROVIDER NUMBER  
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015075023641	02/05/15 - 02/23/15	03/23/15	0.00	2,474.00	0.00	0.00	0.00
615	2015103026579	01/07/15 - 01/12/15	04/20/15	0.00	2,474.00	0.00	0.00	0.00
TOTAL				0.00	4,948.00	0.00	0.00	0.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:40:03  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

MEADOWS REGIONAL MEDICAL CENTER  
1 MEADOWS PKWY  
VIDALIA,GA 30474-8759

PROVIDER NUMBER  
000001086A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:40:03  
Page: 5

MEADOWS REGIONAL MEDICAL CENTER  
1 MEADOWS PKWY  
VIDALIA,GA 30474-8759

PROVIDER NUMBER  
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,315,795.05	ADJUSTMENTS	192,583.22
COVERED CHARGES	14,708,860.98	CONTRACTUAL ALLOW	12,334,227.49
NON-COVERD CHARGES	1,606,934.07	TOTAL MEDICAID LIAB	2,374,633.49
		LESS: COB	2,095.96
		LESS: COPAYMENT	13,004.32
		REIMBURSEMENT	2,359,533.21
		ALL OTHER	2,058,951.51
		FEE SCHEDULE-LAB	169,012.91
		INJECTABLE DRUGS	131,568.79

TOTAL NUMBER OF CLAIMS 5,912

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,862.76	2,677.49	OTHER LAB	97,470.50	965.25
MED/SURG SUPPLY	298,796.67	4,611.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	759.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	645,717.00	23,639.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,939,757.50	194,277.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	44,881.25	24,836.50	FEE SCHEDULE LAB	2,191,120.17	371,293.81
EKG/ECG	137,684.75	315.25	MRI SERVICES	708,239.00	21,971.75
IV THERAPY	210,347.25	1,966.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,840,666.00	283,021.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,671.08	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	171,051.00	108,677.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	300,182.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,241,022.75	8,922.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	146,293.92	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	158.50	INJECTABLE DRUGS	219,682.58	68,928.89
RADIOLOGY THERAPEUTIC	554,432.66	13,650.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	28,957.00	16,450.54	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,269.00	8,332.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,154.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	752,708.69	12,386.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	56,731.45	60,924.18
LITHOTRIPSY	338,248.00	21,140.50	NO CC/INVALID REV CODE	0.00	2,474.00
OTHER IMAGING SERVICE	382,200.75	35,612.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	58,806.75	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	407,797.75	107,276.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	375,580.25	206,189.25			
AMBULATORY SURGERY	9,521.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	350,304.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	77,856.50	3,320.50			
			TOTAL ANCILLARY	14,708,860.98	1,606,934.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,708,860.98	1,606,934.07

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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MEADOWS REGIONAL MEDICAL CENTER  
1 MEADOWS PKWY  
VIDALIA,GA 30474-8759

PROVIDER NUMBER  
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015054025051	02/06/15 - 02/06/15	03/02/15	0.00	2,474.00	0.00	0.00	0.00
TOTAL				0.00	2,474.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER  
1 MEADOWS PKWY  
VIDALIA,GA 30474-8759

PROVIDER NUMBER  
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,353.65	ADJUSTMENTS	0.00
COVERED CHARGES	27,067.22	CONTRACTUAL ALLOW	6,274.08
NON-COVERD CHARGES	20,286.43	TOTAL MEDICAID LIAB	20,793.14
		LESS: COB	20,772.14
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEADOWS REGIONAL MEDICAL CENTER  
 1 MEADOWS PKWY  
 VIDALIA,GA 30474-8759

PROVIDER NUMBER  
 000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	263.16	0.00	OTHER LAB	344.25	0.00
MED/SURG SUPPLY	932.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,383.75	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	6,841.75	503.75
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	19,052.75	DURABLE MED. EQUIP.	0.00	344.25
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	282.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,116.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,295.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,004.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	161.71	63.93
RADIOLOGY THERAPEUTIC	0.00	153.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,811.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	675.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,955.50	168.75			
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	27,067.22	20,286.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,067.22	20,286.43

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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MEADOWS REGIONAL MEDICAL CENTER  
1 MEADOWS PKWY  
VIDALIA,GA 30474-8759

PROVIDER NUMBER  
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	812,562.83	ADJUSTMENTS	1,017.86
COVERED CHARGES	787,235.13	CONTRACTUAL ALLOW	751,601.36
NON-COVERD CHARGES	25,327.70	TOTAL MEDICAID LIAB	35,633.77
		LESS: COB	0.00
		LESS: COPAYMENT	1,305.00
		REIMBURSEMENT	34,328.77
		TOTAL NUMBER OF CLAIMS	637

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,693.80	0.00	OTHER LAB	2,289.50	0.00
MED/SURG SUPPLY	3,835.76	44.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,412.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	69,522.50	4,825.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	292.25	113.25	FEE SCHEDULE LAB	130,388.50	17,895.00
EKG/ECG	11,979.50	0.00	MRI SERVICES	4,291.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,235.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,035.00	131.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	497,768.00	496.75	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	6,636.32	412.36
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,257.75	586.27	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,403.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,517.25	675.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,499.00	148.50			
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	1,179.00	0.00			
			TOTAL ANCILLARY	787,235.13	25,327.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	787,235.13	25,327.70

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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MEADOWS REGIONAL MEDICAL CENTER  
1 MEADOWS PKWY  
VIDALIA,GA 30474-8759

PROVIDER NUMBER  
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,407.02	ADJUSTMENTS	0.00
COVERED CHARGES	3,638.51	CONTRACTUAL ALLOW	2,489.23
NON-COVERD CHARGES	768.51	TOTAL MEDICAID LIAB	1,149.28
		LESS: COB	1,149.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 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	36.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,236.00	150.25
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	2,355.75	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	10.00	0.26
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	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	3,638.51	768.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,638.51	768.51

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MEDICAL CENTER  
1 MEADOWS PKWY  
VIDALIA,GA 30474-8759

PROVIDER NUMBER  
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	339,209.64	ADJUSTMENTS	11,752.30
COVERED CHARGES	305,977.40	CONTRACTUAL ALLOW	258,968.20
NON-COVERD CHARGES	33,232.24	TOTAL MEDICAID LIAB	47,009.20
		LESS: COB	0.00
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	46,895.20

TOTAL NUMBER OF CLAIMS 8

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,539.21	36.77	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,705.15	1,705.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	330.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,524.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,664.00	1,149.00
EKG/ECG	630.50	630.50	MRI SERVICES	0.00	0.00
IV THERAPY	21,198.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,076.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	94,222.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,440.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,975.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	502.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,445.52	4,027.69
RADIOLOGY THERAPEUTIC	10,610.64	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,777.25	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	186.68	24,557.90
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	77,294.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,856.75	1,124.50			
			TOTAL ANCILLARY	305,977.40	33,232.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	305,977.40	33,232.24

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 02:41:01  
Page: 16

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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER 000001108A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,054,949.48	ADJUSTMENTS	1,175,022.09
COVERED CHARGES	15,253,359.48	CONTRACTUAL ALLOW	11,726,079.54
NON-COVERD CHARGES	801,590.00	TOTAL MEDICAID LIAB	3,527,279.94
		LESS: COB	23,972.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,503,307.14

TOTAL NUMBER OF ADMISSIONS 663

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,447		0	1,404,302.00		379,165.00
ROUTINE NURSERY	568		20	819,016.00		134,979.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,015		20	2,223,318.00		514,144.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	189		0	711,774.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	189		0	711,774.00		0.00
TOTAL ACCOMODATIONS	2,204		20	2,935,092.00		514,144.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,186,947.49	29,797.00	OTHER LAB	37,166.00	0.00
MED/SURG SUPPLY	788,663.00	11,692.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,082,432.94	37,518.00	EDUCATION & TRAINING	780.00	0.00
RADIOLOGY-DIAGNOSTIC	193,972.00	1,850.00	OTHER THERAPEUTIC SVC	0.00	2,601.00
CT SCAN	608,191.00	2,400.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	106,953.00	3,250.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	67,370.00	489.00	MRI SERVICES	246,748.00	0.00
IV THERAPY	53,017.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,296,805.00	18,445.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	806,402.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	481,515.00	13,959.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	184,619.00	1,579.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	381,070.00	52.00	SPECIAL SERVICES	0.00	14,550.00
RECOVERY ROOM	143,212.00	1,317.00	DRUG-SPECIFIC/HOME IV	0.00	28,240.00
LABORATORY PATHOLOGIC	79,011.00	424.00	INJECTABLE DRUGS	2,533,959.05	42,479.00
RADIOLOGY THERAPEUTIC	93,383.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	34,249.00	1,390.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	33,184.00	691.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	86,658.00	38,470.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	200,890.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	107,031.00	19,419.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	91,928.00	6,591.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	51,612.00	6,710.00			
AUDIOLOGY	81,536.00	0.00			
CARDIOLOGY	246,074.00	2,365.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,495.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,394.00	1,168.00			
			TOTAL ANCILLARY	12,318,267.48	287,446.00
			TOTAL ACCOMODATIONS	2,935,092.00	514,144.00
			TOTAL CHARGES	15,253,359.48	801,590.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	169,778.00	ADJUSTMENTS	0.00
COVERED CHARGES	162,047.00	CONTRACTUAL ALLOW	99,916.46
NON-COVERD CHARGES	7,731.00	TOTAL MEDICAID LIAB	62,130.54
		LESS: COB	62,130.54
		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	27		0	26,172.00		3,555.00
ROUTINE NURSERY	4		0	9,755.00		1,897.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	31		0	35,927.00		5,452.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	31		0	35,927.00		5,452.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,622.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,335.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,093.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,110.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	628.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,637.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,625.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	767.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,940.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	2,279.00
RECOVERY ROOM	4,140.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,923.00	0.00	INJECTABLE DRUGS	19,956.50	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	2,234.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	744.00	0.00			
CARDIOLOGY	2,365.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	126,120.00	2,279.00
			TOTAL ACCOMODATIONS	35,927.00	5,452.00
			TOTAL CHARGES	162,047.00	7,731.00



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:01:26  
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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,647,239.69	ADJUSTMENTS	638,220.77
COVERED CHARGES	12,617,857.82	CONTRACTUAL ALLOW	10,685,160.78
NON-COVERD CHARGES	2,029,381.87	TOTAL MEDICAID LIAB	1,932,697.04
		LESS: COB	4,225.68
		LESS: COPAYMENT	3,298.81
		REIMBURSEMENT	1,925,172.55
		ALL OTHER	1,738,821.30
		FEE SCHEDULE-LAB	119,516.44
		INJECTABLE DRUGS	66,834.81

TOTAL NUMBER OF CLAIMS 2,876

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	289,246.05	14,759.21	OTHER LAB	138,780.00	0.00
MED/SURG SUPPLY	416,982.00	8,037.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	156.00	0.00
RADIOLOGY-DIAGNOSTIC	482,856.00	1,138.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,552,801.00	487,379.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,067.00	16,498.00	FEE SCHEDULE LAB	2,031,356.88	330,820.70
EKG/ECG	184,318.00	2,512.00	MRI SERVICES	415,193.00	110,696.00
IV THERAPY	471,265.00	2,857.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	820,314.00	66,049.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,348.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58,739.00	1,212.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	171,041.00	3,005.00	AMBULANCE	0.00	0.00
GI SERVICES	6,800.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,044,386.00	13,005.00	SPECIAL SERVICES	0.00	2,676.00
RECOVERY ROOM	194,741.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,983.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	717,702.06	326,398.96
RADIOLOGY THERAPEUTIC	544,975.00	146,652.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,440.00	5,764.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	10,967.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	24,442.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,152.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,231.00	0.00
LITHOTRIPSY	20,172.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	387,804.00	135,810.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	51,809.00	1,653.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	112,506.00	156,105.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	164,150.00	152,472.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,194.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	213,484.83	3,339.00			
			TOTAL ANCILLARY	12,617,857.82	2,029,381.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,617,857.82	2,029,381.87

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:01:48  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC  
201 HOSPITAL RD  
CANTON,GA 30114-2408

PROVIDER NUMBER  
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	287,478.74	ADJUSTMENTS	0.00
COVERED CHARGES	226,279.74	CONTRACTUAL ALLOW	139,930.64
NON-COVERD CHARGES	61,199.00	TOTAL MEDICAID LIAB	86,349.10
		LESS: COB	86,305.61
		LESS: COPAYMENT	43.49
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 66

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER  
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,092.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	18,004.00	56.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	95.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,525.00	470.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,681.00	9,081.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	41,627.00	4,194.00
EKG/ECG	2,512.00	314.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,002.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,289.00	19,242.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,693.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	351.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,607.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,439.00	1,069.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,254.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,801.74	15,371.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,069.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,323.00	11,307.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	725.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,285.00	0.00			
			TOTAL ANCILLARY	226,279.74	61,199.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	226,279.74	61,199.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:01:50  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	766,473.50	ADJUSTMENTS	2,284.14
COVERED CHARGES	711,776.04	CONTRACTUAL ALLOW	690,574.84
NON-COVERD CHARGES	54,697.46	TOTAL MEDICAID LIAB	21,201.20
		LESS: COB	0.00
		LESS: COPAYMENT	706.78
		REIMBURSEMENT	20,494.42
		TOTAL NUMBER OF CLAIMS	379

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,629.96	3.86	OTHER LAB	4,704.00	0.00
MED/SURG SUPPLY	8,493.00	211.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,480.00	887.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,555.00	15,762.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	129,864.30	12,249.70
EKG/ECG	10,048.00	0.00	MRI SERVICES	26,796.00	0.00
IV THERAPY	4,879.00	7,020.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,039.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,306.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	367,222.00	2,482.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,084.34	5,541.38
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	20,610.00	9,269.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,065.44	1,271.52			
			TOTAL ANCILLARY	711,776.04	54,697.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	711,776.04	54,697.46

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,293.00	ADJUSTMENTS	0.00
COVERED CHARGES	17,483.50	CONTRACTUAL ALLOW	12,981.80
NON-COVERD CHARGES	6,809.50	TOTAL MEDICAID LIAB	4,501.70
		LESS: COB	4,495.70
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105.50	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,663.00	2,400.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,685.00	52.00
EKG/ECG	314.00	0.00	MRI SERVICES	2,558.00	3,707.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,686.00	78.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	330.00	572.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,483.50	6,809.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,483.50	6,809.50



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: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,744,359.04	ADJUSTMENTS	43,992.55
COVERED CHARGES	1,474,791.44	CONTRACTUAL ALLOW	1,298,863.74
NON-COVERD CHARGES	269,567.60	TOTAL MEDICAID LIAB	175,927.70
		LESS: COB	0.00
		LESS: COPAYMENT	162.00
		REIMBURSEMENT	175,765.70

TOTAL NUMBER OF CLAIMS 32

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,939.03	0.00	OTHER LAB	764.00	0.00
MED/SURG SUPPLY	224,283.00	2,430.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,976.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,018.00	6,118.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,713.00	FEE SCHEDULE LAB	63,926.00	5,122.00
EKG/ECG	5,652.00	628.00	MRI SERVICES	16,254.00	13,457.00
IV THERAPY	33,271.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	276,469.00	168,745.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,852.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	46,554.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,429.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,257.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	638.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	333,592.81	24,387.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	392.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,382.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,444.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	250,979.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	784.00	1,382.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,475.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	88,932.00	31,254.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,859.60	0.00			
			TOTAL ANCILLARY	1,474,791.44	269,567.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,474,791.44	269,567.60

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:32:22  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER 000001119A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	95,955,462.70	ADJUSTMENTS	1,719,014.47
COVERED CHARGES	93,605,015.47	CONTRACTUAL ALLOW	73,726,643.29
NON-COVERD CHARGES	2,350,447.23	TOTAL MEDICAID LIAB	19,878,372.18
		LESS: COB	195,648.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	19,682,724.04

TOTAL NUMBER OF ADMISSIONS 2,191

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,307		103	6,395,298.00		1,183,615.50
ROUTINE NURSERY	1,762		17	2,376,856.40		62,611.20
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		50,670.50
TOTAL ROUTINE	8,069		120	8,772,154.40		1,296,897.20
SPECIAL CARE SERVICES						
CCU	2,362		13	5,331,339.24		174,800.00
ICU	1,447		0	4,174,818.06		49,170.00
NICU	623		0	1,854,047.10		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	40		0	187,320.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		32	0.00		49,664.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,472		45	11,547,524.40		273,634.00
TOTAL ACCOMODATIONS	12,541		165	20,319,678.80		1,570,531.20

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,338,920.24	139,773.35	OTHER LAB	806,479.82	5,250.00
MED/SURG SUPPLY	4,381,789.83	68,881.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,721,514.38	83,971.00	EDUCATION & TRAINING	59,230.00	0.00
RADIOLOGY-DIAGNOSTIC	1,897,127.11	16,852.00	OTHER THERAPEUTIC SVC	0.00	12,060.06
CT SCAN	5,418,838.00	31,602.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	502,951.09	4,944.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	599,213.00	7,372.00	MRI SERVICES	1,444,699.03	0.00
IV THERAPY	1,095,730.25	17,524.04	PROFESSIONAL FEES	0.00	239.00
OPERATING ROOM	7,538,801.15	40,668.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,609,951.29	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,352,419.03	98,493.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,859,538.15	20,382.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,700,757.49	19,911.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,051,241.85	9,383.00	DRUG-SPECIFIC/HOME IV	0.00	10,399.50
LABORATORY PATHOLOGIC	380,940.37	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	397,429.10	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	200,963.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	261,459.06	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,335,125.03	5,988.00	PATIENT CONVENIENCE	0.00	25.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	91,548.40	5,803.00	TRAUMA RESPONSE	0.00	60,211.00
PSYCHIATRIC SERVICES	4,664.40	3,085.00	IMPL DEV CHARGE PATIENTS	2,791,795.46	34,640.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	457,132.02	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,038,239.46	36,980.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	502,799.00	2,772.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,871,026.00	39,466.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	210,412.48	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	362,601.15	3,240.00			
			TOTAL ANCILLARY	73,285,336.67	779,916.03
			TOTAL ACCOMODATIONS	20,319,678.80	1,570,531.20
			TOTAL CHARGES	93,605,015.47	2,350,447.23

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:32:41  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,557,053.11	ADJUSTMENTS	0.00
COVERED CHARGES	3,511,540.86	CONTRACTUAL ALLOW	1,893,740.73
NON-COVERD CHARGES	45,512.25	TOTAL MEDICAID LIAB	1,617,800.13
		LESS: COB	1,617,800.13
		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	107		6	108,498.00		23,823.25
ROUTINE NURSERY	192		0	451,520.00		21,407.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	299		6	560,018.00		45,230.25
SPECIAL CARE SERVICES						
CCU	27		0	59,105.00		0.00
ICU	13		0	39,649.00		0.00
NICU	203		0	604,128.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	243		0	702,882.00		0.00
TOTAL ACCOMODATIONS	542		6	1,262,900.00		45,230.25

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	426,524.07	0.00	OTHER LAB	15,562.00	0.00
MED/SURG SUPPLY	206,677.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	239,772.00	0.00	EDUCATION & TRAINING	6,001.00	0.00
RADIOLOGY-DIAGNOSTIC	39,972.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,377.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,232.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	5,820.00	0.00	MRI SERVICES	12,471.00	0.00
IV THERAPY	17,354.12	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	141,945.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	373,658.49	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	408,406.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	43,150.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,220.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,714.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,513.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,071.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,330.68	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,117.72	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	36,794.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	32,310.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,132.00	282.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	115,447.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,067.29	0.00			
			TOTAL ANCILLARY	2,248,640.86	282.00
			TOTAL ACCOMODATIONS	1,262,900.00	45,230.25
			TOTAL CHARGES	3,511,540.86	45,512.25

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:32:43  
Page: 5

WELLSTAR KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,203,786.00	ADJUSTMENTS	658,315.62
COVERED CHARGES	27,194,207.90	CONTRACTUAL ALLOW	23,547,083.12
NON-COVERD CHARGES	4,009,578.10	TOTAL MEDICAID LIAB	3,647,124.78
		LESS: COB	46,299.49
		LESS: COPAYMENT	8,381.54
		REIMBURSEMENT	3,592,443.75
		ALL OTHER	3,062,720.58
		FEE SCHEDULE-LAB	351,477.82
		INJECTABLE DRUGS	178,245.35

TOTAL NUMBER OF CLAIMS 9,185



WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	578,665.59	39,899.00	OTHER LAB	585,699.37	1,564.00
MED/SURG SUPPLY	610,972.11	21,254.89	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	353.62	EDUCATION & TRAINING	32.00	0.00
RADIOLOGY-DIAGNOSTIC	1,278,007.69	6,085.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,555,731.60	926,537.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	67,274.00	30,134.62	FEE SCHEDULE LAB	3,884,116.86	665,288.69
EKG/ECG	321,497.01	5,432.00	MRI SERVICES	1,091,041.52	262,142.00
IV THERAPY	1,112,007.45	19,593.72	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,487,674.14	355,105.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	174,462.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	114,566.36	85,911.72	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	864,930.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,147,126.25	7,808.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	645,667.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,155.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,272,086.73	311,329.04
RADIOLOGY THERAPEUTIC	739,649.00	94,692.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,482.00	30,275.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	23,370.00	20,940.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	11,976.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	263,889.36	18,226.72	TRAUMA RESPONSE	0.00	14,287.00
PSYCHIATRIC SERVICES	94,647.60	30,220.00	IMPL DEV CHARGE PATIENTS	95,914.32	124,404.36
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,193,201.61	322,699.14			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	133,945.93	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	527,829.81	245,462.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	722,785.00	334,430.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	55,348.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	511,586.34	22,372.00			
			TOTAL ANCILLARY	27,194,207.90	4,009,578.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,194,207.90	4,009,578.10

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	651,669.76	ADJUSTMENTS	0.00
COVERED CHARGES	563,000.57	CONTRACTUAL ALLOW	297,687.28
NON-COVERD CHARGES	88,669.19	TOTAL MEDICAID LIAB	265,313.29
		LESS: COB	265,207.29
		LESS: COPAYMENT	106.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 166

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR KENNESTONE HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 677 CHURCH ST NE 000001119A SERVICE DATES 07/01/14 THROUGH 06/30/15  
 MARIETTA,GA 30060-1101 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,677.57	2,102.84	OTHER LAB	15,664.90	0.00
MED/SURG SUPPLY	12,368.56	168.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,544.36	439.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	49,607.00	14,719.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	82,284.32	11,497.22
EKG/ECG	3,972.00	0.00	MRI SERVICES	30,294.00	10,811.00
IV THERAPY	29,601.46	790.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,915.00	15,528.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,918.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,926.00	2,019.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,623.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	121,351.53	1.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,859.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,259.49	3,854.33
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	4,144.00	222.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	964.40	0.00	IMPL DEV CHARGE PATIENTS	3,967.92	4,154.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,000.00
OTHER IMAGING SERVICE	11,019.46	21,123.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,588.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,519.00	240.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,140.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,559.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,232.60	0.00			
			TOTAL ANCILLARY	563,000.57	88,669.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	563,000.57	88,669.19

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR KENNESTONE HOSPITAL	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
677 CHURCH ST NE	000001119A	SERVICE DATES	07/01/14	THROUGH	06/30/15
MARIETTA,GA 30060-1101		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
948	2014217044144	07/01/14 - 07/01/14	08/11/14	0.00	100.00	0.00	0.00	0.00
948	2014248047140	08/22/14 - 08/22/14	09/08/14	0.00	100.00	0.00	0.00	0.00
948	2014248047140	08/15/14 - 08/15/14	09/08/14	0.00	100.00	0.00	0.00	0.00
948	2014280042689	09/26/14 - 09/26/14	10/13/14	0.00	100.00	0.00	0.00	0.00
948	2014280042689	09/19/14 - 09/19/14	10/13/14	0.00	100.00	0.00	0.00	0.00
948	2014280042689	09/12/14 - 09/12/14	10/13/14	0.00	100.00	0.00	0.00	0.00
948	2014280042689	09/09/14 - 09/09/14	10/13/14	0.00	100.00	0.00	0.00	0.00
948	2014280042689	09/02/14 - 09/02/14	10/13/14	0.00	100.00	0.00	0.00	0.00
948	2014309052899	10/10/14 - 10/10/14	11/10/14	0.00	100.00	0.00	0.00	0.00
948	2014309052899	10/21/14 - 10/21/14	11/10/14	0.00	100.00	0.00	0.00	0.00
TOTAL				0.00	1,000.00	0.00	0.00	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:33:33  
Page: 10

WELLSTAR KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,203,466.41	ADJUSTMENTS	1,279.56
COVERED CHARGES	1,125,336.35	CONTRACTUAL ALLOW	1,090,396.23
NON-COVERD CHARGES	78,130.06	TOTAL MEDICAID LIAB	34,940.12
		LESS: COB	592.97
		LESS: COPAYMENT	1,131.27
		REIMBURSEMENT	33,215.88
		TOTAL NUMBER OF CLAIMS	614

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,033.00	900.00	OTHER LAB	30,252.00	0.00
MED/SURG SUPPLY	6,549.27	141.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	82,260.08	407.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	81,433.60	25,117.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	187,108.95	17,731.87
EKG/ECG	16,684.00	0.00	MRI SERVICES	4,233.00	7,927.00
IV THERAPY	64,917.76	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	10,774.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,259.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,031.56	837.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,598.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	555,691.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,999.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,981.00	2,673.75
RADIOLOGY THERAPEUTIC	616.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	419.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	11,923.20	2,410.00	IMPL DEV CHARGE PATIENTS	0.00	1,470.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,097.00	7,740.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,249.08	0.00			
			TOTAL ANCILLARY	1,125,336.35	78,130.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,125,336.35	78,130.06

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: 08/12/2016  
Run Time: 02:33:36  
Page: 12

WELLSTAR KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,442.06	ADJUSTMENTS	0.00
COVERED CHARGES	30,286.06	CONTRACTUAL ALLOW	12,502.85
NON-COVERD CHARGES	9,156.00	TOTAL MEDICAID LIAB	17,783.21
		LESS: COB	17,759.21
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	15

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:33:36  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	202.00	300.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	21.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,160.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,726.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,659.00	1,445.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,951.06	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	251.00	1,182.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,808.25	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	254.75	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	482.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,286.06	9,156.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,286.06	9,156.00



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,758,740.08	ADJUSTMENTS	183,373.67
COVERED CHARGES	3,591,720.63	CONTRACTUAL ALLOW	3,247,244.77
NON-COVERD CHARGES	167,019.45	TOTAL MEDICAID LIAB	344,475.86
		LESS: COB	0.00
		LESS: COPAYMENT	873.00
		REIMBURSEMENT	343,602.86
		TOTAL NUMBER OF CLAIMS	60

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,243.49	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	138,621.07	35,711.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,021.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	152,772.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,709.00	35.00
EKG/ECG	1,940.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,844.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	250,494.00	63,802.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,309.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,466.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,952.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,233,125.76	21,338.05
RADIOLOGY THERAPEUTIC	1,288,390.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,025.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	278,507.27	666.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	800.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	75,314.00	45,467.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,187.04	0.00			
			TOTAL ANCILLARY	3,591,720.63	167,019.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,591,720.63	167,019.45

Report : CLM-0814-0  
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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

WELLSTAR KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	141,510.55	ADJUSTMENTS	0.00
COVERED CHARGES	132,213.45	CONTRACTUAL ALLOW	50,167.51
NON-COVERD CHARGES	9,297.10	TOTAL MEDICAID LIAB	82,045.94
		LESS: COB	82,033.94
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,559.50	225.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,688.20	4,535.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	405.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,679.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	79,848.00	1.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,604.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,306.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	835.75	925.25
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	36,288.00	3,609.97
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	132,213.45	9,297.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	132,213.45	9,297.10

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

FAIRVIEW PARK HOSPITAL  
 200 INDUSTRIAL BLVD  
 DUBLIN,GA 31021-2981

PROVIDER NUMBER 000001141A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,035,360.29	ADJUSTMENTS	520,095.67
COVERED CHARGES	32,399,310.94	CONTRACTUAL ALLOW	26,529,594.00
NON-COVERD CHARGES	636,049.35	TOTAL MEDICAID LIAB	5,869,716.94
		LESS: COB	35,417.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,834,299.76

TOTAL NUMBER OF ADMISSIONS 756

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,154		7	2,027,061.00		186,226.00
ROUTINE NURSERY	128		0	82,512.00		1,242.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,282		7	2,109,573.00		187,468.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	812		0	1,770,264.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	812		0	1,770,264.00		0.00
TOTAL ACCOMODATIONS	3,094		7	3,879,837.00		187,468.00

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,129,949.25	54.00	OTHER LAB	150,276.00	0.00
MED/SURG SUPPLY	1,515,941.90	13,185.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,082,239.50	724.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	657,790.25	0.00	OTHER THERAPEUTIC SVC	0.00	9,347.00
CT SCAN	1,266,585.00	280,479.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	338,140.56	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	291,246.00	0.00	MRI SERVICES	285,716.00	0.00
IV THERAPY	6,962.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,414,401.50	1,446.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	226,137.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,265,399.75	2,469.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	236,973.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	142,080.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	982,811.00	1,225.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	267,040.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	40,778.75
LABORATORY PATHOLOGIC	122,026.50	0.00	INJECTABLE DRUGS	7,678,307.06	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	215,208.45	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	62,002.32	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	229,014.00	2,558.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,493.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	541,145.60	0.00
LITHOTRIPSY	22,393.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	252,538.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	95,365.80	96,313.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	403,000.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,526,576.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,220.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	79,494.00	0.00			
			TOTAL ANCILLARY	28,519,473.94	448,581.35
			TOTAL ACCOMODATIONS	3,879,837.00	187,468.00
			TOTAL CHARGES	32,399,310.94	636,049.35

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	503,011.39	ADJUSTMENTS	0.00
COVERED CHARGES	495,085.64	CONTRACTUAL ALLOW	343,508.43
NON-COVERD CHARGES	7,925.75	TOTAL MEDICAID LIAB	151,577.21
		LESS: COB	151,577.21
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	22		0	20,724.00		1,460.00
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	22		0	20,724.00		1,460.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	16		0	39,056.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	16		0	39,056.00		0.00
TOTAL ACCOMODATIONS	38		0	59,780.00		1,460.00

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,069.25	0.00	OTHER LAB	2,486.00	0.00
MED/SURG SUPPLY	15,949.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	74,579.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,986.50	0.00	OTHER THERAPEUTIC SVC	0.00	350.00
CT SCAN	6,762.00	3,634.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,702.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,856.00	0.00	MRI SERVICES	8,368.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,084.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	41,070.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,153.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,094.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,779.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,275.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,908.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,231.00	0.00	INJECTABLE DRUGS	130,169.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,555.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	905.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,070.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,882.64	2,481.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,042.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	328.00	0.00			
			TOTAL ANCILLARY	435,305.64	6,465.75
			TOTAL ACCOMODATIONS	59,780.00	1,460.00
			TOTAL CHARGES	495,085.64	7,925.75



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:09:43  
Page: 5

FAIRVIEW PARK HOSPITAL  
200 INDUSTRIAL BLVD  
DUBLIN,GA 31021-2981

PROVIDER NUMBER  
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,711,475.95	ADJUSTMENTS	102,122.14
COVERED CHARGES	17,608,056.56	CONTRACTUAL ALLOW	15,982,949.12
NON-COVERD CHARGES	2,103,419.39	TOTAL MEDICAID LIAB	1,625,107.44
		LESS: COB	1,853.09
		LESS: COPAYMENT	4,685.27
		REIMBURSEMENT	1,618,569.08
		ALL OTHER	1,432,315.06
		FEE SCHEDULE-LAB	158,999.05
		INJECTABLE DRUGS	27,254.97

TOTAL NUMBER OF CLAIMS 5,129

FAIRVIEW PARK HOSPITAL  
 200 INDUSTRIAL BLVD  
 DUBLIN,GA 31021-2981

PROVIDER NUMBER  
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	350,218.50	1,134.25	OTHER LAB	114,903.75	0.00
MED/SURG SUPPLY	639,267.15	71,422.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	531.40	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,090,564.60	5,320.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,950,034.00	355,604.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	79,974.25	7,559.75	FEE SCHEDULE LAB	4,152,623.82	719,480.90
EKG/ECG	275,697.00	11,860.00	MRI SERVICES	252,157.00	34,104.00
IV THERAPY	317,446.00	31,723.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,640,184.75	180,511.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	48,479.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	115,551.50	4,644.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	448,044.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	337,354.99	49,506.01	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,628,909.00	72,715.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	199,653.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,987.75
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	321,979.07	193,590.88
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,774.00	2,262.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,295.00	6,601.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,072.00	5,562.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	259,278.70	17,954.20
LITHOTRIPSY	22,393.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	547,461.75	36,794.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	25,718.72	26,313.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	230,179.00	52,268.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	247,193.00	194,402.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	167,124.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	100,525.76	17,567.00			
			TOTAL ANCILLARY	17,608,056.56	2,103,419.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,608,056.56	2,103,419.39

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK HOSPITAL  
200 INDUSTRIAL BLVD  
DUBLIN,GA 31021-2981

PROVIDER NUMBER  
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	517,913.74	ADJUSTMENTS	0.00
COVERED CHARGES	429,182.69	CONTRACTUAL ALLOW	252,907.46
NON-COVERD CHARGES	88,731.05	TOTAL MEDICAID LIAB	176,275.23
		LESS: COB	176,158.84
		LESS: COPAYMENT	116.39
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 117

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,796.50	0.00	OTHER LAB	1,910.00	0.00
MED/SURG SUPPLY	13,159.40	5,016.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,422.75	0.00	OTHER THERAPEUTIC SVC	0.00	350.00
CT SCAN	56,689.00	44,909.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,573.50	2,306.75	FEE SCHEDULE LAB	114,159.00	12,803.75
EKG/ECG	3,550.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,743.00	800.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	42,932.00	3,893.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,586.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,672.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,720.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,183.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,186.00	3,064.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,542.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,505.50	2,898.75
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	2,010.75	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,127.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,063.50	3,499.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	515.04	795.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,276.00	2,020.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,888.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,166.00	180.00			
			TOTAL ANCILLARY	429,182.69	88,731.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	429,182.69	88,731.05

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,034,387.50	ADJUSTMENTS	432.52
COVERED CHARGES	984,161.10	CONTRACTUAL ALLOW	952,499.06
NON-COVERD CHARGES	50,226.40	TOTAL MEDICAID LIAB	31,662.04
		LESS: COB	0.00
		LESS: COPAYMENT	1,104.00
		REIMBURSEMENT	30,558.04
		TOTAL NUMBER OF CLAIMS	566

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,785.50	0.00	OTHER LAB	7,376.75	0.00
MED/SURG SUPPLY	6,941.10	398.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	98,412.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	114,070.00	8,848.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	258,629.25	35,156.00
EKG/ECG	20,127.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	30,973.00	782.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,995.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,235.50	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	415,465.00	306.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,634.25	4,109.25
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	9,516.25	626.25			
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	984,161.10	50,226.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	984,161.10	50,226.40

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK HOSPITAL  
 200 INDUSTRIAL BLVD  
 DUBLIN,GA 31021-2981

PROVIDER NUMBER 000001141A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,352.70	ADJUSTMENTS	0.00
COVERED CHARGES	22,318.20	CONTRACTUAL ALLOW	14,971.94
NON-COVERD CHARGES	34.50	TOTAL MEDICAID LIAB	7,346.26
		LESS: COB	7,340.26
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	7

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:10:21  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

FAIRVIEW PARK HOSPITAL  
 200 INDUSTRIAL BLVD  
 DUBLIN,GA 31021-2981

PROVIDER NUMBER  
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	319.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	143.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,962.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,381.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,994.50	0.00
EKG/ECG	952.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	350.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,075.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	139.75	34.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,318.20	34.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,318.20	34.50



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 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,101,407.35	ADJUSTMENTS	10,821.73
COVERED CHARGES	932,018.90	CONTRACTUAL ALLOW	856,215.48
NON-COVERD CHARGES	169,388.45	TOTAL MEDICAID LIAB	75,803.42
		LESS: COB	0.00
		LESS: COPAYMENT	64.33
		REIMBURSEMENT	75,739.09

TOTAL NUMBER OF CLAIMS 14

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,291.25	0.00	OTHER LAB	1,999.50	0.00
MED/SURG SUPPLY	137,405.60	6,132.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,900.50	382.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,231.00	2,778.50
EKG/ECG	1,775.00	2,208.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	162.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	380,587.50	67,815.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	372.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,625.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,435.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,755.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,364.50	15,086.50
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	62.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	299,238.80	12,098.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	34,037.00	62,663.00			
AMBULATORY SURGERY	0.00	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	932,018.90	169,388.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	932,018.90	169,388.45

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 02:10:23  
Page: 15

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	05/01/14	THROUGH	04/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:34:10  
 Page: 1

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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,420,334.40	ADJUSTMENTS	126,698.32
COVERED CHARGES	2,383,922.66	CONTRACTUAL ALLOW	1,751,991.48
NON-COVERD CHARGES	36,411.74	TOTAL MEDICAID LIAB	631,931.18
		LESS: COB	10,807.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	621,123.46

TOTAL NUMBER OF ADMISSIONS 114

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	388		0	370,540.00		32,526.00
ROUTINE NURSERY	46		0	21,974.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	434		0	392,514.00		32,526.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	49		0	74,578.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	49		0	74,578.00		0.00
TOTAL ACCOMODATIONS	483		0	467,092.00		32,526.00

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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	212,880.00	0.00	OTHER LAB	18,390.00	0.00
MED/SURG SUPPLY	114,620.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	330,231.00	0.00	EDUCATION & TRAINING	3,857.00	0.00
RADIOLOGY-DIAGNOSTIC	26,739.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	127,025.52	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,079.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,391.00	0.00	MRI SERVICES	9,748.00	0.00
IV THERAPY	67,561.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	77,884.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,450.00	1,197.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,744.67	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	68,410.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,228.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	617,489.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	169.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	343.88	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	983.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,491.64	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,110.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,772.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,402.00	800.00			
AUDIOLOGY	157.41	1,210.74			
CARDIOLOGY	16,518.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,155.71	678.00			
			TOTAL ANCILLARY	1,916,830.66	3,885.74
			TOTAL ACCOMODATIONS	467,092.00	32,526.00
			TOTAL CHARGES	2,383,922.66	36,411.74

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:34:13  
 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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,198.50	ADJUSTMENTS	0.00
COVERED CHARGES	52,799.50	CONTRACTUAL ALLOW	38,008.55
NON-COVERD CHARGES	399.00	TOTAL MEDICAID LIAB	14,790.95
		LESS: COB	14,790.95
		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	9		0	8,595.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9		0	8,595.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	9		0	8,595.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER  
 462 ELMA G MILES PKWY  
 HINESVILLE,GA 31313-4000

PROVIDER NUMBER  
 000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,858.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,054.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,293.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	694.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,078.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,692.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,147.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	399.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	922.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	450.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,757.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	259.00	0.00			
			TOTAL ANCILLARY	44,204.50	399.00
			TOTAL ACCOMODATIONS	8,595.00	0.00
			TOTAL CHARGES	52,799.50	399.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:34:14  
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 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,284,666.57	ADJUSTMENTS	202,473.13
COVERED CHARGES	3,952,375.08	CONTRACTUAL ALLOW	3,191,307.32
NON-COVERD CHARGES	332,291.49	TOTAL MEDICAID LIAB	761,067.76
		LESS: COB	4,170.71
		LESS: COPAYMENT	2,403.00
		REIMBURSEMENT	754,494.05
		ALL OTHER	670,448.47
		FEE SCHEDULE-LAB	79,115.03
		INJECTABLE DRUGS	4,930.55
		TOTAL NUMBER OF CLAIMS	2,624



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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	210,497.20	2,064.00	OTHER LAB	44,582.00	0.00
MED/SURG SUPPLY	84,255.52	136.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	2,261.00
RADIOLOGY-DIAGNOSTIC	210,866.00	4,747.08	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	538,176.72	61,592.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,656.00	1,021.00	FEE SCHEDULE LAB	865,237.61	75,753.96
EKG/ECG	36,083.00	1,910.00	MRI SERVICES	89,807.00	2,929.00
IV THERAPY	139,826.50	22,038.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	218,140.00	33,908.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,344.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,220.17	9,478.21	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	605.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	847,522.72	29,049.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,566.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	192,105.08	12,226.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	964.16	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	23,394.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,714.00
OTHER IMAGING SERVICE	188,935.48	37,763.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,918.00	3,988.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	44,243.00	6,749.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,224.00	3,922.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	125,170.08	17,078.08			
			TOTAL ANCILLARY	3,952,375.08	332,291.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,952,375.08	332,291.49

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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5915320001458	07/30/15 - 07/30/15	11/23/15	0.00	178.00	0.00	0.00	0.00
948	5915320001458	07/28/15 - 07/28/15	11/23/15	0.00	178.00	0.00	0.00	0.00
948	5915320001458	07/23/15 - 07/23/15	11/23/15	0.00	178.00	0.00	0.00	0.00
948	5915320001458	07/21/15 - 07/21/15	11/23/15	0.00	178.00	0.00	0.00	0.00
948	5915320001458	07/07/15 - 07/07/15	11/23/15	0.00	178.00	0.00	0.00	0.00
948	5915320001458	07/02/15 - 07/02/15	11/23/15	0.00	178.00	0.00	0.00	0.00
-1	2215335001710	08/27/15 - 08/27/15	12/07/15	0.00	178.00	0.00	0.00	0.00
-1	2215335001710	08/25/15 - 08/25/15	12/07/15	0.00	178.00	0.00	0.00	0.00
-1	2215335001710	08/06/15 - 08/06/15	12/07/15	0.00	178.00	0.00	0.00	0.00
-1	2215335001710	08/04/15 - 08/04/15	12/07/15	0.00	178.00	0.00	0.00	0.00
-1	2215335001710	08/20/15 - 08/20/15	12/07/15	0.00	178.00	0.00	0.00	0.00
948	2016060032214	10/13/15 - 10/13/15	03/07/16	0.00	189.00	0.00	0.00	0.00
948	2016060032214	10/20/15 - 10/20/15	03/07/16	0.00	189.00	0.00	0.00	0.00
948	2016060032214	10/22/15 - 10/22/15	03/07/16	0.00	189.00	0.00	0.00	0.00
948	2016060032214	10/08/15 - 10/08/15	03/07/16	0.00	189.00	0.00	0.00	0.00
TOTAL				0.00	2,714.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 02:34:35  
Page: 8

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 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	116,741.62	ADJUSTMENTS	0.00
COVERED CHARGES	92,900.75	CONTRACTUAL ALLOW	52,357.76
NON-COVERD CHARGES	23,840.87	TOTAL MEDICAID LIAB	40,542.99
		LESS: COB	40,524.99
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 51

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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,852.00	90.00	OTHER LAB	1,153.00	0.00
MED/SURG SUPPLY	3,346.06	9.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,689.00	772.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,714.84	3,954.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,802.00	2,235.20
EKG/ECG	548.00	399.00	MRI SERVICES	2,259.00	2,259.00
IV THERAPY	4,183.50	1,921.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,641.00	4,586.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,044.19	1,735.67	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	21,057.16	518.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	686.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,198.00	1,591.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	559.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,598.00	3,479.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,648.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,572.00	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	4,350.00	292.00			
			TOTAL ANCILLARY	92,900.75	23,840.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,900.75	23,840.87

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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LIBERTY REGIONAL MEDICAL CENTER  
462 ELMA G MILES PKWY  
HINESVILLE,GA 31313-4000

PROVIDER NUMBER  
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	399,729.47	ADJUSTMENTS	904.66
COVERED CHARGES	381,034.47	CONTRACTUAL ALLOW	357,759.47
NON-COVERD CHARGES	18,695.00	TOTAL MEDICAID LIAB	23,275.00
		LESS: COB	21.28
		LESS: COPAYMENT	627.34
		REIMBURSEMENT	22,626.38
		TOTAL NUMBER OF CLAIMS	466

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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,856.00	0.00	OTHER LAB	1,598.00	0.00
MED/SURG SUPPLY	3,507.14	44.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	133.00
RADIOLOGY-DIAGNOSTIC	12,495.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,045.00	5,417.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	89,479.00	3,579.00
EKG/ECG	1,995.00	0.00	MRI SERVICES	2,259.00	0.00
IV THERAPY	5,892.00	453.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,283.33	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	203,626.00	1,235.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,773.00	102.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,226.00	7,732.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,000.00	0.00			
			TOTAL ANCILLARY	381,034.47	18,695.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	381,034.47	18,695.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LIBERTY REGIONAL MEDICAL CENTER  
462 ELMA G MILES PKWY  
HINESVILLE,GA 31313-4000

PROVIDER NUMBER  
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,630.78	ADJUSTMENTS	0.00
COVERED CHARGES	8,612.78	CONTRACTUAL ALLOW	6,069.21
NON-COVERD CHARGES	18.00	TOTAL MEDICAID LIAB	2,543.57
		LESS: COB	2,540.57
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	152.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	145.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	213.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,537.00	18.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	126.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,439.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,612.78	18.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,612.78	18.00



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER  
462 ELMA G MILES PKWY  
HINESVILLE,GA 31313-4000

PROVIDER NUMBER  
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/01/14 THROUGH 11/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,417.26	ADJUSTMENTS	4,819.81
COVERED CHARGES	27,329.26	CONTRACTUAL ALLOW	22,509.45
NON-COVERD CHARGES	6,088.00	TOTAL MEDICAID LIAB	4,819.81
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,819.81

TOTAL NUMBER OF CLAIMS 1

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 12/01/14 THROUGH 11/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,133.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,058.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	133.00
RADIOLOGY-DIAGNOSTIC	213.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,439.00	3,809.00
EKG/ECG	133.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,689.00	774.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,528.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	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	1,813.00	865.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	968.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,815.00	400.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	107.00			
			TOTAL ANCILLARY	27,329.26	6,088.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,329.26	6,088.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	12/01/14	THROUGH	11/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:15:46  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	153,822.44	ADJUSTMENTS	4,423.41
COVERED CHARGES	150,892.69	CONTRACTUAL ALLOW	83,061.05
NON-COVERD CHARGES	2,929.75	TOTAL MEDICAID LIAB	67,831.64
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	67,831.64

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	53		0	20,776.00		930.75
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	53		0	20,776.00		930.75
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	53		0	20,776.00		930.75

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:15:46  
 Page: 2

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,525.19	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,210.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	21,121.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,040.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,836.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	506.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,342.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,802.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,859.75	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.	4,599.00	1,999.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,243.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	130,116.69	1,999.00
			TOTAL ACCOMODATIONS	20,776.00	930.75
			TOTAL CHARGES	150,892.69	2,929.75

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:15:47  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:15:47  
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HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	691,438.31	ADJUSTMENTS	9,250.42
COVERED CHARGES	618,826.07	CONTRACTUAL ALLOW	361,680.73
NON-COVERD CHARGES	72,612.24	TOTAL MEDICAID LIAB	257,145.34
		LESS: COB	701.85
		LESS: COPAYMENT	1,038.00
		REIMBURSEMENT	255,405.49
		ALL OTHER	230,155.58
		FEE SCHEDULE-LAB	24,662.40
		INJECTABLE DRUGS	587.51

TOTAL NUMBER OF CLAIMS 844

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,362.32	0.00	OTHER LAB	1,981.50	0.00
MED/SURG SUPPLY	18,090.25	240.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,556.25	1,690.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,440.50	41,013.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,636.75	2,396.00	FEE SCHEDULE LAB	124,828.75	19,499.75
EKG/ECG	11,643.75	506.25	MRI SERVICES	0.00	0.00
IV THERAPY	10,652.50	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	216,581.75	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	12,483.25	2,113.49
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	480.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,031.00	942.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	43.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,487.00	3,730.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	65,877.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,130.00	0.00			
			TOTAL ANCILLARY	618,826.07	72,612.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	618,826.07	72,612.24



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,770.75	ADJUSTMENTS	0.00
COVERED CHARGES	2,476.25	CONTRACTUAL ALLOW	-340.09
NON-COVERD CHARGES	2,294.50	TOTAL MEDICAID LIAB	2,816.34
		LESS: COB	2,816.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	570.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	75.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,007.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	670.25	15.50
EKG/ECG	168.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	130.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	861.50	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	272.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,476.25	2,294.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,476.25	2,294.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	87,837.67	ADJUSTMENTS	50.00
COVERED CHARGES	85,489.80	CONTRACTUAL ALLOW	78,939.80
NON-COVERD CHARGES	2,347.87	TOTAL MEDICAID LIAB	6,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	237.69
		REIMBURSEMENT	6,312.31
		TOTAL NUMBER OF CLAIMS	131

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,502.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,184.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,900.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,648.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,524.50	1,422.25
EKG/ECG	1,350.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	542.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,038.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,799.75	925.62
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	85,489.80	2,347.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	85,489.80	2,347.87

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,544.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,544.00	CONTRACTUAL ALLOW	644.76
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	899.24
		LESS: COB	896.24
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	286.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	34.75	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	242.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	980.75	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	1,544.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,544.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY,  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
 2460 WASHINTGON ROAD N.E.  
 THOMSON,GA 30824-2199

PROVIDER NUMBER  
 000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	707,921.49	ADJUSTMENTS	65,155.53
COVERED CHARGES	707,241.49	CONTRACTUAL ALLOW	391,052.84
NON-COVERD CHARGES	680.00	TOTAL MEDICAID LIAB	316,188.65
		LESS: COB	1,000.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	315,187.87
		TOTAL NUMBER OF ADMISSIONS	37

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	118		0	66,316.00		522.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	118		0	66,316.00		522.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	118		0	66,316.00		522.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 2460 WASHINTGON ROAD N.E. 000001185A SERVICE DATES 01/01/15 THROUGH 12/31/15  
 THOMSON,GA 30824-2199 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	167,660.09	0.00	OTHER LAB	2,054.00	0.00
MED/SURG SUPPLY	43,251.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	30,971.60	0.00	EDUCATION & TRAINING	244.80	0.00
RADIOLOGY-DIAGNOSTIC	8,016.00	0.00	OTHER THERAPEUTIC SVC	0.00	158.00
CT SCAN	14,842.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,081.65	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,486.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,514.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	71,870.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,611.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,869.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,469.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,286.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,199.72	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	378.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	196,585.50	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.	2,268.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,709.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,559.00	0.00			
			TOTAL ANCILLARY	640,925.49	158.00
			TOTAL ACCOMODATIONS	66,316.00	522.00
			TOTAL CHARGES	707,241.49	680.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
2460 WASHINTGON ROAD N.E.  
THOMSON,GA 30824-2199

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:31:59  
Page: 4

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
2460 WASHINTGON ROAD N.E.  
THOMSON,GA 30824-2199

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,229,936.49	ADJUSTMENTS	102,040.36
COVERED CHARGES	2,956,610.94	CONTRACTUAL ALLOW	2,170,823.57
NON-COVERD CHARGES	273,325.55	TOTAL MEDICAID LIAB	785,787.37
		LESS: COB	3,171.16
		LESS: COPAYMENT	1,623.96
		REIMBURSEMENT	780,992.25
		ALL OTHER	728,822.23
		FEE SCHEDULE-LAB	48,087.39
		INJECTABLE DRUGS	4,082.63
		TOTAL NUMBER OF CLAIMS	1,821

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 2460 WASHINTGON ROAD N.E. 000001185A SERVICE DATES 01/01/15 THROUGH 12/31/15  
 THOMSON,GA 30824-2199 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	126,478.52	1,802.70	OTHER LAB	12,793.00	0.00
MED/SURG SUPPLY	161,974.98	47.23	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	40.80
RADIOLOGY-DIAGNOSTIC	131,654.00	3,423.00	OTHER THERAPEUTIC SVC	0.00	14,685.00
CT SCAN	245,137.00	93,301.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,082.10	FEE SCHEDULE LAB	313,944.62	28,304.52
EKG/ECG	38,338.00	694.00	MRI SERVICES	0.00	0.00
IV THERAPY	133,927.00	2,404.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	263,470.57	72,131.43	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	15.00
RESPIRATORY SERVICES	20,751.00	6,545.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,737.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	43,020.00	7,930.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,051,795.00	513.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,160.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	113,347.35	26,033.77
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	740.00	1,111.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	49,752.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	65,991.00	5,892.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	756.00	534.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,941.00	6,557.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,734.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,168.00	279.00			
			TOTAL ANCILLARY	2,956,610.94	273,325.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,956,610.94	273,325.55

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
2460 WASHINTGON ROAD N.E.  
THOMSON,GA 30824-2199

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,026.17	ADJUSTMENTS	0.00
COVERED CHARGES	30,968.38	CONTRACTUAL ALLOW	11,750.48
NON-COVERD CHARGES	12,057.79	TOTAL MEDICAID LIAB	19,217.90
		LESS: COB	19,204.62
		LESS: COPAYMENT	13.28
		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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 2460 WASHINTGON ROAD N.E. 000001185A SERVICE DATES 01/01/15 THROUGH 12/31/15  
 THOMSON,GA 30824-2199 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,328.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	748.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	842.00	0.00	OTHER THERAPEUTIC SVC	0.00	79.00
CT SCAN	0.00	10,447.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,931.04	172.00
EKG/ECG	510.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,458.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	18,190.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	879.13	120.79
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,932.00	1,239.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,968.38	12,057.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,968.38	12,057.79

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

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UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
2460 WASHINTGON ROAD N.E.  
THOMSON,GA 30824-2199

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	185,486.88	ADJUSTMENTS	208.75
COVERED CHARGES	179,411.66	CONTRACTUAL ALLOW	166,868.37
NON-COVERD CHARGES	6,075.22	TOTAL MEDICAID LIAB	12,543.29
		LESS: COB	1,075.60
		LESS: COPAYMENT	396.00
		REIMBURSEMENT	11,071.69
		TOTAL NUMBER OF CLAIMS	205



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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 2460 WASHINTGON ROAD N.E. 000001185A SERVICE DATES 01/01/15 THROUGH 12/31/15  
 THOMSON,GA 30824-2199 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,136.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,501.58	1.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,135.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,449.00
CT SCAN	7,207.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,442.68	1,761.00
EKG/ECG	602.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,419.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	822.00	120.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	123,092.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,054.29	1,675.42
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	68.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	179,411.66	6,075.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	179,411.66	6,075.22

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
2460 WASHINTGON ROAD N.E.  
THOMSON,GA 30824-2199

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,390.99	ADJUSTMENTS	0.00
COVERED CHARGES	1,368.99	CONTRACTUAL ALLOW	966.18
NON-COVERD CHARGES	22.00	TOTAL MEDICAID LIAB	402.81
		LESS: COB	402.81
		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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
 2460 WASHINTGON ROAD N.E.  
 THOMSON,GA 30824-2199

PROVIDER NUMBER  
 000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 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	1.99	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	210.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	131.00	22.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,026.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,368.99	22.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,368.99	22.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
2460 WASHINTGON ROAD N.E.  
THOMSON,GA 30824-2199

PROVIDER NUMBER  
000001185A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:32:16  
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
2460 WASHINTGON ROAD N.E.	000001185A	SERVICE DATES	01/01/15	THROUGH	12/31/15
THOMSON,GA 30824-2199		ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:49:20  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER 000001196A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	56,893,235.31	ADJUSTMENTS	3,792,103.68
COVERED CHARGES	55,077,158.31	CONTRACTUAL ALLOW	37,118,951.77
NON-COVERD CHARGES	1,816,077.00	TOTAL MEDICAID LIAB	17,958,206.54
		LESS: COB	111,975.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,846,230.95

TOTAL NUMBER OF ADMISSIONS 1,548

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,823		0	4,927,106.86		159,546.00
ROUTINE NURSERY	1,219		0	837,900.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9,042		0	5,765,006.86		159,546.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,682		0	2,825,570.00		0.00
NICU	252		0	423,360.00		0.00
PED ICU	53		0	89,040.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,987		0	3,337,970.00		0.00
TOTAL ACCOMODATIONS	11,029		0	9,102,976.86		159,546.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,403,872.27	32,225.85	OTHER LAB	186,677.33	0.00
MED/SURG SUPPLY	4,504,299.73	45,801.31	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,461,111.81	20,925.38	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,177,956.96	960.33	OTHER THERAPEUTIC SVC	0.00	69,056.48
CT SCAN	1,888,670.79	653,242.81	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	285,415.14	5,414.09	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	195,025.10	155.85	MRI SERVICES	863,904.24	0.00
IV THERAPY	517,300.13	1,579.28	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,973,525.66	47,241.45	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	591,354.15	3,052.85	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,629,983.98	37,376.44	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	202,448.25	521.84	AMBULANCE	0.00	57,249.73
GI SERVICES	215,500.00	8,500.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,362,338.27	1,611.94	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	460,104.02	1,736.18	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	157,467.56	0.00	INJECTABLE DRUGS	9,298,160.21	83,220.35
RADIOLOGY THERAPEUTIC	187,984.19	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	134,440.85	1,728.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	125,387.49	747.49	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	333,695.04	7,939.64	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,014.90	30,108.15	TRAUMA RESPONSE	0.00	31,450.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,146,408.64	3,120.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	365,419.93	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	950,853.54	511,565.56			
ONCOLOGY	818.50	0.00			
NUCLEAR MEDICINE	155,812.25	0.00			
AUDIOLOGY	51,786.18	0.00			
CARDIOLOGY	977,611.14	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	85,940.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	73,893.00	0.00			
			TOTAL ANCILLARY	45,974,181.45	1,656,531.00
			TOTAL ACCOMODATIONS	9,102,976.86	159,546.00
			TOTAL CHARGES	55,077,158.31	1,816,077.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	299,327.78	ADJUSTMENTS	0.00
COVERED CHARGES	292,955.78	CONTRACTUAL ALLOW	140,152.20
NON-COVERD CHARGES	6,372.00	TOTAL MEDICAID LIAB	152,803.58
		LESS: COB	152,803.58
		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	86		0	55,694.00		1,170.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	86		0	55,694.00		1,170.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	86		0	55,694.00		1,170.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,172.04	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,899.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,952.08	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,602.89	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,457.05	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	152.32	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,062.60	0.00	MRI SERVICES	3,111.79	0.00
IV THERAPY	180.96	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,324.57	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,474.82	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,963.44	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,877.52	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,935.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,831.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,449.00	0.00	INJECTABLE DRUGS	85,851.10	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	344.20	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,083.42	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,771.00	5,202.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,444.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,082.64	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	237.69	0.00			
			TOTAL ANCILLARY	237,261.78	5,202.00
			TOTAL ACCOMODATIONS	55,694.00	1,170.00
			TOTAL CHARGES	292,955.78	6,372.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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MIDTOWN MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,459,003.63	ADJUSTMENTS	116,877.76
COVERED CHARGES	17,418,854.19	CONTRACTUAL ALLOW	12,442,106.97
NON-COVERD CHARGES	4,040,149.44	TOTAL MEDICAID LIAB	4,976,747.22
		LESS: COB	20,760.09
		LESS: COPAYMENT	26,486.64
		REIMBURSEMENT	4,929,500.49
		ALL OTHER	4,258,587.19
		FEE SCHEDULE-LAB	290,397.82
		INJECTABLE DRUGS	380,515.48
		TOTAL NUMBER OF CLAIMS	13,825

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	490,325.43	3,767.80	OTHER LAB	68,203.11	0.00
MED/SURG SUPPLY	346,529.55	21,421.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	714.02	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	718,504.43	12,407.31	OTHER THERAPEUTIC SVC	0.00	405.68
CT SCAN	1,193,892.91	760,058.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,452.16	7,200.20	FEE SCHEDULE LAB	2,618,049.98	411,710.43
EKG/ECG	160,659.25	5,137.45	MRI SERVICES	312,590.86	56,845.54
IV THERAPY	1,291,202.69	31,245.91	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	858,550.11	258,736.12	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,885.76	359.52	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	125,743.36	6,164.32	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	79,592.40	1,719.89	AMBULANCE	0.00	0.00
GI SERVICES	126,000.00	54,500.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,463,371.12	184,178.87	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	419,209.66	7,658.18	DRUG-SPECIFIC/HOME IV	0.00	205.10
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,125,941.87	1,435,629.68
RADIOLOGY THERAPEUTIC	803,230.16	370,877.30	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,973.68	1,923.58	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	5,555.98	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	47,390.28	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	789,066.50	29,977.69	TRAUMA RESPONSE	0.00	16,444.80
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,399.07	4,456.85
LITHOTRIPSY	8,300.99	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	564,669.17	126,825.19			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	251,364.88	41,985.64			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	56,143.75	73,267.97			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	96,387.50	58,155.93			
AMBULATORY SURGERY	7,305.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	134,201.48	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	217,107.36	3,222.11			
			TOTAL ANCILLARY	17,418,854.19	4,040,149.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,418,854.19	4,040,149.44

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MIDTOWN MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	533,194.46	ADJUSTMENTS	0.00
COVERED CHARGES	326,786.90	CONTRACTUAL ALLOW	154,819.82
NON-COVERD CHARGES	206,407.56	TOTAL MEDICAID LIAB	171,967.08
		LESS: COB	171,761.64
		LESS: COPAYMENT	205.44
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 157

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,900.25	418.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,992.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,719.97	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,032.60	37,767.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	45,089.10	6,317.87
EKG/ECG	2,432.35	139.15	MRI SERVICES	0.00	6,223.58
IV THERAPY	21,344.34	1,265.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,282.61	15,177.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,004.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,734.60	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,841.04	0.00	AMBULANCE	0.00	0.00
GI SERVICES	750.00	3,750.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,303.90	6,196.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,595.31	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	69,555.85	46,774.80
RADIOLOGY THERAPEUTIC	7,316.65	55,856.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	476.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,764.54	873.70	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,675.00	13,261.37
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,746.29	8,700.57			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	796.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	974.68	54.22			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,570.00	3,154.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,949.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,416.49	0.00			
			TOTAL ANCILLARY	326,786.90	206,407.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	326,786.90	206,407.56

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:51:01  
Page: 9

MIDTOWN MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,075,336.57	ADJUSTMENTS	750.16
COVERED CHARGES	944,238.61	CONTRACTUAL ALLOW	882,033.33
NON-COVERD CHARGES	131,097.96	TOTAL MEDICAID LIAB	62,205.28
		LESS: COB	45.00
		LESS: COPAYMENT	1,887.00
		REIMBURSEMENT	60,273.28
		TOTAL NUMBER OF CLAIMS	1,112

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,706.50	0.00	OTHER LAB	2,904.26	0.00
MED/SURG SUPPLY	5,932.00	106.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,408.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,505.25	22,419.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	170,882.84	26,501.78
EKG/ECG	8,888.95	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	53,715.77	2,033.72	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	786.81	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,650.82	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	545,679.23	195.46	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,645.82	11,558.65
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	60,053.36	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,230.81	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,673.86	6,006.54			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,522.00	2,223.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	105.64	0.00			
			TOTAL ANCILLARY	944,238.61	131,097.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	944,238.61	131,097.96

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:51:08  
Page: 11

MIDTOWN MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,793.25	ADJUSTMENTS	0.00
COVERED CHARGES	12,962.14	CONTRACTUAL ALLOW	4,253.39
NON-COVERD CHARGES	4,831.11	TOTAL MEDICAID LIAB	8,708.75
		LESS: COB	8,702.75
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 14



SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	151.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	47.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,199.36	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,501.71	853.05
EKG/ECG	139.15	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,180.42	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,423.70	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	135.35	3,529.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89.90	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	449.06			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	94.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,962.14	4,831.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,962.14	4,831.11

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MIDTOWN MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,326,123.58	ADJUSTMENTS	46,576.64
COVERED CHARGES	5,069,295.78	CONTRACTUAL ALLOW	4,100,252.90
NON-COVERD CHARGES	256,827.80	TOTAL MEDICAID LIAB	969,042.88
		LESS: COB	26,590.71
		LESS: COPAYMENT	3,309.00
		REIMBURSEMENT	939,143.17

TOTAL NUMBER OF CLAIMS 162

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,920.90	24.30	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	146,869.74	5,847.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,389.88	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,976.00	3,809.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,329.28	FEE SCHEDULE LAB	78,947.16	3,332.33
EKG/ECG	606.70	573.30	MRI SERVICES	0.00	0.00
IV THERAPY	324,210.61	5,365.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	388,434.13	17,061.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	315.89	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,991.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,833.95	369.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	130,134.68	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,111,611.68	90,178.75
RADIOLOGY THERAPEUTIC	1,163,339.56	102,241.19	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	51,515.44	1,775.12	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	480,866.54	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,856.85	5,889.96			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,686.50	9,052.16			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,192.10	1,000.36			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	7,970.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,596.11	1,009.00			
			TOTAL ANCILLARY	5,069,295.78	256,827.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,069,295.78	256,827.80

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MIDTOWN MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	96,189.32	ADJUSTMENTS	0.00
COVERED CHARGES	92,429.12	CONTRACTUAL ALLOW	26,318.58
NON-COVERD CHARGES	3,760.20	TOTAL MEDICAID LIAB	66,110.54
		LESS: COB	66,110.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,176.65	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	716.86	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	377.84	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	26,372.96	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,696.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	224.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,944.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	90.25	64.20
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	1,266.72	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	59,626.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	633.84	0.00			
			TOTAL ANCILLARY	92,429.12	3,760.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,429.12	3,760.20

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:35:56  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER 000001207A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	147,939,395.00	ADJUSTMENTS	9,917,403.77
COVERED CHARGES	144,590,750.24	CONTRACTUAL ALLOW	106,286,066.73
NON-COVERD CHARGES	3,348,644.76	TOTAL MEDICAID LIAB	38,304,683.51
		LESS: COB	185,694.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	38,118,988.61

TOTAL NUMBER OF ADMISSIONS 3,224

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	15,507	31	10,847,781.00	1,394,521.00
ROUTINE NURSERY	514	155	667,088.00	245,222.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	16,021	186	11,514,869.00	1,639,743.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	3,727	13	9,032,259.00	99,192.00
NICU	1,127	0	5,038,185.00	0.00
PED ICU	877	5	2,410,242.00	13,750.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,731	18	16,480,686.00	112,942.00
TOTAL ACCOMODATIONS	21,752	204	27,995,555.00	1,752,685.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,090,555.17	161,162.47	OTHER LAB	963,351.00	1,143.00
MED/SURG SUPPLY	5,289,240.00	85,799.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,339,138.07	115,312.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,256,404.00	6,666.00	OTHER THERAPEUTIC SVC	0.00	81,230.00
CT SCAN	6,190,441.00	144,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	587,041.84	4,463.04	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	538,509.00	815.00	MRI SERVICES	2,321,145.00	0.00
IV THERAPY	1,029,758.00	7,239.00	PROFESSIONAL FEES	0.00	2,165.00
OPERATING ROOM	9,306,491.00	27,456.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,235,700.00	4,752.00	REHAB THERAPY	201.00	0.00
RESPIRATORY SERVICES	8,734,409.70	112,188.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,470,707.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,613.00	2,769.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,677,160.01	8,327.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,054,182.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	246,651.00	747.00	INJECTABLE DRUGS	8,320,692.33	40,379.19
RADIOLOGY THERAPEUTIC	109,779.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	286,640.03	4,622.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	335,927.91	2,295.05	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,002,807.00	587,623.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	44.00	33,971.93	TRAUMA RESPONSE	0.00	51,678.00
PSYCHIATRIC SERVICES	121,798.00	0.00	IMPL DEV CHARGE PATIENTS	6,439,510.18	369.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	370,728.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,660,910.00	15,802.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	682,907.00	21,625.00			
AUDIOLOGY	0.00	852.00			
CARDIOLOGY	3,299,563.00	1,214.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	148,831.00	2,238.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,473,360.00	66,234.00			
			TOTAL ANCILLARY	116,595,195.24	1,595,959.76
			TOTAL ACCOMODATIONS	27,995,555.00	1,752,685.00
			TOTAL CHARGES	144,590,750.24	3,348,644.76

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,163,775.21	ADJUSTMENTS	0.00
COVERED CHARGES	1,153,225.21	CONTRACTUAL ALLOW	679,972.45
NON-COVERD CHARGES	10,550.00	TOTAL MEDICAID LIAB	473,252.76
		LESS: COB	473,252.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 27

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	88		0	62,020.00		5,916.00
ROUTINE NURSERY	8		0	33,112.00		429.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	96		0	95,132.00		6,345.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	40		0	110,000.00		0.00
NICU	26		0	120,120.00		0.00
PED ICU	7		0	19,250.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	73		0	249,370.00		0.00
TOTAL ACCOMODATIONS	169		0	344,502.00		6,345.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER, NAVICENT HEALTH (THE)  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	241,597.31	0.00	OTHER LAB	10,111.00	0.00
MED/SURG SUPPLY	19,317.00	1,701.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	80,024.60	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,674.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,392.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,927.08	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	652.00	0.00	MRI SERVICES	38,032.00	0.00
IV THERAPY	2,295.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	57,274.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	63,372.00	2,504.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	55,674.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,038.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,436.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,209.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,812.00	0.00	INJECTABLE DRUGS	36,131.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,163.06	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,634.06	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,813.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,972.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,146.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,450.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,577.00	0.00			
			TOTAL ANCILLARY	808,723.21	4,205.00
			TOTAL ACCOMODATIONS	344,502.00	6,345.00
			TOTAL CHARGES	1,153,225.21	10,550.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:36:47  
Page: 5

MEDICAL CENTER, NAVICENT HEALTH (THE)  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,809,844.82	ADJUSTMENTS	1,891,207.73
COVERED CHARGES	41,637,835.68	CONTRACTUAL ALLOW	32,565,947.53
NON-COVERD CHARGES	5,172,009.14	TOTAL MEDICAID LIAB	9,071,888.15
		LESS: COB	23,526.43
		LESS: COPAYMENT	33,168.32
		REIMBURSEMENT	9,015,193.40
		ALL OTHER	7,366,508.38
		FEE SCHEDULE-LAB	837,868.07
		INJECTABLE DRUGS	810,816.95

TOTAL NUMBER OF CLAIMS 25,046

MEDICAL CENTER, NAVICENT HEALTH (THE)  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,110,077.65	49,081.97	OTHER LAB	245,787.00	3,223.00
MED/SURG SUPPLY	723,479.00	34,337.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,794,240.00	94,874.00	OTHER THERAPEUTIC SVC	0.00	39,032.00
CT SCAN	3,145,019.00	531,085.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,488.02	15,329.85	FEE SCHEDULE LAB	7,753,167.62	814,827.05
EKG/ECG	273,529.00	8,965.00	MRI SERVICES	80,047.00	56,880.00
IV THERAPY	1,237,730.00	23,416.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,375,896.81	728,957.45	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	187,933.00	1,256.00	REHAB THERAPY	0.00	1,809.00
RESPIRATORY SERVICES	173,629.00	46,980.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,101,856.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	35,067.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,843,760.00	53,607.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,353,436.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,522,474.04	1,155,429.04
RADIOLOGY THERAPEUTIC	135,454.00	2,372.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,109.00	5,852.32	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	23,886.04	7,155.70	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,111.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,479,178.00	24,270.00	TRAUMA RESPONSE	0.00	4,698.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	367,057.00	702,513.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	374,880.00	66,816.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	487,446.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	483,700.00	180,076.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	308,324.00	217,292.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	105,834.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,891,351.00	284,763.76			
			TOTAL ANCILLARY	41,637,835.68	5,172,009.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	41,637,835.68	5,172,009.14

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 02:39:17  
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER, NAVICENT HEALTH (THE)  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	480,521.15	ADJUSTMENTS	0.00
COVERED CHARGES	408,765.12	CONTRACTUAL ALLOW	310,720.05
NON-COVERD CHARGES	71,756.03	TOTAL MEDICAID LIAB	98,045.07
		LESS: COB	97,892.79
		LESS: COPAYMENT	152.28
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 161

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER, NAVICENT HEALTH (THE) PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 777 HEMLOCK ST 000001207A SERVICE DATES 10/01/14 THROUGH 09/30/15  
 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	18,917.39	1,119.88	OTHER LAB	3,221.00	0.00
MED/SURG SUPPLY	6,655.00	155.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,541.00	1,846.00	OTHER THERAPEUTIC SVC	0.00	496.00
CT SCAN	13,597.00	13,681.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,919.72	969.00
EKG/ECG	1,630.00	326.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,237.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,739.67	22,368.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,014.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,643.00	106.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,532.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,423.00	69.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,791.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	161,061.34	10,250.82
RADIOLOGY THERAPEUTIC	2,910.00	756.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,352.00	116.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	366.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,151.00	610.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,984.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,247.00	268.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,450.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,383.00	18,619.00			
			TOTAL ANCILLARY	408,765.12	71,756.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	408,765.12	71,756.03

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:39:25  
Page: 9

MEDICAL CENTER, NAVICENT HEALTH (THE)  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,240,388.37	ADJUSTMENTS	1,341.50
COVERED CHARGES	1,180,787.04	CONTRACTUAL ALLOW	1,128,091.56
NON-COVERD CHARGES	59,601.33	TOTAL MEDICAID LIAB	52,695.48
		LESS: COB	10.85
		LESS: COPAYMENT	2,073.95
		REIMBURSEMENT	50,610.68
		TOTAL NUMBER OF CLAIMS	942

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER, NAVICENT HEALTH (THE)  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,648.46	482.94	OTHER LAB	4,526.00	0.00
MED/SURG SUPPLY	2,822.00	108.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	180.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,749.00	5,774.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,699.00	18,150.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	187,381.00	17,543.00
EKG/ECG	8,313.00	163.00	MRI SERVICES	4,568.00	0.00
IV THERAPY	34,669.00	252.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,539.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,256.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,720.00	212.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,615.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	698,217.00	10,288.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36,186.58	780.39
RADIOLOGY THERAPEUTIC	83.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,366.00	78.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,695.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,011.00	5,590.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,723.00	0.00			
			TOTAL ANCILLARY	1,180,787.04	59,601.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,180,787.04	59,601.33

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER, NAVICENT HEALTH (THE)  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,071.72	ADJUSTMENTS	0.00
COVERED CHARGES	9,071.72	CONTRACTUAL ALLOW	3,684.79
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	5,386.93
		LESS: COB	5,380.93
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6



SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER, NAVICENT HEALTH (THE)  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	518.52	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	618.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,047.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	510.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	838.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,422.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	118.20	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	9,071.72	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,071.72	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

MEDICAL CENTER, NAVICENT HEALTH (THE)  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,629,427.28	ADJUSTMENTS	365,419.38
COVERED CHARGES	6,842,109.83	CONTRACTUAL ALLOW	5,819,579.17
NON-COVERD CHARGES	787,317.45	TOTAL MEDICAID LIAB	1,022,530.66
		LESS: COB	0.00
		LESS: COPAYMENT	561.00
		REIMBURSEMENT	1,021,969.66
		TOTAL NUMBER OF CLAIMS	168

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER, NAVICENT HEALTH (THE) PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 777 HEMLOCK ST 000001207A SERVICE DATES 10/01/14 THROUGH 09/30/15  
 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	266,220.57	35,152.16	OTHER LAB	16,795.00	1,253.00
MED/SURG SUPPLY	437,941.00	50,362.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	115,354.00	18,882.00	OTHER THERAPEUTIC SVC	0.00	5,638.00
CT SCAN	110,095.00	39,534.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	849.00	2,355.14	FEE SCHEDULE LAB	180,091.00	15,798.10
EKG/ECG	21,027.00	3,097.00	MRI SERVICES	0.00	9,992.00
IV THERAPY	63,669.00	4,034.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	660,846.87	136,899.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,578.00	214.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,486.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	117,340.87	1,176.13	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,676.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,941,925.52	128,632.69
RADIOLOGY THERAPEUTIC	24,670.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	378.00	952.06	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	909.04	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,900.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	688.00	144.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,334,712.00	94,599.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,925.00	1,424.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,818.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	23,212.00	5,065.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	267,322.00	66,713.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,122,490.00	156,592.00			
			TOTAL ANCILLARY	6,842,109.83	787,317.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,842,109.83	787,317.45

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER, NAVICENT HEALTH (THE)  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WASHINGTON COUNTY REGIONAL MEDICAL  
 610 SPARTA ROAD  
 SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER 000001218A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	515,451.74	ADJUSTMENTS	201,890.16
COVERED CHARGES	514,025.74	CONTRACTUAL ALLOW	128,682.67
NON-COVERD CHARGES	1,426.00	TOTAL MEDICAID LIAB	385,343.07
		LESS: COB	1,777.76
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	383,565.31

TOTAL NUMBER OF ADMISSIONS 46

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	187		0	59,840.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	187		0	59,840.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	2,700.00		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	4		0	2,700.00		0.00
TOTAL ACCOMODATIONS	191		0	62,540.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WASHINGTON COUNTY REGIONAL MEDICAL  
 610 SPARTA ROAD  
 SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER  
 000001218A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110,408.19	0.00	OTHER LAB	647.00	0.00
MED/SURG SUPPLY	31,254.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	104,745.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,310.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,782.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	287.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,363.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,522.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,536.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58,978.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,128.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,565.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,117.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	908.00	0.00	INJECTABLE DRUGS	2,222.50	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	838.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,620.00	1,426.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	648.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	606.00	0.00			
			TOTAL ANCILLARY	451,485.74	1,426.00
			TOTAL ACCOMODATIONS	62,540.00	0.00
			TOTAL CHARGES	514,025.74	1,426.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

WASHINGTON COUNTY REGIONAL MEDICAL  
610 SPARTA ROAD  
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER  
000001218A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,791,220.63	ADJUSTMENTS	213,476.41
COVERED CHARGES	1,720,089.31	CONTRACTUAL ALLOW	1,130,357.30
NON-COVERD CHARGES	71,131.32	TOTAL MEDICAID LIAB	589,732.01
		LESS: COB	921.82
		LESS: COPAYMENT	2,643.46
		REIMBURSEMENT	586,166.73
		ALL OTHER	528,535.50
		FEE SCHEDULE-LAB	49,728.04
		INJECTABLE DRUGS	7,903.19
		TOTAL NUMBER OF CLAIMS	1,737



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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,911.31	40.49	OTHER LAB	10,622.00	0.00
MED/SURG SUPPLY	68,746.95	674.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	94,823.36	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	157,978.00	15,708.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,518.00	6,515.00	FEE SCHEDULE LAB	327,975.35	24,322.15
EKG/ECG	14,250.44	0.00	MRI SERVICES	22,043.85	0.00
IV THERAPY	79,952.47	2,396.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	132,569.36	7,853.89	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,895.14	358.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,115.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	358,635.67	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,144.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	44,399.46	7,286.54
RADIOLOGY THERAPEUTIC	4,210.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,606.00	989.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	874.00	612.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,288.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,966.00	53.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,864.00	3,201.00			
BLOOD	125.00	0.00			
BLOOD STORAGE & PRO.	20,596.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,402.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,354.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	50,950.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	98,273.95	1,122.00			
			TOTAL ANCILLARY	1,720,089.31	71,131.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,720,089.31	71,131.32

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

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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,332.50	ADJUSTMENTS	0.00
COVERED CHARGES	4,006.00	CONTRACTUAL ALLOW	2,525.51
NON-COVERD CHARGES	326.50	TOTAL MEDICAID LIAB	1,480.49
		LESS: COB	1,471.49
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 9

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 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	15.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,338.50	57.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	907.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	269.00	269.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,476.00	0.00			
			TOTAL ANCILLARY	4,006.00	326.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,006.00	326.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:33:51  
Page: 8

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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	84,302.28	ADJUSTMENTS	955.91
COVERED CHARGES	83,907.38	CONTRACTUAL ALLOW	76,229.16
NON-COVERD CHARGES	394.90	TOTAL MEDICAID LIAB	7,678.22
		LESS: COB	0.00
		LESS: COPAYMENT	327.96
		REIMBURSEMENT	7,350.26
		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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,911.51	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,019.90	75.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,650.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,469.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,726.00	273.00
EKG/ECG	551.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,080.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,295.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,419.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	810.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,134.42	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,841.05	46.90
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	83,907.38	394.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	83,907.38	394.90

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:33:52  
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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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 03:33:52  
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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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,842.70	ADJUSTMENTS	0.00
COVERED CHARGES	47,747.45	CONTRACTUAL ALLOW	36,957.27
NON-COVERD CHARGES	95.25	TOTAL MEDICAID LIAB	10,790.18
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	10,766.18
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,462.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	907.75	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	1,481.50	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,640.60	95.25
RADIOLOGY THERAPEUTIC	2,265.50	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	990.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	47,747.45	95.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	47,747.45	95.25



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:33:52  
Page: 13

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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 02:34:47  
 Page: 1

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,813,229.47	ADJUSTMENTS	1,344,326.19
COVERED CHARGES	14,403,188.50	CONTRACTUAL ALLOW	8,928,862.37
NON-COVERD CHARGES	410,040.97	TOTAL MEDICAID LIAB	5,474,326.13
		LESS: COB	25,954.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,448,372.01

TOTAL NUMBER OF ADMISSIONS 572

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,027		8	1,357,975.00		381,950.00
ROUTINE NURSERY	72		0	36,360.00		2,310.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,099		8	1,394,335.00		384,260.00
SPECIAL CARE SERVICES						
CCU	663		0	759,995.00		0.00
ICU	116		0	191,400.00		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	779		0	951,395.00		0.00
TOTAL ACCOMODATIONS	2,878		8	2,345,730.00		384,260.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:34:47  
 Page: 2

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,592,160.42	0.00	OTHER LAB	83,580.00	0.00
MED/SURG SUPPLY	1,053,468.21	2,219.29	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,444,004.00	0.00	EDUCATION & TRAINING	22,495.00	0.00
RADIOLOGY-DIAGNOSTIC	207,281.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	951,021.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	124,253.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	113,709.00	0.00	MRI SERVICES	210,073.00	0.00
IV THERAPY	259,041.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,402,676.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	38,620.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	951,015.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,700.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	164,814.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	480,405.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	52,999.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	14,372.68
LABORATORY PATHOLOGIC	33,187.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	3,890.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,033.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,586.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	108,018.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	614.00	9,189.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	495,922.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	95,964.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	127,321.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	78,967.00	0.00			
AUDIOLOGY	4,864.00	0.00			
CARDIOLOGY	680,752.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,323.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	229,702.00	0.00			
			TOTAL ANCILLARY	12,057,458.50	25,780.97
			TOTAL ACCOMODATIONS	2,345,730.00	384,260.00
			TOTAL CHARGES	14,403,188.50	410,040.97

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,759.95	ADJUSTMENTS	0.00
COVERED CHARGES	53,279.95	CONTRACTUAL ALLOW	16,534.56
NON-COVERD CHARGES	1,480.00	TOTAL MEDICAID LIAB	36,745.39
		LESS: COB	36,745.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	5,360.00		1,480.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	5,360.00		1,480.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	5,360.00		1,480.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,478.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,139.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,134.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	259.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	196.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,914.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,531.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	975.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,379.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,048.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,836.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,030.00	0.00			
			TOTAL ANCILLARY	47,919.95	0.00
			TOTAL ACCOMODATIONS	5,360.00	1,480.00
			TOTAL CHARGES	53,279.95	1,480.00

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: 08/12/2016  
Run Time: 02:34:57  
Page: 5

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,336,355.36	ADJUSTMENTS	562,118.25
COVERED CHARGES	18,440,742.10	CONTRACTUAL ALLOW	14,413,641.03
NON-COVERD CHARGES	1,895,613.26	TOTAL MEDICAID LIAB	4,027,101.07
		LESS: COB	751.96
		LESS: COPAYMENT	13,053.02
		REIMBURSEMENT	4,013,296.09
		ALL OTHER	2,811,777.81
		FEE SCHEDULE-LAB	351,947.98
		INJECTABLE DRUGS	849,570.30
		TOTAL NUMBER OF CLAIMS	8,976

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	875,265.77	410.00	OTHER LAB	415,737.00	1,794.00
MED/SURG SUPPLY	634,348.91	7,336.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	38.00	772.00
RADIOLOGY-DIAGNOSTIC	604,037.00	13,857.00	OTHER THERAPEUTIC SVC	286.00	0.00
CT SCAN	2,282,436.00	373,514.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,034.00	2,899.07	FEE SCHEDULE LAB	2,331,218.00	187,011.00
EKG/ECG	221,405.00	6,664.00	MRI SERVICES	640,364.00	49,232.00
IV THERAPY	926,056.00	8,860.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,219,346.15	140,334.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,399.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	152,262.00	19,232.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,525.00	622.00	AMBULANCE	0.00	0.00
GI SERVICES	595,871.18	29,749.82	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,016,291.00	2,042.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	209,121.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,929,967.81	798,187.73
RADIOLOGY THERAPEUTIC	20,599.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,284.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	406.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	79,090.00	4,278.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	123,490.28	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	724,487.00	83,760.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,316.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	388,555.00	22,045.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	676,892.00	136,449.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,456.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	241,158.00	6,564.00			
			TOTAL ANCILLARY	18,440,742.10	1,895,613.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,440,742.10	1,895,613.26

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:35:39  
Page: 7

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	121,891.03	ADJUSTMENTS	0.00
COVERED CHARGES	100,139.13	CONTRACTUAL ALLOW	30,821.09
NON-COVERD CHARGES	21,751.90	TOTAL MEDICAID LIAB	69,318.04
		LESS: COB	69,282.04
		LESS: COPAYMENT	36.00
		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

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,750.63	0.00	OTHER LAB	795.00	0.00
MED/SURG SUPPLY	3,479.10	82.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,560.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,475.00	9,747.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,374.00	2,642.00
EKG/ECG	1,568.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,851.00	138.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,016.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,010.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	175.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,936.00	2,135.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,037.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,807.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,632.40	258.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	186.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,399.00	781.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,140.00	5,968.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	948.00	0.00			
			TOTAL ANCILLARY	100,139.13	21,751.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	100,139.13	21,751.90

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:35:41  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	760,034.53	ADJUSTMENTS	1,481.61
COVERED CHARGES	734,147.63	CONTRACTUAL ALLOW	689,339.69
NON-COVERD CHARGES	25,886.90	TOTAL MEDICAID LIAB	44,807.94
		LESS: COB	0.00
		LESS: COPAYMENT	1,635.44
		REIMBURSEMENT	43,172.50
		TOTAL NUMBER OF CLAIMS	801

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,012.69	0.00	OTHER LAB	4,262.00	0.00
MED/SURG SUPPLY	12,175.53	2,047.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	154.00
RADIOLOGY-DIAGNOSTIC	57,559.00	833.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	74,811.00	13,738.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	871.00	0.00	FEE SCHEDULE LAB	99,929.00	6,402.00
EKG/ECG	8,624.00	0.00	MRI SERVICES	11,306.00	0.00
IV THERAPY	51,572.00	536.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,944.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,185.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	358,031.00	308.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	404.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,262.41	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	140.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,039.00	1,573.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,160.00	0.00			
			TOTAL ANCILLARY	734,147.63	25,886.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	734,147.63	25,886.90

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,834.20	ADJUSTMENTS	0.00
COVERED CHARGES	14,934.20	CONTRACTUAL ALLOW	6,678.16
NON-COVERD CHARGES	1,900.00	TOTAL MEDICAID LIAB	8,256.04
		LESS: COB	8,238.04
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	232.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	423.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,031.00	382.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,746.00	1,466.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,145.00	52.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	312.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,684.00	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	20.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,256.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,934.20	1,900.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,934.20	1,900.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:35:47  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,843,739.11	ADJUSTMENTS	101,187.31
COVERED CHARGES	1,800,489.45	CONTRACTUAL ALLOW	1,468,626.24
NON-COVERD CHARGES	43,249.66	TOTAL MEDICAID LIAB	331,863.21
		LESS: COB	0.00
		LESS: COPAYMENT	417.00
		REIMBURSEMENT	331,446.21

TOTAL NUMBER OF CLAIMS 59

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:35:47  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,653.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	47,194.83	42.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	76.00	0.00
RADIOLOGY-DIAGNOSTIC	2,154.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,339.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	238.00	0.00	FEE SCHEDULE LAB	17,784.00	104.00
EKG/ECG	2,548.00	196.00	MRI SERVICES	0.00	0.00
IV THERAPY	100,869.00	411.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,295.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,247.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	650.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,654.00	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	1,323,122.15	27,672.76
RADIOLOGY THERAPEUTIC	2,022.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,920.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	72,015.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,099.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	61,260.00	12,705.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,590.00	2,118.00			
			TOTAL ANCILLARY	1,800,489.45	43,249.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,800,489.45	43,249.66

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:51:33  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

COOK MEDICAL CENTER  
 706 N PARRISH AVE  
 ADEL, GA 31620-1511

PROVIDER NUMBER 000001251A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	446,619.98	ADJUSTMENTS	0.00
COVERED CHARGES	403,189.14	CONTRACTUAL ALLOW	231,809.69
NON-COVERD CHARGES	43,430.84	TOTAL MEDICAID LIAB	171,379.45
		LESS: COB	1,088.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	170,290.81

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	124		0	65,448.00		42,038.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	124		0	65,448.00		42,038.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	124		0	65,448.00		42,038.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

COOK MEDICAL CENTER  
 706 N PARRISH AVE  
 ADEL,GA 31620-1511

PROVIDER NUMBER  
 000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,955.50	0.00	OTHER LAB	1,811.00	0.00
MED/SURG SUPPLY	16,167.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	105,242.27	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,629.88	0.00	OTHER THERAPEUTIC SVC	0.00	487.75
CT SCAN	17,649.19	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,478.46	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,769.47	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,950.97	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	266.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,817.08	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	26,287.99	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	64,548.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	985.72	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	906.35	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	202.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,522.04	905.09			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,852.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,699.16	0.00			
			TOTAL ANCILLARY	337,741.14	1,392.84
			TOTAL ACCOMODATIONS	65,448.00	42,038.00
			TOTAL CHARGES	403,189.14	43,430.84

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

COOK MEDICAL CENTER  
706 N PARRISH AVE  
ADEL,GA 31620-1511

PROVIDER NUMBER  
000001251A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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COOK MEDICAL CENTER  
706 N PARRISH AVE  
ADEL,GA 31620-1511

PROVIDER NUMBER  
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,547,815.49	ADJUSTMENTS	15,244.79
COVERED CHARGES	1,281,624.06	CONTRACTUAL ALLOW	1,026,479.12
NON-COVERD CHARGES	266,191.43	TOTAL MEDICAID LIAB	255,144.94
		LESS: COB	0.00
		LESS: COPAYMENT	1,491.00
		REIMBURSEMENT	253,653.94
		ALL OTHER	214,164.54
		FEE SCHEDULE-LAB	39,489.40
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,224

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,495.86	56,768.10	OTHER LAB	57,362.28	0.00
MED/SURG SUPPLY	37,789.96	562.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129,258.23	896.90	OTHER THERAPEUTIC SVC	0.00	1,410.00
CT SCAN	166,241.99	55,408.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	385,547.25	81,981.91
EKG/ECG	15,218.65	2,419.60	MRI SERVICES	5,736.15	0.00
IV THERAPY	22,136.45	1,232.53	PROFESSIONAL FEES	0.00	949.50
OPERATING ROOM	4,550.59	3,895.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,965.19	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,695.74	0.00	AMBULANCE	0.00	0.00
GI SERVICES	60,446.19	17,496.26	CAST ROOM	0.00	0.00
EMERGENCY ROOM	301,440.49	4,892.98	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	594.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	19,919.75
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	1,236.10	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,138.75
OTHER IMAGING SERVICE	53,965.19	7,137.42			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,585.87	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,677.09	1,011.61			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,426.00	7,304.68			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,490.59	528.88			
			TOTAL ANCILLARY	1,281,624.06	266,191.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,281,624.06	266,191.43

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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COOK MEDICAL CENTER  
706 N PARRISH AVE  
ADEL,GA 31620-1511

PROVIDER NUMBER  
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
980	2014276005779	08/21/14 - 08/21/14	10/06/14	0.00	1,138.75	0.00	0.00	0.00
TOTAL				0.00	1,138.75	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

COOK MEDICAL CENTER  
706 N PARRISH AVE  
ADEL,GA 31620-1511

PROVIDER NUMBER  
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,093.10	ADJUSTMENTS	0.00
COVERED CHARGES	28,806.76	CONTRACTUAL ALLOW	15,483.78
NON-COVERD CHARGES	6,286.34	TOTAL MEDICAID LIAB	13,322.98
		LESS: COB	13,316.98
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	495.50	661.50	OTHER LAB	716.29	0.00
MED/SURG SUPPLY	1,170.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,729.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,389.55	838.65
EKG/ECG	224.18	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	519.11	0.00	PROFESSIONAL FEES	0.00	3,015.50
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	150.89	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,119.93	63.44	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	920.34
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	59.75	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	1,565.52	727.16			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,299.89	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,426.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,806.76	6,286.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,806.76	6,286.34



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: 08/12/2016  
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COOK MEDICAL CENTER  
706 N PARRISH AVE  
ADEL,GA 31620-1511

PROVIDER NUMBER  
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	155,771.27	ADJUSTMENTS	52.94
COVERED CHARGES	137,757.98	CONTRACTUAL ALLOW	124,912.67
NON-COVERD CHARGES	18,013.29	TOTAL MEDICAID LIAB	12,845.31
		LESS: COB	0.00
		LESS: COPAYMENT	465.00
		REIMBURSEMENT	12,380.31
		TOTAL NUMBER OF CLAIMS	231

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	377.25	4,983.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,933.42	110.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,259.89	0.00	OTHER THERAPEUTIC SVC	0.00	247.57
CT SCAN	6,518.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,651.13	2,997.97
EKG/ECG	889.43	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	675.17	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	504.28	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	83,498.31	126.88	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	9,241.00
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	59.75	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	156.70	246.17			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	319.21	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	975.19	0.00			
			TOTAL ANCILLARY	137,757.98	18,013.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	137,757.98	18,013.29

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,163.65	ADJUSTMENTS	0.00
COVERED CHARGES	2,121.54	CONTRACTUAL ALLOW	828.58
NON-COVERD CHARGES	42.11	TOTAL MEDICAID LIAB	1,292.96
		LESS: COB	1,289.96
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COOK MEDICAL CENTER  
 706 N PARRISH AVE  
 ADEL,GA 31620-1511

PROVIDER NUMBER  
 000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	9.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	280.29	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	327.30	33.11
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,513.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,121.54	42.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,121.54	42.11

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COOK MEDICAL CENTER  
706 N PARRISH AVE  
ADEL,GA 31620-1511

PROVIDER NUMBER  
000001251A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR  
 1500 E SHOTWELL ST  
 BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER 000001262A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,050,821.40	ADJUSTMENTS	92,075.51
COVERED CHARGES	2,965,734.40	CONTRACTUAL ALLOW	1,660,235.04
NON-COVERD CHARGES	85,087.00	TOTAL MEDICAID LIAB	1,305,499.36
		LESS: COB	7,147.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,298,351.46

TOTAL NUMBER OF ADMISSIONS 237

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	638		0	373,230.00		45,071.00
ROUTINE NURSERY	66		0	34,804.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	704		0	408,034.00		45,071.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	131		0	162,660.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	131		0	162,660.00		0.00
TOTAL ACCOMODATIONS	835		0	570,694.00		45,071.00

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	475,590.13	0.00	OTHER LAB	6,575.00	0.00
MED/SURG SUPPLY	378,235.40	143.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	452,511.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,396.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	151,826.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,361.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	33,256.00	0.00	MRI SERVICES	34,935.00	0.00
IV THERAPY	77.00	0.00	PROFESSIONAL FEES	0.00	1,231.00
OPERATING ROOM	243,766.00	18,813.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	153,815.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	97,556.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,285.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	174,383.00	0.00	SPECIAL SERVICES	0.00	4,482.00
RECOVERY ROOM	42,073.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,012.00	0.00	INJECTABLE DRUGS	7,352.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,370.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,381.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	679.83	1,527.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,158.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,678.00	13,637.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,590.00	0.00			
AUDIOLOGY	3,109.93	0.00			
CARDIOLOGY	11,365.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,704.00	183.00			
			TOTAL ANCILLARY	2,395,040.40	40,016.00
			TOTAL ACCOMODATIONS	570,694.00	45,071.00
			TOTAL CHARGES	2,965,734.40	85,087.00



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR  
 1500 E SHOTWELL ST  
 BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER  
 000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,737.70	ADJUSTMENTS	0.00
COVERED CHARGES	13,587.70	CONTRACTUAL ALLOW	3,015.96
NON-COVERD CHARGES	150.00	TOTAL MEDICAID LIAB	10,571.74
		LESS: COB	10,571.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		0	1,170.00		150.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2		0	1,170.00		150.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	2		0	1,170.00		150.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEMORIAL HOSPITAL AND MANOR  
 1500 E SHOTWELL ST  
 BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER  
 000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	871.70	0.00	OTHER LAB	161.00	0.00
MED/SURG SUPPLY	1,367.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	316.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	132.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,145.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	331.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	94.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	12,417.70	0.00
			TOTAL ACCOMODATIONS	1,170.00	150.00
			TOTAL CHARGES	13,587.70	150.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:45:17  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,805,179.22	ADJUSTMENTS	121,536.79
COVERED CHARGES	3,339,325.89	CONTRACTUAL ALLOW	2,614,339.13
NON-COVERD CHARGES	465,853.33	TOTAL MEDICAID LIAB	724,986.76
		LESS: COB	524.24
		LESS: COPAYMENT	3,594.00
		REIMBURSEMENT	720,868.52
		ALL OTHER	597,869.83
		FEE SCHEDULE-LAB	117,803.37
		INJECTABLE DRUGS	5,195.32

TOTAL NUMBER OF CLAIMS 3,887

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,575.90	134.00	OTHER LAB	15,591.00	0.00
MED/SURG SUPPLY	144,017.00	1,288.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,275.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	229,626.00	3,184.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	337,117.00	71,237.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	59,174.00	9,270.00	FEE SCHEDULE LAB	1,011,448.00	224,754.65
EKG/ECG	48,895.00	3,370.00	MRI SERVICES	98,652.00	16,975.00
IV THERAPY	2,950.00	606.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	293,467.50	66,655.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,181.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,581.00	10,272.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,478.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	589,215.00	10,338.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,460.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	266.00	INJECTABLE DRUGS	38,191.69	22,671.28
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,563.00	1,813.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	397.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,600.00	81.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	320.00	2,560.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	370.00
OTHER IMAGING SERVICE	89,815.00	7,995.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,544.00	3,050.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,119.00	0.00			
AUDIOLOGY	0.00	107.00			
CARDIOLOGY	16,822.00	2,122.00			
AMBULATORY SURGERY	205.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,432.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	105,285.00	5,051.00			
			TOTAL ANCILLARY	3,339,325.89	465,842.93
			TOTAL ACCOMODATIONS	0.00	10.40
			TOTAL CHARGES	3,339,325.89	465,853.33

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:45:17  
Page: 7

MEMORIAL HOSPITAL AND MANOR  
1500 E SHOTWELL ST  
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER  
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2215086011071	03/21/15 - 03/21/15	03/30/15	0.00	176.00	0.00	0.00	0.00
30	2215096002033	12/14/14 - 12/14/14	04/13/15	0.00	194.00	0.00	0.00	0.00
TOTAL				0.00	370.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:46:01  
Page: 8

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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,386.50	ADJUSTMENTS	0.00
COVERED CHARGES	36,307.50	CONTRACTUAL ALLOW	21,744.93
NON-COVERD CHARGES	2,079.00	TOTAL MEDICAID LIAB	14,562.57
		LESS: COB	14,538.57
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 41

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,426.35	0.00	OTHER LAB	161.00	0.00
MED/SURG SUPPLY	1,658.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,210.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,340.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,618.00	549.00
EKG/ECG	225.00	0.00	MRI SERVICES	1,544.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,132.00	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	253.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,991.00	1,235.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,159.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140.35	24.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	465.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	320.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,114.00	271.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,571.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,939.00	0.00			
			TOTAL ANCILLARY	36,307.50	2,079.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,307.50	2,079.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:46:02  
Page: 10

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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	126,811.95	ADJUSTMENTS	429.52
COVERED CHARGES	121,743.05	CONTRACTUAL ALLOW	105,247.96
NON-COVERD CHARGES	5,068.90	TOTAL MEDICAID LIAB	16,495.09
		LESS: COB	0.00
		LESS: COPAYMENT	531.00
		REIMBURSEMENT	15,964.09
		TOTAL NUMBER OF CLAIMS	300



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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,534.80	0.00	OTHER LAB	170.00	0.00
MED/SURG SUPPLY	997.00	45.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,833.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,479.00	2,311.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,298.00	2,143.00
EKG/ECG	869.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,681.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	51.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,888.00	300.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,217.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,986.00	269.90
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	108.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	596.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	121,743.05	5,068.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	121,743.05	5,068.90

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:46:06  
Page: 12

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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,059.40	ADJUSTMENTS	0.00
COVERED CHARGES	1,761.40	CONTRACTUAL ALLOW	1,472.93
NON-COVERD CHARGES	298.00	TOTAL MEDICAID LIAB	288.47
		LESS: COB	285.47
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:46:06  
 Page: 13

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	800.00	298.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	927.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,761.40	298.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,761.40	298.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 02:46:06  
Page: 14

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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,646.90	ADJUSTMENTS	0.00
COVERED CHARGES	23,344.10	CONTRACTUAL ALLOW	17,998.25
NON-COVERD CHARGES	302.80	TOTAL MEDICAID LIAB	5,345.85
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	5,336.85
		TOTAL NUMBER OF CLAIMS	1

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,492.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,844.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	585.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	688.00	0.00
EKG/ECG	132.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,545.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	125.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	446.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,462.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	422.50	32.80
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	1,602.00	270.00			
			TOTAL ANCILLARY	23,344.10	302.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,344.10	302.80

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 02:46:07  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL AND MANOR  
1500 E SHOTWELL ST  
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER  
000001262A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	113,560,459.91	ADJUSTMENTS	12,134,018.93
COVERED CHARGES	109,454,021.79	CONTRACTUAL ALLOW	74,511,827.82
NON-COVERD CHARGES	4,106,438.12	TOTAL MEDICAID LIAB	34,942,193.97
		LESS: COB	318,927.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	34,623,266.45

TOTAL NUMBER OF ADMISSIONS 3,017

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	12,885	97	10,948,931.00	2,982,254.00
ROUTINE NURSERY	1,629	0	3,338,263.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	14,514	97	14,287,194.00	2,982,254.00
SPECIAL CARE SERVICES				
CCU	111	0	335,109.00	0.00
ICU	3,571	1	7,218,815.00	1,472.00
NICU	1,390	0	4,561,980.00	0.00
PED ICU	455	0	1,795,430.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	457	0	1,379,683.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,984	1	15,291,017.00	1,472.00
TOTAL ACCOMODATIONS	20,498	98	29,578,211.00	2,983,726.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:46:14  
 Page: 2

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,442,956.61	58.75	OTHER LAB	702,606.80	0.00
MED/SURG SUPPLY	5,323,302.91	85,422.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,490,780.71	5,572.94	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,577,373.00	0.00	OTHER THERAPEUTIC SVC	4,585.00	78,937.00
CT SCAN	3,962,637.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	841,361.17	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	332,672.00	0.00	MRI SERVICES	1,408,119.12	0.00
IV THERAPY	943,268.97	1,845.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,715,805.06	4,521.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	868,345.00	4,750.00	REHAB THERAPY	14,820.00	0.00
RESPIRATORY SERVICES	5,124,114.64	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,659,754.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	239,308.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,121,094.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,453,561.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	219,756.35
LABORATORY PATHOLOGIC	226,968.96	0.00	INJECTABLE DRUGS	4,669,966.02	0.00
RADIOLOGY THERAPEUTIC	384,691.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	567,176.85	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	326,100.39	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	669,624.00	1,382.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	30,095.00	1,230.00	TRAUMA RESPONSE	0.00	79,452.00
PSYCHIATRIC SERVICES	791.00	0.00	IMPL DEV CHARGE PATIENTS	5,161,670.68	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	629,084.60	37,267.28			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,177,628.00	514,710.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	286,811.42	87,807.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,240,187.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	124,614.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	153,936.34	0.00			
			TOTAL ANCILLARY	79,875,810.79	1,122,712.12
			TOTAL ACCOMODATIONS	29,578,211.00	2,983,726.00
			TOTAL CHARGES	109,454,021.79	4,106,438.12



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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	637,945.04	ADJUSTMENTS	0.00
COVERED CHARGES	586,394.04	CONTRACTUAL ALLOW	414,771.90
NON-COVERD CHARGES	51,551.00	TOTAL MEDICAID LIAB	171,622.14
		LESS: COB	171,622.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	73		0	62,187.00		41,225.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	73		0	62,187.00		41,225.00
SPECIAL CARE SERVICES						
CCU	3		0	9,057.00		0.00
ICU	10		0	25,549.00		0.00
NICU	0		0	0.00		0.00
PED ICU	3		0	11,838.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	16		0	46,444.00		0.00
TOTAL ACCOMODATIONS	89		0	108,631.00		41,225.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,869.27	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26,095.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,626.46	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,745.00	0.00	OTHER THERAPEUTIC SVC	0.00	606.00
CT SCAN	5,137.14	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,798.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	368.00	0.00	MRI SERVICES	12,559.00	0.00
IV THERAPY	3,386.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	141,561.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,549.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,566.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,570.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,633.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,587.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,798.00	0.00	INJECTABLE DRUGS	37,969.57	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,642.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,019.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	346.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,417.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,500.00	4,968.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,023.00	3,420.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,332.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	959.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,039.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	477,763.04	10,326.00
			TOTAL ACCOMODATIONS	108,631.00	41,225.00
			TOTAL CHARGES	586,394.04	51,551.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:47:08  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,610,781.71	ADJUSTMENTS	755,842.70
COVERED CHARGES	30,533,796.81	CONTRACTUAL ALLOW	25,798,577.35
NON-COVERD CHARGES	7,076,984.90	TOTAL MEDICAID LIAB	4,735,219.46
		LESS: COB	20,680.41
		LESS: COPAYMENT	12,389.78
		REIMBURSEMENT	4,702,149.27
		ALL OTHER	4,000,751.89
		FEE SCHEDULE-LAB	362,968.72
		INJECTABLE DRUGS	338,428.66
		TOTAL NUMBER OF CLAIMS	11,922

SUMMARY TYPE III  
 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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	815,343.56	405.33	OTHER LAB	704,754.92	2,324.00
MED/SURG SUPPLY	1,268,096.01	260,297.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,492,976.00	20,956.24	OTHER THERAPEUTIC SVC	21,793.00	43,991.84
CT SCAN	2,828,062.62	627,505.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	171,616.00	53,235.42	FEE SCHEDULE LAB	2,604,939.08	197,522.77
EKG/ECG	241,744.00	14,904.00	MRI SERVICES	1,065,058.44	220,645.80
IV THERAPY	1,260,554.00	25,198.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,355,474.35	652,975.63	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	110,935.00	0.00	REHAB THERAPY	0.00	936.00
RESPIRATORY SERVICES	152,383.00	4,641.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,605,544.00	10,399.00	AMBULANCE	0.00	0.00
GI SERVICES	245,443.00	98,702.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,542,335.00	34,444.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	987,044.00	1,627.00	DRUG-SPECIFIC/HOME IV	0.00	8,720.94
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,265,984.82	554,137.87
RADIOLOGY THERAPEUTIC	999,989.00	2,404,615.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	55,460.00	68,423.23	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	33,965.00	11,301.14	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	194.00	7,612.00	PATIENT CONVENIENCE	0.00	5.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	116,341.00	8,988.00	TRAUMA RESPONSE	0.00	8,828.00
PSYCHIATRIC SERVICES	3,164.00	0.00	IMPL DEV CHARGE PATIENTS	441,171.12	467,588.29
LITHOTRIPSY	102,781.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	765,398.36	245,626.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	225,839.00	98,398.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	296,724.39	417,683.80			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	275,592.00	504,131.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	33,768.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	443,329.14	214.78			
			TOTAL ANCILLARY	30,533,796.81	7,076,984.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,533,796.81	7,076,984.90

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HEALTH UNIV MED CEN, INC  
4700 WATERS AVE  
SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	421,745.99	ADJUSTMENTS	0.00
COVERED CHARGES	309,665.09	CONTRACTUAL ALLOW	221,744.43
NON-COVERD CHARGES	112,080.90	TOTAL MEDICAID LIAB	87,920.66
		LESS: COB	87,818.63
		LESS: COPAYMENT	102.03
		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

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,118.35	257.25	OTHER LAB	11,471.72	0.00
MED/SURG SUPPLY	15,082.28	102.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,317.00	680.00	OTHER THERAPEUTIC SVC	3,420.00	5,130.00
CT SCAN	19,339.84	19,831.64	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,123.00	942.02	FEE SCHEDULE LAB	23,334.44	2,412.45
EKG/ECG	1,104.00	368.00	MRI SERVICES	17,581.82	4,918.80
IV THERAPY	8,054.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,228.00	19,060.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,212.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	909.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,741.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,675.00	1,409.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,695.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,747.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,835.01	41,344.21
RADIOLOGY THERAPEUTIC	5,728.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	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	1,479.00	206.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	108.20	845.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,697.00	8,666.32			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,461.00	1,994.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,489.08	3,367.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,714.35	98.26			
			TOTAL ANCILLARY	309,665.09	112,080.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	309,665.09	112,080.90

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:48:59  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	975,242.45	ADJUSTMENTS	438.52
COVERED CHARGES	926,404.54	CONTRACTUAL ALLOW	881,764.42
NON-COVERD CHARGES	48,837.91	TOTAL MEDICAID LIAB	44,640.12
		LESS: COB	0.00
		LESS: COPAYMENT	996.77
		REIMBURSEMENT	43,643.35
		TOTAL NUMBER OF CLAIMS	798

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,345.91	0.00	OTHER LAB	4,253.00	0.00
MED/SURG SUPPLY	6,692.55	689.05	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,565.00	952.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,549.46	21,999.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	75,291.15	4,900.44
EKG/ECG	2,944.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	27,017.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,152.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	989.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,149.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,402.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	623,899.00	128.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,353.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,649.85	1,441.16
RADIOLOGY THERAPEUTIC	8,063.00	13,108.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	206.00	171.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	673.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,771.00	5,448.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,629.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,809.82	0.00			
			TOTAL ANCILLARY	926,404.54	48,837.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	926,404.54	48,837.91



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

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,421.01	ADJUSTMENTS	0.00
COVERED CHARGES	6,342.01	CONTRACTUAL ALLOW	4,647.33
NON-COVERD CHARGES	79.00	TOTAL MEDICAID LIAB	1,694.68
		LESS: COB	1,691.68
		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

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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	369.01	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	610.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	614.00	79.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	107.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	4,530.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,342.01	79.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,342.01	79.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL 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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,999,308.38	ADJUSTMENTS	67,892.39
COVERED CHARGES	3,614,256.12	CONTRACTUAL ALLOW	3,237,123.41
NON-COVERD CHARGES	385,052.26	TOTAL MEDICAID LIAB	377,132.71
		LESS: COB	0.00
		LESS: COPAYMENT	255.66
		REIMBURSEMENT	376,877.05

TOTAL NUMBER OF CLAIMS 61

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,023.12	0.00	OTHER LAB	3,115.00	4,287.00
MED/SURG SUPPLY	330,982.58	2,603.05	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,372.00	20,002.00	OTHER THERAPEUTIC SVC	0.00	1,600.00
CT SCAN	16,005.32	2,114.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,386.00	FEE SCHEDULE LAB	17,763.05	450.00
EKG/ECG	1,472.00	184.00	MRI SERVICES	0.00	7,172.00
IV THERAPY	11,855.00	986.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	457,495.50	152,216.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	624.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	94,686.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,585.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,442.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	374,490.96	12,632.71
RADIOLOGY THERAPEUTIC	125,015.00	4,570.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,008.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,075.00	118.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,901,845.19	15,125.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,895.00	6,296.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,985.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,187.92	7,396.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	134,635.00	144,282.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,330.48	0.00			
			TOTAL ANCILLARY	3,614,256.12	385,052.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,614,256.12	385,052.26

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

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,924.83	ADJUSTMENTS	0.00
COVERED CHARGES	59,018.71	CONTRACTUAL ALLOW	43,875.33
NON-COVERD CHARGES	906.12	TOTAL MEDICAID LIAB	15,143.38
		LESS: COB	15,143.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,040.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,755.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	9,215.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,944.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,090.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,693.99	906.12
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	35,280.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	59,018.71	906.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,018.71	906.12

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	125,185.88	ADJUSTMENTS	34,210.22
COVERED CHARGES	124,796.88	CONTRACTUAL ALLOW	47,324.41
NON-COVERD CHARGES	389.00	TOTAL MEDICAID LIAB	77,472.47
		LESS: COB	781.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	76,691.37

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	49		0	25,480.00		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	49		0	25,480.00		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	49		0	25,480.00		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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,043.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,784.44	71.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	23,327.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,076.00	0.00	OTHER THERAPEUTIC SVC	0.00	318.00
CT SCAN	9,100.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	168.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,572.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,569.60	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	495.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,419.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,545.84	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	201.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	5,016.00	0.00			
			TOTAL ANCILLARY	99,316.88	389.00
			TOTAL ACCOMODATIONS	25,480.00	0.00
			TOTAL CHARGES	124,796.88	389.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	672,040.76	ADJUSTMENTS	6,528.47
COVERED CHARGES	552,427.59	CONTRACTUAL ALLOW	401,374.27
NON-COVERD CHARGES	119,613.17	TOTAL MEDICAID LIAB	151,053.32
		LESS: COB	76.00
		LESS: COPAYMENT	513.00
		REIMBURSEMENT	150,464.32
		ALL OTHER	133,553.44
		FEE SCHEDULE-LAB	14,970.01
		INJECTABLE DRUGS	1,940.87

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: 08/12/2016  
 Run Time: 03:33:22  
 Page: 5

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,251.00	15,109.50	OTHER LAB	4,260.00	0.00
MED/SURG SUPPLY	13,434.75	1,016.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,969.00	487.00	OTHER THERAPEUTIC SVC	0.00	20,317.00
CT SCAN	64,690.00	40,923.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	122,176.24	16,112.00
EKG/ECG	13,970.00	2,286.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,936.40	312.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,141.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,949.00	1,497.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	29,693.00	2,427.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	194,214.00	2,154.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,470.20	11,542.77
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,012.00	998.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	440.00	3,076.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,364.00	1,355.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,369.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,088.00	0.00			
			TOTAL ANCILLARY	552,427.59	119,613.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	552,427.59	119,613.17

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 03:33:28  
Page: 6

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,459.50	ADJUSTMENTS	0.00
COVERED CHARGES	7,290.50	CONTRACTUAL ALLOW	-440.75
NON-COVERD CHARGES	5,169.00	TOTAL MEDICAID LIAB	7,731.25
		LESS: COB	7,730.45
		LESS: COPAYMENT	0.80
		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

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88.00	46.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	197.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,041.00	0.00	OTHER THERAPEUTIC SVC	0.00	159.00
CT SCAN	0.00	4,854.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,066.00	109.00
EKG/ECG	254.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	265.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,941.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	438.50	1.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,290.50	5,169.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,290.50	5,169.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:33:28  
Page: 8

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	86,943.70	ADJUSTMENTS	188.00
COVERED CHARGES	77,786.00	CONTRACTUAL ALLOW	70,536.00
NON-COVERD CHARGES	9,157.70	TOTAL MEDICAID LIAB	7,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	357.00
		REIMBURSEMENT	6,893.00
		TOTAL NUMBER OF CLAIMS	145

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	394.00	467.00	OTHER LAB	376.00	0.00
MED/SURG SUPPLY	566.00	48.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,320.00	186.00	OTHER THERAPEUTIC SVC	0.00	3,972.00
CT SCAN	6,195.00	2,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,485.00	1,797.00
EKG/ECG	1,524.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,279.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	133.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,384.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,130.00	486.80
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
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	77,786.00	9,157.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	77,786.00	9,157.70

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:33:29  
Page: 10

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	681.00	ADJUSTMENTS	0.00
COVERED CHARGES	681.00	CONTRACTUAL ALLOW	102.15
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	578.85
		LESS: COB	578.85
		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

Run Date: 08/12/2016  
 Run Time: 03:33:29  
 Page: 11

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	203.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	475.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	681.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	681.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:33:29  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER HEALTHCARE, LLC  
5995 SPRING ST  
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER  
000001284A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:33:29  
Page: 13

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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:51:26  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL  
 209 N CUTHBERT ST  
 COLQUITT,GA 39837-3518

PROVIDER NUMBER 000001317A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,368,498.49	ADJUSTMENTS	18,381.44
COVERED CHARGES	1,338,521.49	CONTRACTUAL ALLOW	822,020.73
NON-COVERD CHARGES	29,977.00	TOTAL MEDICAID LIAB	516,500.76
		LESS: COB	3,197.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	513,303.35

TOTAL NUMBER OF ADMISSIONS 84

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	391		0	148,995.00		1,540.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	391		0	148,995.00		1,540.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	391		0	148,995.00		1,540.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	405,961.32	0.00	OTHER LAB	932.00	0.00
MED/SURG SUPPLY	223,215.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	165,399.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,857.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	68,982.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,580.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,213.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	348.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,988.00	18,084.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	135,648.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,805.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	92.75	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	1,278.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	145.00
OTHER IMAGING SERVICE	10,528.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,608.00	10,208.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	791.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,504.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,046.00	0.00			
			TOTAL ANCILLARY	1,189,526.49	28,437.00
			TOTAL ACCOMODATIONS	148,995.00	1,540.00
			TOTAL CHARGES	1,338,521.49	29,977.00

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2214224002001	07/28/14 - 08/01/14	08/25/14	0.00	145.00	0.00	0.00	0.00
TOTAL				0.00	145.00	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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,832,430.81	ADJUSTMENTS	34,497.66
COVERED CHARGES	2,411,480.43	CONTRACTUAL ALLOW	1,483,035.34
NON-COVERD CHARGES	420,950.38	TOTAL MEDICAID LIAB	928,445.09
		LESS: COB	0.00
		LESS: COPAYMENT	2,763.00
		REIMBURSEMENT	925,682.09
		ALL OTHER	809,199.08
		FEE SCHEDULE-LAB	116,462.54
		INJECTABLE DRUGS	20.47
		TOTAL NUMBER OF CLAIMS	4,447



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	65,352.69	97,682.80	OTHER LAB	33,604.00	0.00
MED/SURG SUPPLY	159,687.41	2,233.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,277.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	166,563.03	8,714.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	112,655.00	21,280.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	418.00	FEE SCHEDULE LAB	770,846.00	220,790.70
EKG/ECG	14,617.00	1,199.00	MRI SERVICES	5,687.00	1,936.00
IV THERAPY	5,980.00	1,289.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	648,019.00	24,538.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,686.00	4,395.00	FREE STANDING CLINIC	17.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	132,769.00	8,631.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	79,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42.30	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	628.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,889.00	13.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,257.00	1,160.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,796.00	15,874.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,246.00	1,131.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,051.00	3,854.00			
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	110,588.00	3,906.00			
			TOTAL ANCILLARY	2,411,480.43	420,950.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,411,480.43	420,950.38

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,890.30	ADJUSTMENTS	0.00
COVERED CHARGES	3,946.80	CONTRACTUAL ALLOW	2,320.09
NON-COVERD CHARGES	943.50	TOTAL MEDICAID LIAB	1,626.71
		LESS: COB	1,623.71
		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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	415.80	780.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	509.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	145.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,320.00	163.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,557.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,946.80	943.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,946.80	943.50

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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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	87,517.05	ADJUSTMENTS	0.00
COVERED CHARGES	77,742.40	CONTRACTUAL ALLOW	71,058.40
NON-COVERD CHARGES	9,774.65	TOTAL MEDICAID LIAB	6,684.00
		LESS: COB	0.00
		LESS: COPAYMENT	231.00
		REIMBURSEMENT	6,453.00
		TOTAL NUMBER OF CLAIMS	135

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,469.65	5,790.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,548.75	117.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,727.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,644.00	1,401.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,693.00	1,438.00
EKG/ECG	436.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,224.00	113.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	915.00			
			TOTAL ANCILLARY	77,742.40	9,774.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	77,742.40	9,774.65

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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MILLER COUNTY HOSPITAL  
209 N CUTHBERT ST  
COLQUITT,GA 39837-3518

PROVIDER NUMBER  
000001317A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	273.00	ADJUSTMENTS	0.00
COVERED CHARGES	273.00	CONTRACTUAL ALLOW	40.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	232.05
		LESS: COB	232.05
		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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	273.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	273.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	273.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER COUNTY HOSPITAL  
209 N CUTHBERT ST  
COLQUITT,GA 39837-3518

PROVIDER NUMBER  
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,474.55	ADJUSTMENTS	4,822.45
COVERED CHARGES	52,794.20	CONTRACTUAL ALLOW	33,504.40
NON-COVERD CHARGES	1,680.35	TOTAL MEDICAID LIAB	19,289.80
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	19,286.80

TOTAL NUMBER OF CLAIMS 4



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,295.90	816.35	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,145.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	550.00	695.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	719.00	26.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,842.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	143.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,492.00	0.00			
			TOTAL ANCILLARY	52,794.20	1,680.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,794.20	1,680.35

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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Run Time: 02:51:52  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER COUNTY HOSPITAL  
209 N CUTHBERT ST  
COLQUITT,GA 39837-3518

PROVIDER NUMBER  
000001317A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER 000001328A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	451,580.04	ADJUSTMENTS	42,881.84
COVERED CHARGES	413,081.04	CONTRACTUAL ALLOW	249,225.20
NON-COVERD CHARGES	38,499.00	TOTAL MEDICAID LIAB	163,855.84
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	163,855.84

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	91		0	68,250.00		25,480.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	91		0	68,250.00		25,480.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	91		0	68,250.00		25,480.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103,552.04	0.00	OTHER LAB	1,982.00	0.00
MED/SURG SUPPLY	9,301.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	59,332.00	0.00	EDUCATION & TRAINING	224.00	0.00
RADIOLOGY-DIAGNOSTIC	7,986.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,976.00	11,790.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,117.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,455.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,814.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,136.00	1,229.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,988.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,325.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,402.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,186.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	66.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	75,486.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,207.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,960.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,336.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	344,831.04	13,019.00
			TOTAL ACCOMODATIONS	68,250.00	25,480.00
			TOTAL CHARGES	413,081.04	38,499.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC  
5401 LAKE OCONEE PARKWAY  
GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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GOOD SAMARITAN HOSPITAL INC  
5401 LAKE OCONEE PARKWAY  
GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,386,573.91	ADJUSTMENTS	44,193.09
COVERED CHARGES	1,229,421.77	CONTRACTUAL ALLOW	704,659.95
NON-COVERD CHARGES	157,152.14	TOTAL MEDICAID LIAB	524,761.82
		LESS: COB	2,969.97
		LESS: COPAYMENT	921.00
		REIMBURSEMENT	520,870.85
		ALL OTHER	497,611.21
		FEE SCHEDULE-LAB	21,326.12
		INJECTABLE DRUGS	1,933.52

TOTAL NUMBER OF CLAIMS 941

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,321.24	14,057.98	OTHER LAB	11,120.00	0.00
MED/SURG SUPPLY	9,574.00	3,682.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	168.00	0.00
RADIOLOGY-DIAGNOSTIC	78,525.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	249,109.00	31,560.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,001.00	1,745.00	FEE SCHEDULE LAB	188,041.00	43,416.00
EKG/ECG	15,675.00	990.00	MRI SERVICES	84,878.00	5,737.00
IV THERAPY	78,833.00	1,398.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	74,377.00	8,672.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,430.00	2,354.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,566.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	213,900.00	7,057.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,561.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	48,587.53	18,915.16
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	427.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	858.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	990.00	330.00	IMPL DEV CHARGE PATIENTS	0.00	729.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,625.00	5,532.00			
BLOOD	1,246.00	0.00			
BLOOD STORAGE & PRO.	5,610.00	1,979.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,235.00	1,804.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,752.00	6,336.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,664.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,206.00	0.00			
			TOTAL ANCILLARY	1,229,421.77	157,152.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,229,421.77	157,152.14

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GOOD SAMARITAN HOSPITAL INC  
5401 LAKE OCONEE PARKWAY  
GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,291.86	ADJUSTMENTS	0.00
COVERED CHARGES	25,162.86	CONTRACTUAL ALLOW	11,687.72
NON-COVERD CHARGES	8,129.00	TOTAL MEDICAID LIAB	13,475.14
		LESS: COB	13,475.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	803.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,210.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,730.00	5,082.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,300.00	401.00
EKG/ECG	495.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,841.00	272.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	263.00	812.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,510.00	601.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,463.81	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	440.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	165.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	66.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	382.00	455.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,162.86	8,129.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,162.86	8,129.00

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: 08/12/2016  
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GOOD SAMARITAN HOSPITAL INC  
5401 LAKE OCONEE PARKWAY  
GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	155,350.62	ADJUSTMENTS	235.00
COVERED CHARGES	143,118.32	CONTRACTUAL ALLOW	132,218.32
NON-COVERD CHARGES	12,232.30	TOTAL MEDICAID LIAB	10,900.00
		LESS: COB	43.81
		LESS: COPAYMENT	438.00
		REIMBURSEMENT	10,418.19
		TOTAL NUMBER OF CLAIMS	218

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,622.25	0.00	OTHER LAB	893.00	0.00
MED/SURG SUPPLY	574.00	908.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,087.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,755.00	5,222.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,533.00	3,264.00
EKG/ECG	1,650.00	165.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,083.00	71.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,088.00	146.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	60,700.00	566.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,133.07	1,095.30
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	66.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	729.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	143,118.32	12,232.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	143,118.32	12,232.30

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: 08/12/2016  
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Page: 10

GOOD SAMARITAN HOSPITAL INC  
5401 LAKE OCONEE PARKWAY  
GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	830.06	ADJUSTMENTS	0.00
COVERED CHARGES	805.06	CONTRACTUAL ALLOW	355.07
NON-COVERD CHARGES	25.00	TOTAL MEDICAID LIAB	449.99
		LESS: COB	446.99
		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

GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	188.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	73.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	457.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	25.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	805.06	25.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	805.06	25.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GOOD SAMARITAN HOSPITAL INC  
5401 LAKE OCONEE PARKWAY  
GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	217,665.34	ADJUSTMENTS	26,506.45
COVERED CHARGES	214,073.95	CONTRACTUAL ALLOW	151,207.07
NON-COVERD CHARGES	3,591.39	TOTAL MEDICAID LIAB	62,866.88
		LESS: COB	0.00
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	62,812.88

TOTAL NUMBER OF CLAIMS 12

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,509.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41,261.00	906.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	155.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,924.00	110.00
EKG/ECG	165.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	90,473.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	26,954.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	44,132.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,559.40	1,309.39
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,266.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	941.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	214,073.95	3,591.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	214,073.95	3,591.39

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GOOD SAMARITAN HOSPITAL INC  
5401 LAKE OCONEE PARKWAY  
GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
000001328A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 02:51:58  
 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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,731.00	ADJUSTMENTS	5,049.87
COVERED CHARGES	43,410.00	CONTRACTUAL ALLOW	20,772.54
NON-COVERD CHARGES	321.00	TOTAL MEDICAID LIAB	22,637.46
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	22,637.46

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12		0	6,903.00		321.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	6,903.00		321.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	12		0	6,903.00		321.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL  
 90 E STEPHENS ST  
 CAMILLA,GA 31730-1836

PROVIDER NUMBER  
 000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,724.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	467.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,439.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,508.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,610.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	759.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,797.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,684.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	978.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	36,507.00	0.00
			TOTAL ACCOMODATIONS	6,903.00	321.00
			TOTAL CHARGES	43,410.00	321.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:51:59  
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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:51:59  
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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,925,440.85	ADJUSTMENTS	24,106.73
COVERED CHARGES	1,791,207.85	CONTRACTUAL ALLOW	1,363,902.92
NON-COVERD CHARGES	134,233.00	TOTAL MEDICAID LIAB	427,304.93
		LESS: COB	62.34
		LESS: COPAYMENT	2,535.00
		REIMBURSEMENT	424,707.59
		ALL OTHER	363,340.74
		FEE SCHEDULE-LAB	54,797.79
		INJECTABLE DRUGS	6,569.06

TOTAL NUMBER OF CLAIMS 1,993

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	141,259.20	0.00	OTHER LAB	6,009.00	0.00
MED/SURG SUPPLY	21,743.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	161,223.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	254,281.00	59,536.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	78,856.00	4,282.00	FEE SCHEDULE LAB	474,054.65	38,920.00
EKG/ECG	25,505.00	0.00	MRI SERVICES	24,561.00	0.00
IV THERAPY	86,790.00	1,076.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,471.00	3,524.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	362,838.00	525.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	832.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	57,190.00	8,143.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,032.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,484.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	69.00
OTHER IMAGING SERVICE	34,959.00	5,116.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	489.00	489.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,288.00	10,069.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,827.00	0.00			
			TOTAL ANCILLARY	1,791,207.85	134,233.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,791,207.85	134,233.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:51:59  
Page: 6

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015279013155	09/28/15 - 09/28/15	10/12/15	0.00	69.00	0.00	0.00	0.00
TOTAL				0.00	69.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:52:08  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL  
90 E STEPHENS ST  
CAMILLA,GA 31730-1836

PROVIDER NUMBER  
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,484.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,434.00	CONTRACTUAL ALLOW	3,039.86
NON-COVERD CHARGES	50.00	TOTAL MEDICAID LIAB	6,394.14
		LESS: COB	6,391.14
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 15

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL  
 90 E STEPHENS ST  
 CAMILLA,GA 31730-1836

PROVIDER NUMBER  
 000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	155.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,197.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,668.00	50.00
EKG/ECG	474.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	262.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	184.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,132.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	362.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,434.00	50.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,434.00	50.00



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:52:08  
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MITCHELL COUNTY HOSPITAL  
90 E STEPHENS ST  
CAMILLA,GA 31730-1836

PROVIDER NUMBER  
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	90,776.11	ADJUSTMENTS	379.00
COVERED CHARGES	86,581.11	CONTRACTUAL ALLOW	80,631.11
NON-COVERD CHARGES	4,195.00	TOTAL MEDICAID LIAB	5,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	252.00
		REIMBURSEMENT	5,698.00
		TOTAL NUMBER OF CLAIMS	119

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	585.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,989.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,386.00	3,000.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,573.11	944.00
EKG/ECG	381.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,310.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	358.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	5,022.00	251.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	86,581.11	4,195.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	86,581.11	4,195.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,607.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,607.00	CONTRACTUAL ALLOW	461.18
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,145.82
		LESS: COB	1,145.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MITCHELL COUNTY HOSPITAL  
 90 E STEPHENS ST  
 CAMILLA,GA 31730-1836

PROVIDER NUMBER  
 000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	714.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	874.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,607.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,607.00	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

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	207,370.28	ADJUSTMENTS	0.00
COVERED CHARGES	206,750.28	CONTRACTUAL ALLOW	169,053.48
NON-COVERD CHARGES	620.00	TOTAL MEDICAID LIAB	37,696.80
		LESS: COB	0.00
		LESS: COPAYMENT	306.00
		REIMBURSEMENT	37,390.80

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: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113,537.28	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	33,735.00	620.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	59,478.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	206,750.28	620.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	206,750.28	620.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 02:52:10  
Page: 15

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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:53:32  
 Page: 1

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	236,618.28	ADJUSTMENTS	15,379.58
COVERED CHARGES	236,266.28	CONTRACTUAL ALLOW	121,919.40
NON-COVERD CHARGES	352.00	TOTAL MEDICAID LIAB	114,346.88
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	114,346.88

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	70		0	32,550.00		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	70		0	32,550.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	13		0	11,804.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	11,804.00		0.00
TOTAL ACCOMODATIONS	83		0	44,354.00		0.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL  
 88 MARTIN LUTHER KING JR DR  
 FORSYTH,GA 31029-1682

PROVIDER NUMBER  
 000001361A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,578.31	0.00	OTHER LAB	2,253.00	0.00
MED/SURG SUPPLY	18,813.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	41,865.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,707.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,476.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,544.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,228.00	0.00	MRI SERVICES	5,790.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,610.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,169.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,950.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,201.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	255.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,585.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	972.00	352.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,450.00	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	465.00	0.00			
			TOTAL ANCILLARY	191,912.28	352.00
			TOTAL ACCOMODATIONS	44,354.00	0.00
			TOTAL CHARGES	236,266.28	352.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:53:33  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

MONROE COUNTY HOSPITAL  
88 MARTIN LUTHER KING JR DR  
FORSYTH,GA 31029-1682

PROVIDER NUMBER  
000001361A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:53:33  
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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	598,703.65	ADJUSTMENTS	19,458.34
COVERED CHARGES	550,316.00	CONTRACTUAL ALLOW	346,406.17
NON-COVERD CHARGES	48,387.65	TOTAL MEDICAID LIAB	203,909.83
		LESS: COB	934.63
		LESS: COPAYMENT	471.00
		REIMBURSEMENT	202,504.20
		ALL OTHER	191,341.07
		FEE SCHEDULE-LAB	10,290.89
		INJECTABLE DRUGS	872.24

TOTAL NUMBER OF CLAIMS 594

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
 Run Time: 02:53:33  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,749.44	1,192.65	OTHER LAB	3,242.00	0.00
MED/SURG SUPPLY	8,529.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	50,575.00	347.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	122,318.00	15,457.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	103,298.00	11,184.00
EKG/ECG	7,381.00	810.00	MRI SERVICES	17,648.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,297.00	7,197.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,532.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	7,830.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	165,314.00	2,348.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,742.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,076.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	477.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,796.00	363.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,341.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	1,659.00			
			TOTAL ANCILLARY	550,316.00	48,387.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	550,316.00	48,387.65

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,507.51	ADJUSTMENTS	0.00
COVERED CHARGES	1,385.51	CONTRACTUAL ALLOW	722.80
NON-COVERD CHARGES	122.00	TOTAL MEDICAID LIAB	662.71
		LESS: COB	659.74
		LESS: COPAYMENT	2.97
		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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27.34	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	43.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	137.00	122.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	486.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	676.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15.20	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	1,385.51	122.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,385.51	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

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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,519.50	ADJUSTMENTS	0.00
COVERED CHARGES	53,561.26	CONTRACTUAL ALLOW	47,761.26
NON-COVERD CHARGES	958.24	TOTAL MEDICAID LIAB	5,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	243.00
		REIMBURSEMENT	5,557.00
		TOTAL NUMBER OF CLAIMS	116

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,167.87	83.24	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	572.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	83.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,305.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,601.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,327.00	792.00
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	34,302.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	123.97	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	53,561.26	958.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	53,561.26	958.24



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: 08/12/2016  
Run Time: 02:53:39  
Page: 10

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	289.35	ADJUSTMENTS	0.00
COVERED CHARGES	289.35	CONTRACTUAL ALLOW	222.49
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	66.86
		LESS: COB	66.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	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	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	289.35	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	289.35	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:53:40  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:37:40  
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SUMMARY TYPE I  
INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/15	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/15 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:37:40  
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ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/15 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	837,122.43	ADJUSTMENTS	4,554.26
COVERED CHARGES	792,863.72	CONTRACTUAL ALLOW	656,361.94
NON-COVERD CHARGES	44,258.71	TOTAL MEDICAID LIAB	136,501.78
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	136,420.78
		ALL OTHER	116,252.76
		FEE SCHEDULE-LAB	18,994.26
		INJECTABLE DRUGS	1,173.76

TOTAL NUMBER OF CLAIMS 487

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
 Run Time: 03:37:40  
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ADVENTIST HEALTH SYSTEM GEORGIA INC  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/15 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,254.60	0.00	OTHER LAB	3,487.09	0.00
MED/SURG SUPPLY	11,040.82	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	64,180.98	159.26	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	125,756.91	36,993.38	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	262,319.17	726.61
EKG/ECG	17,378.46	259.38	MRI SERVICES	18,987.41	0.00
IV THERAPY	77,638.84	114.69	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,638.59	2,725.54	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	171,872.21	97.83	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	8,020.70	1,497.58
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	489.15	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,459.67	1,195.29			
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	5,828.27	0.00			
			TOTAL ANCILLARY	792,863.72	44,258.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	792,863.72	44,258.71



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 03:37:44  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/15 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,033.39	ADJUSTMENTS	0.00
COVERED CHARGES	3,006.65	CONTRACTUAL ALLOW	1,345.79
NON-COVERD CHARGES	26.74	TOTAL MEDICAID LIAB	1,660.86
		LESS: COB	1,660.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:37:44  
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SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/15 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	2.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,142.35	26.74
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	862.30	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,006.65	26.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,006.65	26.74

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/15 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	86,151.48	ADJUSTMENTS	52.94
COVERED CHARGES	82,303.05	CONTRACTUAL ALLOW	74,359.57
NON-COVERD CHARGES	3,848.43	TOTAL MEDICAID LIAB	7,943.48
		LESS: COB	0.00
		LESS: COPAYMENT	288.13
		REIMBURSEMENT	7,655.35
		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: 08/12/2016  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/15 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,448.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	544.76	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,359.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,579.09	3,750.87	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,557.29	37.56
EKG/ECG	778.14	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,081.83	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,999.82	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	954.12	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	82,303.05	3,848.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	82,303.05	3,848.43

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER 000001383A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/15 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,446.77	ADJUSTMENTS	0.00
COVERED CHARGES	1,446.77	CONTRACTUAL ALLOW	890.52
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	556.25
		LESS: COB	553.25
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:37:45  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ADVENTIST HEALTH SYSTEM GEORGIA INC  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/15 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	687.37	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	703.40	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	15.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,446.77	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,446.77	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/15	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/15	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I  
INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 04/30/14  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 04/30/14  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 04/30/14  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 04/30/14  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ADVENTIST HEALTH SYSTEM GEORGIA INC  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	04/30/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER 000001394A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,027,455.54	ADJUSTMENTS	574,870.56
COVERED CHARGES	6,589,647.54	CONTRACTUAL ALLOW	4,281,906.87
NON-COVERD CHARGES	437,808.00	TOTAL MEDICAID LIAB	2,307,740.67
		LESS: COB	29,366.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,278,373.71

TOTAL NUMBER OF ADMISSIONS 348

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	838		9	514,391.50		21,547.75
ROUTINE NURSERY	258		0	154,720.80		274,808.40
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,096		9	669,112.30		296,356.15
SPECIAL CARE SERVICES						
CCU	5		0	5,335.25		0.00
ICU	169		2	247,061.10		2,923.80
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	174		2	252,396.35		2,923.80
TOTAL ACCOMODATIONS	1,270		11	921,508.65		299,279.95

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,202,187.10	0.00	OTHER LAB	40,500.35	0.00
MED/SURG SUPPLY	556,703.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,043,413.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	147,090.55	0.00	OTHER THERAPEUTIC SVC	262.80	55,170.90
CT SCAN	513,860.10	55,482.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	94,895.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	44,981.10	0.00	MRI SERVICES	74,637.00	0.00
IV THERAPY	31,232.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	369,589.65	4,958.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	64,426.85	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	144,605.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,264.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	29,534.80	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	199,557.65	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	164,677.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,386.40	0.00	INJECTABLE DRUGS	204,219.05	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	19,481.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	24,003.00	3,429.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,160.40	4,987.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	201,934.93	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	65,201.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	107,348.45	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,609.75	14,499.00			
AUDIOLOGY	6,707.70	0.00			
CARDIOLOGY	184,625.90	0.00			
AMBULATORY SURGERY	45,166.05	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,466.10	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,407.95	0.00			
			TOTAL ANCILLARY	5,668,138.89	138,528.05
			TOTAL ACCOMODATIONS	921,508.65	299,279.95
			TOTAL CHARGES	6,589,647.54	437,808.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,773.76	ADJUSTMENTS	0.00
COVERED CHARGES	28,773.76	CONTRACTUAL ALLOW	18,726.59
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	10,047.17
		LESS: COB	10,047.17
		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	3,163.75		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	3,163.75		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5		0	3,163.75		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT NEWTON HOSPITAL  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,688.09	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,947.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,530.65	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,469.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,942.35	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,563.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	468.67	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,610.01	0.00
			TOTAL ACCOMODATIONS	3,163.75	0.00
			TOTAL CHARGES	28,773.76	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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PIEDMONT NEWTON HOSPITAL  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,589,527.74	ADJUSTMENTS	108,793.99
COVERED CHARGES	8,692,264.03	CONTRACTUAL ALLOW	7,070,174.14
NON-COVERD CHARGES	897,263.71	TOTAL MEDICAID LIAB	1,622,089.89
		LESS: COB	7,492.66
		LESS: COPAYMENT	3,736.26
		REIMBURSEMENT	1,610,860.97
		ALL OTHER	1,395,083.39
		FEE SCHEDULE-LAB	131,445.24
		INJECTABLE DRUGS	84,332.34

TOTAL NUMBER OF CLAIMS 3,956

PIEDMONT NEWTON HOSPITAL  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	391,019.00	1,190.30	OTHER LAB	86,368.35	0.00
MED/SURG SUPPLY	303,256.20	6,067.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	991.95	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	355,906.15	2,209.65	OTHER THERAPEUTIC SVC	0.00	58,674.00
CT SCAN	1,657,049.45	173,957.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	77,768.15	34,338.10	FEE SCHEDULE LAB	1,669,661.14	158,459.67
EKG/ECG	98,488.20	2,203.70	MRI SERVICES	299,873.30	30,626.65
IV THERAPY	13,194.75	31,162.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	615,682.44	73,854.81	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73,108.15	896.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,880.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	16,959.45	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,608,739.62	7,334.08	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	90,014.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	438,827.71	129,489.52
RADIOLOGY THERAPEUTIC	65,534.75	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	4,078.60	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	2,395.93	319.11	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	70,113.05	17,251.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	177.15
OTHER IMAGING SERVICE	235,361.00	45,934.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,490.35	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	22,668.80	45,072.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	118,796.70	64,157.60			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	97,332.45	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	264,774.74	8,816.95			
			TOTAL ANCILLARY	8,692,264.03	897,263.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,692,264.03	897,263.71

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: 08/12/2016  
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PIEDMONT NEWTON HOSPITAL  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
9300	5215092000861	01/27/15 - 01/27/15	04/13/15	0.00	177.15	0.00	0.00	0.00
TOTAL				0.00	177.15	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

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT NEWTON HOSPITAL  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,139.83	ADJUSTMENTS	0.00
COVERED CHARGES	46,576.37	CONTRACTUAL ALLOW	27,572.67
NON-COVERD CHARGES	14,563.46	TOTAL MEDICAID LIAB	19,003.70
		LESS: COB	18,985.70
		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

PIEDMONT NEWTON HOSPITAL  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,946.55	0.00	OTHER LAB	262.85	0.00
MED/SURG SUPPLY	1,404.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,469.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,516.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,301.65	1,301.10
EKG/ECG	354.30	0.00	MRI SERVICES	3,151.20	0.00
IV THERAPY	0.00	239.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,765.99	7,019.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	339.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,999.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,096.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	975.88	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	2,298.45	2,487.20			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,286.10	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	744.35	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,179.05	0.00			
			TOTAL ANCILLARY	46,576.37	14,563.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	46,576.37	14,563.46

Report : CLM-0808-0  
Process : CLMJ0800  
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 NEWTON HOSPITAL  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	647,782.38	ADJUSTMENTS	531.87
COVERED CHARGES	631,245.81	CONTRACTUAL ALLOW	599,136.25
NON-COVERD CHARGES	16,536.57	TOTAL MEDICAID LIAB	32,109.56
		LESS: COB	0.00
		LESS: COPAYMENT	1,074.53
		REIMBURSEMENT	31,035.03
		TOTAL NUMBER OF CLAIMS	574

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWTON HOSPITAL  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,619.09	69.12	OTHER LAB	2,100.70	0.00
MED/SURG SUPPLY	5,133.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,179.10	0.00	OTHER THERAPEUTIC SVC	0.00	778.00
CT SCAN	89,254.40	1,758.15	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	139,030.65	9,188.55
EKG/ECG	4,783.05	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,436.45	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	303,638.30	477.20	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	11,164.62	705.15
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,233.90	3,560.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	672.40	0.00			
			TOTAL ANCILLARY	631,245.81	16,536.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	631,245.81	16,536.57

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY 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 NEWTON HOSPITAL  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,755.25	ADJUSTMENTS	0.00
COVERED CHARGES	6,294.00	CONTRACTUAL ALLOW	5,260.80
NON-COVERD CHARGES	461.25	TOTAL MEDICAID LIAB	1,033.20
		LESS: COB	1,027.20
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT NEWTON HOSPITAL  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	261.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,889.70	36.60
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,853.50	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	47.90	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,241.20	424.65			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,294.00	461.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,294.00	461.25

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

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWTON HOSPITAL  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	415,411.56	ADJUSTMENTS	16,417.40
COVERED CHARGES	397,580.89	CONTRACTUAL ALLOW	288,264.77
NON-COVERD CHARGES	17,830.67	TOTAL MEDICAID LIAB	109,316.12
		LESS: COB	0.00
		LESS: COPAYMENT	72.74
		REIMBURSEMENT	109,243.38

TOTAL NUMBER OF CLAIMS 20

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWTON HOSPITAL  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,424.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,135.71	94.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	261.70	0.00	OTHER THERAPEUTIC SVC	0.00	1,051.20
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	680.35	FEE SCHEDULE LAB	2,071.75	61.00
EKG/ECG	255.05	177.15	MRI SERVICES	0.00	0.00
IV THERAPY	1,313.00	2,031.15	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	60,141.85	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	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,145.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	276,510.95	1,134.68
RADIOLOGY THERAPEUTIC	21,603.55	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,599.25	12,600.44
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	6,118.26	0.00			
			TOTAL ANCILLARY	397,580.89	17,830.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	397,580.89	17,830.67

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT NEWTON HOSPITAL  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:57:54  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL  
 1000 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1606

PROVIDER NUMBER 000001405A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	124,866,844.55	ADJUSTMENTS	11,784,467.32
COVERED CHARGES	117,886,952.52	CONTRACTUAL ALLOW	89,495,891.68
NON-COVERD CHARGES	6,979,892.03	TOTAL MEDICAID LIAB	28,391,060.84
		LESS: COB	351,915.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	28,039,144.86

TOTAL NUMBER OF ADMISSIONS 4,880

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9,011		0	9,244,122.00		1,101,290.04
ROUTINE NURSERY	8,855		252	13,593,503.00		3,947,178.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	17,866		252	22,837,625.00		5,048,468.04
SPECIAL CARE SERVICES						
CCU	18		0	68,051.50		0.00
ICU	2,393		0	8,633,916.50		0.00
NICU	924		0	5,079,454.00		38,601.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,335		0	13,781,422.00		38,601.00
TOTAL ACCOMODATIONS	21,201		252	36,619,047.00		5,087,069.04

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,040,142.09	172,057.53	OTHER LAB	448,071.00	0.00
MED/SURG SUPPLY	4,254,954.60	150,494.26	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,708,617.80	75,964.70	EDUCATION & TRAINING	12,275.00	497.00
RADIOLOGY-DIAGNOSTIC	1,354,109.00	11,500.00	OTHER THERAPEUTIC SVC	0.00	47,642.00
CT SCAN	1,752,674.00	4,281.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	593,156.00	3,194.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	240,756.00	314.00	MRI SERVICES	752,754.00	0.00
IV THERAPY	198,314.00	32,955.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,214,287.50	124,070.00	DURABLE MED. EQUIP.	0.00	3,752.00
LABOR/DELIVERY ROOM	7,466,324.72	11,292.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,469,152.00	67,489.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,010,344.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,700.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,042,177.00	498.00	SPECIAL SERVICES	0.00	15,821.00
RECOVERY ROOM	1,287,621.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	64,709.00
LABORATORY PATHOLOGIC	1,316,039.00	0.00	INJECTABLE DRUGS	20,017,849.31	103,030.50
RADIOLOGY THERAPEUTIC	438,089.00	2,731.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	534,679.50	2,686.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	148,032.50	992.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	280,083.00	28,274.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	396.00	124.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	526,271.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	653,801.50	70,849.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,684,439.00	848,536.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	159,074.00	43,588.00			
AUDIOLOGY	574,884.00	0.00			
CARDIOLOGY	930,010.50	5,358.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	69,640.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	84,187.00	124.00			
			TOTAL ANCILLARY	81,267,905.52	1,892,822.99
			TOTAL ACCOMODATIONS	36,619,047.00	5,087,069.04
			TOTAL CHARGES	117,886,952.52	6,979,892.03

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,905,540.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,392,326.00	CONTRACTUAL ALLOW	2,829,053.22
NON-COVERD CHARGES	513,214.00	TOTAL MEDICAID LIAB	2,563,272.78
		LESS: COB	2,563,272.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 102

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	205		0	212,670.00		14,540.00
ROUTINE NURSERY	554		0	1,294,803.00		472,887.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	759		0	1,507,473.00		487,427.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	62		0	197,389.00		0.00
NICU	188		0	1,041,787.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	250		0	1,239,176.00		0.00
TOTAL ACCOMODATIONS	1,009		0	2,746,649.00		487,427.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	409,032.00	0.00	OTHER LAB	42,582.00	0.00
MED/SURG SUPPLY	198,680.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	353,242.00	0.00	EDUCATION & TRAINING	1,136.00	0.00
RADIOLOGY-DIAGNOSTIC	89,734.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,295.00
CT SCAN	4,800.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,460.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,570.00	0.00	MRI SERVICES	8,840.00	0.00
IV THERAPY	1,951.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	135,198.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	225,568.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	472,167.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,915.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,991.00	0.00	SPECIAL SERVICES	0.00	23,492.00
RECOVERY ROOM	28,680.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	26,687.00	0.00	INJECTABLE DRUGS	391,170.00	0.00
RADIOLOGY THERAPEUTIC	6,416.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	61,274.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,004.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,974.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,229.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	45,424.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	21,108.00	0.00			
CARDIOLOGY	38,561.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,451.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	833.00	0.00			
			TOTAL ANCILLARY	2,645,677.00	25,787.00
			TOTAL ACCOMODATIONS	2,746,649.00	487,427.00
			TOTAL CHARGES	5,392,326.00	513,214.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,536,412.14	ADJUSTMENTS	1,589,144.89
COVERED CHARGES	32,041,397.65	CONTRACTUAL ALLOW	25,222,957.09
NON-COVERD CHARGES	3,495,014.49	TOTAL MEDICAID LIAB	6,818,440.56
		LESS: COB	44,750.11
		LESS: COPAYMENT	31,708.78
		REIMBURSEMENT	6,741,981.67
		ALL OTHER	4,412,611.09
		FEE SCHEDULE-LAB	571,107.69
		INJECTABLE DRUGS	1,758,262.89

TOTAL NUMBER OF CLAIMS 10,402

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	389,084.08	8,669.43	OTHER LAB	193,543.00	444.00
MED/SURG SUPPLY	978,076.32	8,257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,376.00	EDUCATION & TRAINING	4,403.00	804.00
RADIOLOGY-DIAGNOSTIC	450,590.00	2,454.00	OTHER THERAPEUTIC SVC	0.00	931.00
CT SCAN	2,198,105.00	375,381.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,018.00	32,259.00	FEE SCHEDULE LAB	8,877,613.08	805,963.10
EKG/ECG	119,735.00	3,140.00	MRI SERVICES	1,419,341.00	88,832.00
IV THERAPY	3,292,968.00	45,067.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,122,056.00	241,709.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	140,627.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53,178.00	719.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	413,221.00	16,227.00	AMBULANCE	0.00	0.00
GI SERVICES	63,925.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,894,587.00	19,380.00	SPECIAL SERVICES	0.00	532.00
RECOVERY ROOM	498,054.00	1,307.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,629,137.73	912,757.51
RADIOLOGY THERAPEUTIC	958,905.00	198,513.00	HOME HEALTH SERVICES	0.00	59.00
OCCUPATIONAL THERAPY	6,628.00	9,545.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,832.00	1,919.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,888.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,600.00	1,584.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	180,013.00	45,739.00	IMPL DEV CHARGE PATIENTS	149,802.00	21,581.00
LITHOTRIPSY	20,172.00	0.00	NO CC/INVALID REV CODE	0.00	3,814.00
OTHER IMAGING SERVICE	1,467,215.00	439,381.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,085,649.00	1,450.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	110,701.00	63,381.00			
AUDIOLOGY	13,186.00	1,318.00			
CARDIOLOGY	116,192.00	50,703.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,540.00	0.00			
ORGAN ACQUISITION	0.00	77,145.45			
TREATMENT/OBSERV. RM	1,147,700.44	1,785.00			
			TOTAL ANCILLARY	32,041,397.65	3,495,014.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,041,397.65	3,495,014.49

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
20	5914346001528	12/01/14 - 12/01/14	12/15/14	0.00	107.00	0.00	0.00	0.00
614	2015168054664	06/01/15 - 06/01/15	06/22/15	0.00	3,707.00	0.00	0.00	0.00
TOTAL				0.00	3,814.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,557,825.63	ADJUSTMENTS	0.00
COVERED CHARGES	792,971.06	CONTRACTUAL ALLOW	48,279.67
NON-COVERD CHARGES	764,854.57	TOTAL MEDICAID LIAB	744,691.39
		LESS: COB	744,028.53
		LESS: COPAYMENT	662.86
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 266



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,678.50	0.00	OTHER LAB	11,003.00	0.00
MED/SURG SUPPLY	28,452.00	306.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	390.80	EDUCATION & TRAINING	134.00	0.00
RADIOLOGY-DIAGNOSTIC	9,309.00	370.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,138.00	41,461.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	317.00	FEE SCHEDULE LAB	196,010.91	26,657.80
EKG/ECG	1,884.00	0.00	MRI SERVICES	12,230.00	9,116.00
IV THERAPY	90,268.00	845.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,879.00	51,087.00	DURABLE MED. EQUIP.	0.00	3,651.00
LABOR/DELIVERY ROOM	23,378.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,249.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,754.00	1,803.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	90,107.00	1,321.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,416.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	71,976.65	557,817.97
RADIOLOGY THERAPEUTIC	30,313.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	392.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	101.00	36.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,507.00	0.00	IMPL DEV CHARGE PATIENTS	2,844.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,702.00	49,622.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,391.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,484.00	380.00			
AUDIOLOGY	1,318.00	1,064.00			
CARDIOLOGY	0.00	17,992.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	27,444.00	225.00			
			TOTAL ANCILLARY	792,971.06	764,854.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	792,971.06	764,854.57

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	513,482.22	ADJUSTMENTS	1,774.02
COVERED CHARGES	477,381.87	CONTRACTUAL ALLOW	463,452.83
NON-COVERD CHARGES	36,100.35	TOTAL MEDICAID LIAB	13,929.04
		LESS: COB	0.00
		LESS: COPAYMENT	566.04
		REIMBURSEMENT	13,363.00
		TOTAL NUMBER OF CLAIMS	249

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,188.43	0.05	OTHER LAB	2,292.00	0.00
MED/SURG SUPPLY	8,967.00	361.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,089.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,036.00	4,281.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	568.00	FEE SCHEDULE LAB	106,790.00	6,788.00
EKG/ECG	6,280.00	0.00	MRI SERVICES	12,547.00	8,840.00
IV THERAPY	2,495.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	515.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	271,285.00	2,646.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,998.44	724.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	784.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	760.00	1,140.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,690.00	9,932.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,449.00	0.00			
			TOTAL ANCILLARY	477,381.87	36,100.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	477,381.87	36,100.35

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,097.05	ADJUSTMENTS	0.00
COVERED CHARGES	16,945.00	CONTRACTUAL ALLOW	11,791.32
NON-COVERD CHARGES	2,152.05	TOTAL MEDICAID LIAB	5,153.68
		LESS: COB	5,141.68
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	289.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	370.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,351.00	819.00
EKG/ECG	314.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,672.00	26.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	494.05
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	380.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	569.00	813.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,945.00	2,152.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,945.00	2,152.05

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,407,863.17	ADJUSTMENTS	217,394.39
COVERED CHARGES	4,203,093.87	CONTRACTUAL ALLOW	2,975,227.10
NON-COVERD CHARGES	204,769.30	TOTAL MEDICAID LIAB	1,227,866.77
		LESS: COB	7,808.76
		LESS: COPAYMENT	2,089.16
		REIMBURSEMENT	1,217,968.85

TOTAL NUMBER OF CLAIMS 215

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,123.97	987.52	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	237,491.43	2,642.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,373.00	3,639.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,237.00	13,001.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	393,221.00	23,108.00
EKG/ECG	1,884.00	314.00	MRI SERVICES	3,707.00	0.00
IV THERAPY	693,762.00	3,280.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	502,434.00	66,417.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,742.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	72,633.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,239.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,878.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,692,930.15	63,128.78
RADIOLOGY THERAPEUTIC	120,942.00	412.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	160,155.00	1,690.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,701.00	610.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	50,041.00	1,653.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,660.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	26,358.00	15,627.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	8,260.00			
TREATMENT/OBSERV. RM	115,581.32	0.00			
			TOTAL ANCILLARY	4,203,093.87	204,769.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,203,093.87	204,769.30

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL  
1000 JOHNSON FERRY RD NE  
ATLANTA,GA 30342-1606

PROVIDER NUMBER  
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	310,796.50	ADJUSTMENTS	0.00
COVERED CHARGES	284,916.00	CONTRACTUAL ALLOW	35,357.32
NON-COVERD CHARGES	25,880.50	TOTAL MEDICAID LIAB	249,558.68
		LESS: COB	249,516.68
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	822.00	0.00	OTHER LAB	229.00	0.00
MED/SURG SUPPLY	5,773.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	740.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,911.00	52.00
EKG/ECG	0.00	628.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,908.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,000.00	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	119,924.00	25,200.50
RADIOLOGY THERAPEUTIC	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	97,735.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,434.00	0.00			
			TOTAL ANCILLARY	284,916.00	25,880.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	284,916.00	25,880.50

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 03:19:16  
 Page: 1

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER 000001427A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	168,474.62	ADJUSTMENTS	8,989.21
COVERED CHARGES	166,063.62	CONTRACTUAL ALLOW	77,027.53
NON-COVERD CHARGES	2,411.00	TOTAL MEDICAID LIAB	89,036.09
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	89,036.09

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	50		0	24,950.00		1,250.00
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	50		0	24,950.00		1,250.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	50		0	24,950.00		1,250.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:19:16  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,264.62	0.00	OTHER LAB	643.00	0.00
MED/SURG SUPPLY	20,880.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,449.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,946.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,198.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,025.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,730.00	0.00	PROFESSIONAL FEES	0.00	102.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,272.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,947.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,707.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	336.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,325.00	1,059.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,391.00	0.00			
			TOTAL ANCILLARY	141,113.62	1,161.00
			TOTAL ACCOMODATIONS	24,950.00	1,250.00
			TOTAL CHARGES	166,063.62	2,411.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:19:17  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
000001427A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/14	THROUGH	07/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:19:17  
Page: 4

SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	927,538.96	ADJUSTMENTS	13,919.44
COVERED CHARGES	828,472.34	CONTRACTUAL ALLOW	539,526.65
NON-COVERD CHARGES	99,066.62	TOTAL MEDICAID LIAB	288,945.69
		LESS: COB	0.00
		LESS: COPAYMENT	558.00
		REIMBURSEMENT	288,387.69
		ALL OTHER	255,123.56
		FEE SCHEDULE-LAB	26,639.56
		INJECTABLE DRUGS	6,624.57

TOTAL NUMBER OF CLAIMS 860

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,688.05	415.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	40,152.00	298.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,338.00	1,993.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	68,739.00	12,636.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,319.00	4,833.04	FEE SCHEDULE LAB	186,310.10	42,879.00
EKG/ECG	21,150.00	675.00	MRI SERVICES	8,528.00	5,923.00
IV THERAPY	10,677.00	1,067.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,011.00	5,354.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	774.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,312.00	2,069.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,090.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	259,716.00	11,720.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,520.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,757.14	1,342.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	580.00	405.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,246.00	2,676.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,180.00	419.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	45,315.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,314.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	948.05	1,866.54			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,848.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,902.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,906.00	648.00			
			TOTAL ANCILLARY	828,472.34	99,066.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	828,472.34	99,066.62

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
99	5915181000674	03/14/15 - 03/14/15	07/06/15	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 03:19:20  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,075.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,055.00	CONTRACTUAL ALLOW	361.00
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	694.00
		LESS: COB	694.00
		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

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 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	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	0.00	0.00	FEE SCHEDULE LAB	306.00	20.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	521.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,055.00	20.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,055.00	20.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,236.55	ADJUSTMENTS	78.00
COVERED CHARGES	62,453.55	CONTRACTUAL ALLOW	57,790.55
NON-COVERD CHARGES	783.00	TOTAL MEDICAID LIAB	4,663.00
		LESS: COB	0.00
		LESS: COPAYMENT	177.00
		REIMBURSEMENT	4,486.00
		TOTAL NUMBER OF CLAIMS	102

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,259.49	16.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	835.00	40.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,416.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,056.00	469.00
EKG/ECG	225.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	258.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	48,765.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,337.06	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	422.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	82.00	0.00			
			TOTAL ANCILLARY	62,453.55	783.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	62,453.55	783.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,139.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,139.00	CONTRACTUAL ALLOW	364.48
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	774.52
		LESS: COB	774.52
		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

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 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	11.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	427.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	692.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,139.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,139.00	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

SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	175,918.25	ADJUSTMENTS	0.00
COVERED CHARGES	174,231.25	CONTRACTUAL ALLOW	122,496.82
NON-COVERD CHARGES	1,687.00	TOTAL MEDICAID LIAB	51,734.43
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	51,734.43

TOTAL NUMBER OF CLAIMS 11

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,185.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,363.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	323.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,225.00	758.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	619.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	1,114.00	16.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	520.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	154,755.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	930.00	393.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	661.00	0.00			
			TOTAL ANCILLARY	174,231.25	1,687.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	174,231.25	1,687.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTHWEST GEORGIA REGIONAL MEDICAL  
361 RANDOLPH ST  
CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
000001427A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/14	THROUGH	07/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:05:15  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL  
 2518 JIMMY LEE SMITH PKWY  
 HIRAM,GA 30141-2068

PROVIDER NUMBER 000001438A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,811,119.94	ADJUSTMENTS	82,550.41
COVERED CHARGES	6,719,986.34	CONTRACTUAL ALLOW	4,915,524.01
NON-COVERD CHARGES	91,133.60	TOTAL MEDICAID LIAB	1,804,462.33
		LESS: COB	11,208.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,793,253.71

TOTAL NUMBER OF ADMISSIONS 223

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	385		4	390,390.00		65,126.75
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	385		4	390,390.00		65,126.75
SPECIAL CARE SERVICES						
CCU	371		6	813,168.57		13,110.85
ICU	106		4	331,558.68		12,488.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	477		10	1,144,727.25		25,598.85
TOTAL ACCOMODATIONS	862		14	1,535,117.25		90,725.60

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL  
 2518 JIMMY LEE SMITH PKWY  
 HIRAM,GA 30141-2068

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	708,610.00	0.00	OTHER LAB	31,795.17	0.00
MED/SURG SUPPLY	223,040.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,049,790.55	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	156,959.00	0.00	OTHER THERAPEUTIC SVC	0.00	408.00
CT SCAN	506,614.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,897.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	103,655.00	0.00	MRI SERVICES	62,659.59	0.00
IV THERAPY	193,019.31	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	252,693.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	553,365.82	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	125,700.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	503,475.36	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	50,673.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	22,671.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	30,611.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,755.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	71,855.95	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,853.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	13,878.00	0.00	IMPL DEV CHARGE PATIENTS	23,852.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	47,288.92	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	90,960.86	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	58,331.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	267,538.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,326.19	0.00			
			TOTAL ANCILLARY	5,184,869.09	408.00
			TOTAL ACCOMODATIONS	1,535,117.25	90,725.60
			TOTAL CHARGES	6,719,986.34	91,133.60

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:05:18  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL  
 2518 JIMMY LEE SMITH PKWY  
 HIRAM,GA 30141-2068

PROVIDER NUMBER 000001438A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,795.55	ADJUSTMENTS	0.00
COVERED CHARGES	35,638.55	CONTRACTUAL ALLOW	21,003.52
NON-COVERD CHARGES	157.00	TOTAL MEDICAID LIAB	14,635.03
		LESS: COB	14,635.03
		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	1		0	1,014.00		157.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1		0	1,014.00		157.00
SPECIAL CARE SERVICES						
CCU	4		0	8,740.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4		0	8,740.00		0.00
TOTAL ACCOMODATIONS	5		0	9,754.00		157.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL  
 2518 JIMMY LEE SMITH PKWY  
 HIRAM,GA 30141-2068

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,575.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	603.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,794.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,845.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,552.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,445.05	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,070.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	25,884.55	0.00
			TOTAL ACCOMODATIONS	9,754.00	157.00
			TOTAL CHARGES	35,638.55	157.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:05:18  
Page: 5

WELLSTAR PAULDING HOSPITAL  
2518 JIMMY LEE SMITH PKWY  
HIRAM,GA 30141-2068

PROVIDER NUMBER  
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,584,289.06	ADJUSTMENTS	118,299.07
COVERED CHARGES	9,717,107.79	CONTRACTUAL ALLOW	8,561,434.28
NON-COVERD CHARGES	867,181.27	TOTAL MEDICAID LIAB	1,155,673.51
		LESS: COB	22,794.14
		LESS: COPAYMENT	2,031.00
		REIMBURSEMENT	1,130,848.37
		ALL OTHER	1,041,736.85
		FEE SCHEDULE-LAB	73,480.04
		INJECTABLE DRUGS	15,631.48
		TOTAL NUMBER OF CLAIMS	2,998

WELLSTAR PAULDING HOSPITAL  
 2518 JIMMY LEE SMITH PKWY  
 HIRAM,GA 30141-2068

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	197,115.75	14,103.00	OTHER LAB	79,734.65	0.00
MED/SURG SUPPLY	146,985.47	4,062.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	621,555.77	2,993.65	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,668,795.80	303,551.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,075.00	1,317.00	FEE SCHEDULE LAB	1,322,474.32	169,597.57
EKG/ECG	154,804.00	1,164.00	MRI SERVICES	420,189.18	54,196.00
IV THERAPY	487,016.50	8,094.09	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	283,564.00	48,606.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	59,384.40	40,769.22	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	166,381.65	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,757,870.56	3,874.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	109,561.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140,734.25	23,827.00
RADIOLOGY THERAPEUTIC	318,414.00	56,841.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,499.00	4,429.34	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	44,016.80	12,050.00	IMPL DEV CHARGE PATIENTS	18,265.48	7,744.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	239,372.76	54,858.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,638.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	84,870.00	21,385.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	106,369.00	33,718.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	143,637.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	113,783.25	0.00			
			TOTAL ANCILLARY	9,717,107.79	867,181.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,717,107.79	867,181.27

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: 08/12/2016  
Run Time: 03:05:31  
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR PAULDING HOSPITAL  
2518 JIMMY LEE SMITH PKWY  
HIRAM,GA 30141-2068

PROVIDER NUMBER  
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	240,085.45	ADJUSTMENTS	0.00
COVERED CHARGES	182,252.69	CONTRACTUAL ALLOW	65,381.90
NON-COVERD CHARGES	57,832.76	TOTAL MEDICAID LIAB	116,870.79
		LESS: COB	116,850.39
		LESS: COPAYMENT	20.40
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 64

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR PAULDING HOSPITAL  
 2518 JIMMY LEE SMITH PKWY  
 HIRAM,GA 30141-2068

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,967.75	1,500.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,215.32	140.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,316.00	615.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,303.00	36,513.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,652.00	7,384.00
EKG/ECG	3,104.00	388.00	MRI SERVICES	13,553.59	0.00
IV THERAPY	15,648.81	645.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,200.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	901.00	837.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,034.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,688.28	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	440.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,785.50	1,693.50
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	7,980.00	1,086.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,199.00	1,156.00			
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	4,679.44	1,675.14			
			TOTAL ANCILLARY	182,252.69	57,832.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	182,252.69	57,832.76



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:05:33  
Page: 9

WELLSTAR PAULDING HOSPITAL  
2518 JIMMY LEE SMITH PKWY  
HIRAM,GA 30141-2068

PROVIDER NUMBER  
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	659,136.72	ADJUSTMENTS	753.15
COVERED CHARGES	619,239.04	CONTRACTUAL ALLOW	597,366.74
NON-COVERD CHARGES	39,897.68	TOTAL MEDICAID LIAB	21,872.30
		LESS: COB	726.00
		LESS: COPAYMENT	663.00
		REIMBURSEMENT	20,483.30
		TOTAL NUMBER OF CLAIMS	379

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR PAULDING HOSPITAL  
 2518 JIMMY LEE SMITH PKWY  
 HIRAM,GA 30141-2068

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,444.25	0.00	OTHER LAB	2,840.00	0.00
MED/SURG SUPPLY	1,645.08	257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,625.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,450.60	13,609.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	113,460.40	17,292.90
EKG/ECG	8,148.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	30,530.14	145.28	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,468.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	333,662.39	2,120.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,047.25	992.50
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	222.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,628.40	2,410.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,160.14	2,849.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,925.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,204.39	0.00			
			TOTAL ANCILLARY	619,239.04	39,897.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	619,239.04	39,897.68

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR PAULDING HOSPITAL  
2518 JIMMY LEE SMITH PKWY  
HIRAM,GA 30141-2068

PROVIDER NUMBER  
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,087.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,488.00	CONTRACTUAL ALLOW	4,613.01
NON-COVERD CHARGES	1,599.00	TOTAL MEDICAID LIAB	7,874.99
		LESS: COB	7,871.99
		LESS: COPAYMENT	3.00
		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

WELLSTAR PAULDING HOSPITAL  
 2518 JIMMY LEE SMITH PKWY  
 HIRAM,GA 30141-2068

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	842.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,673.00	762.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	91.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	148.00	837.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,067.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	482.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,488.00	1,599.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,488.00	1,599.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR PAULDING HOSPITAL  
2518 JIMMY LEE SMITH PKWY  
HIRAM,GA 30141-2068

PROVIDER NUMBER  
000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	606,871.01	ADJUSTMENTS	5,807.88
COVERED CHARGES	606,871.01	CONTRACTUAL ALLOW	554,731.67
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	52,139.34
		LESS: COB	0.00
		LESS: COPAYMENT	333.00
		REIMBURSEMENT	51,806.34
		TOTAL NUMBER OF CLAIMS	9

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR PAULDING HOSPITAL  
 2518 JIMMY LEE SMITH PKWY  
 HIRAM,GA 30141-2068

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	844.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	528.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	182,864.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,895.00	0.00
EKG/ECG	388.00	0.00	MRI SERVICES	4,986.00	0.00
IV THERAPY	1,199.01	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,905.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,077.75	0.00
RADIOLOGY THERAPEUTIC	394,765.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	419.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	606,871.01	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	606,871.01	0.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR PAULDING HOSPITAL  
2518 JIMMY LEE SMITH PKWY  
HIRAM,GA 30141-2068

PROVIDER NUMBER  
000001438A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:05:47  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
 1960 HIGHWAY 247 CONNECTOR  
 BYRON,GA 31008-5663

PROVIDER NUMBER 000001449A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	725,587.81	ADJUSTMENTS	31,293.07
COVERED CHARGES	659,004.81	CONTRACTUAL ALLOW	317,376.56
NON-COVERD CHARGES	66,583.00	TOTAL MEDICAID LIAB	341,628.25
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	341,628.25

TOTAL NUMBER OF ADMISSIONS 67

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	243		9	91,775.00		61,370.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	243		9	91,775.00		61,370.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	243		9	91,775.00		61,370.00



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:05:47  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
 1960 HIGHWAY 247 CONNECTOR  
 BYRON,GA 31008-5663

PROVIDER NUMBER  
 000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	168,580.22	0.00	OTHER LAB	932.00	0.00
MED/SURG SUPPLY	20,746.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	119,680.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,691.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	45,380.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	586.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,773.00	0.00	MRI SERVICES	1,368.00	0.00
IV THERAPY	9,457.00	0.00	PROFESSIONAL FEES	0.00	36.00
OPERATING ROOM	1,849.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,498.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,535.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	353.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	126,469.57	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	405.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,145.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,642.00	0.00			
BLOOD	4,390.00	0.00			
BLOOD STORAGE & PRO.	8,210.00	3,032.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,685.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	567,229.81	5,213.00
			TOTAL ACCOMODATIONS	91,775.00	61,370.00
			TOTAL CHARGES	659,004.81	66,583.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
1960 HIGHWAY 247 CONNECTOR  
BYRON,GA 31008-5663

PROVIDER NUMBER  
000001449A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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THE MEDICAL CENTER OF PEACH COUNTY, INC.  
1960 HIGHWAY 247 CONNECTOR  
BYRON,GA 31008-5663

PROVIDER NUMBER  
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,286,184.65	ADJUSTMENTS	58,194.49
COVERED CHARGES	1,129,581.11	CONTRACTUAL ALLOW	667,237.63
NON-COVERD CHARGES	156,603.54	TOTAL MEDICAID LIAB	462,343.48
		LESS: COB	1,084.65
		LESS: COPAYMENT	1,425.00
		REIMBURSEMENT	459,833.83
		ALL OTHER	409,894.27
		FEE SCHEDULE-LAB	45,571.62
		INJECTABLE DRUGS	4,367.94
		TOTAL NUMBER OF CLAIMS	1,457

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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THE MEDICAL CENTER OF PEACH COUNTY, INC.  
 1960 HIGHWAY 247 CONNECTOR  
 BYRON,GA 31008-5663

PROVIDER NUMBER  
 000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75,462.38	541.10	OTHER LAB	33,390.00	0.00
MED/SURG SUPPLY	19,631.00	352.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	9,652.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	75,340.00	300.00	OTHER THERAPEUTIC SVC	0.00	252.00
CT SCAN	117,437.00	41,118.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,357.00	978.00	FEE SCHEDULE LAB	333,650.00	52,571.20
EKG/ECG	12,415.00	222.00	MRI SERVICES	8,206.00	0.00
IV THERAPY	30,828.00	2,051.00	PROFESSIONAL FEES	0.00	487.00
OPERATING ROOM	56,889.33	5,991.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,517.00	4,918.00	FREE STANDING CLINIC	2,601.00	0.00
ANESTHESIA	10,160.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	203,786.14	5,190.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,703.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,408.26	17,343.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	377.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	805.00	1,350.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	49,874.00	5,716.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,950.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	955.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,062.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,154.00	243.00			
			TOTAL ANCILLARY	1,129,581.11	149,653.54
			TOTAL ACCOMODATIONS	0.00	6,950.00
			TOTAL CHARGES	1,129,581.11	156,603.54

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,188.53	ADJUSTMENTS	0.00
COVERED CHARGES	4,263.53	CONTRACTUAL ALLOW	1,590.97
NON-COVERD CHARGES	3,925.00	TOTAL MEDICAID LIAB	2,672.56
		LESS: COB	2,672.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
 1960 HIGHWAY 247 CONNECTOR  
 BYRON,GA 31008-5663

PROVIDER NUMBER  
 000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	366.23	124.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	64.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,818.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,401.00	195.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	157.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	351.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,806.00	54.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	57.30	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	36.00
OTHER IMAGING SERVICE	412.00	1,347.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,263.53	3,925.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,263.53	3,925.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8502	2214336008388	10/05/14 - 10/05/14	12/08/14	0.00	36.00	0.00	377.75	0.00
TOTAL				0.00	36.00	0.00	377.75	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

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THE MEDICAL CENTER OF PEACH COUNTY, INC.  
1960 HIGHWAY 247 CONNECTOR  
BYRON,GA 31008-5663

PROVIDER NUMBER  
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	92,726.53	ADJUSTMENTS	1,154.11
COVERED CHARGES	86,991.45	CONTRACTUAL ALLOW	76,524.25
NON-COVERD CHARGES	5,735.08	TOTAL MEDICAID LIAB	10,467.20
		LESS: COB	0.00
		LESS: COPAYMENT	459.00
		REIMBURSEMENT	10,008.20
		TOTAL NUMBER OF CLAIMS	219



Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
 1960 HIGHWAY 247 CONNECTOR  
 BYRON,GA 31008-5663

PROVIDER NUMBER  
 000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,456.25	0.00	OTHER LAB	668.00	0.00
MED/SURG SUPPLY	821.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,594.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,805.00	1,871.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,937.00	612.00
EKG/ECG	444.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,264.00	27.00	PROFESSIONAL FEES	0.00	36.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	566.00	297.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,277.00	54.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,041.20	1,042.08
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	1,118.00	1,796.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	86,991.45	5,735.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	86,991.45	5,735.08

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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THE MEDICAL CENTER OF PEACH COUNTY, INC.  
1960 HIGHWAY 247 CONNECTOR  
BYRON,GA 31008-5663

PROVIDER NUMBER  
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,643.55	ADJUSTMENTS	0.00
COVERED CHARGES	2,984.00	CONTRACTUAL ALLOW	1,928.51
NON-COVERD CHARGES	1,659.55	TOTAL MEDICAID LIAB	1,055.49
		LESS: COB	1,055.49
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
 1960 HIGHWAY 247 CONNECTOR  
 BYRON,GA 31008-5663

PROVIDER NUMBER  
 000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	215.00	392.55	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	116.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	658.00	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	108.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	863.00	350.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	824.00	898.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,984.00	1,659.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,984.00	1,659.55

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
1960 HIGHWAY 247 CONNECTOR  
BYRON,GA 31008-5663

PROVIDER NUMBER  
000001449A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
1960 HIGHWAY 247 CONNECTOR  
BYRON,GA 31008-5663

PROVIDER NUMBER  
000001449A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:06:11  
 Page: 1

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,348,252.82	ADJUSTMENTS	182,839.10
COVERED CHARGES	1,266,178.87	CONTRACTUAL ALLOW	705,090.04
NON-COVERD CHARGES	82,073.95	TOTAL MEDICAID LIAB	561,088.83
		LESS: COB	30,798.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	530,290.04

TOTAL NUMBER OF ADMISSIONS 67

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	331		0	202,734.00		56,487.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	331		0	202,734.00		56,487.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	38		0	86,544.00		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		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	38		0	86,544.00		0.00
TOTAL ACCOMODATIONS	369		0	289,278.00		56,487.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	167,967.82	14,452.12	OTHER LAB	4,178.37	0.00
MED/SURG SUPPLY	19,004.52	413.91	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	215,980.41	919.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,538.76	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	78,034.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,670.74	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	23,840.00	0.00	MRI SERVICES	19,160.00	0.00
IV THERAPY	1,518.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	118,448.37	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,102.00	184.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,993.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	63,805.00	1,061.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,532.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,154.55	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	394.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,876.95	248.22	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	317.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,430.10	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,395.00
OTHER IMAGING SERVICE	13,196.12	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,599.02	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,459.40	3,716.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	43,704.74	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,995.50	1,196.00			
			TOTAL ANCILLARY	976,900.87	25,586.95
			TOTAL ACCOMODATIONS	289,278.00	56,487.00
			TOTAL CHARGES	1,266,178.87	82,073.95

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
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Page: 3

PERRY HOSPITAL  
1120 MORNINGSIDE DR  
PERRY,GA 31069-2906

PROVIDER NUMBER  
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2315231000182	02/22/15 - 03/13/15	09/28/15	0.00	3,395.00	0.00	2,032.84	0.00
TOTAL				0.00	3,395.00	0.00	2,032.84	0.00



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PERRY HOSPITAL  
 1120 MORNINGSIDE DR  
 PERRY,GA 31069-2906

PROVIDER NUMBER  
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,334.09	ADJUSTMENTS	0.00
COVERED CHARGES	54,334.09	CONTRACTUAL ALLOW	22,013.33
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	32,320.76
		LESS: COB	32,320.76
		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	17		0	10,863.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	17		0	10,863.00		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	17		0	10,863.00		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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,876.45	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	422.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,754.73	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,637.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,684.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	894.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,088.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,384.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	500.58	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,338.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,391.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	649.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	852.00	0.00			
			TOTAL ANCILLARY	43,471.09	0.00
			TOTAL ACCOMODATIONS	10,863.00	0.00
			TOTAL CHARGES	54,334.09	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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PERRY HOSPITAL  
1120 MORNINGSIDE DR  
PERRY,GA 31069-2906

PROVIDER NUMBER  
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,451,938.14	ADJUSTMENTS	74,423.00
COVERED CHARGES	2,325,706.27	CONTRACTUAL ALLOW	1,876,656.99
NON-COVERD CHARGES	126,231.87	TOTAL MEDICAID LIAB	449,049.28
		LESS: COB	1,311.84
		LESS: COPAYMENT	1,528.29
		REIMBURSEMENT	446,209.15
		ALL OTHER	392,896.33
		FEE SCHEDULE-LAB	46,931.83
		INJECTABLE DRUGS	6,380.99
		TOTAL NUMBER OF CLAIMS	1,375

PERRY HOSPITAL  
 1120 MORNINGSIDE DR  
 PERRY,GA 31069-2906

PROVIDER NUMBER  
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,801.20	0.00	OTHER LAB	59,517.69	373.78
MED/SURG SUPPLY	9,820.42	392.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	109,335.03	1,788.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	301,921.00	13,544.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	298.44	FEE SCHEDULE LAB	352,709.66	38,234.42
EKG/ECG	51,225.00	0.00	MRI SERVICES	57,798.00	5,185.00
IV THERAPY	91,994.00	1,410.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	170,340.26	44,004.51	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,998.00	1,437.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,196.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	918,200.00	1,700.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,656.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,816.43	7,852.09
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	499.00	249.30	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	609.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	173.48	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	41,445.48	2,526.12			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,272.44	2,323.81			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,837.87	2,391.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,149.31	1,912.90			
			TOTAL ANCILLARY	2,325,706.27	126,231.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,325,706.27	126,231.87

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,250.58	ADJUSTMENTS	0.00
COVERED CHARGES	43,241.63	CONTRACTUAL ALLOW	18,539.79
NON-COVERD CHARGES	5,008.95	TOTAL MEDICAID LIAB	24,701.84
		LESS: COB	24,684.02
		LESS: COPAYMENT	17.82
		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

PERRY HOSPITAL  
 1120 MORNINGSIDE DR  
 PERRY,GA 31069-2906

PROVIDER NUMBER  
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	416.86	0.00	OTHER LAB	5,027.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	804.62	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,410.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,811.65	481.75
EKG/ECG	894.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,114.50	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	184.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,616.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	451.82	51.25
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	529.68	2,065.95			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,391.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	43,241.63	5,008.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,241.63	5,008.95

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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PERRY HOSPITAL  
1120 MORNINGSIDE DR  
PERRY,GA 31069-2906

PROVIDER NUMBER  
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	67,814.76	ADJUSTMENTS	264.70
COVERED CHARGES	67,520.17	CONTRACTUAL ALLOW	63,828.13
NON-COVERD CHARGES	294.59	TOTAL MEDICAID LIAB	3,692.04
		LESS: COB	0.00
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	3,575.04
		TOTAL NUMBER OF CLAIMS	66

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	47.40	195.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,027.44	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,673.12	71.93
EKG/ECG	894.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,283.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,443.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,626.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	466.81	27.46
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	67,520.17	294.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,520.17	294.59



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL  
1120 MORNINGSIDE DR  
PERRY,GA 31069-2906

PROVIDER NUMBER  
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,655.86	ADJUSTMENTS	0.00
COVERED CHARGES	9,561.86	CONTRACTUAL ALLOW	5,819.23
NON-COVERD CHARGES	94.00	TOTAL MEDICAID LIAB	3,742.63
		LESS: COB	3,730.63
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PERRY HOSPITAL  
 1120 MORNINGSIDE DR  
 PERRY,GA 31069-2906

PROVIDER NUMBER  
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105.94	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	164.54	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,596.00	32.00
EKG/ECG	298.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	77.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,140.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	173.52	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	62.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,561.86	94.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,561.86	94.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:06:25  
Page: 15

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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:06:33  
 Page: 1

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	67,943,383.78	ADJUSTMENTS	2,741,135.34
COVERED CHARGES	64,809,011.37	CONTRACTUAL ALLOW	43,841,893.37
NON-COVERD CHARGES	3,134,372.41	TOTAL MEDICAID LIAB	20,967,118.00
		LESS: COB	84,539.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	20,882,578.88

TOTAL NUMBER OF ADMISSIONS 2,194

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,056		29	4,773,755.00		989,001.00
ROUTINE NURSERY	1,012		0	535,272.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11,068		29	5,309,027.00		989,001.00
SPECIAL CARE SERVICES						
CCU	443		0	589,028.00		0.00
ICU	1,452		0	1,894,888.00		0.00
NICU	995		0	1,520,945.00		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	2,890		0	4,004,861.00		0.00
TOTAL ACCOMODATIONS	13,958		29	9,313,888.00		989,001.00

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,214,983.67	85,339.90	OTHER LAB	391,211.00	2,429.00
MED/SURG SUPPLY	6,249,690.85	126,508.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,568,339.31	38,646.00	EDUCATION & TRAINING	324.00	0.00
RADIOLOGY-DIAGNOSTIC	1,116,516.00	7,291.00	OTHER THERAPEUTIC SVC	0.00	1,320.00
CT SCAN	1,112,849.00	815,396.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	517,379.16	13,190.02	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	235,279.00	0.00	MRI SERVICES	535,474.00	0.00
IV THERAPY	148,699.00	406.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,201,300.00	44,664.00	DURABLE MED. EQUIP.	0.00	1,094.00
LABOR/DELIVERY ROOM	124,620.00	0.00	REHAB THERAPY	10,992.00	0.00
RESPIRATORY SERVICES	2,866,605.18	9,408.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	412,875.00	450.00	AMBULANCE	0.00	0.00
GI SERVICES	249,692.00	1,570.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,924,625.00	8,120.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,012,763.50	3,620.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	153,024.00	0.00	INJECTABLE DRUGS	3,378,517.75	24,715.21
RADIOLOGY THERAPEUTIC	331,070.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	238,485.02	1,620.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	91,434.33	408.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	307,684.00	9,552.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	180.00	84,432.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	122,300.00	0.00	IMPL DEV CHARGE PATIENTS	3,235,053.76	1,405.00
LITHOTRIPSY	33,436.00	0.00	NO CC/INVALID REV CODE	0.00	52,294.00
OTHER IMAGING SERVICE	277,265.00	4,250.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	916,509.00	722,265.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	241,353.00	0.00			
AUDIOLOGY	63,385.00	1,500.00			
CARDIOLOGY	1,605,643.00	65,073.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	43,362.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	562,203.84	18,405.00			
			TOTAL ANCILLARY	55,495,123.37	2,145,371.41
			TOTAL ACCOMODATIONS	9,313,888.00	989,001.00
			TOTAL CHARGES	64,809,011.37	3,134,372.41

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014253007817	08/25/14 - 08/28/14	09/15/14	0.00	2,171.00	0.00	0.00	0.00
615	2014268098848	08/02/14 - 08/05/14	09/29/14	0.00	2,171.00	0.00	0.00	0.00
615	2014275065816	09/16/14 - 09/22/14	10/06/14	0.00	2,171.00	0.00	0.00	0.00
615	2014279027821	09/09/14 - 09/11/14	10/13/14	0.00	2,171.00	0.00	0.00	0.00
615	2314301000065	08/01/14 - 09/02/14	11/17/14	0.00	2,171.00	0.00	0.00	0.00
615	2014316091167	09/03/14 - 09/05/14	11/17/14	0.00	2,171.00	0.00	0.00	0.00
615	2014338008950	10/10/14 - 10/19/14	12/08/14	0.00	2,171.00	0.00	0.00	0.00
615	2015020073419	12/23/14 - 12/24/14	01/26/15	0.00	2,171.00	0.00	0.00	0.00
615	2215049011737	11/29/14 - 12/05/14	02/23/15	0.00	2,171.00	0.00	0.00	0.00
615	2015089032251	02/23/15 - 02/25/15	04/06/15	0.00	2,171.00	0.00	0.00	0.00
615	2015107068142	03/09/15 - 03/12/15	04/27/15	0.00	4,532.00	0.00	0.00	0.00
615	2015141111797	02/13/15 - 03/06/15	05/25/15	0.00	2,171.00	0.00	0.00	0.00
615	9815153000041	09/03/14 - 12/12/14	06/08/15	0.00	2,171.00	0.00	0.00	0.00
615	2015159030316	05/12/15 - 05/15/15	06/15/15	0.00	2,171.00	0.00	0.00	0.00
615	2015181059728	03/01/15 - 03/10/15	07/06/15	0.00	2,171.00	0.00	0.00	0.00
615	2215205013679	04/19/15 - 05/01/15	07/27/15	0.00	2,171.00	0.00	0.00	0.00
615	2015209054251	05/16/15 - 05/23/15	08/03/15	0.00	2,171.00	0.00	0.00	0.00
615	2015232007174	02/26/15 - 03/23/15	08/24/15	0.00	2,171.00	0.00	0.00	0.00
615	2015265042851	02/15/15 - 03/20/15	09/28/15	0.00	2,171.00	0.00	0.00	0.00
615	2115286000008	12/14/14 - 12/30/14	11/02/15	0.00	2,171.00	0.00	3,457.82	0.00
615	5215362002030	07/06/15 - 07/15/15	02/22/16	0.00	2,171.00	0.00	0.00	0.00
615	2216041005565	02/11/15 - 02/19/15	02/15/16	0.00	2,171.00	0.00	0.00	0.00
615	5216201000224	12/10/14 - 03/03/15	07/25/16	0.00	2,171.00	0.00	0.00	0.00
TOTAL				0.00	52,294.00	0.00	3,457.82	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:07:06  
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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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	198,511.06	ADJUSTMENTS	0.00
COVERED CHARGES	196,340.06	CONTRACTUAL ALLOW	42,284.80
NON-COVERD CHARGES	2,171.00	TOTAL MEDICAID LIAB	154,055.26
		LESS: COB	154,055.26
		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	45		0	20,235.00		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	45		0	20,235.00		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	45		0	20,235.00		0.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,683.95	0.00	OTHER LAB	921.00	0.00
MED/SURG SUPPLY	25,023.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,036.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,481.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,403.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,554.05	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	186.00	0.00	MRI SERVICES	4,881.00	0.00
IV THERAPY	9,202.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,920.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,278.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	924.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,320.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,062.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,437.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,030.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,145.00	0.00	INJECTABLE DRUGS	5,765.97	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	495.06	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,365.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,478.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,171.00
OTHER IMAGING SERVICE	765.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	656.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,093.00	0.00			
			TOTAL ANCILLARY	176,105.06	2,171.00
			TOTAL ACCOMODATIONS	20,235.00	0.00
			TOTAL CHARGES	196,340.06	2,171.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015048081137	12/30/14 - 01/15/15	02/23/15	0.00	2,171.00	0.00	42,881.91	0.00
TOTAL				0.00	2,171.00	0.00	42,881.91	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:07:11  
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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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,918,444.61	ADJUSTMENTS	898,289.24
COVERED CHARGES	32,987,421.34	CONTRACTUAL ALLOW	24,673,825.19
NON-COVERD CHARGES	2,931,023.27	TOTAL MEDICAID LIAB	8,313,596.15
		LESS: COB	3,055.05
		LESS: COPAYMENT	30,927.84
		REIMBURSEMENT	8,279,613.26
		ALL OTHER	6,870,983.51
		FEE SCHEDULE-LAB	441,655.38
		INJECTABLE DRUGS	966,974.37

TOTAL NUMBER OF CLAIMS 16,191

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,564,861.52	7,357.94	OTHER LAB	200,519.00	3,308.00
MED/SURG SUPPLY	2,551,358.99	12,330.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	445.69	EDUCATION & TRAINING	2,312.00	0.00
RADIOLOGY-DIAGNOSTIC	866,930.00	22,246.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,082,014.00	291,499.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	75,370.00	20,127.44	FEE SCHEDULE LAB	2,754,627.13	517,506.96
EKG/ECG	226,917.00	19,530.00	MRI SERVICES	648,253.00	56,751.00
IV THERAPY	966,817.00	5,353.00	PROFESSIONAL FEES	0.00	642.00
OPERATING ROOM	2,075,213.00	388,775.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	71,290.00	0.00	REHAB THERAPY	0.00	7,820.00
RESPIRATORY SERVICES	220,676.00	35,987.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	326,687.00	1,170.00	AMBULANCE	0.00	0.00
GI SERVICES	813,768.00	50,443.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,090,708.00	26,979.32	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,341,886.75	9,240.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,321,051.56	900,219.90
RADIOLOGY THERAPEUTIC	1,519,806.00	157,691.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,543.00	1,986.13	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	20,300.00	10,182.53	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	796.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	838,906.56	25,267.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	189,995.00	555.00	IMPL DEV CHARGE PATIENTS	320,052.00	13,658.00
LITHOTRIPSY	66,872.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	787,429.00	67,205.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	116,286.00	8,552.01			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	602,003.00	48,204.00			
AUDIOLOGY	4,336.00	378.00			
CARDIOLOGY	345,360.00	91,957.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	282,244.00	0.00			
ORGAN ACQUISITION	0.00	30,024.00			
TREATMENT/OBSERV. RM	688,028.83	96,836.34			
			TOTAL ANCILLARY	32,987,421.34	2,931,023.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,987,421.34	2,931,023.27

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	420,019.03	ADJUSTMENTS	0.00
COVERED CHARGES	360,525.43	CONTRACTUAL ALLOW	128,114.59
NON-COVERD CHARGES	59,493.60	TOTAL MEDICAID LIAB	232,410.84
		LESS: COB	232,202.60
		LESS: COPAYMENT	208.24
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 165

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,169.43	427.75	OTHER LAB	1,688.00	0.00
MED/SURG SUPPLY	35,319.00	870.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	38.00	0.00
RADIOLOGY-DIAGNOSTIC	8,704.00	469.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,732.00	16,734.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	504.00	252.00	FEE SCHEDULE LAB	32,685.00	6,991.00
EKG/ECG	2,176.00	186.00	MRI SERVICES	18,187.00	5,914.00
IV THERAPY	11,170.00	812.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,595.00	7,595.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,538.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,092.00	422.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,510.00	360.00	AMBULANCE	0.00	0.00
GI SERVICES	6,731.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,801.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,307.00	2,511.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,109.64	476.55
RADIOLOGY THERAPEUTIC	205.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	756.00	189.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,085.00	2,704.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,697.00	162.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,853.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,337.00	9,718.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,456.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,334.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,897.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,849.36	2,700.27			
			TOTAL ANCILLARY	360,525.43	59,493.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	360,525.43	59,493.60

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,016,332.10	ADJUSTMENTS	911.98
COVERED CHARGES	980,656.60	CONTRACTUAL ALLOW	918,786.96
NON-COVERD CHARGES	35,675.50	TOTAL MEDICAID LIAB	61,869.64
		LESS: COB	0.00
		LESS: COPAYMENT	2,616.00
		REIMBURSEMENT	59,253.64
		TOTAL NUMBER OF CLAIMS	1,106

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,605.58	19.00	OTHER LAB	6,083.00	0.00
MED/SURG SUPPLY	30,992.92	885.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	48,778.00	2,280.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,768.00	4,885.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	87,592.00	20,767.00
EKG/ECG	9,486.00	186.00	MRI SERVICES	8,255.00	0.00
IV THERAPY	4,210.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,300.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,278.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,428.00	424.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	560.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	651,905.00	2,971.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,595.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,639.35	1,064.25
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	266.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,198.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,285.00	1,609.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,431.75	585.25			
			TOTAL ANCILLARY	980,656.60	35,675.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	980,656.60	35,675.50



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,083.40	ADJUSTMENTS	0.00
COVERED CHARGES	8,945.40	CONTRACTUAL ALLOW	1,597.20
NON-COVERD CHARGES	3,138.00	TOTAL MEDICAID LIAB	7,348.20
		LESS: COB	7,336.20
		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

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	373.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	308.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,084.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,343.00	2,879.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,096.00	259.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,617.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	123.80	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	8,945.40	3,138.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,945.40	3,138.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,540,428.91	ADJUSTMENTS	346,810.13
COVERED CHARGES	6,856,347.91	CONTRACTUAL ALLOW	5,770,721.87
NON-COVERD CHARGES	684,081.00	TOTAL MEDICAID LIAB	1,085,626.04
		LESS: COB	0.00
		LESS: COPAYMENT	1,313.79
		REIMBURSEMENT	1,084,312.25
		TOTAL NUMBER OF CLAIMS	187

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	244,817.65	3,056.25	OTHER LAB	1,519.00	0.00
MED/SURG SUPPLY	311,593.00	6,868.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,928.00	17,733.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,883.00	4,112.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,207.00	1,544.11	FEE SCHEDULE LAB	63,188.00	5,291.00
EKG/ECG	10,840.00	930.00	MRI SERVICES	0.00	0.00
IV THERAPY	161,101.00	2,468.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	533,178.01	89,740.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,386.00	422.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,540.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,570.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,452.00	250.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	164,843.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,572,331.00	119,678.75
RADIOLOGY THERAPEUTIC	368,887.00	5,711.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	734.00	1,468.09	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	718.00	617.05	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,886.00	328.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	989,250.00	0.00
LITHOTRIPSY	105,070.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,316.00	4,250.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,390.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,139.00	5,091.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	155,005.00	408,112.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,576.25	6,410.75			
			TOTAL ANCILLARY	6,856,347.91	684,081.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,856,347.91	684,081.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:09:26  
Page: 17

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,283.00	ADJUSTMENTS	0.00
COVERED CHARGES	69,243.00	CONTRACTUAL ALLOW	58,416.66
NON-COVERD CHARGES	40.00	TOTAL MEDICAID LIAB	10,826.34
		LESS: COB	10,811.34
		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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,376.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,331.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	471.00	40.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,802.00	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	54,986.00	0.00
RADIOLOGY THERAPEUTIC	615.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	69,243.00	40.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	69,243.00	40.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,728,714.74	ADJUSTMENTS	166,869.18
COVERED CHARGES	6,612,983.74	CONTRACTUAL ALLOW	4,973,191.81
NON-COVERD CHARGES	115,731.00	TOTAL MEDICAID LIAB	1,639,791.93
		LESS: COB	6,679.66
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,633,112.27

TOTAL NUMBER OF ADMISSIONS 206

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	742		0	671,510.00		64,023.00
ROUTINE NURSERY	44		0	29,801.00		111.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	786		0	701,311.00		64,134.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	145		0	352,520.00		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	145		0	352,520.00		0.00
TOTAL ACCOMODATIONS	931		0	1,053,831.00		64,134.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:52:16  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
 1266 HIGHWAY 515 S  
 JASPER,GA 30143-4872

PROVIDER NUMBER  
 000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,262,345.48	0.00	OTHER LAB	43,484.00	0.00
MED/SURG SUPPLY	136,137.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,154,334.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	177,161.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	608,833.00	6,120.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,830.27	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	73,186.00	0.00	MRI SERVICES	63,469.00	0.00
IV THERAPY	5,531.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	516,484.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	62,978.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	341,348.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	67,638.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	29,746.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	446,236.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	111,528.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,239.00	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	3,218.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,264.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	63,664.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	64,578.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	107,341.00	42,910.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	27,008.00	2,567.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	121,197.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	40,174.40	0.00			
			TOTAL ANCILLARY	5,559,152.74	51,597.00
			TOTAL ACCOMODATIONS	1,053,831.00	64,134.00
			TOTAL CHARGES	6,612,983.74	115,731.00



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,674.70	ADJUSTMENTS	0.00
COVERED CHARGES	15,377.70	CONTRACTUAL ALLOW	10,894.56
NON-COVERD CHARGES	297.00	TOTAL MEDICAID LIAB	4,483.14
		LESS: COB	4,483.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	2,715.00		297.00
ROUTINE NURSERY	0		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	2,715.00		297.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	2,715.00		297.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,005.70	0.00	OTHER LAB	1,226.00	0.00
MED/SURG SUPPLY	191.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	919.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	5,521.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,800.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,662.70	0.00
			TOTAL ACCOMODATIONS	2,715.00	297.00
			TOTAL CHARGES	15,377.70	297.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,284,418.10	ADJUSTMENTS	252,735.87
COVERED CHARGES	8,908,039.84	CONTRACTUAL ALLOW	7,628,049.31
NON-COVERD CHARGES	1,376,378.26	TOTAL MEDICAID LIAB	1,279,990.53
		LESS: COB	18,625.12
		LESS: COPAYMENT	3,566.79
		REIMBURSEMENT	1,257,798.62
		ALL OTHER	1,178,964.66
		FEE SCHEDULE-LAB	63,339.64
		INJECTABLE DRUGS	15,494.32

TOTAL NUMBER OF CLAIMS 2,696

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	158,294.78	19,758.95	OTHER LAB	139,640.00	0.00
MED/SURG SUPPLY	201,850.01	16,040.23	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	554,533.80	19,136.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,630,124.00	368,951.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,062.14	FEE SCHEDULE LAB	1,013,607.50	154,052.90
EKG/ECG	108,683.00	7,794.00	MRI SERVICES	384,524.00	12,117.00
IV THERAPY	60,765.00	2,238.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	750,074.00	131,244.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,357.00	980.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,784.00	93,604.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	106,443.00	1,714.00	AMBULANCE	0.00	0.00
GI SERVICES	197,255.00	71,151.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,881,793.00	43,947.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	328,940.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	146,147.59	188,603.56
RADIOLOGY THERAPEUTIC	2,384.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,756.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38,794.00	4,347.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,731.46	22,378.88
LITHOTRIPSY	21,655.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	424,344.00	35,758.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,186.00	4,904.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	171,278.00	109,686.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	222,782.00	54,433.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	105,488.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	147,581.70	9,721.60			
			TOTAL ANCILLARY	8,908,039.84	1,376,378.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,908,039.84	1,376,378.26

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	212,975.37	ADJUSTMENTS	0.00
COVERED CHARGES	171,265.27	CONTRACTUAL ALLOW	123,048.12
NON-COVERD CHARGES	41,710.10	TOTAL MEDICAID LIAB	48,217.15
		LESS: COB	48,157.07
		LESS: COPAYMENT	60.08
		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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,492.12	348.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,912.41	165.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,979.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,934.00	12,473.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,179.00	1,438.00
EKG/ECG	2,165.00	433.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,781.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,175.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	106.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,884.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,817.00	6,652.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,266.00	228.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,955.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,421.54	2,887.70
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	4,457.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	858.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,033.00	8,605.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	6,224.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,603.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,856.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,249.20	1,398.00			
			TOTAL ANCILLARY	171,265.27	41,710.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	171,265.27	41,710.10

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	527,135.03	ADJUSTMENTS	591.34
COVERED CHARGES	484,635.89	CONTRACTUAL ALLOW	465,746.44
NON-COVERD CHARGES	42,499.14	TOTAL MEDICAID LIAB	18,889.45
		LESS: COB	2,778.73
		LESS: COPAYMENT	606.00
		REIMBURSEMENT	15,504.72
		TOTAL NUMBER OF CLAIMS	288

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,147.70	249.60	OTHER LAB	2,544.00	0.00
MED/SURG SUPPLY	1,342.00	62.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,492.00	1,228.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	75,322.00	18,094.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	76,506.00	8,452.00
EKG/ECG	3,031.00	433.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,925.00	156.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	262,013.00	5,025.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,683.19	1,338.54
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,630.00	7,461.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	484,635.89	42,499.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	484,635.89	42,499.14



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,771.82	ADJUSTMENTS	0.00
COVERED CHARGES	10,923.62	CONTRACTUAL ALLOW	9,351.62
NON-COVERD CHARGES	1,848.20	TOTAL MEDICAID LIAB	1,572.00
		LESS: COB	1,557.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68.62	83.20	OTHER LAB	1,310.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,260.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,322.00	369.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,948.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,396.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,923.62	1,848.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,923.62	1,848.20

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	90,437.98	ADJUSTMENTS	5,538.79
COVERED CHARGES	89,527.34	CONTRACTUAL ALLOW	78,443.76
NON-COVERD CHARGES	910.64	TOTAL MEDICAID LIAB	11,083.58
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	11,077.58

TOTAL NUMBER OF CLAIMS 2

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,045.44	83.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,282.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,178.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,318.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,482.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,187.00	583.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,144.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	933.59	244.44
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	25,956.37	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	89,527.34	910.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	89,527.34	910.64

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
1266 HIGHWAY 515 S  
JASPER,GA 30143-4872

PROVIDER NUMBER  
000001493A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER 000001504A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,182,660.51	ADJUSTMENTS	1,914,613.32
COVERED CHARGES	63,096,604.14	CONTRACTUAL ALLOW	48,322,904.61
NON-COVERD CHARGES	3,086,056.37	TOTAL MEDICAID LIAB	14,773,699.53
		LESS: COB	215,360.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	14,558,339.35

TOTAL NUMBER OF ADMISSIONS 893

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,477		5	4,947,248.00		835,997.00
ROUTINE NURSERY	221		7	274,575.00		27,327.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,698		12	5,221,823.00		863,324.00
SPECIAL CARE SERVICES						
CCU	284		0	773,900.00		0.00
ICU	790		0	2,186,343.00		140,874.00
NICU	89		0	243,059.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,163		0	3,203,302.00		140,874.00
TOTAL ACCOMODATIONS	6,861		12	8,425,125.00		1,004,198.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,397,382.84	331,773.02	OTHER LAB	549,930.00	80,550.00
MED/SURG SUPPLY	2,954,906.71	625,740.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,783,479.00	284,506.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,585,530.00	28,891.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,458,569.00	19,592.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	442,627.61	32,458.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	492,345.00	2,370.00	MRI SERVICES	669,727.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,219,594.00	33,171.00	DURABLE MED. EQUIP.	0.00	78.00
LABOR/DELIVERY ROOM	89,796.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,575,665.00	128,200.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	909,070.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	821,016.00	21,069.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,612,892.00	16,075.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	421,479.00	7,125.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	377,811.00	1,099.00	INJECTABLE DRUGS	12,837.33	0.00
RADIOLOGY THERAPEUTIC	44,226.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	135,862.14	4,456.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	140,892.02	7,785.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,061,372.00	40,205.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,463.00	256,857.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,606,205.69	518.32
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	70,279.00
OTHER IMAGING SERVICE	326,620.00	2,643.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,019,363.00	60,175.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	222,460.00	26,243.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,645,997.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	38,099.00	0.00			
ORGAN ACQUISITION	826,799.00	0.00			
TREATMENT/OBSERV. RM	202,462.80	0.00			
			TOTAL ANCILLARY	54,671,479.14	2,081,858.37
			TOTAL ACCOMODATIONS	8,425,125.00	1,004,198.00
			TOTAL CHARGES	63,096,604.14	3,086,056.37

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014213050189	07/09/14 - 07/23/14	08/04/14	0.00	3,996.00	0.00	0.00	0.00
614	2214246004244	08/12/14 - 08/14/14	09/08/14	0.00	3,996.00	0.00	0.00	0.00
614	2014258009872	09/05/14 - 09/10/14	09/22/14	0.00	3,996.00	0.00	0.00	0.00
614	2214279008023	09/18/14 - 09/26/14	10/13/14	0.00	3,996.00	0.00	0.00	0.00
614	2214335002026	11/06/14 - 11/25/14	12/08/14	0.00	4,351.00	0.00	0.00	0.00
614	2214335002724	10/29/14 - 11/22/14	12/08/14	0.00	3,996.00	0.00	0.00	0.00
614	2214358005943	12/07/14 - 12/16/14	12/29/14	0.00	4,782.00	0.00	0.00	0.00
614	2015012013114	12/29/14 - 01/06/15	01/19/15	0.00	3,996.00	0.00	0.00	0.00
614	2215055004975	01/07/15 - 01/20/15	03/02/15	0.00	3,996.00	0.00	0.00	0.00
614	2215056003108	12/17/14 - 12/18/14	03/02/15	0.00	3,996.00	0.00	0.00	0.00
614	2015147020074	05/11/15 - 05/18/15	06/01/15	0.00	3,996.00	0.00	0.00	0.00
614	2215167000473	05/09/15 - 05/20/15	06/22/15	0.00	4,782.00	0.00	0.00	0.00
614	2015173001521	06/10/15 - 06/19/15	06/29/15	0.00	3,996.00	0.00	0.00	0.00
614	2015252018434	01/19/15 - 01/31/15	09/14/15	0.00	3,996.00	0.00	0.00	0.00
614	2215264008779	02/01/15 - 02/09/15	09/28/15	0.00	3,996.00	0.00	0.00	0.00
614	2215350005730	06/07/15 - 06/23/15	12/21/15	0.00	3,996.00	0.00	0.00	0.00
614	9816029000086	04/07/15 - 04/24/15	02/08/16	0.00	3,996.00	0.00	0.00	0.00
948	2016042045230	05/30/15 - 06/03/15	02/15/16	0.00	420.00	0.00	0.00	0.00
TOTAL				0.00	70,279.00	0.00	0.00	0.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER 000001504A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	792,956.68	ADJUSTMENTS	0.00
COVERED CHARGES	778,537.68	CONTRACTUAL ALLOW	273,640.58
NON-COVERD CHARGES	14,419.00	TOTAL MEDICAID LIAB	504,897.10
		LESS: COB	504,897.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	69		0	64,860.00		7,322.00
ROUTINE NURSERY	29		0	46,668.00		4,581.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	98		0	111,528.00		11,903.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	8,175.00		0.00
NICU	36		0	98,316.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	106,491.00		0.00
TOTAL ACCOMODATIONS	137		0	218,019.00		11,903.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120,077.88	0.00	OTHER LAB	9,220.00	0.00
MED/SURG SUPPLY	24,584.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	83,348.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,488.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,552.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,594.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,318.00	0.00	MRI SERVICES	4,020.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	68,828.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	39,121.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,959.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,178.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,134.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,927.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,134.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,548.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	7,548.00	2,516.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,746.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,913.86	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,701.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,663.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,092.00	0.00			
AMBULATORY SURGERY	0.00	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	560,518.68	2,516.00
			TOTAL ACCOMODATIONS	218,019.00	11,903.00
			TOTAL CHARGES	778,537.68	14,419.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:19:43  
Page: 6

PIEDMONT HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,018,625.81	ADJUSTMENTS	620,987.71
COVERED CHARGES	16,216,721.57	CONTRACTUAL ALLOW	13,724,321.25
NON-COVERD CHARGES	4,801,904.24	TOTAL MEDICAID LIAB	2,492,400.32
		LESS: COB	134,235.26
		LESS: COPAYMENT	6,798.00
		REIMBURSEMENT	2,351,367.06
		ALL OTHER	1,915,539.93
		FEE SCHEDULE-LAB	245,272.86
		INJECTABLE DRUGS	190,554.27

TOTAL NUMBER OF CLAIMS 5,511

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER  
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	264,426.38	90,170.20	OTHER LAB	245,027.00	6,669.00
MED/SURG SUPPLY	465,380.94	283,420.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	469.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	719,904.00	39,692.00	OTHER THERAPEUTIC SVC	0.00	1,368.00
CT SCAN	1,726,338.00	369,411.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,640.00	19,201.08	FEE SCHEDULE LAB	3,284,776.50	844,826.40
EKG/ECG	214,516.00	10,428.00	MRI SERVICES	362,972.00	70,394.00
IV THERAPY	44,273.00	2,766.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,162,836.00	423,696.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,850.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	94,205.00	15,272.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	145,778.00	1,750.00	AMBULANCE	0.00	2,456.00
GI SERVICES	254,612.00	81,452.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,025,314.00	42,459.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	202,584.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,265,748.76	682,853.09
RADIOLOGY THERAPEUTIC	290,816.00	189,222.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,412.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,485.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	65,416.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	271,146.00	51,016.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	173,137.02	719,922.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	30,623.77
OTHER IMAGING SERVICE	402,534.00	114,519.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	185,636.00	30,267.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	271,267.00	123,418.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,347,664.00	465,755.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	417,444.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	364,895.97	19,095.00			
			TOTAL ANCILLARY	16,216,721.57	4,801,904.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,216,721.57	4,801,904.24

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
 Run Time: 02:19:43  
 Page: 8

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER  
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015019010809	01/16/15 - 01/16/15	01/26/15	0.00	3,996.00	0.00	0.00	0.00
614	2015057048280	02/23/15 - 02/23/15	03/02/15	0.00	3,996.00	0.00	0.00	0.00
614	5915061000628	11/17/14 - 11/17/14	03/09/15	0.00	355.00	0.00	0.00	0.00
614	5915061000628	11/17/14 - 11/17/14	03/09/15	0.00	3,996.00	0.00	0.00	0.00
614	5915097000363	03/26/15 - 03/26/15	04/13/15	0.00	3,996.00	0.00	0.00	0.00
614	5915097000363	03/26/15 - 03/26/15	04/13/15	0.00	355.00	0.00	0.00	0.00
639	2215105010185	10/29/14 - 10/29/14	04/20/15	0.00	14.77	0.00	0.00	0.00
614	2015180011928	06/25/15 - 06/25/15	07/06/15	0.00	3,996.00	0.00	0.00	0.00
613	5915225001740	05/12/15 - 05/12/15	08/17/15	0.00	4,782.00	0.00	0.00	0.00
614	9815307000056	04/13/15 - 04/13/15	11/09/15	0.00	4,782.00	0.00	0.00	0.00
614	9815307000056	04/13/15 - 04/13/15	11/09/15	0.00	355.00	0.00	0.00	0.00
TOTAL				0.00	30,623.77	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: 08/12/2016  
Run Time: 02:20:27  
Page: 9

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	680,447.85	ADJUSTMENTS	0.00
COVERED CHARGES	332,306.42	CONTRACTUAL ALLOW	147,595.74
NON-COVERD CHARGES	348,141.43	TOTAL MEDICAID LIAB	184,710.68
		LESS: COB	184,563.68
		LESS: COPAYMENT	147.00
		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

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER  
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,909.87	985.60	OTHER LAB	13,687.00	1,448.00
MED/SURG SUPPLY	16,027.31	4,942.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,566.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,925.00	50,775.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	47,152.00	14,235.00
EKG/ECG	7,584.00	474.00	MRI SERVICES	10,090.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,806.00	35,904.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,365.00	595.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,145.00	280.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,482.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,578.00	4,140.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,966.00	1,551.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,118.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,569.04	130,194.57
RADIOLOGY THERAPEUTIC	2,141.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,058.00	1,719.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	36,181.01
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,637.00	2,039.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,318.00	2,282.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	33,010.00	60,396.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,854.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,318.20	0.00			
			TOTAL ANCILLARY	332,306.42	348,141.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	332,306.42	348,141.43

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:20:29  
Page: 11

PIEDMONT HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	304,436.37	ADJUSTMENTS	220.76
COVERED CHARGES	282,566.62	CONTRACTUAL ALLOW	270,319.72
NON-COVERD CHARGES	21,869.75	TOTAL MEDICAID LIAB	12,246.90
		LESS: COB	1,898.00
		LESS: COPAYMENT	459.00
		REIMBURSEMENT	9,889.90
		TOTAL NUMBER OF CLAIMS	185



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,167.51	83.20	OTHER LAB	14,197.00	0.00
MED/SURG SUPPLY	5,064.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,328.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,763.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	51,297.00	9,017.00
EKG/ECG	4,266.00	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	970.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	143,896.00	288.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	708.71	990.55
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	2,516.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,193.00	8,975.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	282,566.62	21,869.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	282,566.62	21,869.75

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:20:31  
Page: 13

PIEDMONT HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,187.59	ADJUSTMENTS	0.00
COVERED CHARGES	11,283.02	CONTRACTUAL ALLOW	6,140.16
NON-COVERD CHARGES	904.57	TOTAL MEDICAID LIAB	5,142.86
		LESS: COB	5,124.86
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	343.42	0.00	OTHER LAB	1,363.00	0.00
MED/SURG SUPPLY	95.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	548.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,158.00	426.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,721.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54.60	478.57
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	11,283.02	904.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,283.02	904.57

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,301,366.01	ADJUSTMENTS	115,425.88
COVERED CHARGES	1,900,349.46	CONTRACTUAL ALLOW	1,654,475.18
NON-COVERD CHARGES	401,016.55	TOTAL MEDICAID LIAB	245,874.28
		LESS: COB	0.00
		LESS: COPAYMENT	237.00
		REIMBURSEMENT	245,637.28

TOTAL NUMBER OF CLAIMS 38

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,966.68	1,790.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	114,740.82	102,318.39	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,821.00	35,575.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,160.00	3,076.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,396.00	4,584.00
EKG/ECG	1,896.00	948.00	MRI SERVICES	5,051.00	0.00
IV THERAPY	5,736.00	2,766.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	361,040.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,183.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,290.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,265.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	308,931.72	20,165.75
RADIOLOGY THERAPEUTIC	102,618.00	53,975.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	634,350.84	120,371.61
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,929.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	241,305.00	55,446.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,669.40	0.00			
			TOTAL ANCILLARY	1,900,349.46	401,016.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,900,349.46	401,016.55

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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Page: 17

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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:11:06  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER 000001526A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 11/05/14  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,820.50	ADJUSTMENTS	0.00
COVERED CHARGES	20,820.50	CONTRACTUAL ALLOW	11,951.76
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	8,868.74
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,868.74

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	2,200.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4		0	2,200.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	4		0	2,200.00		0.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:11:06  
 Page: 2

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 11/05/14  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	918.50	0.00	OTHER LAB	479.00	0.00
MED/SURG SUPPLY	1,591.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,860.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	518.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,123.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,202.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,549.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	380.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,620.50	0.00
			TOTAL ACCOMODATIONS	2,200.00	0.00
			TOTAL CHARGES	20,820.50	0.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:11:07  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 11/05/14  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:11:07  
Page: 4

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 11/05/14  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,775,437.89	ADJUSTMENTS	24,074.21
COVERED CHARGES	1,703,809.39	CONTRACTUAL ALLOW	1,369,819.33
NON-COVERD CHARGES	71,628.50	TOTAL MEDICAID LIAB	333,990.06
		LESS: COB	0.00
		LESS: COPAYMENT	204.00
		REIMBURSEMENT	333,786.06
		ALL OTHER	306,959.64
		FEE SCHEDULE-LAB	22,848.56
		INJECTABLE DRUGS	3,977.86

TOTAL NUMBER OF CLAIMS 892

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
 Run Time: 03:11:07  
 Page: 5

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 11/05/14  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,431.00	31.00	OTHER LAB	2,451.00	0.00
MED/SURG SUPPLY	35,080.64	1,052.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105,465.00	212.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	140,364.00	1,637.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	308,231.00	50,607.00
EKG/ECG	17,000.00	750.00	MRI SERVICES	2,497.00	0.00
IV THERAPY	15,160.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,390.00	107.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	970,260.00	9,231.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	66,244.75	2,211.50
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	4,874.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,280.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,369.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,112.00	550.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,794.00	4,316.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,806.00	924.00			
			TOTAL ANCILLARY	1,703,809.39	71,628.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,703,809.39	71,628.50

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 03:11:15  
Page: 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 11/05/14  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,854.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,183.00	CONTRACTUAL ALLOW	3,746.96
NON-COVERD CHARGES	1,671.00	TOTAL MEDICAID LIAB	5,436.04
		LESS: COB	5,436.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 11/05/14  
 ADMISSION DATES 00/00/00 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	376.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,637.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,252.00	34.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,061.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	294.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	200.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,183.00	1,671.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,183.00	1,671.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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Page: 8

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 11/05/14  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	146,223.25	ADJUSTMENTS	1,167.01
COVERED CHARGES	144,124.25	CONTRACTUAL ALLOW	140,049.11
NON-COVERD CHARGES	2,099.00	TOTAL MEDICAID LIAB	4,075.14
		LESS: COB	0.00
		LESS: COPAYMENT	185.00
		REIMBURSEMENT	3,890.14
		TOTAL NUMBER OF CLAIMS	106

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 11/05/14  
 ADMISSION DATES 00/00/00 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	1,033.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,589.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,637.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,570.00	2,099.00
EKG/ECG	250.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	113,793.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,643.25	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	548.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	144,124.25	2,099.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	144,124.25	2,099.00





Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 11/05/14  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	399.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,555.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,501.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,093.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	414.75	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	54,979.75	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,979.75	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 11/05/14  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,231.25	ADJUSTMENTS	4,959.21
COVERED CHARGES	27,333.25	CONTRACTUAL ALLOW	22,374.04
NON-COVERD CHARGES	898.00	TOTAL MEDICAID LIAB	4,959.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,959.21
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 11/05/14  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	214.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	744.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	350.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,680.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,399.00	348.00
EKG/ECG	250.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,776.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,601.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,006.75	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.	1,112.00	550.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,200.00	0.00			
			TOTAL ANCILLARY	27,333.25	898.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,333.25	898.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	11/05/14
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:37:53  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER 000001526A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 11/06/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,149.50	ADJUSTMENTS	0.00
COVERED CHARGES	49,149.50	CONTRACTUAL ALLOW	34,933.81
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	14,215.69
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	14,215.69

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	4,400.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	4,400.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	8		0	4,400.00		0.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:37:53  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 11/06/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,472.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,062.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,459.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	250.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	341.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,349.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,202.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,692.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	44,749.50	0.00
			TOTAL ACCOMODATIONS	4,400.00	0.00
			TOTAL CHARGES	49,149.50	0.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:37:54  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	11/06/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:37:54  
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POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 11/06/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,850,661.57	ADJUSTMENTS	160,231.33
COVERED CHARGES	4,636,097.57	CONTRACTUAL ALLOW	3,741,126.43
NON-COVERD CHARGES	214,564.00	TOTAL MEDICAID LIAB	894,971.14
		LESS: COB	359.25
		LESS: COPAYMENT	534.00
		REIMBURSEMENT	894,077.89
		ALL OTHER	824,580.70
		FEE SCHEDULE-LAB	58,111.65
		INJECTABLE DRUGS	11,385.54

TOTAL NUMBER OF CLAIMS 2,064



Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 11/06/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,569.75	31.00	OTHER LAB	8,424.00	0.00
MED/SURG SUPPLY	122,761.32	4,665.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	31.00	EDUCATION & TRAINING	36.00	0.00
RADIOLOGY-DIAGNOSTIC	260,529.00	417.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	444,385.00	16,380.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	152.00	FEE SCHEDULE LAB	866,882.00	108,048.00
EKG/ECG	36,750.00	1,250.00	MRI SERVICES	4,078.00	0.00
IV THERAPY	29,652.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,581.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,238.00	3,458.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,032.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,393,244.00	25,135.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,788.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	51.00	INJECTABLE DRUGS	202,277.50	39,377.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,498.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,868.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,245.00	1,060.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,224.00	1,650.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	29,840.00	8,476.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,486.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	70,709.00	4,383.00			
			TOTAL ANCILLARY	4,636,097.57	214,564.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,636,097.57	214,564.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 11/06/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,173.25	ADJUSTMENTS	0.00
COVERED CHARGES	32,658.25	CONTRACTUAL ALLOW	8,826.44
NON-COVERD CHARGES	6,515.00	TOTAL MEDICAID LIAB	23,831.81
		LESS: COB	23,831.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 11/06/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	139.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	554.00	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	0.00	6,317.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,598.00	68.00
EKG/ECG	250.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	107.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,066.00	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	1,631.25	130.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,658.25	6,515.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,658.25	6,515.00

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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POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 11/06/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	432,943.75	ADJUSTMENTS	570.00
COVERED CHARGES	431,188.00	CONTRACTUAL ALLOW	413,888.00
NON-COVERD CHARGES	1,755.75	TOTAL MEDICAID LIAB	17,300.00
		LESS: COB	44.48
		LESS: COPAYMENT	732.00
		REIMBURSEMENT	16,523.52
		TOTAL NUMBER OF CLAIMS	346

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 11/06/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	417.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,488.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,805.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,911.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	76.00	FEE SCHEDULE LAB	27,014.00	1,072.00
EKG/ECG	1,000.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	428.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	357,494.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,145.00	607.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,486.00	0.00			
			TOTAL ANCILLARY	431,188.00	1,755.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	431,188.00	1,755.75

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 11/06/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,893.50	ADJUSTMENTS	0.00
COVERED CHARGES	4,893.50	CONTRACTUAL ALLOW	3,547.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,345.55
		LESS: COB	1,344.55
		LESS: COPAYMENT	1.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 11/06/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 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	338.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,461.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	94.50	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
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	4,893.50	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,893.50	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VII

Run Date: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 11/06/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,943.50	ADJUSTMENTS	4,959.21
COVERED CHARGES	33,577.50	CONTRACTUAL ALLOW	28,618.29
NON-COVERD CHARGES	2,366.00	TOTAL MEDICAID LIAB	4,959.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,959.21

TOTAL NUMBER OF CLAIMS 1



Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER, INC  
 2360 ROCKMART HWY  
 CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 11/06/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,210.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	375.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,264.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,569.00	102.00
EKG/ECG	250.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,396.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,080.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,482.00	10.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,100.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,894.00	154.00			
			TOTAL ANCILLARY	33,577.50	2,366.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,577.50	2,366.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

POLK MEDICAL CENTER, INC  
2360 ROCKMART HWY  
CEDARTOWN,GA 30125-6029

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	11/06/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 03:11:26  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	466,604.91	ADJUSTMENTS	42,008.17
COVERED CHARGES	454,735.60	CONTRACTUAL ALLOW	191,083.27
NON-COVERD CHARGES	11,869.31	TOTAL MEDICAID LIAB	263,652.33
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	263,652.33

TOTAL NUMBER OF ADMISSIONS 51

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	160		0	56,000.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	160		0	56,000.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	27		1	18,225.00		675.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	27		1	18,225.00		675.00
TOTAL ACCOMODATIONS	187		1	74,225.00		675.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	117,629.72	0.00	OTHER LAB	1,553.25	0.00
MED/SURG SUPPLY	44,046.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	77,930.37	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,131.66	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,715.41	10,116.66	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	640.64	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,324.82	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,673.62	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,020.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,946.76	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,488.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,075.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,345.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	2,165.98	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,213.60	1,017.65			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,550.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,059.15	0.00			
			TOTAL ANCILLARY	380,510.60	11,194.31
			TOTAL ACCOMODATIONS	74,225.00	675.00
			TOTAL CHARGES	454,735.60	11,869.31

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL  
101 LAKE OCONEE PARKWAY  
EATONTON,GA 31024-6054

PROVIDER NUMBER  
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	775,315.54	ADJUSTMENTS	18,157.62
COVERED CHARGES	709,022.06	CONTRACTUAL ALLOW	465,406.08
NON-COVERD CHARGES	66,293.48	TOTAL MEDICAID LIAB	243,615.98
		LESS: COB	2,110.81
		LESS: COPAYMENT	423.00
		REIMBURSEMENT	241,082.17
		ALL OTHER	213,607.92
		FEE SCHEDULE-LAB	25,559.43
		INJECTABLE DRUGS	1,914.82

TOTAL NUMBER OF CLAIMS 858

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

PUTNAM GENERAL HOSPITAL  
 101 LAKE OCONEE PARKWAY  
 EATONTON,GA 31024-6054

PROVIDER NUMBER  
 000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,215.50	11,389.20	OTHER LAB	16,750.46	0.00
MED/SURG SUPPLY	24,327.58	1,420.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,003.15	1,348.56	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	152,900.74	13,986.18	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	334.23	702.00	FEE SCHEDULE LAB	140,891.52	15,042.29
EKG/ECG	12,783.52	796.51	MRI SERVICES	13,592.29	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,559.39	2,011.29	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,982.11	1,462.08	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,612.32	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	239,418.06	1,641.89	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,935.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,796.97	14,188.19
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,557.59	562.94	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,491.41	1,025.14			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	650.00	650.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,220.08	66.85			
			TOTAL ANCILLARY	709,022.06	66,293.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	709,022.06	66,293.48

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,656.76	ADJUSTMENTS	0.00
COVERED CHARGES	7,830.67	CONTRACTUAL ALLOW	2,966.37
NON-COVERD CHARGES	3,826.09	TOTAL MEDICAID LIAB	4,864.30
		LESS: COB	4,861.30
		LESS: COPAYMENT	3.00
		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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10.00	64.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	295.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	209.96	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,044.42	3,308.78	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,028.23	432.31
EKG/ECG	144.82	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,601.68	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	496.00	21.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,830.67	3,826.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,830.67	3,826.09

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	119,027.26	ADJUSTMENTS	252.97
COVERED CHARGES	113,680.79	CONTRACTUAL ALLOW	104,788.63
NON-COVERD CHARGES	5,346.47	TOTAL MEDICAID LIAB	8,892.16
		LESS: COB	0.00
		LESS: COPAYMENT	366.98
		REIMBURSEMENT	8,525.18
		TOTAL NUMBER OF CLAIMS	186

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,993.50	1,783.50	OTHER LAB	348.14	0.00
MED/SURG SUPPLY	3,840.07	41.23	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,426.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,192.18	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,883.75	621.59
EKG/ECG	685.13	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	549.08	53.06	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	54,386.05	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	13,355.00	1,593.99
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	15,642.68	593.24	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	321.36	659.86			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,057.35	0.00			
			TOTAL ANCILLARY	113,680.79	5,346.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	113,680.79	5,346.47

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	469.84	ADJUSTMENTS	0.00
COVERED CHARGES	452.70	CONTRACTUAL ALLOW	308.12
NON-COVERD CHARGES	17.14	TOTAL MEDICAID LIAB	144.58
		LESS: COB	144.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	94.70	17.14
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	452.70	17.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	452.70	17.14

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL  
101 LAKE OCONEE PARKWAY  
EATONTON,GA 31024-6054

PROVIDER NUMBER  
000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,602.47	ADJUSTMENTS	0.00
COVERED CHARGES	27,525.33	CONTRACTUAL ALLOW	22,502.09
NON-COVERD CHARGES	77.14	TOTAL MEDICAID LIAB	5,023.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,023.24

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PUTNAM GENERAL HOSPITAL  
 101 LAKE OCONEE PARKWAY  
 EATONTON,GA 31024-6054

PROVIDER NUMBER  
 000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,390.00	60.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	77.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	942.66	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	459.08	17.14
EKG/ECG	72.41	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	583.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,525.33	77.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,525.33	77.14

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:26:20  
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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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,160,204.30	ADJUSTMENTS	36,358.01
COVERED CHARGES	1,128,818.80	CONTRACTUAL ALLOW	397,590.73
NON-COVERD CHARGES	31,385.50	TOTAL MEDICAID LIAB	731,228.07
		LESS: COB	63,961.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	667,266.43

TOTAL NUMBER OF ADMISSIONS 106

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	267		0	138,840.00		9,670.00
ROUTINE NURSERY	20		0	10,400.00		200.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	287		0	149,240.00		9,870.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	65		0	82,745.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	65		0	82,745.00		0.00
TOTAL ACCOMODATIONS	352		0	231,985.00		9,870.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TAYLOR REGIONAL HOSPITAL  
 222 PERRY HWY  
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	140,420.30	0.00	OTHER LAB	9,132.50	0.00
MED/SURG SUPPLY	77,156.99	171.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	166,643.00	0.00	EDUCATION & TRAINING	3.00	0.00
RADIOLOGY-DIAGNOSTIC	23,577.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	34,708.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,593.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,591.50	0.00	MRI SERVICES	6,437.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	93,728.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,756.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,002.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,140.00	0.00	AMBULANCE	0.00	5,127.50
GI SERVICES	6,461.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,113.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,505.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,042.00	0.00	INJECTABLE DRUGS	90,400.50	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	140.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	27.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	34,508.28	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,795.00
OTHER IMAGING SERVICE	4,590.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,924.00	12,222.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,264.50	1,200.00			
AUDIOLOGY	2,925.00	0.00			
CARDIOLOGY	12,021.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,022.20	0.00			
			TOTAL ANCILLARY	896,833.80	21,515.50
			TOTAL ACCOMODATIONS	231,985.00	9,870.00
			TOTAL CHARGES	1,128,818.80	31,385.50

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
Run Time: 03:26:20  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015085066224	08/15/14 - 08/23/14	03/30/15	0.00	2,795.00	0.00	0.00	0.00
TOTAL				0.00	2,795.00	0.00	0.00	0.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:26:23  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,087,092.64	ADJUSTMENTS	58,663.51
COVERED CHARGES	1,889,988.19	CONTRACTUAL ALLOW	1,472,009.26
NON-COVERD CHARGES	197,104.45	TOTAL MEDICAID LIAB	417,978.93
		LESS: COB	992.23
		LESS: COPAYMENT	3,156.00
		REIMBURSEMENT	413,830.70
		ALL OTHER	333,735.01
		FEE SCHEDULE-LAB	73,296.20
		INJECTABLE DRUGS	6,799.49
		TOTAL NUMBER OF CLAIMS	2,118

TAYLOR REGIONAL HOSPITAL  
 222 PERRY HWY  
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	56,728.70	6,183.80	OTHER LAB	37,526.00	0.00
MED/SURG SUPPLY	56,036.50	484.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	102.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105,834.00	2,035.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	168,548.00	7,405.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,551.00	1,790.00	FEE SCHEDULE LAB	443,843.15	97,705.57
EKG/ECG	17,135.50	2,651.00	MRI SERVICES	127,542.00	0.00
IV THERAPY	6,050.00	1,452.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	157,017.00	11,141.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,345.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,161.00	969.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	67,925.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	65,014.50	6,320.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	277,413.34	2,336.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,740.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55,883.00	33,677.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	193.00	280.08	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	5,025.00	686.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	729.00	0.00
LITHOTRIPSY	11,984.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	65,618.50	7,362.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,639.50	3,721.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	46,989.50	9,115.00			
AUDIOLOGY	0.00	292.50			
CARDIOLOGY	43,800.00	1,309.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,715.50	82.50			
			TOTAL ANCILLARY	1,889,988.19	197,104.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,889,988.19	197,104.45

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONAL HOSPITAL  
222 PERRY HWY  
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,683.50	ADJUSTMENTS	0.00
COVERED CHARGES	13,997.50	CONTRACTUAL ALLOW	6,382.08
NON-COVERD CHARGES	1,686.00	TOTAL MEDICAID LIAB	7,615.42
		LESS: COB	7,600.42
		LESS: COPAYMENT	15.00
		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

TAYLOR REGIONAL HOSPITAL  
 222 PERRY HWY  
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	391.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	278.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,588.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,836.00	1,232.00
EKG/ECG	132.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	40.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	212.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	145.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,944.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	688.00	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	660.50	254.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	82.50	165.00			
			TOTAL ANCILLARY	13,997.50	1,686.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,997.50	1,686.00



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	117,343.25	ADJUSTMENTS	624.50
COVERED CHARGES	114,114.75	CONTRACTUAL ALLOW	105,229.15
NON-COVERD CHARGES	3,228.50	TOTAL MEDICAID LIAB	8,885.60
		LESS: COB	0.00
		LESS: COPAYMENT	396.00
		REIMBURSEMENT	8,489.60
		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: 08/12/2016  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

TAYLOR REGIONAL HOSPITAL  
 222 PERRY HWY  
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,574.00	59.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	797.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,767.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,641.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,114.00	2,118.50
EKG/ECG	792.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,406.50	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	62,484.00	531.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,725.00	520.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	813.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	114,114.75	3,228.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	114,114.75	3,228.50

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,428.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,428.00	CONTRACTUAL ALLOW	1,913.19
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,514.81
		LESS: COB	1,511.81
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	386.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	787.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,783.50	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	60.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	406.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,428.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,428.00	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	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:53:58  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
 196 RIDGECREST CIR  
 CLAYTON,GA 30525-4111

PROVIDER NUMBER 000001559A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	297,258.08	ADJUSTMENTS	74,850.12
COVERED CHARGES	261,502.08	CONTRACTUAL ALLOW	152,604.95
NON-COVERD CHARGES	35,756.00	TOTAL MEDICAID LIAB	108,897.13
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	108,897.13

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	27		34	13,851.00		28,949.00
ROUTINE NURSERY	0		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		34	13,851.00		28,949.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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		34	13,851.00		28,949.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,412.92	0.00	OTHER LAB	1,170.00	0.00
MED/SURG SUPPLY	32,493.18	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	46,687.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,312.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,204.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	813.54	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,454.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,712.76	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,500.00	5,000.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,724.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,920.00	0.00	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	41,181.22	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,662.00
OTHER IMAGING SERVICE	2,540.00	0.00			
BLOOD	0.00	145.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,230.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,296.44	0.00			
			TOTAL ANCILLARY	247,651.08	6,807.00
			TOTAL ACCOMODATIONS	13,851.00	28,949.00
			TOTAL CHARGES	261,502.08	35,756.00



Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
392	5915321000173	10/18/15 - 10/21/15	11/23/15	0.00	1,662.00	0.00	0.00	0.00
TOTAL				0.00	1,662.00	0.00	0.00	0.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:53:58  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	779,778.62	ADJUSTMENTS	134,408.77
COVERED CHARGES	637,286.67	CONTRACTUAL ALLOW	386,997.25
NON-COVERD CHARGES	142,491.95	TOTAL MEDICAID LIAB	250,289.42
		LESS: COB	3,497.41
		LESS: COPAYMENT	617.64
		REIMBURSEMENT	246,174.37
		ALL OTHER	230,093.82
		FEE SCHEDULE-LAB	15,027.63
		INJECTABLE DRUGS	1,052.92

TOTAL NUMBER OF CLAIMS 547

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,266.40	6,645.80	OTHER LAB	3,731.00	0.00
MED/SURG SUPPLY	36,986.49	4,798.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,953.00	1,605.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	97,784.00	52,104.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	132,329.00	18,619.30
EKG/ECG	6,808.00	1,892.00	MRI SERVICES	0.00	0.00
IV THERAPY	62,882.12	5,520.56	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,000.00	24,616.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,578.00	2,433.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	110,744.00	1,974.00	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	19,769.97	8,133.99
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	4,155.00
OTHER IMAGING SERVICE	7,219.00	1,714.00			
BLOOD	0.00	870.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	3,690.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	50,235.69	3,720.50			
			TOTAL ANCILLARY	637,286.67	142,491.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	637,286.67	142,491.95

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
392	2215352005226	12/15/15 - 12/15/15	12/21/15	0.00	1,662.00	0.00	0.00	0.00
392	5915355000056	12/02/15 - 12/02/15	12/28/15	0.00	831.00	0.00	0.00	0.00
392	5916053000039	11/16/15 - 11/16/15	02/29/16	0.00	1,662.00	0.00	0.00	0.00
TOTAL				0.00	4,155.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,666.60	ADJUSTMENTS	0.00
COVERED CHARGES	3,510.56	CONTRACTUAL ALLOW	2,160.05
NON-COVERD CHARGES	1,156.04	TOTAL MEDICAID LIAB	1,350.51
		LESS: COB	1,347.56
		LESS: COPAYMENT	2.95
		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

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133.68	8.24	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	211.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	184.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,021.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,557.00	60.00
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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,284.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	66.80
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	3,510.56	1,156.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,510.56	1,156.04

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,235.81	ADJUSTMENTS	232.00
COVERED CHARGES	25,141.13	CONTRACTUAL ALLOW	22,941.13
NON-COVERD CHARGES	3,094.68	TOTAL MEDICAID LIAB	2,200.00
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	2,119.00
		TOTAL NUMBER OF CLAIMS	44



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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	668.16	316.88	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	757.32	40.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	711.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,433.00	2,433.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,871.00	238.00
EKG/ECG	146.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	893.13	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,460.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	787.88	66.80
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	413.64	0.00			
			TOTAL ANCILLARY	25,141.13	3,094.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,141.13	3,094.68

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
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  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

Run Date: 08/12/2016  
Run Time: 02:54:04  
Page: 13

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,148.02	ADJUSTMENTS	4,675.86
COVERED CHARGES	16,025.02	CONTRACTUAL ALLOW	11,349.16
NON-COVERD CHARGES	1,123.00	TOTAL MEDICAID LIAB	4,675.86
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,675.86

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
 196 RIDGECREST CIR  
 CLAYTON,GA 30525-4111

PROVIDER NUMBER  
 000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,698.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	573.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	391.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,148.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,598.00	300.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,286.62	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	376.00	203.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	620.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	933.78	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,020.50	0.00			
			TOTAL ANCILLARY	16,025.02	1,123.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,025.02	1,123.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER  
 501 REDMOND RD  
 ROME,GA 30165-1415

PROVIDER NUMBER 000001581A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,855,757.59	ADJUSTMENTS	565,969.24
COVERED CHARGES	32,314,012.59	CONTRACTUAL ALLOW	26,022,204.78
NON-COVERD CHARGES	541,745.00	TOTAL MEDICAID LIAB	6,291,807.81
		LESS: COB	37,641.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,254,166.63

TOTAL NUMBER OF ADMISSIONS 493

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,278		0	1,358,544.00		368,660.00
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	2,278		0	1,358,544.00		368,660.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	730		0	1,562,423.70		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		9	0.00		9,180.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	730		9	1,562,423.70		9,180.00
TOTAL ACCOMODATIONS	3,008		9	2,920,967.70		377,840.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	790,797.43	0.00	OTHER LAB	195,203.00	0.00
MED/SURG SUPPLY	2,507,889.25	2,926.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,828,666.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	818,789.00	0.00	OTHER THERAPEUTIC SVC	0.00	4,918.00
CT SCAN	1,618,309.00	34,697.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	454,305.36	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	320,204.00	0.00	MRI SERVICES	314,338.00	0.00
IV THERAPY	39,635.73	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,433,604.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,765,738.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	500,644.00	0.00	AMBULANCE	0.00	4,998.00
GI SERVICES	66,147.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	994,045.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	305,074.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	10,095.00
LABORATORY PATHOLOGIC	231,436.00	0.00	INJECTABLE DRUGS	3,193,085.99	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	292,184.10	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	80,848.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	125,023.00	14,995.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,765.00	160.00	TRAUMA RESPONSE	0.00	9,900.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,290,161.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	131,068.00	20,322.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	224,268.00	60,894.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	319,027.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,451,213.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,556.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	66,021.00	0.00			
			TOTAL ANCILLARY	29,393,044.89	163,905.00
			TOTAL ACCOMODATIONS	2,920,967.70	377,840.00
			TOTAL CHARGES	32,314,012.59	541,745.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:11:47  
 Page: 3

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	191,035.08	ADJUSTMENTS	0.00
COVERED CHARGES	190,826.08	CONTRACTUAL ALLOW	127,881.03
NON-COVERD CHARGES	209.00	TOTAL MEDICAID LIAB	62,945.05
		LESS: COB	62,945.05
		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	1,194.00		209.00
ROUTINE NURSERY	0		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	1,194.00		209.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	4,153.80		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	4,153.80		0.00
TOTAL ACCOMODATIONS	4		0	5,347.80		209.00



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,666.28	0.00	OTHER LAB	505.00	0.00
MED/SURG SUPPLY	19,645.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,239.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,532.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,005.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	58,195.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,965.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,980.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,480.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,685.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	31,581.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	185,478.28	0.00
			TOTAL ACCOMODATIONS	5,347.80	209.00
			TOTAL CHARGES	190,826.08	209.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:11:48  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,614,152.90	ADJUSTMENTS	77,943.93
COVERED CHARGES	15,237,800.93	CONTRACTUAL ALLOW	13,446,548.25
NON-COVERD CHARGES	2,376,351.97	TOTAL MEDICAID LIAB	1,791,252.68
		LESS: COB	357.41
		LESS: COPAYMENT	5,331.02
		REIMBURSEMENT	1,785,564.25
		ALL OTHER	1,665,624.22
		FEE SCHEDULE-LAB	99,034.72
		INJECTABLE DRUGS	20,905.31

TOTAL NUMBER OF CLAIMS 3,146

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,675.08	2,355.00	OTHER LAB	62,504.00	4,418.00
MED/SURG SUPPLY	553,200.00	170,706.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	945,711.00	4,114.00	OTHER THERAPEUTIC SVC	0.00	916.00
CT SCAN	2,386,790.00	319,702.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	135,645.00	83,445.00	FEE SCHEDULE LAB	3,400,540.65	551,779.40
EKG/ECG	315,278.00	15,297.00	MRI SERVICES	106,090.00	23,332.00
IV THERAPY	622,414.00	43,844.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	900,675.59	169,835.41	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	57,951.00	64,434.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	303,062.00	946.00	AMBULANCE	0.00	0.00
GI SERVICES	102,228.00	16,135.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,582,365.00	82,297.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	290,830.00	961.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	164,605.45	80,704.16
RADIOLOGY THERAPEUTIC	26,170.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	22,149.00	18,039.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,484.00	1,857.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	468.00	2,428.00	TRAUMA RESPONSE	0.00	39,600.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	254,930.00	22,848.00
LITHOTRIPSY	373,913.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	121,581.00	42,077.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	24,266.00	19,714.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	241,346.00	101,186.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	731,836.00	451,118.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	395,093.16	42,264.00			
			TOTAL ANCILLARY	15,237,800.93	2,376,351.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,237,800.93	2,376,351.97

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	328,162.08	ADJUSTMENTS	0.00
COVERED CHARGES	253,294.75	CONTRACTUAL ALLOW	198,681.57
NON-COVERD CHARGES	74,867.33	TOTAL MEDICAID LIAB	54,613.18
		LESS: COB	54,405.16
		LESS: COPAYMENT	208.02
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 45

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER  
 501 REDMOND RD  
 ROME,GA 30165-1415

PROVIDER NUMBER  
 000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,450.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,058.00	3,643.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,633.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,791.00	11,300.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,196.00	20,747.00	FEE SCHEDULE LAB	60,238.00	11,036.00
EKG/ECG	4,738.00	962.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,405.00	229.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,922.67	6,393.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	720.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,066.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,136.00	2,892.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,350.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	664.08	25.00
RADIOLOGY THERAPEUTIC	6,960.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,079.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	48,900.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,262.00	2,262.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,726.00	15,378.00			
			TOTAL ANCILLARY	253,294.75	74,867.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	253,294.75	74,867.33

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:12:08  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	941,299.65	ADJUSTMENTS	373.58
COVERED CHARGES	889,749.45	CONTRACTUAL ALLOW	862,282.91
NON-COVERD CHARGES	51,550.20	TOTAL MEDICAID LIAB	27,466.54
		LESS: COB	0.00
		LESS: COPAYMENT	1,260.00
		REIMBURSEMENT	26,206.54
		TOTAL NUMBER OF CLAIMS	491

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,256.40	0.00	OTHER LAB	2,868.00	0.00
MED/SURG SUPPLY	4,511.00	137.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78,602.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,796.00	11,789.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	187,395.25	35,793.00
EKG/ECG	11,845.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	42,485.00	662.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,835.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	929.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,813.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	471,432.00	151.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,289.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,182.80	756.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,510.00	2,262.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	889,749.45	51,550.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	889,749.45	51,550.20

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

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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,107.60	ADJUSTMENTS	0.00
COVERED CHARGES	10,096.80	CONTRACTUAL ALLOW	4,713.93
NON-COVERD CHARGES	10.80	TOTAL MEDICAID LIAB	5,382.87
		LESS: COB	5,373.87
		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

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 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	1,311.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,624.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	374.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,777.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10.80	10.80
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	10,096.80	10.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,096.80	10.80

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,076,167.12	ADJUSTMENTS	16,616.44
COVERED CHARGES	2,933,563.12	CONTRACTUAL ALLOW	2,791,773.62
NON-COVERD CHARGES	142,604.00	TOTAL MEDICAID LIAB	141,789.50
		LESS: COB	0.00
		LESS: COPAYMENT	108.00
		REIMBURSEMENT	141,681.50

TOTAL NUMBER OF CLAIMS 25

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,330.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	94,800.00	23,872.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,162.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	376.00	FEE SCHEDULE LAB	17,487.00	1,707.00
EKG/ECG	9,368.00	445.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,117.00	212.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	952,129.00	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	17,884.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,278.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,789.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	96,338.12	592.00
RADIOLOGY THERAPEUTIC	3,342.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,614,756.00	34,850.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	495.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	93,674.00	72,500.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,936.00	7,555.00			
			TOTAL ANCILLARY	2,933,563.12	142,604.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,933,563.12	142,604.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD AVENUE, NE  
 CONYERS,GA 30012-3877

PROVIDER NUMBER 000001603A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,633,462.27	ADJUSTMENTS	2,401,570.18
COVERED CHARGES	23,488,048.44	CONTRACTUAL ALLOW	17,680,981.08
NON-COVERD CHARGES	1,145,413.83	TOTAL MEDICAID LIAB	5,807,067.36
		LESS: COB	54,562.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,752,505.04

TOTAL NUMBER OF ADMISSIONS 924

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,471		24	1,385,062.00		615,266.00
ROUTINE NURSERY	506		4	762,878.60		70,337.40
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,977		28	2,147,940.60		685,603.40
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	346		0	551,789.00		0.00
NICU	388		0	2,315,727.75		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	734		0	2,867,516.75		0.00
TOTAL ACCOMODATIONS	3,711		28	5,015,457.35		685,603.40

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD AVENUE, NE  
 CONYERS,GA 30012-3877

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,353,432.61	1,469.95	OTHER LAB	154,696.00	0.00
MED/SURG SUPPLY	1,198,267.69	11,110.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,508,231.08	19,129.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311,471.00	0.00	OTHER THERAPEUTIC SVC	0.00	163.00
CT SCAN	1,011,755.00	2,980.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	92,855.67	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	171,223.50	0.00	MRI SERVICES	257,125.00	0.00
IV THERAPY	302,639.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,036,430.20	11,931.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,165,655.50	35,403.45	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,176,428.55	30,210.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	349,551.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	134,331.72	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	910,146.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	319,398.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	20,133.63
LABORATORY PATHOLOGIC	144,880.80	0.00	INJECTABLE DRUGS	1,477,391.20	230.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	34,770.88	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	28,900.16	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	246,751.06	14,040.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	32,231.00	360.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	584,163.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	70,584.00
OTHER IMAGING SERVICE	209,635.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	343,897.00	228,536.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	83,012.00	13,530.00			
AUDIOLOGY	30,004.00	0.00			
CARDIOLOGY	650,775.47	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	30,524.55	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	122,016.00	0.00			
			TOTAL ANCILLARY	18,472,591.09	459,810.43
			TOTAL ACCOMODATIONS	5,015,457.35	685,603.40
			TOTAL CHARGES	23,488,048.44	1,145,413.83

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD AVENUE, NE  
 CONYERS,GA 30012-3877

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5914329002862	11/12/14 - 11/13/14	12/01/14	0.00	2,402.00	0.00	0.00	0.00
615	2014335038321	11/18/14 - 11/25/14	12/08/14	0.00	2,402.00	0.00	0.00	0.00
615	2014351073509	11/19/14 - 12/12/14	12/22/14	0.00	4,752.00	0.00	0.00	0.00
615	2015012030169	12/27/14 - 01/07/15	01/19/15	0.00	4,752.00	0.00	0.00	0.00
615	2215027005173	12/12/14 - 12/15/14	02/02/15	0.00	4,752.00	0.00	0.00	0.00
615	2015037077026	01/29/15 - 02/01/15	02/16/15	0.00	4,991.00	0.00	0.00	0.00
614	2315092000337	11/06/14 - 11/18/14	04/13/15	0.00	2,829.00	0.00	1,785.15	0.00
615	2015105067836	04/09/15 - 04/10/15	04/20/15	0.00	2,523.00	0.00	0.00	0.00
615	2215189002468	05/29/15 - 06/24/15	07/13/15	0.00	4,991.00	0.00	0.00	0.00
615	2215209000160	06/23/15 - 07/08/15	08/03/15	0.00	4,991.00	0.00	0.00	0.00
615	2015266073775	04/09/15 - 04/14/15	09/28/15	0.00	2,523.00	0.00	0.00	0.00
615	2315320000207	08/29/15 - 08/31/15	12/21/15	0.00	2,523.00	0.00	1,389.55	0.00
615	5215362000253	07/04/15 - 07/09/15	02/22/16	0.00	2,523.00	0.00	0.00	0.00
615	5215362000254	07/07/15 - 07/09/15	02/22/16	0.00	4,991.00	0.00	0.00	0.00
615	5215362004958	08/01/15 - 08/03/15	02/22/16	0.00	2,523.00	0.00	0.00	0.00
615	5215362006726	08/05/15 - 08/10/15	02/22/16	0.00	2,523.00	0.00	0.00	0.00
615	5215362006727	08/07/15 - 08/11/15	02/22/16	0.00	3,556.00	0.00	0.00	0.00
615	5215362006728	08/09/15 - 08/11/15	02/22/16	0.00	2,523.00	0.00	0.00	0.00
615	5215363006732	07/09/15 - 07/10/15	02/22/16	0.00	2,523.00	0.00	0.00	0.00
615	2216200002895	04/24/15 - 06/11/15	07/25/16	0.00	4,991.00	0.00	0.00	0.00
TOTAL				0.00	70,584.00	0.00	3,174.70	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:12:30  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD AVENUE, NE  
 CONYERS,GA 30012-3877

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	147,003.97	ADJUSTMENTS	0.00
COVERED CHARGES	136,978.37	CONTRACTUAL ALLOW	79,314.67
NON-COVERD CHARGES	10,025.60	TOTAL MEDICAID LIAB	57,663.70
		LESS: COB	57,663.70
		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	31		0	16,802.00		2,637.00
ROUTINE NURSERY	0		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	16,802.00		2,637.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	31		0	16,802.00		2,637.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD AVENUE, NE  
 CONYERS,GA 30012-3877

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,312.15	0.00	OTHER LAB	1,501.00	0.00
MED/SURG SUPPLY	6,765.00	195.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,474.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,876.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,423.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	690.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,551.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,105.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,444.35	2,665.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	182.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,019.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,898.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,576.30	0.00	INJECTABLE DRUGS	16,712.57	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	445.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,786.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	363.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	830.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,390.00	4,528.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,833.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	120,176.37	7,388.60
			TOTAL ACCOMODATIONS	16,802.00	2,637.00
			TOTAL CHARGES	136,978.37	10,025.60

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:12:31  
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ROCKDALE MEDICAL CENTER  
1412 MILSTEAD AVENUE, NE  
CONYERS,GA 30012-3877

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,940,693.77	ADJUSTMENTS	488,530.37
COVERED CHARGES	15,232,710.09	CONTRACTUAL ALLOW	13,296,573.05
NON-COVERD CHARGES	1,707,983.68	TOTAL MEDICAID LIAB	1,936,137.04
		LESS: COB	12,071.68
		LESS: COPAYMENT	4,064.37
		REIMBURSEMENT	1,920,000.99
		ALL OTHER	1,718,245.48
		FEE SCHEDULE-LAB	192,666.02
		INJECTABLE DRUGS	9,089.49

TOTAL NUMBER OF CLAIMS 4,976

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD AVENUE, NE  
 CONYERS,GA 30012-3877

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	192,414.13	13,013.90	OTHER LAB	286,067.10	2,804.00
MED/SURG SUPPLY	364,075.11	101,740.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	491,620.00	11,132.00	OTHER THERAPEUTIC SVC	0.00	652.55
CT SCAN	2,175,526.00	426,104.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,531.55	10,591.00	FEE SCHEDULE LAB	3,759,228.65	463,376.69
EKG/ECG	269,515.50	10,660.50	MRI SERVICES	273,555.70	26,990.00
IV THERAPY	842,921.80	7,199.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	799,044.22	83,682.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,692.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50,470.05	22,125.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	254,255.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	217,203.33	29,073.67	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,256,489.60	3,681.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	226,134.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,156.93	34,750.02
RADIOLOGY THERAPEUTIC	3,776.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,868.90	1,423.70	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,285.00	836.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,560.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	29,688.00	4,458.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	95,042.27	29,781.00
LITHOTRIPSY	9,847.00	0.00	NO CC/INVALID REV CODE	0.00	19,901.00
OTHER IMAGING SERVICE	683,188.00	101,058.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	66,616.00	10,134.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	120,123.00	77,466.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	182,862.50	213,789.65			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,632.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	490,880.75	0.00			
			TOTAL ANCILLARY	15,232,710.09	1,707,983.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,232,710.09	1,707,983.68

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD AVENUE, NE  
 CONYERS,GA 30012-3877

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2215006009931	11/13/14 - 11/13/14	01/12/15	0.00	2,350.00	0.00	0.00	0.00
615	5915196000028	06/11/15 - 06/11/15	07/20/15	0.00	2,523.00	0.00	0.00	0.00
615	5915197000244	05/13/15 - 05/13/15	07/20/15	0.00	2,468.00	0.00	0.00	0.00
615	5915197000244	05/13/15 - 05/13/15	07/20/15	0.00	2,523.00	0.00	0.00	0.00
615	5915223001243	07/07/15 - 07/07/15	08/17/15	0.00	2,523.00	0.00	0.00	0.00
615	2015244083755	08/21/15 - 08/21/15	09/07/15	0.00	2,523.00	0.00	0.00	0.00
615	2216082008462	06/23/15 - 06/23/15	03/28/16	0.00	2,523.00	0.00	0.00	0.00
615	5016099958006	07/31/15 - 07/31/15	04/11/16	0.00	2,468.00	0.00	0.00	0.00
TOTAL				0.00	19,901.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 03:12:58  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD AVENUE, NE  
CONYERS,GA 30012-3877

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	276,314.90	ADJUSTMENTS	0.00
COVERED CHARGES	215,603.18	CONTRACTUAL ALLOW	147,359.63
NON-COVERD CHARGES	60,711.72	TOTAL MEDICAID LIAB	68,243.55
		LESS: COB	68,174.55
		LESS: COPAYMENT	69.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 99

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD AVENUE, NE  
 CONYERS,GA 30012-3877

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,980.77	347.34	OTHER LAB	3,944.00	0.00
MED/SURG SUPPLY	9,365.50	3,534.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,073.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,309.00	17,408.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	60,176.30	3,925.45
EKG/ECG	2,070.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,764.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,870.00	3,982.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	925.00	1,164.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,725.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,088.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,685.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,716.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,131.61	3,388.18
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	522.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,816.00	13,306.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,530.00	2,521.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	9,047.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	215,603.18	60,711.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	215,603.18	60,711.72

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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ROCKDALE MEDICAL CENTER  
1412 MILSTEAD AVENUE, NE  
CONYERS,GA 30012-3877

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	674,189.28	ADJUSTMENTS	2,722.00
COVERED CHARGES	632,858.57	CONTRACTUAL ALLOW	602,762.85
NON-COVERD CHARGES	41,330.71	TOTAL MEDICAID LIAB	30,095.72
		LESS: COB	0.00
		LESS: COPAYMENT	780.34
		REIMBURSEMENT	29,315.38
		TOTAL NUMBER OF CLAIMS	538

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD AVENUE, NE  
 CONYERS,GA 30012-3877

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,666.43	0.00	OTHER LAB	13,938.00	0.00
MED/SURG SUPPLY	2,001.00	172.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,600.00	204.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,682.00	7,026.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	930.00	FEE SCHEDULE LAB	171,892.45	14,465.55
EKG/ECG	9,539.25	0.00	MRI SERVICES	10,958.00	0.00
IV THERAPY	24,634.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	916.00	135.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	334,001.00	1,189.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	301.44	56.16
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	570.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	910.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	97.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,991.00
OTHER IMAGING SERVICE	18,019.00	7,752.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,833.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,710.00	0.00			
			TOTAL ANCILLARY	632,858.57	41,330.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	632,858.57	41,330.71



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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ROCKDALE MEDICAL CENTER  
1412 MILSTEAD AVENUE, NE  
CONYERS,GA 30012-3877

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015356009386	06/10/15 - 06/10/15	12/28/15	0.00	2,468.00	0.00	0.00	0.00
615	2015356009386	06/10/15 - 06/10/15	12/28/15	0.00	2,523.00	0.00	0.00	0.00
TOTAL				0.00	4,991.00	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

Run Date: 08/12/2016  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD AVENUE, NE  
CONYERS,GA 30012-3877

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,105.99	87.31	OTHER LAB	2,204.00	0.00
MED/SURG SUPPLY	110.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,071.70	2,083.00
EKG/ECG	345.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,599.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,504.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27.84	221.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	593.00	556.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,380.00	0.00			
			TOTAL ANCILLARY	28,940.53	2,948.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,940.53	2,948.14

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD AVENUE, NE  
CONYERS,GA 30012-3877

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	796,469.60	ADJUSTMENTS	61,034.73
COVERED CHARGES	583,875.38	CONTRACTUAL ALLOW	522,783.65
NON-COVERD CHARGES	212,594.22	TOTAL MEDICAID LIAB	61,091.73
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	61,034.73

TOTAL NUMBER OF CLAIMS 11

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD AVENUE, NE  
 CONYERS,GA 30012-3877

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,232.28	286.32	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	182,234.33	20,109.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,672.00	9,806.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,924.00	0.00
EKG/ECG	345.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,834.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	149,776.10	130,276.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	555.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,764.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,288.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	129.67	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	170,981.00	14,258.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	37,858.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,140.00	0.00			
			TOTAL ANCILLARY	583,875.38	212,594.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	583,875.38	212,594.22

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

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD AVENUE, NE  
CONYERS,GA 30012-3877

PROVIDER NUMBER  
000001603A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,740,973.71	ADJUSTMENTS	1,672,007.64
COVERED CHARGES	40,970,157.96	CONTRACTUAL ALLOW	35,362,656.82
NON-COVERD CHARGES	770,815.75	TOTAL MEDICAID LIAB	5,607,501.14
		LESS: COB	10,302.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,597,198.81

TOTAL NUMBER OF ADMISSIONS 718

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,434		0	3,237,955.00		517,664.25
ROUTINE NURSERY	191		0	255,405.00		42,055.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,625		0	3,493,360.00		559,719.25
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	567		0	2,119,105.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	567		0	2,119,105.00		0.00
TOTAL ACCOMODATIONS	3,192		0	5,612,465.00		559,719.25

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/14 THROUGH 09/30/15  
 CARTERSVILLE,GA 30120-2129 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,955,862.26	0.00	OTHER LAB	160,543.25	0.00
MED/SURG SUPPLY	1,450,659.75	4,478.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,122,296.01	3,341.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	789,538.95	0.00	OTHER THERAPEUTIC SVC	0.00	3,101.50
CT SCAN	2,313,554.78	46,016.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	371,074.86	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	462,863.05	0.00	MRI SERVICES	652,220.75	0.00
IV THERAPY	33,177.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,330,942.05	257.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	618,414.51	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,895,201.49	2,521.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	964,084.31	0.00	AMBULANCE	0.00	0.00
GI SERVICES	310,670.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,261,736.00	1,504.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	480,924.47	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	224,732.49	0.00	INJECTABLE DRUGS	6,153,828.93	0.00
RADIOLOGY THERAPEUTIC	203,179.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	142,305.81	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	48,661.74	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	91,033.28	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,732.50	834.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	387,456.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	237,649.73	70,782.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	183,831.75	62,838.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	565,613.00	0.00			
AUDIOLOGY	0.00	14,033.75			
CARDIOLOGY	1,874,331.25	1,387.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,184.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,388.49	0.00			
			TOTAL ANCILLARY	35,357,692.96	211,096.50
			TOTAL ACCOMODATIONS	5,612,465.00	559,719.25
			TOTAL CHARGES	40,970,157.96	770,815.75



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

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	124,660.75	ADJUSTMENTS	0.00
COVERED CHARGES	117,932.00	CONTRACTUAL ALLOW	75,792.99
NON-COVERD CHARGES	6,728.75	TOTAL MEDICAID LIAB	42,139.01
		LESS: COB	42,139.01
		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	13		2	16,845.00		6,330.00
ROUTINE NURSERY	1		0	1,275.00		270.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	14		2	18,120.00		6,600.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	14		2	18,120.00		6,600.00

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 10/01/14 THROUGH 09/30/15  
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	9,232.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,707.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,720.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,753.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	49,387.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,539.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,850.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,542.25	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	80.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	128.75			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	99,812.00	128.75
			TOTAL ACCOMODATIONS	18,120.00	6,600.00
			TOTAL CHARGES	117,932.00	6,728.75

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,034,841.31	ADJUSTMENTS	59,562.34
COVERED CHARGES	26,726,072.52	CONTRACTUAL ALLOW	24,758,563.74
NON-COVERD CHARGES	2,308,768.79	TOTAL MEDICAID LIAB	1,967,508.78
		LESS: COB	4,623.49
		LESS: COPAYMENT	4,263.20
		REIMBURSEMENT	1,958,622.09
		ALL OTHER	1,753,831.20
		FEE SCHEDULE-LAB	163,676.61
		INJECTABLE DRUGS	41,114.28

TOTAL NUMBER OF CLAIMS 4,933

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/14 THROUGH 09/30/15  
 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	617,068.00	209.50	OTHER LAB	179,318.00	0.00
MED/SURG SUPPLY	662,918.75	67,077.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	31.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,220,716.50	20,414.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,306,445.45	457,795.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	10,443.50	FEE SCHEDULE LAB	6,286,238.46	775,432.18
EKG/ECG	559,862.55	9,919.00	MRI SERVICES	360,024.25	49,172.75
IV THERAPY	651,391.29	24,535.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,958,938.98	224,491.83	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	77,409.00	707.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	117,895.00	1,585.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,266,932.94	3,967.00	AMBULANCE	0.00	0.00
GI SERVICES	442,078.83	59,633.67	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,368,932.50	92,394.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	692,855.97	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	373,020.19	72,706.69
RADIOLOGY THERAPEUTIC	511,482.75	16,273.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,937.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	6,799.75	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	6,326.25	4,190.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	93,131.00	10,363.00
LITHOTRIpsy	11,976.25	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	610,255.25	80,062.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,828.00	10,473.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	551,204.25	113,436.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	599,744.58	193,715.92			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,805.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	163,272.03	0.00			
			TOTAL ANCILLARY	26,726,072.52	2,308,768.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,726,072.52	2,308,768.79

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CARTERSVILLE MEDICAL CENTER  
960 JOE FRANK HARRIS PKWY SE  
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER  
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	449,310.00	ADJUSTMENTS	0.00
COVERED CHARGES	374,728.53	CONTRACTUAL ALLOW	282,114.57
NON-COVERD CHARGES	74,581.47	TOTAL MEDICAID LIAB	92,613.96
		LESS: COB	92,583.96
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 78

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/14 THROUGH 09/30/15  
 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	9,502.00	198.75	OTHER LAB	13,425.00	0.00
MED/SURG SUPPLY	6,750.50	250.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,718.50	458.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,481.00	24,292.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	67,674.75	8,367.75
EKG/ECG	7,085.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,039.75	2,112.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	84,024.03	20,982.22	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,720.50	870.75	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	975.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	49,606.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,210.00	1,638.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,058.00	3,675.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,833.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,236.50	1,638.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	142.75	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	16,291.00	7,926.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,913.50			
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	4,427.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,227.25	257.75			
			TOTAL ANCILLARY	374,728.53	74,581.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	374,728.53	74,581.47

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,372,054.15	ADJUSTMENTS	267.70
COVERED CHARGES	2,193,727.33	CONTRACTUAL ALLOW	2,148,195.93
NON-COVERD CHARGES	178,326.82	TOTAL MEDICAID LIAB	45,531.40
		LESS: COB	0.00
		LESS: COPAYMENT	1,878.00
		REIMBURSEMENT	43,653.40
		TOTAL NUMBER OF CLAIMS	818

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 10/01/14 THROUGH 09/30/15  
 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	38,250.00	0.00	OTHER LAB	12,333.50	0.00
MED/SURG SUPPLY	12,134.00	141.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	156,007.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	295,923.25	29,563.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	586,045.00	120,437.00
EKG/ECG	43,218.50	0.00	MRI SERVICES	5,090.25	10,180.50
IV THERAPY	53,960.75	961.50	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	4,491.50	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	933,219.25	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	19,087.83	5,274.07
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	165.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,604.50	11,604.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	361.50	0.00			
			TOTAL ANCILLARY	2,193,727.33	178,326.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,193,727.33	178,326.82



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,155.00	ADJUSTMENTS	0.00
COVERED CHARGES	42,395.00	CONTRACTUAL ALLOW	33,079.31
NON-COVERD CHARGES	4,760.00	TOTAL MEDICAID LIAB	9,315.69
		LESS: COB	9,294.69
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,379.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	100.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,678.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,678.50	4,048.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,938.25	15.50
EKG/ECG	708.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	226.50	695.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,308.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,377.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,395.00	4,760.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,395.00	4,760.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CARTERSVILLE MEDICAL CENTER  
960 JOE FRANK HARRIS PKWY SE  
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER  
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,002,398.04	ADJUSTMENTS	0.00
COVERED CHARGES	888,087.95	CONTRACTUAL ALLOW	822,220.19
NON-COVERD CHARGES	114,310.09	TOTAL MEDICAID LIAB	65,867.76
		LESS: COB	0.00
		LESS: COPAYMENT	105.00
		REIMBURSEMENT	65,762.76

TOTAL NUMBER OF CLAIMS 12

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 10/01/14 THROUGH 09/30/15  
 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	17,591.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	64,626.50	20,173.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,541.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,580.50	5,768.50
EKG/ECG	4,959.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,121.25	2,721.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	217,546.75	22,364.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,215.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	98,956.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,019.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,390.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	61,100.00	4,429.50
RADIOLOGY THERAPEUTIC	61,502.75	4,221.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	248.75	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	93.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,630.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	223,659.16	54,382.34			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,553.04	0.00			
			TOTAL ANCILLARY	888,087.95	114,310.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	888,087.95	114,310.09

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: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CARTERSVILLE MEDICAL CENTER  
960 JOE FRANK HARRIS PKWY SE  
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER  
000001625A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA  
 1001 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1605

PROVIDER NUMBER 000001636A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	149,866,910.59	ADJUSTMENTS	20,770,278.43
COVERED CHARGES	144,190,249.04	CONTRACTUAL ALLOW	94,393,562.52
NON-COVERD CHARGES	5,676,661.55	TOTAL MEDICAID LIAB	49,796,686.52
		LESS: COB	294,900.58
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	49,501,785.94

TOTAL NUMBER OF ADMISSIONS 2,653

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	10,323	24	11,003,206.00	4,955,570.00
ROUTINE NURSERY	559	5	1,280,996.50	25,210.50
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10,882	29	12,284,202.50	4,980,780.50
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	1,378	0	7,452,834.00	0.00
PED ICU	4,151	1	17,021,695.50	4,029.50
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	5,529	1	24,474,529.50	4,029.50
TOTAL ACCOMODATIONS	16,411	30	36,758,732.00	4,984,810.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,482,636.28	15,412.50	OTHER LAB	304,171.50	0.00
MED/SURG SUPPLY	6,524,803.45	34,330.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,501,489.41	77,977.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,610,062.00	0.00	OTHER THERAPEUTIC SVC	15,981.00	102,087.00
CT SCAN	1,398,339.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	612,575.00	364.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	53,487.50	0.00	MRI SERVICES	1,572,051.00	0.00
IV THERAPY	134,957.50	0.00	PROFESSIONAL FEES	0.00	11,004.00
OPERATING ROOM	10,270,257.00	26,793.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,640,448.95	59,064.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,438,087.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,040,615.50	27,331.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	847,013.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	813,875.00	521.00	INJECTABLE DRUGS	11,179.75	0.00
RADIOLOGY THERAPEUTIC	593,709.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	294,754.50	455.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	272,973.00	202.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	39,645.00	PATIENT CONVENIENCE	0.00	940.50
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	422.00	27,855.50	TRAUMA RESPONSE	0.00	20,874.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,080,303.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,284.00
OTHER IMAGING SERVICE	311,039.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	870,301.50	235,397.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	112,274.50	5,251.00			
AUDIOLOGY	62,479.00	0.00			
CARDIOLOGY	726,048.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,612,258.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	222,924.00	1,062.50			
			TOTAL ANCILLARY	107,431,517.04	691,851.55
			TOTAL ACCOMODATIONS	36,758,732.00	4,984,810.00
			TOTAL CHARGES	144,190,249.04	5,676,661.55

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA  
 1001 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1605

PROVIDER NUMBER  
 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015036018329	01/22/15 - 01/30/15	02/09/15	0.00	660.50	0.00	0.00	0.00
614	2015064022811	02/24/15 - 02/26/15	03/09/15	0.00	660.50	0.00	0.00	0.00
614	2015100039361	04/02/15 - 04/04/15	04/13/15	0.00	660.50	0.00	0.00	0.00
614	2015105028647	04/02/15 - 04/07/15	04/20/15	0.00	660.50	0.00	0.00	0.00
614	2215160007768	05/04/15 - 05/06/15	06/15/15	0.00	660.50	0.00	0.00	0.00
614	5915175000117	05/12/15 - 05/22/15	06/29/15	0.00	660.50	0.00	0.00	0.00
614	2015177038578	06/15/15 - 06/16/15	06/29/15	0.00	660.50	0.00	0.00	0.00
614	2015232078336	06/09/15 - 06/16/15	08/24/15	0.00	660.50	0.00	0.00	0.00
TOTAL				0.00	5,284.00	0.00	0.00	0.00



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA  
 1001 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1605

PROVIDER NUMBER  
 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,602,559.68	ADJUSTMENTS	0.00
COVERED CHARGES	9,286,692.18	CONTRACTUAL ALLOW	1,886,815.77
NON-COVERD CHARGES	315,867.50	TOTAL MEDICAID LIAB	7,399,876.41
		LESS: COB	7,399,876.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 187

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	599		0	617,282.00		210,091.00
ROUTINE NURSERY	41		0	98,960.50		1,448.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	640		0	716,242.50		211,539.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	195		0	1,048,905.00		0.00
PED ICU	110		0	445,593.00		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	305		0	1,494,498.00		0.00
TOTAL ACCOMODATIONS	945		0	2,210,740.50		211,539.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,838,126.50	0.00	OTHER LAB	41,549.50	0.00
MED/SURG SUPPLY	405,579.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	985,578.28	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	129,545.50	0.00	OTHER THERAPEUTIC SVC	415.00	6,464.00
CT SCAN	113,697.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	39,333.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,565.00	0.00	MRI SERVICES	60,548.00	0.00
IV THERAPY	11,680.00	0.00	PROFESSIONAL FEES	0.00	93,142.00
OPERATING ROOM	671,777.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	754,299.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	283,435.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	250,692.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,094.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	169,772.70	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	42,946.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,854.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,983.50	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	92.00	3,637.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	585,330.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,690.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	104,589.50	1,085.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,759.50	0.00			
AUDIOLOGY	4,167.50	0.00			
CARDIOLOGY	74,024.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	383,371.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,454.50	0.00			
			TOTAL ANCILLARY	7,075,951.68	104,328.50
			TOTAL ACCOMODATIONS	2,210,740.50	211,539.00
			TOTAL CHARGES	9,286,692.18	315,867.50

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	52,605,977.12	ADJUSTMENTS	2,299,781.63
COVERED CHARGES	49,478,523.76	CONTRACTUAL ALLOW	35,416,389.17
NON-COVERD CHARGES	3,127,453.36	TOTAL MEDICAID LIAB	14,062,134.59
		LESS: COB	19,882.67
		LESS: COPAYMENT	204.00
		REIMBURSEMENT	14,042,047.92
		ALL OTHER	12,497,557.58
		FEE SCHEDULE-LAB	463,035.57
		INJECTABLE DRUGS	1,081,454.77

TOTAL NUMBER OF CLAIMS 21,171

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,586,388.25	19,423.25	OTHER LAB	386,280.50	2,313.50
MED/SURG SUPPLY	2,912,106.00	536.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	2,116.00	0.00
RADIOLOGY-DIAGNOSTIC	1,542,573.00	19,549.00	OTHER THERAPEUTIC SVC	0.00	3,887.50
CT SCAN	1,770,998.00	80,302.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,536,627.00	69,753.50	FEE SCHEDULE LAB	7,312,456.73	1,020,523.84
EKG/ECG	33,816.00	570.00	MRI SERVICES	3,652,947.00	272,937.50
IV THERAPY	1,157,469.50	31,056.50	PROFESSIONAL FEES	0.00	20,155.50
OPERATING ROOM	5,285,987.98	433,103.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	282,478.00	50,612.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,248,261.50	768.00	AMBULANCE	0.00	0.00
GI SERVICES	154,635.50	52,963.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,020,959.00	37,485.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	829,313.50	586.50	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,418,174.50	603,518.75
RADIOLOGY THERAPEUTIC	495,742.50	11,490.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	615,229.00	54,984.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	553,602.50	26,775.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	693.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,144,215.50	205,611.50	TRAUMA RESPONSE	0.00	33,449.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	223,321.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	632,543.50	7,864.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,000,671.50	5,571.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	194,812.50	11,199.00			
AUDIOLOGY	292,397.50	8,519.50			
CARDIOLOGY	73,581.00	25,052.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,333,565.30	4,347.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	785,254.00	11,851.50			
			TOTAL ANCILLARY	49,478,523.76	3,127,453.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	49,478,523.76	3,127,453.36

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015065063110	01/14/15 - 01/14/15	03/09/15	0.00	0.00	0.00	0.00	0.00
932	2215098004363	03/17/15 - 03/17/15	04/13/15	0.00	0.00	0.00	0.00	0.00
932	2215111001112	03/27/15 - 03/27/15	04/27/15	0.00	0.00	0.00	0.00	0.00
932	2215134000843	03/19/15 - 03/19/15	05/18/15	0.00	0.00	0.00	0.00	0.00
932	2015141054363	05/07/15 - 05/07/15	05/25/15	0.00	0.00	0.00	0.00	0.00
932	2015149055410	05/12/15 - 05/12/15	06/08/15	0.00	0.00	0.00	0.00	0.00
932	2015162029144	05/28/15 - 05/28/15	06/15/15	0.00	0.00	0.00	0.00	0.00
932	2015167031556	01/22/15 - 01/22/15	06/22/15	0.00	0.00	0.00	0.00	0.00
932	2015167031557	01/29/15 - 01/29/15	06/22/15	0.00	0.00	0.00	0.00	0.00
932	2015167031558	02/05/15 - 02/05/15	06/22/15	0.00	0.00	0.00	0.00	0.00
932	2015167031559	02/16/15 - 02/16/15	06/22/15	0.00	0.00	0.00	0.00	0.00
932	2015167031560	02/19/15 - 02/19/15	06/22/15	0.00	0.00	0.00	0.00	0.00
932	2015167031561	02/23/15 - 02/23/15	06/22/15	0.00	0.00	0.00	0.00	0.00
932	2015167031562	04/16/15 - 04/16/15	06/22/15	0.00	0.00	0.00	0.00	0.00
932	2015176054459	06/09/15 - 06/09/15	06/29/15	0.00	0.00	0.00	0.00	0.00
932	2015184004443	06/05/15 - 06/05/15	07/06/15	0.00	0.00	0.00	0.00	0.00
932	2015184004445	06/19/15 - 06/19/15	07/06/15	0.00	0.00	0.00	0.00	0.00
932	2015191027208	06/23/15 - 06/23/15	07/13/15	0.00	0.00	0.00	0.00	0.00
932	2015233001404	05/13/15 - 05/13/15	08/24/15	0.00	0.00	0.00	0.00	0.00
932	2015233001408	06/25/15 - 06/25/15	08/24/15	0.00	0.00	0.00	0.00	0.00
932	2015233001413	07/06/15 - 07/06/15	08/24/15	0.00	0.00	0.00	0.00	0.00
932	2015247069981	07/06/15 - 07/06/15	09/14/15	0.00	0.00	0.00	27.75	0.00
932	2015247069981	07/02/15 - 07/02/15	09/14/15	0.00	0.00	0.00	27.75	0.00
932	2015247069981	07/01/15 - 07/01/15	09/14/15	0.00	0.00	0.00	27.75	0.00
932	2015247069992	07/30/15 - 07/30/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/29/15 - 07/29/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/28/15 - 07/28/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/27/15 - 07/27/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/24/15 - 07/24/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/23/15 - 07/23/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/22/15 - 07/22/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/21/15 - 07/21/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/20/15 - 07/20/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/17/15 - 07/17/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/16/15 - 07/16/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/15/15 - 07/15/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/14/15 - 07/14/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/13/15 - 07/13/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/09/15 - 07/09/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015247069992	07/08/15 - 07/08/15	09/14/15	0.00	0.00	0.00	102.76	0.00
932	2015257029137	07/15/15 - 07/15/15	09/21/15	0.00	0.00	0.00	0.00	0.00
932	2015257029973	06/17/15 - 06/17/15	09/21/15	0.00	0.00	0.00	0.00	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 01:42:51  
Page: 9

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

932	2015257029979	07/14/15 - 07/14/15	09/21/15	0.00	0.00	0.00	0.00	0.00
932	2015265038039	07/09/15 - 07/09/15	09/28/15	0.00	0.00	0.00	0.00	0.00
932	2215311001039	02/11/15 - 02/11/15	11/16/15	0.00	0.00	0.00	52.65	0.00
932	2215311001066	02/10/15 - 02/10/15	11/16/15	0.00	0.00	0.00	325.50	0.00
932	2215311001066	02/09/15 - 02/09/15	11/16/15	0.00	0.00	0.00	325.50	0.00
932	2215311001066	02/06/15 - 02/06/15	11/16/15	0.00	0.00	0.00	325.50	0.00
932	2215311001066	02/05/15 - 02/05/15	11/16/15	0.00	0.00	0.00	325.50	0.00
932	2215311001066	02/04/15 - 02/04/15	11/16/15	0.00	0.00	0.00	325.50	0.00
932	2215311001066	02/03/15 - 02/03/15	11/16/15	0.00	0.00	0.00	325.50	0.00
932	2215311001106	02/16/15 - 02/16/15	11/16/15	0.00	0.00	0.00	124.50	0.00
932	2215311001106	02/18/15 - 02/18/15	11/16/15	0.00	0.00	0.00	124.50	0.00
932	2215311001106	02/19/15 - 02/19/15	11/16/15	0.00	0.00	0.00	124.50	0.00
932	2215311001106	02/20/15 - 02/20/15	11/16/15	0.00	0.00	0.00	124.50	0.00
TOTAL				0.00	0.00	0.00	4,231.06	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

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,473,587.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,214,923.75	CONTRACTUAL ALLOW	295,203.31
NON-COVERD CHARGES	258,663.25	TOTAL MEDICAID LIAB	1,919,720.44
		LESS: COB	1,919,702.44
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 396

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,434.75	1,500.00	OTHER LAB	4,708.00	0.00
MED/SURG SUPPLY	182,606.00	235.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,591.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	98,333.50	15,165.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,461.50	1,989.00	FEE SCHEDULE LAB	207,958.50	23,000.50
EKG/ECG	855.00	0.00	MRI SERVICES	321,635.50	40,219.00
IV THERAPY	5,825.00	2,552.00	PROFESSIONAL FEES	0.00	39,646.50
OPERATING ROOM	369,334.50	49,177.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,649.00	3,900.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	292,868.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,964.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	127,492.50	521.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,496.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	130,670.00	53,698.75
RADIOLOGY THERAPEUTIC	36,411.00	750.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,707.00	1,595.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,347.00	875.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,958.50	3,303.50	TRAUMA RESPONSE	0.00	3,131.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,691.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,009.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,491.50	4,342.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	29,163.50	2,889.00			
AUDIOLOGY	6,915.00	0.00			
CARDIOLOGY	1,057.50	7,208.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	105,019.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36,234.00	0.00			
			TOTAL ANCILLARY	2,214,923.75	258,663.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,214,923.75	258,663.25



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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015252046559	07/17/15 - 07/17/15	09/14/15	0.00	0.00	0.00	12,272.75	0.00
932	2015252046559	07/15/15 - 07/15/15	09/14/15	0.00	0.00	0.00	12,272.75	0.00
932	2015252046559	07/14/15 - 07/14/15	09/14/15	0.00	0.00	0.00	12,272.75	0.00
932	2015252046559	07/13/15 - 07/13/15	09/14/15	0.00	0.00	0.00	12,272.75	0.00
932	2015252046559	07/10/15 - 07/10/15	09/14/15	0.00	0.00	0.00	12,272.75	0.00
932	2015252046559	07/09/15 - 07/09/15	09/14/15	0.00	0.00	0.00	12,272.75	0.00
932	2015252046559	07/08/15 - 07/08/15	09/14/15	0.00	0.00	0.00	12,272.75	0.00
932	2015252046559	07/07/15 - 07/07/15	09/14/15	0.00	0.00	0.00	12,272.75	0.00
932	2015252046559	07/02/15 - 07/02/15	09/14/15	0.00	0.00	0.00	12,272.75	0.00
932	2015252046559	07/16/15 - 07/16/15	09/14/15	0.00	0.00	0.00	12,272.75	0.00
932	2015257032778	06/03/15 - 06/03/15	09/21/15	0.00	0.00	0.00	572.09	0.00
TOTAL				0.00	0.00	0.00	123,299.59	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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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,147,495.75	ADJUSTMENTS	1,230.68
COVERED CHARGES	1,109,786.00	CONTRACTUAL ALLOW	1,050,153.96
NON-COVERD CHARGES	37,709.75	TOTAL MEDICAID LIAB	59,632.04
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	59,632.04
		TOTAL NUMBER OF CLAIMS	1,066

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,710.75	0.00	OTHER LAB	2,354.00	0.00
MED/SURG SUPPLY	36,125.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,105.50	494.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,938.00	6,760.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,687.00	1,258.00	FEE SCHEDULE LAB	206,592.50	16,321.25
EKG/ECG	1,425.00	0.00	MRI SERVICES	12,773.00	3,582.50
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	3,715.00
OPERATING ROOM	5,725.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,319.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,578.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	680,393.00	1,435.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,004.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,037.00	248.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	336.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	516.50	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	13,422.50	1,128.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,430.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,078.50	0.00			
			TOTAL ANCILLARY	1,109,786.00	37,709.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,109,786.00	37,709.75

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,207.00	ADJUSTMENTS	0.00
COVERED CHARGES	37,974.00	CONTRACTUAL ALLOW	6,872.37
NON-COVERD CHARGES	6,233.00	TOTAL MEDICAID LIAB	31,101.63
		LESS: COB	31,101.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	944.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	242.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	565.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,690.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,861.00	1,623.50
EKG/ECG	285.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	4,134.50
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	19,194.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	370.50	475.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,821.50	0.00			
			TOTAL ANCILLARY	37,974.00	6,233.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,974.00	6,233.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA  
1001 JOHNSON FERRY RD NE  
ATLANTA,GA 30342-1605

PROVIDER NUMBER  
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,838,590.30	ADJUSTMENTS	217,008.92
COVERED CHARGES	6,502,929.80	CONTRACTUAL ALLOW	5,725,744.75
NON-COVERD CHARGES	335,660.50	TOTAL MEDICAID LIAB	777,185.05
		LESS: COB	29,896.70
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	747,285.35

TOTAL NUMBER OF CLAIMS 84

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 01/01/15 THROUGH 12/31/15  
 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	140,644.50	157.75	OTHER LAB	2,354.00	0.00
MED/SURG SUPPLY	566,394.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,635.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,287.00	5,070.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	34,194.00	4,064.50	FEE SCHEDULE LAB	43,567.50	6,571.00
EKG/ECG	570.00	744.00	MRI SERVICES	16,357.50	0.00
IV THERAPY	1,915.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	899,726.00	114,700.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,533.50	16,140.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	476,562.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	15,871.50	3,012.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,665.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	63,397.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	170,769.25	11,776.25
RADIOLOGY THERAPEUTIC	3,383.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	37,170.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	20,634.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	297.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,085.50	309.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,840,113.00	152,890.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	954.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,671.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,637.50	370.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,430.50	2,430.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	40,745.30	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,659.50	17,127.00			
			TOTAL ANCILLARY	6,502,929.80	335,660.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,502,929.80	335,660.50

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA  
 1001 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1605

PROVIDER NUMBER  
 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2216189013149	06/30/15 - 06/30/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/29/15 - 06/29/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/26/15 - 06/26/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/25/15 - 06/25/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/24/15 - 06/24/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/23/15 - 06/23/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/22/15 - 06/22/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/19/15 - 06/19/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/18/15 - 06/18/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/17/15 - 06/17/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/16/15 - 06/16/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/15/15 - 06/15/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/12/15 - 06/12/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/11/15 - 06/11/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/10/15 - 06/10/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/09/15 - 06/09/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/08/15 - 06/08/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/05/15 - 06/05/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/04/15 - 06/04/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/03/15 - 06/03/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/02/15 - 06/02/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
932	2216189013149	06/01/15 - 06/01/15	07/11/16	0.00	0.00	0.00	29,896.70	0.00
TOTAL				0.00	0.00	0.00	657,727.40	0.00



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 01:44:59  
Page: 20

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	737,383.00	ADJUSTMENTS	0.00
COVERED CHARGES	719,248.50	CONTRACTUAL ALLOW	28,572.11
NON-COVERD CHARGES	18,134.50	TOTAL MEDICAID LIAB	690,676.39
		LESS: COB	690,673.39
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,414.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	63,585.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,386.00	586.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,177.00	568.00
EKG/ECG	186.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	109,994.50	11,108.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,021.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,012.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,721.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,622.50	676.50
RADIOLOGY THERAPEUTIC	1,340.50	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	345.00	154.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	426,031.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,969.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,346.00	2,029.50			
			TOTAL ANCILLARY	719,248.50	18,134.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	719,248.50	18,134.50

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SCREVEN COUNTY HOSPITAL, LLC  
 215 MIMS RD  
 SYLVANIA,GA 30467-1994

PROVIDER NUMBER 000001647A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	450,724.53	ADJUSTMENTS	38,179.48
COVERED CHARGES	260,429.81	CONTRACTUAL ALLOW	114,744.11
NON-COVERD CHARGES	190,294.72	TOTAL MEDICAID LIAB	145,685.70
		LESS: COB	1,175.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	144,510.10

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	83		0	64,042.00		190,294.72
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	83		0	64,042.00		190,294.72
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	83		0	64,042.00		190,294.72

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,123.95	0.00	OTHER LAB	64.50	0.00
MED/SURG SUPPLY	18,449.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,540.26	0.00	EDUCATION & TRAINING	47.72	0.00
RADIOLOGY-DIAGNOSTIC	3,629.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,732.45	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,931.65	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,311.27	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,226.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,480.53	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	260.70	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	4,573.10	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	3,015.88	0.00			
			TOTAL ANCILLARY	196,387.81	0.00
			TOTAL ACCOMODATIONS	64,042.00	190,294.72
			TOTAL CHARGES	260,429.81	190,294.72

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

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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	840,253.17	ADJUSTMENTS	37,421.31
COVERED CHARGES	776,636.48	CONTRACTUAL ALLOW	430,230.42
NON-COVERD CHARGES	63,616.69	TOTAL MEDICAID LIAB	346,406.06
		LESS: COB	80.00
		LESS: COPAYMENT	1,440.00
		REIMBURSEMENT	344,886.06
		ALL OTHER	310,602.02
		FEE SCHEDULE-LAB	34,068.14
		INJECTABLE DRUGS	215.90
		TOTAL NUMBER OF CLAIMS	1,061

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,036.61	1,524.60	OTHER LAB	5,143.15	0.00
MED/SURG SUPPLY	15,457.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	47.72	47.72
RADIOLOGY-DIAGNOSTIC	45,154.35	143.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,677.60	15,973.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,051.81	5,094.65	FEE SCHEDULE LAB	176,061.88	25,397.90
EKG/ECG	20,176.65	517.35	MRI SERVICES	0.00	0.00
IV THERAPY	39,932.80	192.96	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,207.00	9,068.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,108.40	2,231.26	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	192,430.51	319.55	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	990.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,282.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,871.05	1,095.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,007.20	1,385.40			
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	31,000.48	625.00			
			TOTAL ANCILLARY	776,636.48	63,616.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	776,636.48	63,616.69

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: 08/12/2016  
Run Time: 03:05:03  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,421.91	ADJUSTMENTS	0.00
COVERED CHARGES	883.01	CONTRACTUAL ALLOW	590.49
NON-COVERD CHARGES	3,538.90	TOTAL MEDICAID LIAB	292.52
		LESS: COB	292.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SCREVEN COUNTY HOSPITAL, LLC  
 215 MIMS RD  
 SYLVANIA,GA 30467-1994

PROVIDER NUMBER  
 000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	912.75	OTHER LAB	0.00	21.50
MED/SURG SUPPLY	0.00	309.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	143.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	621.76	24.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	640.68	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	118.25	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	0.00	982.72	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	647.50			
			TOTAL ANCILLARY	883.01	3,538.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	883.01	3,538.90

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:05:03  
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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	105,800.92	ADJUSTMENTS	97.00
COVERED CHARGES	104,857.44	CONTRACTUAL ALLOW	96,207.44
NON-COVERD CHARGES	943.48	TOTAL MEDICAID LIAB	8,650.00
		LESS: COB	0.00
		LESS: COPAYMENT	363.00
		REIMBURSEMENT	8,287.00
		TOTAL NUMBER OF CLAIMS	173

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,840.80	261.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	104.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,356.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,703.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,908.00	681.68
EKG/ECG	1,896.95	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,426.53	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,081.96	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	56,171.14	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,367.10	0.00			
			TOTAL ANCILLARY	104,857.44	943.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	104,857.44	943.48

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:05:05  
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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 03:05:05  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC  
215 MIMS RD  
SYLVANIA,GA 30467-1994

PROVIDER NUMBER  
000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,227.84	ADJUSTMENTS	4,859.89
COVERED CHARGES	60,215.84	CONTRACTUAL ALLOW	40,796.58
NON-COVERD CHARGES	12.00	TOTAL MEDICAID LIAB	19,419.26
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	19,410.26

TOTAL NUMBER OF CLAIMS 4

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC  
 215 MIMS RD  
 SYLVANIA,GA 30467-1994

PROVIDER NUMBER  
 000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,204.82	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,076.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	110.20	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	169.52	12.00
EKG/ECG	172.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,043.19	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	502.82	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,936.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	60,215.84	12.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	60,215.84	12.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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Page: 13

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC  
215 MIMS RD  
SYLVANIA,GA 30467-1994

PROVIDER NUMBER  
000001647A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:16:29  
 Page: 1

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,636,802.72	ADJUSTMENTS	2,387,527.95
COVERED CHARGES	31,755,695.52	CONTRACTUAL ALLOW	22,442,606.35
NON-COVERD CHARGES	881,107.20	TOTAL MEDICAID LIAB	9,313,089.17
		LESS: COB	56,306.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,256,782.86

TOTAL NUMBER OF ADMISSIONS 1,138

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,224		2	2,661,120.00		532,334.25
ROUTINE NURSERY	377		0	286,148.25		7,150.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,601		2	2,947,268.25		539,484.25
SPECIAL CARE SERVICES						
CCU	306		0	493,675.75		0.00
ICU	654		0	1,054,490.25		0.00
NICU	70		0	101,920.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,030		0	1,650,086.00		0.00
TOTAL ACCOMODATIONS	5,631		2	4,597,354.25		539,484.25



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,343,769.79	2,604.00	OTHER LAB	189,988.00	0.00
MED/SURG SUPPLY	3,427,032.23	46,137.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,965,763.75	2,968.25	EDUCATION & TRAINING	8,274.50	29.50
RADIOLOGY-DIAGNOSTIC	396,468.50	0.00	OTHER THERAPEUTIC SVC	0.00	95.25
CT SCAN	1,357,430.25	266.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	200,824.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	249,518.50	0.00	MRI SERVICES	371,536.25	0.00
IV THERAPY	386,881.75	1,847.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,540,017.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	230,081.25	3,968.25	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,970,152.00	141.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	332,328.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,932.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	468,329.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	287,330.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	98,858.50	0.00	INJECTABLE DRUGS	1,886,082.75	0.00
RADIOLOGY THERAPEUTIC	44,844.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	63,564.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	33,898.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	166,637.00	17,822.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	28,351.00	836.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,875,307.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,133.00
OTHER IMAGING SERVICE	134,960.25	0.00			
BLOOD	10,395.50	0.00			
BLOOD STORAGE & PRO.	263,356.75	260,580.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,588.50	262.50			
AUDIOLOGY	48,925.75	0.00			
CARDIOLOGY	970,480.25	0.00			
AMBULATORY SURGERY	160,715.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,065.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	547,650.00	1,931.50			
			TOTAL ANCILLARY	27,158,341.27	341,622.95
			TOTAL ACCOMODATIONS	4,597,354.25	539,484.25
			TOTAL CHARGES	31,755,695.52	881,107.20

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
Run Time: 03:16:29  
Page: 3

SOUTH GEORGIA MEDICAL CENTER  
2501 N PATTERSON ST  
VALDOSTA,GA 31602-1735

PROVIDER NUMBER  
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2215086009343	03/08/15 - 03/20/15	03/30/15	0.00	1,967.25	0.00	0.00	0.00
10	2215099001036	01/13/15 - 01/15/15	04/13/15	0.00	165.75	0.00	2,602.46	0.00
TOTAL				0.00	2,133.00	0.00	2,602.46	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 03:16:42  
 Page: 4

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	233,693.25	ADJUSTMENTS	0.00
COVERED CHARGES	226,062.25	CONTRACTUAL ALLOW	116,317.18
NON-COVERD CHARGES	7,631.00	TOTAL MEDICAID LIAB	109,745.07
		LESS: COB	109,745.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 13

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	43		0	27,090.00		5,339.00
ROUTINE NURSERY	10		0	12,480.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	53		0	39,570.00		5,339.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	6		0	9,672.00		0.00
NICU	7		0	10,192.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	13		0	19,864.00		0.00
TOTAL ACCOMODATIONS	66		0	59,434.00		5,339.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,575.25	0.00	OTHER LAB	3,046.00	0.00
MED/SURG SUPPLY	21,518.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,186.50	0.00	EDUCATION & TRAINING	204.75	0.00
RADIOLOGY-DIAGNOSTIC	2,252.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,651.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	163.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	170.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,376.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,937.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,172.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,488.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,063.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	872.00	0.00	INJECTABLE DRUGS	18,073.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,814.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	573.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	363.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,404.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,364.25	1,588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	796.25	704.00			
AUDIOLOGY	581.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,978.25	0.00			
			TOTAL ANCILLARY	166,628.25	2,292.00
			TOTAL ACCOMODATIONS	59,434.00	5,339.00
			TOTAL CHARGES	226,062.25	7,631.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,571,586.61	ADJUSTMENTS	667,083.83
COVERED CHARGES	18,845,961.51	CONTRACTUAL ALLOW	14,104,938.84
NON-COVERD CHARGES	1,725,625.10	TOTAL MEDICAID LIAB	4,741,022.67
		LESS: COB	10,494.06
		LESS: COPAYMENT	12,635.62
		REIMBURSEMENT	4,717,892.99
		ALL OTHER	3,626,908.90
		FEE SCHEDULE-LAB	328,754.91
		INJECTABLE DRUGS	762,229.18

TOTAL NUMBER OF CLAIMS 9,701

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,832,815.15	991.00	OTHER LAB	118,660.00	0.00
MED/SURG SUPPLY	1,187,079.45	4,465.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	26.00	EDUCATION & TRAINING	453.25	316.50
RADIOLOGY-DIAGNOSTIC	515,884.75	16,419.75	OTHER THERAPEUTIC SVC	0.00	232.00
CT SCAN	1,891,165.75	327,846.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	7,388.75	FEE SCHEDULE LAB	1,820,262.99	381,184.56
EKG/ECG	194,782.50	5,567.50	MRI SERVICES	157,050.75	43,249.25
IV THERAPY	1,127,047.50	5,974.00	PROFESSIONAL FEES	0.00	262.00
OPERATING ROOM	786,846.89	143,751.43	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	188,661.25	26,270.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	352,674.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,065.25	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,409,980.00	2,559.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	625,870.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,206,447.75	157,256.64
RADIOLOGY THERAPEUTIC	266,266.00	65,134.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	4,292.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,760.50	6,546.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,814.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	35,993.00	7,015.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	148,405.00	9,149.00
LITHOTRIPSY	69,662.50	0.00	NO CC/INVALID REV CODE	0.00	29.25
OTHER IMAGING SERVICE	478,018.75	134,500.50			
BLOOD	2,277.25	0.00			
BLOOD STORAGE & PRO.	63,269.25	64,186.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	107,787.75	26,669.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	274,021.25	194,861.25			
AMBULATORY SURGERY	197,063.28	61,357.22			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	37,920.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	747,834.75	24,245.00			
			TOTAL ANCILLARY	18,845,961.51	1,725,625.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,845,961.51	1,725,625.10

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2215134000486	03/12/15 - 03/12/15	05/18/15	0.00	29.25	0.00	83.54	0.00
TOTAL				0.00	29.25	0.00	83.54	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	417,441.03	ADJUSTMENTS	0.00
COVERED CHARGES	258,750.66	CONTRACTUAL ALLOW	3,819.26
NON-COVERD CHARGES	158,690.37	TOTAL MEDICAID LIAB	254,931.40
		LESS: COB	254,766.40
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 196



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,201.66	0.00	OTHER LAB	2,308.25	0.00
MED/SURG SUPPLY	30,330.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	230.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,813.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,015.50	34,559.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	294.75	FEE SCHEDULE LAB	37,117.25	3,405.75
EKG/ECG	2,128.75	163.75	MRI SERVICES	0.00	12,498.75
IV THERAPY	5,426.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,034.00	10,475.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	356.00	178.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,040.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,420.00	627.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,747.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,883.25	72,774.37
RADIOLOGY THERAPEUTIC	482.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	211.75	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	44.75	81.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	694.50	15,085.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,992.25	4,601.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	909.50	1,011.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	642.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,062.75	0.00			
AMBULATORY SURGERY	0.00	1,697.75			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	478.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,621.25	792.50			
			TOTAL ANCILLARY	258,750.66	158,690.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	258,750.66	158,690.37

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	226,714.67	ADJUSTMENTS	688.21
COVERED CHARGES	215,152.17	CONTRACTUAL ALLOW	200,775.61
NON-COVERD CHARGES	11,562.50	TOTAL MEDICAID LIAB	14,376.56
		LESS: COB	44.90
		LESS: COPAYMENT	612.01
		REIMBURSEMENT	13,719.65
		TOTAL NUMBER OF CLAIMS	257

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,170.67	0.00	OTHER LAB	1,266.25	0.00
MED/SURG SUPPLY	15,578.00	197.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,586.75	198.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,692.50	1,289.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	567.50	FEE SCHEDULE LAB	27,315.25	4,475.00
EKG/ECG	1,801.25	0.00	MRI SERVICES	3,106.25	0.00
IV THERAPY	12,292.25	469.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,210.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	581.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,451.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,082.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,315.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,030.50	62.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	468.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,814.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	83.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	269.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	991.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,411.25	938.00			
			TOTAL ANCILLARY	215,152.17	11,562.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	215,152.17	11,562.50



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SOUTH GEORGIA MEDICAL CENTER  
 2501 N PATTERSON ST  
 VALDOSTA,GA 31602-1735

PROVIDER NUMBER  
 000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	922.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,330.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	978.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	779.25	12,370.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,976.25	653.75
EKG/ECG	655.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	853.75	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	534.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,522.00	96.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,286.75	65.12
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	906.50	461.25			
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	366.50	0.00			
			TOTAL ANCILLARY	22,112.10	13,646.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,112.10	13,646.37

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: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GEORGIA MEDICAL CENTER  
2501 N PATTERSON ST  
VALDOSTA,GA 31602-1735

PROVIDER NUMBER  
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,140,501.67	ADJUSTMENTS	152,080.75
COVERED CHARGES	5,963,703.84	CONTRACTUAL ALLOW	5,100,497.16
NON-COVERD CHARGES	176,797.83	TOTAL MEDICAID LIAB	863,206.68
		LESS: COB	0.00
		LESS: COPAYMENT	894.00
		REIMBURSEMENT	862,312.68

TOTAL NUMBER OF CLAIMS 153

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,036,667.47	0.00	OTHER LAB	2,210.75	0.00
MED/SURG SUPPLY	110,948.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	64.75	0.00
RADIOLOGY-DIAGNOSTIC	4,736.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,023.75	19,156.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,337.25	FEE SCHEDULE LAB	28,974.25	3,308.25
EKG/ECG	7,532.50	491.25	MRI SERVICES	2,425.75	4,541.00
IV THERAPY	166,213.25	96.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	67,945.17	9,038.83	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	55,569.50	19,436.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,599.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,197.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,909.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	793,596.75	6,356.75
RADIOLOGY THERAPEUTIC	153,015.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	896.75	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	675.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,876.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	162.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	271,534.75	0.00
LITHOTRIPSY	27,865.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	531.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,037.00	3,316.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,206.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	135,183.75	103,363.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	478.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,073.50	1,908.00			
			TOTAL ANCILLARY	5,963,703.84	176,797.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,963,703.84	176,797.83

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:17:56  
Page: 17

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GEORGIA MEDICAL CENTER  
2501 N PATTERSON ST  
VALDOSTA,GA 31602-1735

PROVIDER NUMBER  
000001724A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST. FRANCIS HEALTH, LLC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,640,320.94	ADJUSTMENTS	1,923,684.13
COVERED CHARGES	23,014,135.86	CONTRACTUAL ALLOW	14,589,919.28
NON-COVERD CHARGES	1,626,185.08	TOTAL MEDICAID LIAB	8,424,216.58
		LESS: COB	59,953.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,364,263.10

TOTAL NUMBER OF ADMISSIONS 1,024

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,755		3	4,060,215.00		1,577,615.00
ROUTINE NURSERY	112		0	63,210.00		3,533.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1,120.00
TOTAL ROUTINE	6,867		3	4,123,425.00		1,582,268.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	546		0	724,775.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	546		0	724,775.00		0.00
TOTAL ACCOMODATIONS	7,413		3	4,848,200.00		1,582,268.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST. FRANCIS HEALTH, LLC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,995,004.20	0.00	OTHER LAB	61,344.00	0.00
MED/SURG SUPPLY	1,782,819.68	4,654.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,880,989.80	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	307,032.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	527,114.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	206,253.80	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	151,411.50	0.00	MRI SERVICES	313,252.50	1,159.00
IV THERAPY	69,649.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,773,633.00	11,410.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	117,256.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	794,477.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	454,013.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	161,694.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	526,545.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	95,653.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	245,405.00	0.00	INJECTABLE DRUGS	25,097.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	111,035.58	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	59,255.81	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	119,499.25	15,174.75	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	114.00	2,953.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,490,751.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	59,213.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	186,005.75	1,572.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,200.25	5,964.00			
AUDIOLOGY	17,986.00	0.00			
CARDIOLOGY	510,491.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,642.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	82,093.24	1,028.00			
			TOTAL ANCILLARY	18,165,935.86	43,917.08
			TOTAL ACCOMODATIONS	4,848,200.00	1,582,268.00
			TOTAL CHARGES	23,014,135.86	1,626,185.08

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ST. FRANCIS HEALTH, LLC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,795.92	ADJUSTMENTS	0.00
COVERED CHARGES	19,588.92	CONTRACTUAL ALLOW	6,868.48
NON-COVERD CHARGES	3,207.00	TOTAL MEDICAID LIAB	12,720.44
		LESS: COB	12,720.44
		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	11		0	6,565.00		3,070.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	11		0	6,565.00		3,070.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	11		0	6,565.00		3,070.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ST. FRANCIS HEALTH, LLC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,445.67	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	851.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,498.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,023.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	845.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	476.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	115.75	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,768.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,023.92	137.00
			TOTAL ACCOMODATIONS	6,565.00	3,070.00
			TOTAL CHARGES	19,588.92	3,207.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:20:52  
Page: 5

ST. FRANCIS HEALTH, LLC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,809,126.16	ADJUSTMENTS	189,901.42
COVERED CHARGES	7,261,921.83	CONTRACTUAL ALLOW	5,519,466.89
NON-COVERD CHARGES	547,204.33	TOTAL MEDICAID LIAB	1,742,454.94
		LESS: COB	5,034.15
		LESS: COPAYMENT	5,028.87
		REIMBURSEMENT	1,732,391.92
		ALL OTHER	1,543,452.53
		FEE SCHEDULE-LAB	186,274.49
		INJECTABLE DRUGS	2,664.90
		TOTAL NUMBER OF CLAIMS	4,486

ST. FRANCIS HEALTH, LLC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	485,380.35	555.23	OTHER LAB	26,057.50	0.00
MED/SURG SUPPLY	570,678.50	3,678.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	148.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	344,863.25	1,900.50	OTHER THERAPEUTIC SVC	0.00	114.25
CT SCAN	558,396.25	68,984.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	49,072.00	14,967.64	FEE SCHEDULE LAB	1,442,855.65	102,134.42
EKG/ECG	141,397.75	1,603.25	MRI SERVICES	126,087.00	18,740.50
IV THERAPY	108,900.75	3,177.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	856,844.59	149,012.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	55,770.75	7,707.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	223,133.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	116,412.59	6,797.16	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,360,243.50	16,719.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	77,516.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,509.25	5,859.65
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,347.00	10,473.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	638.50	5,875.84	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	667.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	30,185.00	2,031.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	65,307.00	59,985.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	117,781.25	10,561.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,304.00	2,705.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,566.50	16,491.25			
AUDIOLOGY	1,107.00	0.00			
CARDIOLOGY	278,703.00	34,105.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	91,281.00	425.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	57,582.90	1,783.15			
			TOTAL ANCILLARY	7,261,921.83	547,204.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,261,921.83	547,204.33

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: 08/12/2016  
Run Time: 03:21:24  
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST. FRANCIS HEALTH, LLC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	138,682.21	ADJUSTMENTS	0.00
COVERED CHARGES	92,252.39	CONTRACTUAL ALLOW	40,508.93
NON-COVERD CHARGES	46,429.82	TOTAL MEDICAID LIAB	51,743.46
		LESS: COB	51,702.12
		LESS: COPAYMENT	41.34
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 68

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST. FRANCIS HEALTH, LLC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,898.14	0.00	OTHER LAB	695.00	0.00
MED/SURG SUPPLY	15,272.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,548.75	122.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,674.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	400.50	FEE SCHEDULE LAB	18,945.50	1,357.25
EKG/ECG	1,457.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,903.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,610.00	24,509.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	239.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,172.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,969.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,788.25	310.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,030.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,478.00	1,741.07
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	458.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	696.50	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	377.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	165.00	3,517.00	IMPL DEV CHARGE PATIENTS	5,223.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	967.00	285.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,823.50	348.50			
AUDIOLOGY	85.00	40.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	572.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	92,252.39	46,429.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,252.39	46,429.82



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: 08/12/2016  
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ST. FRANCIS HEALTH, LLC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	469,042.38	ADJUSTMENTS	488.46
COVERED CHARGES	450,357.63	CONTRACTUAL ALLOW	421,492.59
NON-COVERD CHARGES	18,684.75	TOTAL MEDICAID LIAB	28,865.04
		LESS: COB	0.00
		LESS: COPAYMENT	1,185.00
		REIMBURSEMENT	27,680.04
		TOTAL NUMBER OF CLAIMS	516

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ST. FRANCIS HEALTH, LLC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,767.63	0.00	OTHER LAB	719.00	0.00
MED/SURG SUPPLY	13,184.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,533.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,924.25	4,713.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	110,701.25	10,782.75
EKG/ECG	8,318.75	0.00	MRI SERVICES	2,514.25	0.00
IV THERAPY	9,888.00	264.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,136.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	838.25	318.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	676.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	215,437.75	293.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	759.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	508.50	257.75
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	38.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	349.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,178.50	1,552.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,922.50	464.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	450,357.63	18,684.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	450,357.63	18,684.75

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:21:29  
 Page: 11

SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST. FRANCIS HEALTH, LLC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,054.67	ADJUSTMENTS	0.00
COVERED CHARGES	9,729.45	CONTRACTUAL ALLOW	5,183.38
NON-COVERD CHARGES	325.22	TOTAL MEDICAID LIAB	4,546.07
		LESS: COB	4,528.07
		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: 08/12/2016  
 Run Time: 03:21:29  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST. FRANCIS HEALTH, LLC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	433.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	197.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	347.50	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	3,633.25	320.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	332.25	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	4,421.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	204.50	4.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	160.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,729.45	325.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,729.45	325.22

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST. FRANCIS HEALTH, LLC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,210,153.30	ADJUSTMENTS	39,107.31
COVERED CHARGES	2,003,410.45	CONTRACTUAL ALLOW	1,750,906.29
NON-COVERD CHARGES	206,742.85	TOTAL MEDICAID LIAB	252,504.16
		LESS: COB	0.00
		LESS: COPAYMENT	229.89
		REIMBURSEMENT	252,274.27

TOTAL NUMBER OF CLAIMS 44

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST. FRANCIS HEALTH, LLC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	267,785.31	150.00	OTHER LAB	322.00	0.00
MED/SURG SUPPLY	208,237.50	2,547.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,106.50	6,580.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,053.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	212.75	FEE SCHEDULE LAB	23,061.75	1,345.75
EKG/ECG	4,226.75	1,457.50	MRI SERVICES	0.00	0.00
IV THERAPY	354.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	487,002.38	101,269.37	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	946.50	63.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,306.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,237.50	188.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,830.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,498.00	460.23
RADIOLOGY THERAPEUTIC	1,783.50	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	570.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	625,084.75	18,600.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,673.00	821.50			
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	254,885.00	71,992.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,498.76	0.00			
			TOTAL ANCILLARY	2,003,410.45	206,742.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,003,410.45	206,742.85

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST. FRANCIS HEALTH, LLC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,830,510.55	ADJUSTMENTS	122,760.43
COVERED CHARGES	9,672,136.23	CONTRACTUAL ALLOW	8,423,085.54
NON-COVERD CHARGES	158,374.32	TOTAL MEDICAID LIAB	1,249,050.69
		LESS: COB	17,509.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,231,541.26

TOTAL NUMBER OF ADMISSIONS 157

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	542		0	740,713.85		136,605.36
ROUTINE NURSERY	23		3	19,614.50		2,488.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	565		3	760,328.35		139,093.86
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	409		0	1,066,287.12		0.00
NICU	2		0	5,036.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	411		0	1,071,323.12		0.00
TOTAL ACCOMODATIONS	976		3	1,831,651.47		139,093.86



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,181,972.61	0.00	OTHER LAB	12,275.01	0.00
MED/SURG SUPPLY	1,268,401.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	485,170.05	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	113,623.48	0.00	OTHER THERAPEUTIC SVC	0.00	24.61
CT SCAN	131,811.52	2,073.74	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	135,728.65	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	19,455.04	0.00	MRI SERVICES	6,511.01	0.00
IV THERAPY	21,220.62	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	744,284.12	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	193,258.13	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	928,664.33	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	334,467.58	0.00	AMBULANCE	0.00	0.00
GI SERVICES	20,567.61	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	322,210.79	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	163,697.11	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	22,102.27	0.00	INJECTABLE DRUGS	4,604.72	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	134,201.36	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	14,790.59	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	202,895.45	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	618.69	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	143,231.76	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,227.45
OTHER IMAGING SERVICE	15,655.17	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,789.13	13,553.22			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,991.12	1,401.44			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	55,144.04	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	106,141.01	0.00			
			TOTAL ANCILLARY	7,840,484.76	19,280.46
			TOTAL ACCOMODATIONS	1,831,651.47	139,093.86
			TOTAL CHARGES	9,672,136.23	158,374.32

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
Run Time: 03:28:37  
Page: 3

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015149001922	04/06/15 - 04/09/15	06/01/15	0.00	2,227.45	0.00	0.00	0.00
TOTAL				0.00	2,227.45	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:28:39  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

TRINITY HOSPITAL OF AUGUSTA  
 2260 WRIGHTSBORO RD  
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER 000001779A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	67,384.87	ADJUSTMENTS	0.00
COVERED CHARGES	65,856.37	CONTRACTUAL ALLOW	47,655.93
NON-COVERD CHARGES	1,528.50	TOTAL MEDICAID LIAB	18,200.44
		LESS: COB	18,200.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	11,208.00		1,528.50
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	11,208.00		1,528.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	8		0	11,208.00		1,528.50

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,876.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	535.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,756.22	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	248.62	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,810.57	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,056.76	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,271.69	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,365.48	0.00	INJECTABLE DRUGS	1,727.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	54,648.37	0.00
			TOTAL ACCOMODATIONS	11,208.00	1,528.50
			TOTAL CHARGES	65,856.37	1,528.50

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,612,309.53	ADJUSTMENTS	247,199.41
COVERED CHARGES	5,148,770.33	CONTRACTUAL ALLOW	4,377,022.51
NON-COVERD CHARGES	463,539.20	TOTAL MEDICAID LIAB	771,747.82
		LESS: COB	17,394.68
		LESS: COPAYMENT	1,713.00
		REIMBURSEMENT	752,640.14
		ALL OTHER	686,198.54
		FEE SCHEDULE-LAB	53,696.04
		INJECTABLE DRUGS	12,745.56

TOTAL NUMBER OF CLAIMS 1,920

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,852.80	66,739.65	OTHER LAB	213,279.65	0.00
MED/SURG SUPPLY	107,778.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	180,368.52	23,930.24	OTHER THERAPEUTIC SVC	80,866.73	41,020.38
CT SCAN	282,362.40	49,455.77	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,576.84	FEE SCHEDULE LAB	489,714.78	50,695.72
EKG/ECG	50,801.42	1,015.36	MRI SERVICES	10,023.52	0.00
IV THERAPY	393,945.30	3,188.45	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	460,663.68	48,221.07	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	968.10	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,829.70	550.43	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	391,407.41	0.00	AMBULANCE	0.00	0.00
GI SERVICES	259,866.20	38,328.34	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,390,166.40	998.88	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	334,330.32	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	131,142.55	36,139.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	563.59	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,069.39	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,358.26	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	21,063.01	4,548.58	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,562.93	67,525.71
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	98,191.66	16,055.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,436.28	6,081.31			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,875.14	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	27,942.23	2,475.95			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	162,331.17	0.00			
			TOTAL ANCILLARY	5,148,770.33	463,539.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,148,770.33	463,539.20

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: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	109,674.01	ADJUSTMENTS	0.00
COVERED CHARGES	78,576.72	CONTRACTUAL ALLOW	53,033.86
NON-COVERD CHARGES	31,097.29	TOTAL MEDICAID LIAB	25,542.86
		LESS: COB	25,518.22
		LESS: COPAYMENT	24.64
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 35

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,616.74	1,703.42	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,136.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,856.41	301.95	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,538.22	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,482.87	776.43
EKG/ECG	1,025.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,209.06	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,318.83	6,784.50	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	13,483.34	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,129.76	13,536.38	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,279.98	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,469.49	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	682.96	1,197.79
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	1,039.09	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	603.30
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	440.86	616.21			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,444.33	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	78,576.72	31,097.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	78,576.72	31,097.29



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: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	284,101.18	ADJUSTMENTS	688.21
COVERED CHARGES	269,770.45	CONTRACTUAL ALLOW	254,321.82
NON-COVERD CHARGES	14,330.73	TOTAL MEDICAID LIAB	15,448.63
		LESS: COB	232.97
		LESS: COPAYMENT	552.00
		REIMBURSEMENT	14,663.66
		TOTAL NUMBER OF CLAIMS	272

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	542.25	2,245.06	OTHER LAB	1,055.66	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,159.56	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,276.14	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,025.12	1,623.92
EKG/ECG	1,512.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,828.63	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	199,675.79	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,198.92	9,346.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	153.41	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,338.79	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,156.99	962.24			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	269,770.45	14,330.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	269,770.45	14,330.73

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,341.75	ADJUSTMENTS	0.00
COVERED CHARGES	2,341.75	CONTRACTUAL ALLOW	861.59
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,480.16
		LESS: COB	1,477.16
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 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	369.31	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,972.44	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,341.75	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,341.75	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	104,050.92	ADJUSTMENTS	5,658.34
COVERED CHARGES	90,989.33	CONTRACTUAL ALLOW	79,660.65
NON-COVERD CHARGES	13,061.59	TOTAL MEDICAID LIAB	11,328.68
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	11,313.68

TOTAL NUMBER OF CLAIMS 2

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	164.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,661.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	218.21	24.61
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	10,175.65	10,175.65	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,124.02	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,343.88	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,969.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,433.59	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,963.97	2,758.38
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	37,935.42	0.00			
			TOTAL ANCILLARY	90,989.33	13,061.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	90,989.33	13,061.59

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:22:10  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH  
 11705 MERCY BLVD  
 SAVANNAH,GA 31419-1711

PROVIDER NUMBER 000001801A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,408,794.00	ADJUSTMENTS	577,430.73
COVERED CHARGES	29,992,802.56	CONTRACTUAL ALLOW	23,653,061.15
NON-COVERD CHARGES	415,991.44	TOTAL MEDICAID LIAB	6,339,741.41
		LESS: COB	60,514.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,279,226.67

TOTAL NUMBER OF ADMISSIONS 409

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,250		3	1,078,875.00		17,500.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,250		3	1,078,875.00		17,500.00
SPECIAL CARE SERVICES						
CCU	449		0	1,426,950.00		0.00
ICU	1,877		0	3,689,050.00		45,720.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,326		0	5,116,000.00		45,720.00
TOTAL ACCOMODATIONS	3,576		3	6,194,875.00		63,220.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH  
 11705 MERCY BLVD  
 SAVANNAH,GA 31419-1711

PROVIDER NUMBER  
 000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,417,362.00	29,182.00	OTHER LAB	81,189.00	625.00
MED/SURG SUPPLY	1,696,454.10	14,297.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,625,360.00	34,824.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,029,321.00	4,467.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	967,778.00	38,203.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	166,198.31	518.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	63,787.00	0.00	MRI SERVICES	347,847.00	0.00
IV THERAPY	195,766.00	2,071.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,493,406.00	27,319.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,203,288.00	14,892.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	482,149.00	2,504.00	AMBULANCE	0.00	0.00
GI SERVICES	74,112.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	361,126.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	228,948.00	2,591.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	63,070.00	1,520.00	INJECTABLE DRUGS	3,059,434.62	42,305.90
RADIOLOGY THERAPEUTIC	61,933.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	72,568.51	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	155,912.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	357,716.00	3,338.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	218.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,166,104.00	6,448.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	113,116.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	613,215.00	29,633.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	57,471.00	72,859.00			
AUDIOLOGY	390.00	0.00			
CARDIOLOGY	520,217.00	17,358.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	51,081.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	71,390.00	7,816.00			
			TOTAL ANCILLARY	23,797,927.56	352,771.44
			TOTAL ACCOMODATIONS	6,194,875.00	63,220.00
			TOTAL CHARGES	29,992,802.56	415,991.44

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH  
11705 MERCY BLVD  
SAVANNAH,GA 31419-1711

PROVIDER NUMBER  
000001801A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:22:16  
Page: 4

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,719,460.20	ADJUSTMENTS	88,029.08
COVERED CHARGES	6,013,907.76	CONTRACTUAL ALLOW	5,119,806.23
NON-COVERD CHARGES	705,552.44	TOTAL MEDICAID LIAB	894,101.53
		LESS: COB	3,952.87
		LESS: COPAYMENT	2,601.00
		REIMBURSEMENT	887,547.66
		ALL OTHER	816,675.81
		FEE SCHEDULE-LAB	69,075.63
		INJECTABLE DRUGS	1,796.22
		TOTAL NUMBER OF CLAIMS	2,314

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	341,163.20	2,746.00	OTHER LAB	44,749.00	0.00
MED/SURG SUPPLY	159,269.00	65,459.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	378,731.00	28,672.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	693,676.00	161,209.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,887.90	10,285.00	FEE SCHEDULE LAB	540,378.00	68,197.50
EKG/ECG	51,668.00	1,862.00	MRI SERVICES	103,922.00	6,660.00
IV THERAPY	399,193.00	29,243.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	828,510.71	82,923.29	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	362,018.00	9,502.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	216,204.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	16,212.00	772.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	999,122.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	117,611.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,123.00	4,311.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,521.15	993.65	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,287.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,345.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	218.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	177,214.00	56,005.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	83,001.00	21,145.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,173.00	297.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	37,191.00	65,595.00			
AUDIOLOGY	71,144.00	15,277.00			
CARDIOLOGY	200,130.00	62,640.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	17,853.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	75,242.80	1,908.00			
			TOTAL ANCILLARY	6,013,907.76	705,552.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,013,907.76	705,552.44

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	124,630.00	ADJUSTMENTS	0.00
COVERED CHARGES	64,297.00	CONTRACTUAL ALLOW	38,250.81
NON-COVERD CHARGES	60,333.00	TOTAL MEDICAID LIAB	26,046.19
		LESS: COB	26,022.19
		LESS: COPAYMENT	24.00
		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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,110.00	0.00	OTHER LAB	904.00	0.00
MED/SURG SUPPLY	1,769.00	1,634.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,234.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,855.00	20,753.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,180.00	208.00
EKG/ECG	399.00	0.00	MRI SERVICES	2,220.00	0.00
IV THERAPY	8,581.00	92.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,604.00	12,150.00	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	5,444.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,088.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,276.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,099.00	1,214.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,134.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,457.00	852.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	150.00			
CARDIOLOGY	0.00	22,146.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	931.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	64,297.00	60,333.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,297.00	60,333.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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Page: 8

ST JOSEPH'S HOSPITAL SAVANNAH  
11705 MERCY BLVD  
SAVANNAH,GA 31419-1711

PROVIDER NUMBER  
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	437,458.00	ADJUSTMENTS	214.76
COVERED CHARGES	418,632.00	CONTRACTUAL ALLOW	399,612.40
NON-COVERD CHARGES	18,826.00	TOTAL MEDICAID LIAB	19,019.60
		LESS: COB	0.00
		LESS: COPAYMENT	768.00
		REIMBURSEMENT	18,251.60
		TOTAL NUMBER OF CLAIMS	340

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,024.00	50.00	OTHER LAB	5,760.00	0.00
MED/SURG SUPPLY	198.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,227.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,402.00	6,770.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	44,765.00	4,871.00
EKG/ECG	3,192.00	266.00	MRI SERVICES	0.00	0.00
IV THERAPY	57,484.00	545.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,278.00	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	1,688.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	210,108.00	819.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,601.00	258.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,759.00	5,247.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	418,632.00	18,826.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	418,632.00	18,826.00



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,225.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,209.00	CONTRACTUAL ALLOW	5,216.09
NON-COVERD CHARGES	16.00	TOTAL MEDICAID LIAB	992.91
		LESS: COB	983.91
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	212.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,303.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,168.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	2,678.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	212.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,209.00	16.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,209.00	16.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST JOSEPH'S HOSPITAL SAVANNAH  
11705 MERCY BLVD  
SAVANNAH,GA 31419-1711

PROVIDER NUMBER  
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	797,839.00	ADJUSTMENTS	30,839.82
COVERED CHARGES	726,832.00	CONTRACTUAL ALLOW	665,847.83
NON-COVERD CHARGES	71,007.00	TOTAL MEDICAID LIAB	60,984.17
		LESS: COB	0.00
		LESS: COPAYMENT	47.73
		REIMBURSEMENT	60,936.44
		TOTAL NUMBER OF CLAIMS	10

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,300.00	53.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	31,093.00	3,143.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,545.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,737.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,003.00	130.00
EKG/ECG	266.00	266.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,291.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,319.00	21,300.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	30,048.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,730.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,287.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	630.00	212.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	514,311.00	14,000.00
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	68,498.00	23,258.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,774.00	8,645.00			
			TOTAL ANCILLARY	726,832.00	71,007.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	726,832.00	71,007.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:21:39  
 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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,272,824.38	ADJUSTMENTS	940,355.68
COVERED CHARGES	22,560,076.07	CONTRACTUAL ALLOW	15,482,589.54
NON-COVERD CHARGES	712,748.31	TOTAL MEDICAID LIAB	7,077,486.53
		LESS: COB	214,161.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,863,324.67

TOTAL NUMBER OF ADMISSIONS 513

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,720		4	3,287,508.00		400,692.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,720		4	3,287,508.00		400,692.00
SPECIAL CARE SERVICES						
CCU	153		0	707,625.00		0.00
ICU	724		0	2,553,685.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	877		0	3,261,310.00		0.00
TOTAL ACCOMODATIONS	3,597		4	6,548,818.00		400,692.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	916,599.21	521.29	OTHER LAB	148,367.00	993.00
MED/SURG SUPPLY	1,055,442.00	5,001.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,685,533.49	15,811.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	491,968.00	7,486.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,082,185.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	145,846.30	4,850.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	87,793.00	0.00	MRI SERVICES	328,946.00	0.00
IV THERAPY	302.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,269,273.00	8,342.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	743,574.00	1,332.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	409,148.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	153,259.00	1,502.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	628,076.00	1,052.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	131,024.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	58,072.38
LABORATORY PATHOLOGIC	165,491.00	0.00	INJECTABLE DRUGS	1,987,213.54	4,701.60
RADIOLOGY THERAPEUTIC	29,103.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	65,494.52	2,694.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	78,638.21	2,405.04	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	392,224.00	24,811.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	84.00	1,965.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	420,050.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	146,785.00
OTHER IMAGING SERVICE	85,025.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	303,424.00	604.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	112,497.00	21,394.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,046,377.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,318.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,982.00	1,734.00			
			TOTAL ANCILLARY	16,011,258.07	312,056.31
			TOTAL ACCOMODATIONS	6,548,818.00	400,692.00
			TOTAL CHARGES	22,560,076.07	712,748.31

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014282024504	09/17/14 - 09/24/14	10/13/14	0.00	6,597.00	0.00	0.00	0.00
615	2214309006701	10/01/14 - 10/07/14	11/10/14	0.00	8,910.00	0.00	0.00	0.00
614	2014337033440	10/28/14 - 11/10/14	12/08/14	0.00	2,907.00	0.00	0.00	0.00
615	2015036017306	01/20/15 - 01/22/15	02/09/15	0.00	14,805.00	0.00	0.00	0.00
614	2015042019851	01/06/15 - 01/11/15	02/16/15	0.00	13,194.00	0.00	0.00	0.00
615	2015042020267	01/24/15 - 01/26/15	02/16/15	0.00	3,015.00	0.00	0.00	0.00
615	9115043002449	09/22/14 - 09/30/14	03/09/15	0.00	6,030.00	0.00	2,994.67	0.00
615	9115090001376	10/05/14 - 10/10/14	04/06/15	0.00	6,030.00	0.00	2,125.93	0.00
615	2315105000252	01/22/15 - 01/27/15	04/27/15	0.00	6,030.00	0.00	1,869.53	0.00
614	2315135000013	11/29/14 - 12/12/14	06/08/15	0.00	9,504.00	0.00	1,853.61	0.00
614	2315139000156	03/06/15 - 03/21/15	06/01/15	0.00	6,597.00	0.00	6,880.50	0.00
615	2315166000248	01/09/15 - 01/14/15	07/13/15	0.00	6,030.00	0.00	1,703.40	0.00
614	2015184003994	04/22/15 - 05/11/15	08/03/15	0.00	2,974.00	0.00	0.00	0.00
615	2315190000361	04/13/15 - 04/15/15	08/17/15	0.00	11,790.00	0.00	0.00	0.00
615	2215195007472	03/29/15 - 04/15/15	07/20/15	0.00	6,030.00	0.00	0.00	0.00
614	2315267000336	06/23/15 - 07/01/15	10/26/15	0.00	6,597.00	0.00	861.67	0.00
615	2315285000038	12/30/14 - 01/02/15	11/02/15	0.00	5,895.00	0.00	3,308.92	0.00
615	2315285000038	12/30/14 - 01/02/15	11/02/15	0.00	5,895.00	0.00	3,308.92	0.00
615	2315289000032	05/17/15 - 05/22/15	11/09/15	0.00	8,910.00	0.00	2,042.58	0.00
615	2315338000139	04/04/15 - 04/21/15	01/11/16	0.00	3,015.00	0.00	3,142.83	0.00
615	2315342000023	07/20/15 - 07/22/15	01/11/16	0.00	6,030.00	0.00	3,010.45	0.00
TOTAL				0.00	146,785.00	0.00	33,103.01	0.00



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,238.26	ADJUSTMENTS	0.00
COVERED CHARGES	41,110.26	CONTRACTUAL ALLOW	24,170.81
NON-COVERD CHARGES	1,128.00	TOTAL MEDICAID LIAB	16,939.45
		LESS: COB	16,939.45
		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	8,519.00		931.00
ROUTINE NURSERY	0		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	8,519.00		931.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	8,519.00		931.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	206.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,448.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,367.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,126.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	138.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,885.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,528.26	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.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,024.00	197.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,834.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,591.26	197.00
			TOTAL ACCOMODATIONS	8,519.00	931.00
			TOTAL CHARGES	41,110.26	1,128.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,324,245.04	ADJUSTMENTS	107,636.51
COVERED CHARGES	3,280,518.69	CONTRACTUAL ALLOW	2,522,910.01
NON-COVERD CHARGES	2,043,726.35	TOTAL MEDICAID LIAB	757,608.68
		LESS: COB	2,143.90
		LESS: COPAYMENT	1,844.38
		REIMBURSEMENT	753,620.40
		ALL OTHER	700,146.65
		FEE SCHEDULE-LAB	44,407.97
		INJECTABLE DRUGS	9,065.78

TOTAL NUMBER OF CLAIMS 1,379

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,487.39	26,043.42	OTHER LAB	51,980.00	886.00
MED/SURG SUPPLY	82,590.00	44,999.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	56.00	EDUCATION & TRAINING	0.00	257.00
RADIOLOGY-DIAGNOSTIC	201,942.00	34,414.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	348,578.00	333,924.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	371.00	1,397.00	FEE SCHEDULE LAB	384,218.00	24,527.00
EKG/ECG	41,218.00	2,622.00	MRI SERVICES	257,215.00	191,141.00
IV THERAPY	755.00	870.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	339,636.50	262,778.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,427.00	2,966.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,298.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	22,107.00	39,069.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	711,866.00	10,569.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	63,037.00	0.00	DRUG-SPECIFIC/HOME IV	1,407.40	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	62,669.80	131,889.37
RADIOLOGY THERAPEUTIC	91,739.00	222,025.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	430.00	610.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,455.04	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	27,782.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	16,277.00	996.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,393.00	253,468.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	48,564.00
OTHER IMAGING SERVICE	178,313.00	51,404.00			
BLOOD	34.00	0.00			
BLOOD STORAGE & PRO.	2,300.00	582.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,677.00	58,527.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	205,284.00	269,905.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,268.60	0.00			
			TOTAL ANCILLARY	3,280,518.69	2,043,726.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,280,518.69	2,043,726.35

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014305026137	10/24/14 - 10/24/14	11/10/14	0.00	5,706.00	0.00	0.00	0.00
614	2014330019335	11/17/14 - 11/17/14	12/01/14	0.00	6,597.00	0.00	0.00	0.00
614	2014358032142	12/12/14 - 12/12/14	12/29/14	0.00	6,597.00	0.00	0.00	0.00
618	5215092004749	01/07/15 - 01/07/15	04/13/15	0.00	2,907.00	0.00	0.00	0.00
618	5215092004749	01/07/15 - 01/07/15	04/13/15	0.00	2,907.00	0.00	0.00	0.00
615	2015099026402	03/29/15 - 03/29/15	04/13/15	0.00	3,015.00	0.00	0.00	0.00
615	2015099026402	03/29/15 - 03/29/15	04/13/15	0.00	5,895.00	0.00	0.00	0.00
615	2015118028721	04/16/15 - 04/16/15	05/04/15	0.00	5,895.00	0.00	0.00	0.00
615	2015118028721	04/16/15 - 04/16/15	05/04/15	0.00	3,015.00	0.00	0.00	0.00
615	2015232004231	07/31/15 - 07/31/15	08/24/15	0.00	3,015.00	0.00	0.00	0.00
615	2015232004231	07/31/15 - 07/31/15	08/24/15	0.00	3,015.00	0.00	0.00	0.00
TOTAL				0.00	48,564.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	165,596.97	ADJUSTMENTS	0.00
COVERED CHARGES	60,602.15	CONTRACTUAL ALLOW	-3,586.58
NON-COVERD CHARGES	104,994.82	TOTAL MEDICAID LIAB	64,188.73
		LESS: COB	64,158.73
		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

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	493.39	1,087.81	OTHER LAB	2,323.00	0.00
MED/SURG SUPPLY	4,432.00	41.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,345.00	598.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,318.00	7,249.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,255.00	77.00
EKG/ECG	414.00	276.00	MRI SERVICES	0.00	3,489.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,844.00	14,904.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,196.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,105.00	264.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,622.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	357.76	539.01
RADIOLOGY THERAPEUTIC	8,341.00	36,894.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	262.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	23,412.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	622.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	34.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,372.00	15,542.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	888.00	0.00			
			TOTAL ANCILLARY	60,602.15	104,994.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	60,602.15	104,994.82

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	104,324.96	ADJUSTMENTS	105.88
COVERED CHARGES	83,802.72	CONTRACTUAL ALLOW	79,103.76
NON-COVERD CHARGES	20,522.24	TOTAL MEDICAID LIAB	4,698.96
		LESS: COB	0.00
		LESS: COPAYMENT	231.00
		REIMBURSEMENT	4,467.96
		TOTAL NUMBER OF CLAIMS	84



Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2.79	322.56	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	622.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,893.00	2,317.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,095.00	3,973.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,951.00	685.00
EKG/ECG	1,656.00	138.00	MRI SERVICES	0.00	2,907.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,132.00	230.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	353.93	1,424.68
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	15.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,015.00
OTHER IMAGING SERVICE	518.00	726.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	914.00	548.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	4,221.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	506.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,000.00	0.00			
			TOTAL ANCILLARY	83,802.72	20,522.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	83,802.72	20,522.24

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015097028522	03/26/15 - 03/26/15	04/13/15	0.00	3,015.00	0.00	0.00	0.00
TOTAL				0.00	3,015.00	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

Run Date: 08/12/2016  
 Run Time: 03:22:01  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8.37	664.00	OTHER LAB	1,563.00	0.00
MED/SURG SUPPLY	134.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	160.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,638.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	655.00	FEE SCHEDULE LAB	2,924.00	64.00
EKG/ECG	138.00	0.00	MRI SERVICES	0.00	6,449.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,219.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	447.12	28.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	611.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	623.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	11,790.00
OTHER IMAGING SERVICE	259.00	993.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,403.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,852.49	24,918.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,852.49	24,918.83

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:22:01  
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SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015233078555	07/08/15 - 07/08/15	08/31/15	0.00	5,895.00	0.00	787.90	0.00
615	2015233078555	07/08/15 - 07/08/15	08/31/15	0.00	5,895.00	0.00	787.90	0.00
TOTAL				0.00	11,790.00	0.00	1,575.80	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: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	508,496.08	ADJUSTMENTS	55,408.80
COVERED CHARGES	489,344.53	CONTRACTUAL ALLOW	420,031.03
NON-COVERD CHARGES	19,151.55	TOTAL MEDICAID LIAB	69,313.50
		LESS: COB	0.00
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	69,223.50
		TOTAL NUMBER OF CLAIMS	10

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,103.49	510.47	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	46,695.00	45.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	480.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,084.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,442.40	2,474.20
EKG/ECG	138.00	414.00	MRI SERVICES	13,194.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	78,809.00	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	122.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,737.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,546.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	915.64	1,378.88
RADIOLOGY THERAPEUTIC	37,798.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	166,557.00	10,237.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	124,564.00	3,970.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	489,344.53	19,151.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	489,344.53	19,151.55

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,045.94	ADJUSTMENTS	0.00
COVERED CHARGES	32,437.75	CONTRACTUAL ALLOW	15,144.19
NON-COVERD CHARGES	3,608.19	TOTAL MEDICAID LIAB	17,293.56
		LESS: COB	17,293.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
5665 PEACHTREE DUNWOODY RD NE  
ATLANTA,GA 30342-1701

PROVIDER NUMBER  
000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,001.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	123.00	0.00
EKG/ECG	0.00	138.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,621.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	689.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	674.19
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	2,796.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,437.75	3,608.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,437.75	3,608.19

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER 000001823A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,350,022.84	ADJUSTMENTS	209,717.34
COVERED CHARGES	12,266,637.84	CONTRACTUAL ALLOW	8,379,474.26
NON-COVERD CHARGES	1,083,385.00	TOTAL MEDICAID LIAB	3,887,163.58
		LESS: COB	73,443.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,813,719.91

TOTAL NUMBER OF ADMISSIONS 436

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,056		6	790,704.00		298,126.00
ROUTINE NURSERY	362		6	403,720.00		9,317.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,418		12	1,194,424.00		307,443.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	605		5	1,146,280.00		8,695.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		243	0.00		244,386.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	605		248	1,146,280.00		253,081.00
TOTAL ACCOMODATIONS	2,023		260	2,340,704.00		560,524.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,460,651.76	0.00	OTHER LAB	95,855.00	0.00
MED/SURG SUPPLY	393,711.86	10,170.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	713,175.00	36.00	EDUCATION & TRAINING	378.00	0.00
RADIOLOGY-DIAGNOSTIC	236,770.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	403,589.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	179,079.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	73,209.00	0.00	MRI SERVICES	158,113.00	0.00
IV THERAPY	185,015.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,221,878.00	3,618.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	174,220.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	458,604.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	430,521.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	41,994.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	400,478.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	313,673.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	55,229.00	0.00	INJECTABLE DRUGS	5,363.22	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	144,168.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	60,801.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	63,000.00	3,600.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	102.00	456.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,459,031.00	0.00
LITHOTRIPSY	15,167.00	0.00	NO CC/INVALID REV CODE	0.00	91,634.00
OTHER IMAGING SERVICE	90,485.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	88,847.00	5,084.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	23,993.00	4,674.00			
AUDIOLOGY	6,982.00	0.00			
CARDIOLOGY	361,780.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,660.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,925,933.84	522,861.00
			TOTAL ACCOMODATIONS	2,340,704.00	560,524.00
			TOTAL CHARGES	12,266,637.84	1,083,385.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014311078197	10/18/14 - 10/21/14	11/17/14	0.00	2,880.00	0.00	0.00	0.00
615	2014351073765	11/20/14 - 11/22/14	12/22/14	0.00	2,395.00	0.00	0.00	0.00
615	2014351073765	11/20/14 - 11/22/14	12/22/14	0.00	2,382.00	0.00	0.00	0.00
614	2014351073772	11/20/14 - 11/21/14	12/22/14	0.00	846.00	0.00	0.00	0.00
615	2014351073772	11/20/14 - 11/21/14	12/22/14	0.00	2,395.00	0.00	0.00	0.00
614	2014357089061	11/29/14 - 12/02/14	12/29/14	0.00	2,651.00	0.00	0.00	0.00
615	2014358072857	12/05/14 - 12/06/14	12/29/14	0.00	2,395.00	0.00	0.00	0.00
615	2015035091369	01/13/15 - 01/16/15	03/09/15	0.00	2,156.00	0.00	0.00	0.00
614	2015054034393	01/21/15 - 02/18/15	03/02/15	0.00	2,482.00	0.00	0.00	0.00
614	2015055063879	01/31/15 - 02/04/15	03/02/15	0.00	2,386.00	0.00	0.00	0.00
615	2215063004155	01/12/15 - 01/15/15	03/09/15	0.00	3,322.00	0.00	0.00	0.00
615	2215063004155	01/12/15 - 01/15/15	03/09/15	0.00	2,156.00	0.00	0.00	0.00
614	2015065003203	01/24/15 - 01/30/15	03/09/15	0.00	2,383.00	0.00	0.00	0.00
615	2015077086493	03/02/15 - 03/04/15	03/23/15	0.00	2,156.00	0.00	0.00	0.00
614	2015103032828	03/15/15 - 03/17/15	04/20/15	0.00	3,080.00	0.00	0.00	0.00
614	2015113074335	03/09/15 - 03/19/15	04/27/15	0.00	2,910.00	0.00	0.00	0.00
614	2015118058227	04/14/15 - 04/20/15	05/04/15	0.00	2,386.00	0.00	0.00	0.00
615	2015133076903	04/26/15 - 05/05/15	05/25/15	0.00	2,156.00	0.00	0.00	0.00
614	2015133076905	04/27/15 - 04/29/15	05/18/15	0.00	2,386.00	0.00	0.00	0.00
614	2015166053769	04/26/15 - 04/29/15	06/22/15	0.00	2,386.00	0.00	0.00	0.00
615	2015168068946	06/05/15 - 06/07/15	06/22/15	0.00	2,156.00	0.00	0.00	0.00
614	2015201032974	06/29/15 - 07/04/15	07/27/15	0.00	2,386.00	0.00	0.00	0.00
614	2015219007576	05/30/15 - 07/09/15	08/10/15	0.00	4,467.00	0.00	0.00	0.00
614	2215243000271	05/29/15 - 08/01/15	09/07/15	0.00	14,298.00	0.00	0.00	0.00
614	2215243000271	05/29/15 - 08/01/15	09/07/15	0.00	2,383.00	0.00	0.00	0.00
614	2215243000271	05/29/15 - 08/01/15	09/07/15	0.00	2,617.00	0.00	0.00	0.00
615	2015244086341	12/12/14 - 12/17/14	09/07/15	0.00	2,395.00	0.00	0.00	0.00
615	2015245078239	04/24/15 - 04/25/15	09/07/15	0.00	2,156.00	0.00	0.00	0.00
615	2015245078239	04/24/15 - 04/25/15	09/07/15	0.00	2,144.00	0.00	0.00	0.00
614	2215251000299	12/03/14 - 12/08/14	09/14/15	0.00	1,415.00	0.00	0.00	0.00
615	2015288084538	01/05/15 - 01/21/15	10/19/15	0.00	2,156.00	0.00	0.00	0.00
614	2016007008660	05/16/15 - 05/23/15	01/11/16	0.00	2,386.00	0.00	0.00	0.00
614	2016027101161	05/08/15 - 05/13/15	02/01/16	0.00	2,386.00	0.00	0.00	0.00
TOTAL				0.00	91,634.00	0.00	0.00	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	255,601.75	ADJUSTMENTS	0.00
COVERED CHARGES	249,368.75	CONTRACTUAL ALLOW	115,177.55
NON-COVERD CHARGES	6,233.00	TOTAL MEDICAID LIAB	134,191.20
		LESS: COB	134,191.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12		0	9,000.00		3,264.00
ROUTINE NURSERY	15		0	16,924.00		170.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	27		0	25,924.00		3,434.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	10		0	17,390.00		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	10		0	17,390.00		0.00
TOTAL ACCOMODATIONS	37		0	43,314.00		3,434.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,430.56	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,207.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,748.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,020.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,799.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,291.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	487.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,842.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,736.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,338.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,766.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,926.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,421.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,746.00	0.00	INJECTABLE DRUGS	3,181.19	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	564.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	68,423.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	186.00	0.00			
CARDIOLOGY	1,742.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	206,054.75	2,799.00
			TOTAL ACCOMODATIONS	43,314.00	3,434.00
			TOTAL CHARGES	249,368.75	6,233.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,961,418.01	ADJUSTMENTS	284,235.09
COVERED CHARGES	10,618,813.98	CONTRACTUAL ALLOW	8,448,781.14
NON-COVERD CHARGES	1,342,604.03	TOTAL MEDICAID LIAB	2,170,032.84
		LESS: COB	9,228.32
		LESS: COPAYMENT	5,405.98
		REIMBURSEMENT	2,155,398.54
		ALL OTHER	1,850,927.86
		FEE SCHEDULE-LAB	138,868.33
		INJECTABLE DRUGS	165,602.35

TOTAL NUMBER OF CLAIMS 4,830

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	322,106.29	1,165.04	OTHER LAB	93,950.00	4,164.00
MED/SURG SUPPLY	243,338.00	104,624.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	438.00	EDUCATION & TRAINING	803.00	0.00
RADIOLOGY-DIAGNOSTIC	668,536.00	3,715.00	OTHER THERAPEUTIC SVC	0.00	28,383.00
CT SCAN	814,007.00	145,951.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,913.00	12,686.00	FEE SCHEDULE LAB	652,546.40	125,012.80
EKG/ECG	148,874.00	4,684.00	MRI SERVICES	308,900.00	42,411.00
IV THERAPY	736,180.00	24,384.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,381,809.17	127,118.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	98,319.00	8,124.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	517,759.00	1,696.00	AMBULANCE	0.00	0.00
GI SERVICES	104,932.00	18,445.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,847,126.00	14,467.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	575,858.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	892,933.12	242,454.69
RADIOLOGY THERAPEUTIC	14,964.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,658.00	14,438.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,963.00	4,538.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	110,522.00	6,222.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	351.00	0.00	IMPL DEV CHARGE PATIENTS	11,110.00	146,200.00
LITHOTRIPSY	60,668.00	0.00	NO CC/INVALID REV CODE	0.00	11,285.00
OTHER IMAGING SERVICE	226,934.00	34,116.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,903.00	11,754.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	131,576.00	55,123.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	414,288.00	145,831.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	73,293.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	118,694.00	3,174.00			
			TOTAL ANCILLARY	10,618,813.98	1,342,604.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,618,813.98	1,342,604.03



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1114204001293	07/08/14 - 07/08/14	09/01/14	0.00	40.00	0.00	0.00	0.00
615	2015049005181	01/09/15 - 01/09/15	02/23/15	0.00	2,156.00	0.00	0.00	0.00
615	2015049052034	12/08/14 - 12/08/14	02/23/15	0.00	2,382.00	0.00	0.00	0.00
615	2015049052034	12/07/14 - 12/07/14	02/23/15	0.00	2,395.00	0.00	0.00	0.00
615	2015140011478	05/04/15 - 05/04/15	05/25/15	0.00	2,156.00	0.00	0.00	0.00
615	2016008016924	03/27/15 - 03/27/15	01/11/16	0.00	2,156.00	0.00	0.00	0.00
TOTAL				0.00	11,285.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	307,454.61	ADJUSTMENTS	0.00
COVERED CHARGES	161,203.70	CONTRACTUAL ALLOW	66,942.84
NON-COVERD CHARGES	146,250.91	TOTAL MEDICAID LIAB	94,260.86
		LESS: COB	94,175.53
		LESS: COPAYMENT	85.33
		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

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,585.53	0.00	OTHER LAB	314.00	0.00
MED/SURG SUPPLY	14,977.00	8,383.06	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	268.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,852.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	6,529.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,031.00	2,838.00
EKG/ECG	1,794.00	232.00	MRI SERVICES	0.00	3,239.00
IV THERAPY	2,959.00	1,540.32	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,535.00	35,429.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	277.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,544.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,379.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,959.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,846.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	117.00	INJECTABLE DRUGS	4,755.17	13,855.98
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	3,549.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	38,454.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,502.55
OTHER IMAGING SERVICE	1,612.00	5,306.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,322.00	1,250.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,057.00	8,215.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	24,622.00	14,713.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	833.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,780.00	0.00			
			TOTAL ANCILLARY	161,203.70	146,250.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	161,203.70	146,250.91

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
268	1114262004052	08/27/14 - 08/27/14	09/29/14	0.00	87.55	0.00	6,605.71	0.00
614	2015176044766	06/09/15 - 06/09/15	06/29/15	0.00	1,415.00	0.00	1,391.97	0.00
TOTAL				0.00	1,502.55	0.00	7,997.68	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: 08/12/2016  
Run Time: 03:23:35  
Page: 12

ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	705,998.67	ADJUSTMENTS	1,291.56
COVERED CHARGES	682,362.89	CONTRACTUAL ALLOW	641,862.35
NON-COVERD CHARGES	23,635.78	TOTAL MEDICAID LIAB	40,500.54
		LESS: COB	0.00
		LESS: COPAYMENT	1,419.00
		REIMBURSEMENT	39,081.54
		TOTAL NUMBER OF CLAIMS	724

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,950.00	0.00	OTHER LAB	3,445.00	0.00
MED/SURG SUPPLY	0.00	1,282.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	92,891.00	271.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,544.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	48,880.00	11,447.00
EKG/ECG	5,890.00	0.00	MRI SERVICES	2,591.00	0.00
IV THERAPY	52,938.00	278.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,240.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	378,098.00	2,872.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,488.89	2,207.78
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,536.00	5,278.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	871.00	0.00			
			TOTAL ANCILLARY	682,362.89	23,635.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	682,362.89	23,635.78

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

Run Date: 08/12/2016  
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Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,456.33	ADJUSTMENTS	0.00
COVERED CHARGES	11,992.55	CONTRACTUAL ALLOW	5,607.34
NON-COVERED CHARGES	8,463.78	TOTAL MEDICAID LIAB	6,385.21
		LESS: COB	6,370.21
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,432.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	949.00	457.00
EKG/ECG	232.00	0.00	MRI SERVICES	0.00	5,632.00
IV THERAPY	869.00	755.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,163.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	560.70	84.78
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	513.00	1,535.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,992.55	8,463.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,992.55	8,463.78



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	577,906.77	ADJUSTMENTS	11,279.24
COVERED CHARGES	440,306.39	CONTRACTUAL ALLOW	367,136.35
NON-COVERD CHARGES	137,600.38	TOTAL MEDICAID LIAB	73,170.04
		LESS: COB	0.00
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	73,125.04

TOTAL NUMBER OF CLAIMS 13

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,861.43	0.00	OTHER LAB	1,865.00	0.00
MED/SURG SUPPLY	14,597.00	34,992.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,781.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,960.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,651.00	503.00
EKG/ECG	1,925.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,604.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	183,756.00	1,220.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,873.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,188.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,738.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	81,918.96	9,227.38
RADIOLOGY THERAPEUTIC	2,494.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	90.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	90,736.00
LITHOTRIPSY	16,852.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,934.00	832.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	51,005.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,303.00	0.00			
			TOTAL ANCILLARY	440,306.39	137,600.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	440,306.39	137,600.38

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:23:42  
Page: 18

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:23:49  
 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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,388,074.69	ADJUSTMENTS	190,747.70
COVERED CHARGES	2,361,992.84	CONTRACTUAL ALLOW	1,321,344.34
NON-COVERD CHARGES	26,081.85	TOTAL MEDICAID LIAB	1,040,648.50
		LESS: COB	1,502.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,039,146.40

TOTAL NUMBER OF ADMISSIONS 156

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	317		0	182,545.00		18,115.00
ROUTINE NURSERY	44		0	20,700.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	361		0	203,245.00		18,115.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	227		0	238,580.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	238,580.00		0.00
TOTAL ACCOMODATIONS	588		0	441,825.00		18,115.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	353,451.54	0.00	OTHER LAB	13,081.80	0.00
MED/SURG SUPPLY	522,779.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	218,121.90	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,644.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	81,843.45	4,862.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	35,395.95	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	15,085.60	0.00	MRI SERVICES	13,568.50	0.00
IV THERAPY	16,885.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	154,594.45	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,651.55	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	99,391.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,403.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	65,269.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	30,304.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,403.05	0.00	INJECTABLE DRUGS	23,815.51	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,371.20	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,367.10	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	6,145.65	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,417.71	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,101.55	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,670.80	216.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,899.30	2,881.50			
AUDIOLOGY	1,497.10	0.00			
CARDIOLOGY	18,678.85	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	584.30	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	66,744.60	6.35			
			TOTAL ANCILLARY	1,920,167.84	7,966.85
			TOTAL ACCOMODATIONS	441,825.00	18,115.00
			TOTAL CHARGES	2,361,992.84	26,081.85

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:23:52  
 Page: 3

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,791.06	ADJUSTMENTS	0.00
COVERED CHARGES	21,581.06	CONTRACTUAL ALLOW	6,782.91
NON-COVERD CHARGES	210.00	TOTAL MEDICAID LIAB	14,798.15
		LESS: COB	14,798.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	1,695.00		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	3		0	1,695.00		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	3		0	1,695.00		210.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL  
 163 HOSPITAL DR  
 TOCCOA,GA 30577-6820

PROVIDER NUMBER  
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,652.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,873.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	488.95	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	320.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,395.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,706.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	62.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	555.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	287.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	880.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	243.25	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	419.10	0.00			
			TOTAL ANCILLARY	19,886.06	0.00
			TOTAL ACCOMODATIONS	1,695.00	210.00
			TOTAL CHARGES	21,581.06	210.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:23:52  
Page: 5

STEPHENS COUNTY HOSPITAL  
163 HOSPITAL DR  
TOCCOA,GA 30577-6820

PROVIDER NUMBER  
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,352,375.30	ADJUSTMENTS	30,262.27
COVERED CHARGES	2,161,090.35	CONTRACTUAL ALLOW	1,281,814.30
NON-COVERD CHARGES	191,284.95	TOTAL MEDICAID LIAB	879,276.05
		LESS: COB	3,532.05
		LESS: COPAYMENT	2,518.81
		REIMBURSEMENT	873,225.19
		ALL OTHER	821,616.31
		FEE SCHEDULE-LAB	46,190.10
		INJECTABLE DRUGS	5,418.78

TOTAL NUMBER OF CLAIMS 2,005



STEPHENS COUNTY HOSPITAL  
 163 HOSPITAL DR  
 TOCCOA,GA 30577-6820

PROVIDER NUMBER  
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	132,509.24	22,998.92	OTHER LAB	43,906.10	0.00
MED/SURG SUPPLY	291,738.66	225.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	116,890.65	3,986.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	209,023.85	18,714.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	27,880.95	4,338.84	FEE SCHEDULE LAB	263,625.91	24,707.25
EKG/ECG	26,617.65	3,443.35	MRI SERVICES	66,391.70	1,499.75
IV THERAPY	39,110.00	4,445.00	PROFESSIONAL FEES	0.00	170.00
OPERATING ROOM	99,033.94	28,334.89	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,187.54	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,515.65	6,850.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	45,840.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	19,603.65	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	264,305.26	7,277.45	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	40,955.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,534.00	12,356.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,857.30	3,945.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,200.60	181.40	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	682.85	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	587.40	7,218.65
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	45,346.20	3,674.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	569.85	2,215.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	53,528.20	19,023.45			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,812.05	1,499.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,752.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	281,764.85	13,496.60			
			TOTAL ANCILLARY	2,161,090.35	191,284.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,161,090.35	191,284.95

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: 08/12/2016  
Run Time: 03:24:05  
Page: 7

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,212.17	ADJUSTMENTS	0.00
COVERED CHARGES	54,711.62	CONTRACTUAL ALLOW	9,503.49
NON-COVERD CHARGES	14,500.55	TOTAL MEDICAID LIAB	45,208.13
		LESS: COB	45,199.13
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 52

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL  
 163 HOSPITAL DR  
 TOCCOA,GA 30577-6820

PROVIDER NUMBER  
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,746.09	761.70	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,527.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,135.50	322.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,606.80	9,201.05	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	261.65	FEE SCHEDULE LAB	9,821.62	944.50
EKG/ECG	425.90	212.95	MRI SERVICES	1,499.75	0.00
IV THERAPY	820.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,800.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	780.90	334.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	675.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,073.45	914.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	675.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	97.55
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	2,174.40	1,293.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	379.90	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,206.85	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,362.60	156.05			
			TOTAL ANCILLARY	54,711.62	14,500.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,711.62	14,500.55

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:24:06  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	226,763.74	ADJUSTMENTS	52.94
COVERED CHARGES	216,537.45	CONTRACTUAL ALLOW	193,098.59
NON-COVERD CHARGES	10,226.29	TOTAL MEDICAID LIAB	23,438.86
		LESS: COB	59.89
		LESS: COPAYMENT	789.00
		REIMBURSEMENT	22,589.97
		TOTAL NUMBER OF CLAIMS	419

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,759.04	1,484.94	OTHER LAB	1,948.45	0.00
MED/SURG SUPPLY	13,527.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,853.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,259.20	202.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,938.55	1,803.80
EKG/ECG	2,856.00	170.55	MRI SERVICES	0.00	0.00
IV THERAPY	2,240.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,200.00	1,200.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,222.85	142.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	900.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	111,093.35	1,087.10	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	675.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	485.00	3,093.00
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	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	772.70	1,041.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,805.85	0.00			
			TOTAL ANCILLARY	216,537.45	10,226.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	216,537.45	10,226.29

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:24:08  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,331.79	ADJUSTMENTS	0.00
COVERED CHARGES	4,198.65	CONTRACTUAL ALLOW	1,938.85
NON-COVERD CHARGES	133.14	TOTAL MEDICAID LIAB	2,259.80
		LESS: COB	2,253.80
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	220.95	6.19	OTHER LAB	215.55	0.00
MED/SURG SUPPLY	185.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	449.75	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	726.35	126.95
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	85.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	124.80	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,190.95	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,198.65	133.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,198.65	133.14

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: 08/12/2016  
Run Time: 03:24:08  
Page: 13

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	481,382.67	ADJUSTMENTS	11,028.65
COVERED CHARGES	456,155.40	CONTRACTUAL ALLOW	318,207.15
NON-COVERD CHARGES	25,227.27	TOTAL MEDICAID LIAB	137,948.25
		LESS: COB	0.00
		LESS: COPAYMENT	264.05
		REIMBURSEMENT	137,684.20
		TOTAL NUMBER OF CLAIMS	25



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,760.46	557.12	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	170,636.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,107.60	1,370.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	202.60	3,428.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	254.90	0.00	FEE SCHEDULE LAB	7,082.26	0.00
EKG/ECG	212.95	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,120.00	1,440.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	61,705.95	17,491.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	47,228.90	76.35	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,887.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,761.15	439.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,209.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	537.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	52,447.70	424.35			
			TOTAL ANCILLARY	456,155.40	25,227.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	456,155.40	25,227.27

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: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEPHENS COUNTY HOSPITAL  
163 HOSPITAL DR  
TOCCOA,GA 30577-6820

PROVIDER NUMBER  
000001834A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:24:17  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR SYLVAN GROVE HOSPITAL, INC  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER 000001856A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,956.39	ADJUSTMENTS	5,054.14
COVERED CHARGES	59,452.39	CONTRACTUAL ALLOW	45,727.37
NON-COVERD CHARGES	2,504.00	TOTAL MEDICAID LIAB	13,725.02
		LESS: COB	544.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,180.21

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	10,496.00		2,504.00
ROUTINE NURSERY	0		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	10,496.00		2,504.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	10,496.00		2,504.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR SYLVAN GROVE HOSPITAL, INC  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,786.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,625.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,430.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,270.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	780.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,950.00	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	6,000.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	115.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	48,956.39	0.00
			TOTAL ACCOMODATIONS	10,496.00	2,504.00
			TOTAL CHARGES	59,452.39	2,504.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR SYLVAN GROVE HOSPITAL, INC  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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WELLSTAR SYLVAN GROVE HOSPITAL, INC  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,340,155.41	ADJUSTMENTS	36,176.55
COVERED CHARGES	2,182,970.91	CONTRACTUAL ALLOW	1,914,234.21
NON-COVERD CHARGES	157,184.50	TOTAL MEDICAID LIAB	268,736.70
		LESS: COB	0.00
		LESS: COPAYMENT	318.00
		REIMBURSEMENT	268,418.70
		ALL OTHER	247,471.97
		FEE SCHEDULE-LAB	18,203.32
		INJECTABLE DRUGS	2,743.41

TOTAL NUMBER OF CLAIMS 1,028

WELLSTAR SYLVAN GROVE HOSPITAL, INC  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,845.45	2,520.00	OTHER LAB	4,515.00	0.00
MED/SURG SUPPLY	32,059.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	203,266.28	1,683.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	348,361.53	77,647.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,581.80	2,223.75	FEE SCHEDULE LAB	292,216.14	35,819.75
EKG/ECG	42,042.00	390.00	MRI SERVICES	0.00	0.00
IV THERAPY	107,871.50	2,448.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,527.00	5,634.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	940,489.08	4,869.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	96,658.82	19,648.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,506.50	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	7,597.81	2,740.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,939.00	55.00			
			TOTAL ANCILLARY	2,182,970.91	157,184.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,182,970.91	157,184.50

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR SYLVAN GROVE HOSPITAL, INC  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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WELLSTAR SYLVAN GROVE HOSPITAL, INC  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	395,821.95	ADJUSTMENTS	564.00
COVERED CHARGES	382,353.32	CONTRACTUAL ALLOW	367,953.32
NON-COVERD CHARGES	13,468.63	TOTAL MEDICAID LIAB	14,400.00
		LESS: COB	0.00
		LESS: COPAYMENT	591.30
		REIMBURSEMENT	13,808.70
		TOTAL NUMBER OF CLAIMS	288

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SYLVAN GROVE HOSPITAL, INC  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,291.97	255.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,214.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,506.25	540.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,514.25	6,160.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,391.25	1,960.00
EKG/ECG	3,510.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,311.50	120.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	765.00	445.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	241,845.75	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	16,036.60	1,429.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	966.00	2,559.63			
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	0.00	0.00			
			TOTAL ANCILLARY	382,353.32	13,468.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	382,353.32	13,468.63

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SYLVAN GROVE HOSPITAL, INC  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	485.00	ADJUSTMENTS	0.00
COVERED CHARGES	485.00	CONTRACTUAL ALLOW	419.43
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	65.57
		LESS: COB	62.57
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR SYLVAN GROVE HOSPITAL, INC  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 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	485.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	485.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	485.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SYLVAN GROVE HOSPITAL, INC  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR SYLVAN GROVE HOSPITAL, INC  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON  
 705 DIXIE ST  
 CARROLLTON,GA 30117-3818

PROVIDER NUMBER 000001867A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,996,722.37	ADJUSTMENTS	304,424.96
COVERED CHARGES	16,645,647.46	CONTRACTUAL ALLOW	11,484,454.80
NON-COVERD CHARGES	351,074.91	TOTAL MEDICAID LIAB	5,161,192.66
		LESS: COB	22,067.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,139,125.06

TOTAL NUMBER OF ADMISSIONS 570

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,249		0	1,145,922.00		204,133.00
ROUTINE NURSERY	202		0	131,300.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,451		0	1,277,222.00		204,133.00
SPECIAL CARE SERVICES						
CCU	699		0	1,184,685.00		0.00
ICU	216		1	540,000.00		2,500.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	915		1	1,724,685.00		2,500.00
TOTAL ACCOMODATIONS	2,366		1	3,001,907.00		206,633.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,926,568.78	47,712.69	OTHER LAB	105,493.08	0.00
MED/SURG SUPPLY	1,316,845.25	2,774.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,170,833.00	18,416.00	EDUCATION & TRAINING	4,635.00	195.00
RADIOLOGY-DIAGNOSTIC	230,097.00	1,143.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	602,813.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	151,145.35	10,435.41	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	119,686.00	0.00	MRI SERVICES	116,115.00	3,645.00
IV THERAPY	308,132.00	2,365.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,648,702.00	6,912.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	257,146.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	913,016.55	665.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	239,573.00	1,992.00	AMBULANCE	0.00	0.00
GI SERVICES	86,040.00	2,258.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	548,082.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,314.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	6,692.35
LABORATORY PATHOLOGIC	37,989.00	0.00	INJECTABLE DRUGS	321,757.55	285.85
RADIOLOGY THERAPEUTIC	142,887.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	32,665.00	780.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	27,001.00	2,155.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	108,808.00	30,912.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,725.00	1,185.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	977,575.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	42,452.00	570.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	203,932.00	1,888.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	96,686.00	0.00			
AUDIOLOGY	7,735.00	0.00			
CARDIOLOGY	748,781.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,110.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	114,399.00	1,460.00			
			TOTAL ANCILLARY	13,643,740.46	144,441.91
			TOTAL ACCOMODATIONS	3,001,907.00	206,633.00
			TOTAL CHARGES	16,645,647.46	351,074.91



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,614.54	ADJUSTMENTS	0.00
COVERED CHARGES	13,614.54	CONTRACTUAL ALLOW	5,642.56
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	7,971.98
		LESS: COB	7,971.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	0		0	0.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	0		0	0.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,500.00		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	1		0	2,500.00		0.00
TOTAL ACCOMODATIONS	1		0	2,500.00		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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,847.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	472.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,455.00	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	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	241.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	875.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,623.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,350.00	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	11,114.54	0.00
			TOTAL ACCOMODATIONS	2,500.00	0.00
			TOTAL CHARGES	13,614.54	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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TANNER MEDICAL CENTER - CARROLLTON  
705 DIXIE ST  
CARROLLTON,GA 30117-3818

PROVIDER NUMBER  
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,343,431.85	ADJUSTMENTS	475,479.84
COVERED CHARGES	17,301,810.02	CONTRACTUAL ALLOW	13,304,112.77
NON-COVERD CHARGES	1,041,621.83	TOTAL MEDICAID LIAB	3,997,697.25
		LESS: COB	3,241.96
		LESS: COPAYMENT	11,910.00
		REIMBURSEMENT	3,982,545.29
		ALL OTHER	3,639,799.38
		FEE SCHEDULE-LAB	161,586.98
		INJECTABLE DRUGS	181,158.93

TOTAL NUMBER OF CLAIMS 6,588

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	655,366.51	6,155.98	OTHER LAB	124,817.18	707.00
MED/SURG SUPPLY	382,165.51	172.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	935.00
RADIOLOGY-DIAGNOSTIC	708,970.00	13,460.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,032,798.00	107,099.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,015.00	5,030.00	FEE SCHEDULE LAB	2,008,832.10	304,010.10
EKG/ECG	211,333.00	2,410.00	MRI SERVICES	743,747.00	28,717.00
IV THERAPY	1,152,612.00	23,180.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	922,800.27	61,309.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,238.00	55.00	REHAB THERAPY	0.00	1,800.00
RESPIRATORY SERVICES	248,430.85	25,771.95	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	220,084.00	3,120.00	AMBULANCE	0.00	0.00
GI SERVICES	200,371.00	9,822.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,873,457.00	15,391.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,025.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	785,159.69	159,695.42
RADIOLOGY THERAPEUTIC	568,439.00	44,977.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,320.00	1,658.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	19,320.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	418,481.00	33,881.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	624,965.00	7,260.00	IMPL DEV CHARGE PATIENTS	73,054.91	756.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,460.00
OTHER IMAGING SERVICE	529,553.00	51,018.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,248.00	800.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	376,987.00	17,704.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	626,201.00	90,077.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	111,348.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	624,991.00	3,869.00			
			TOTAL ANCILLARY	17,301,810.02	1,041,621.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,301,810.02	1,041,621.83

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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TANNER MEDICAL CENTER - CARROLLTON  
705 DIXIE ST  
CARROLLTON,GA 30117-3818

PROVIDER NUMBER  
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015105051874	02/19/15 - 02/19/15	04/20/15	0.00	365.00	0.00	0.00	0.00
905	2015105051874	02/18/15 - 02/18/15	04/20/15	0.00	365.00	0.00	0.00	0.00
905	2015105051874	02/17/15 - 02/17/15	04/20/15	0.00	365.00	0.00	0.00	0.00
905	2015105051874	02/16/15 - 02/16/15	04/20/15	0.00	365.00	0.00	0.00	0.00
TOTAL				0.00	1,460.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER - CARROLLTON  
705 DIXIE ST  
CARROLLTON,GA 30117-3818

PROVIDER NUMBER  
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,273.51	ADJUSTMENTS	0.00
COVERED CHARGES	26,514.36	CONTRACTUAL ALLOW	9,415.49
NON-COVERD CHARGES	12,759.15	TOTAL MEDICAID LIAB	17,098.87
		LESS: COB	17,092.87
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 10

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,177.66	342.56	OTHER LAB	300.00	0.00
MED/SURG SUPPLY	560.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	240.00
RADIOLOGY-DIAGNOSTIC	2,051.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,924.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,255.00	915.00
EKG/ECG	241.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,010.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,709.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,931.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	743.59
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15.18	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,864.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	450.00	730.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,814.00	0.00			
			TOTAL ANCILLARY	26,514.36	12,759.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,514.36	12,759.15

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:26:05  
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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	984,166.38	ADJUSTMENTS	598.20
COVERED CHARGES	962,617.19	CONTRACTUAL ALLOW	925,193.35
NON-COVERD CHARGES	21,549.19	TOTAL MEDICAID LIAB	37,423.84
		LESS: COB	0.00
		LESS: COPAYMENT	1,464.00
		REIMBURSEMENT	35,959.84
		TOTAL NUMBER OF CLAIMS	669



Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:26:05  
 Page: 11

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,248.24	0.00	OTHER LAB	4,242.00	0.00
MED/SURG SUPPLY	4,711.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,305.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	68,700.00	5,469.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	137,960.00	10,521.00
EKG/ECG	11,809.00	0.00	MRI SERVICES	3,873.00	0.00
IV THERAPY	66,255.00	1,375.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	165.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,581.00	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	426,454.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,727.58	1,238.19
RADIOLOGY THERAPEUTIC	132,615.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	299.00	70.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,653.00	2,626.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,481.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	538.00	0.00			
			TOTAL ANCILLARY	962,617.19	21,549.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	962,617.19	21,549.19

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:26:09  
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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 03:26:09  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,124,292.38	ADJUSTMENTS	182,634.65
COVERED CHARGES	3,931,993.39	CONTRACTUAL ALLOW	3,365,560.61
NON-COVERD CHARGES	192,298.99	TOTAL MEDICAID LIAB	566,432.78
		LESS: COB	0.00
		LESS: COPAYMENT	1,590.00
		REIMBURSEMENT	564,842.78
		TOTAL NUMBER OF CLAIMS	96

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,457.41	1,163.70	OTHER LAB	8,640.00	2,136.18
MED/SURG SUPPLY	327,093.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	325.00
RADIOLOGY-DIAGNOSTIC	39,251.00	9,572.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	40,099.00	2,393.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,420.00	FEE SCHEDULE LAB	99,455.90	18,196.10
EKG/ECG	14,460.00	1,687.00	MRI SERVICES	10,982.00	0.00
IV THERAPY	181,587.00	7,610.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	574,028.26	20,504.74	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	81,111.95	560.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,196.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,650.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,237.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	294,108.40	27,561.27
RADIOLOGY THERAPEUTIC	1,141,462.00	16,657.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	850.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	664.00	1,202.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,311.00	1,050.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	507,384.92	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,567.00	10,968.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,664.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,836.00	4,785.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	268,318.00	62,548.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	86,429.00	110.00			
			TOTAL ANCILLARY	3,931,993.39	192,298.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,931,993.39	192,298.99

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:26:12  
Page: 15

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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:03:56  
 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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,338,026.13	ADJUSTMENTS	343,124.01
COVERED CHARGES	6,139,001.85	CONTRACTUAL ALLOW	5,690,972.16
NON-COVERD CHARGES	199,024.28	TOTAL MEDICAID LIAB	448,029.69
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	448,029.69

TOTAL NUMBER OF ADMISSIONS 39

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	89		0	66,661.00		199,024.28
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	89		0	66,661.00		199,024.28
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	89		0	66,661.00		199,024.28

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:03:56  
 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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	115,697.84	0.00	OTHER LAB	2,701.24	0.00
MED/SURG SUPPLY	25,708.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	36,978.46	0.00	EDUCATION & TRAINING	524.92	0.00
RADIOLOGY-DIAGNOSTIC	4,869.12	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,848.18	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,860.65	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,379.60	0.00	MRI SERVICES	2,243.57	0.00
IV THERAPY	3,661.48	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,721,119.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,246.57	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	5,403.16	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	741.32	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,165.18	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,104,630.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,848.70	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,712.08	0.00			
			TOTAL ANCILLARY	6,072,340.85	0.00
			TOTAL ACCOMODATIONS	66,661.00	199,024.28
			TOTAL CHARGES	6,139,001.85	199,024.28

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:03:57  
 Page: 3

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	227,974.78	ADJUSTMENTS	0.00
COVERED CHARGES	225,723.78	CONTRACTUAL ALLOW	122,606.20
NON-COVERD CHARGES	2,251.00	TOTAL MEDICAID LIAB	103,117.58
		LESS: COB	103,117.58
		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	1		0	749.00		2,251.00
ROUTINE NURSERY	0		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	749.00		2,251.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	749.00		2,251.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL  
 247 S MAIN ST  
 REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
 000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,977.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,512.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	202.56	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	177.96	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	647.46	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	104,659.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	500.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	266.75	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	113,000.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	224,974.78	0.00
			TOTAL ACCOMODATIONS	749.00	2,251.00
			TOTAL CHARGES	225,723.78	2,251.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:03:58  
Page: 5

DOCTORS HOSPITAL OF TATTNALL  
247 S MAIN ST  
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,415,681.72	ADJUSTMENTS	100,124.22
COVERED CHARGES	5,153,523.19	CONTRACTUAL ALLOW	4,552,171.55
NON-COVERD CHARGES	262,158.53	TOTAL MEDICAID LIAB	601,351.64
		LESS: COB	106.02
		LESS: COPAYMENT	2,451.00
		REIMBURSEMENT	598,794.62
		ALL OTHER	554,337.85
		FEE SCHEDULE-LAB	44,452.28
		INJECTABLE DRUGS	4.49
		TOTAL NUMBER OF CLAIMS	1,797

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100,197.69	0.00	OTHER LAB	70,681.93	2,500.00
MED/SURG SUPPLY	13,763.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	190.88
RADIOLOGY-DIAGNOSTIC	120,343.58	44,487.48	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	213,538.43	57,501.99	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,337.28	5,731.29	FEE SCHEDULE LAB	418,815.76	47,383.24
EKG/ECG	25,867.50	1,207.15	MRI SERVICES	206,131.24	8,437.45
IV THERAPY	51,254.51	5,153.65	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,544,790.00	75,840.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,156.37	532.85	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	500.00	5,500.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	199,072.57	2,736.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	485.35	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42.79	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	126,959.92	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,375.58	3,385.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,394.80	1,570.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,048.44	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,765.73	0.00			
			TOTAL ANCILLARY	5,153,523.19	262,158.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,153,523.19	262,158.53

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:04:09  
Page: 7

SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL  
247 S MAIN ST  
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,945.75	ADJUSTMENTS	0.00
COVERED CHARGES	24,237.97	CONTRACTUAL ALLOW	16,660.35
NON-COVERD CHARGES	6,707.78	TOTAL MEDICAID LIAB	7,577.62
		LESS: COB	7,562.62
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,965.89	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	34.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	948.36	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,759.19	4,820.62	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,367.68	96.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	403.24	274.36	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,168.00	1,516.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	133.16	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,458.05	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	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,237.97	6,707.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,237.97	6,707.78

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:04:10  
Page: 9

DOCTORS HOSPITAL OF TATTNALL  
247 S MAIN ST  
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	105,818.28	ADJUSTMENTS	282.00
COVERED CHARGES	96,358.94	CONTRACTUAL ALLOW	89,108.94
NON-COVERD CHARGES	9,459.34	TOTAL MEDICAID LIAB	7,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	312.00
		REIMBURSEMENT	6,938.00
		TOTAL NUMBER OF CLAIMS	145

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL  
 247 S MAIN ST  
 REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
 000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,085.18	0.00	OTHER LAB	640.26	0.00
MED/SURG SUPPLY	146.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	47.72
RADIOLOGY-DIAGNOSTIC	3,416.52	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,778.38	2,577.05	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,246.60	4,236.96
EKG/ECG	689.80	0.00	MRI SERVICES	0.00	1,353.87
IV THERAPY	7,943.11	666.96	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	133.16	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,515.41	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	576.78			
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	764.49	0.00			
			TOTAL ANCILLARY	96,358.94	9,459.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	96,358.94	9,459.34

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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Page: 11

SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL  
247 S MAIN ST  
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	471.66	ADJUSTMENTS	0.00
COVERED CHARGES	471.66	CONTRACTUAL ALLOW	306.40
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	165.26
		LESS: COB	165.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:04:11  
 Page: 12

SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL  
 247 S MAIN ST  
 REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
 000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 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	0.00	0.00
IV THERAPY	190.56	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	221.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	471.66	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	471.66	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 03:04:12  
Page: 13

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,946,337.77	ADJUSTMENTS	20,663.80
COVERED CHARGES	1,934,574.78	CONTRACTUAL ALLOW	1,832,963.98
NON-COVERD CHARGES	11,762.99	TOTAL MEDICAID LIAB	101,610.80
		LESS: COB	0.00
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	101,556.80
		TOTAL NUMBER OF CLAIMS	19

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 247 S MAIN ST 000001878A SERVICE DATES 01/01/15 THROUGH 12/31/15  
 REIDSVILLE,GA 30453-4605 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,809.89	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,259.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	95.44
RADIOLOGY-DIAGNOSTIC	204.66	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,142.27	FEE SCHEDULE LAB	608.40	48.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,349,839.24	6,977.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	225.26	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	2,500.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,141.97	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35.54	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	537,450.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,934,574.78	11,762.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,934,574.78	11,762.99

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:04:12  
Page: 15

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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:27:00  
 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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,778,519.43	ADJUSTMENTS	1,162,804.76
COVERED CHARGES	24,107,143.78	CONTRACTUAL ALLOW	17,962,295.43
NON-COVERD CHARGES	671,375.65	TOTAL MEDICAID LIAB	6,144,848.35
		LESS: COB	30,624.73
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,114,223.62

TOTAL NUMBER OF ADMISSIONS 744

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,584		1	1,817,640.00		202,585.00
ROUTINE NURSERY	233		2	149,580.00		54,575.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,817		3	1,967,220.00		257,160.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	849		0	1,418,590.00		18,405.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	849		0	1,418,590.00		18,405.00
TOTAL ACCOMODATIONS	3,666		3	3,385,810.00		275,565.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,498,100.64	13,778.05	OTHER LAB	78,603.65	0.00
MED/SURG SUPPLY	1,928,281.74	23,202.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,568,655.00	8,916.58	EDUCATION & TRAINING	291.00	0.00
RADIOLOGY-DIAGNOSTIC	483,920.67	1,099.44	OTHER THERAPEUTIC SVC	0.00	19,558.69
CT SCAN	1,106,503.82	6,637.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	208,288.70	2,974.84	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	738,584.34	7,510.29	MRI SERVICES	250,650.01	0.00
IV THERAPY	81,660.41	0.00	PROFESSIONAL FEES	0.00	8,095.63
OPERATING ROOM	1,213,394.47	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	109,410.31	0.00	REHAB THERAPY	632.50	0.00
RESPIRATORY SERVICES	675,179.73	3,808.37	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	106,090.77	0.00	AMBULANCE	0.00	0.00
GI SERVICES	180,865.23	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,216,235.05	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	117,688.11	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	98,745.08	0.00	INJECTABLE DRUGS	2,457,781.00	14,908.20
RADIOLOGY THERAPEUTIC	19,275.83	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	44,397.26	1,949.68	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	12,179.10	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	77,977.50	11,942.50	PATIENT CONVENIENCE	0.00	1,170.56
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,094.35	265.74	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	609,757.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	115,114.54	6,677.14			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	316,295.73	214,515.93			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	101,872.44	37,350.37			
AUDIOLOGY	14,924.26	0.00			
CARDIOLOGY	891,840.46	0.00			
AMBULATORY SURGERY	342.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,442.48	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	376,258.16	11,448.29			
			TOTAL ANCILLARY	20,721,333.78	395,810.65
			TOTAL ACCOMODATIONS	3,385,810.00	275,565.00
			TOTAL CHARGES	24,107,143.78	671,375.65

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:27:12  
 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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	227,873.46	ADJUSTMENTS	0.00
COVERED CHARGES	213,300.12	CONTRACTUAL ALLOW	48,649.61
NON-COVERD CHARGES	14,573.34	TOTAL MEDICAID LIAB	164,650.51
		LESS: COB	164,650.51
		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	36		0	25,280.00		4,540.00
ROUTINE NURSERY	2		0	1,400.00		390.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	38		0	26,680.00		4,930.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	5,680.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4		0	5,680.00		0.00
TOTAL ACCOMODATIONS	42		0	32,360.00		4,930.00

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,617.50	0.00	OTHER LAB	1,333.74	0.00
MED/SURG SUPPLY	16,910.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	22,737.48	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,815.08	0.00	OTHER THERAPEUTIC SVC	0.00	122.07
CT SCAN	9,292.84	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,642.93	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	917.42	0.00	PROFESSIONAL FEES	0.00	6,793.00
OPERATING ROOM	35,593.37	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,942.95	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,862.64	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,056.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,004.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,550.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,885.36	0.00	INJECTABLE DRUGS	9,424.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	483.20	13.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,419.82	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,575.29	2,715.27			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	244.66	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	5,630.14	0.00			
			TOTAL ANCILLARY	180,940.12	9,643.34
			TOTAL ACCOMODATIONS	32,360.00	4,930.00
			TOTAL CHARGES	213,300.12	14,573.34



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:27:14  
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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,999,395.12	ADJUSTMENTS	490,918.69
COVERED CHARGES	19,103,457.00	CONTRACTUAL ALLOW	16,128,370.40
NON-COVERD CHARGES	4,895,938.12	TOTAL MEDICAID LIAB	2,975,086.60
		LESS: COB	1,187.07
		LESS: COPAYMENT	16,832.58
		REIMBURSEMENT	2,957,066.95
		ALL OTHER	2,316,169.56
		FEE SCHEDULE-LAB	396,220.17
		INJECTABLE DRUGS	244,677.22

TOTAL NUMBER OF CLAIMS 8,937

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	483,232.04	1,000,218.76	OTHER LAB	551,711.19	6,253.98
MED/SURG SUPPLY	749,163.77	127,326.33	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	97.00	242.50
RADIOLOGY-DIAGNOSTIC	899,487.96	18,660.03	OTHER THERAPEUTIC SVC	0.00	104,166.42
CT SCAN	2,433,627.24	478,091.59	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,615.24	36,391.23	FEE SCHEDULE LAB	4,437,131.08	711,848.38
EKG/ECG	218,180.36	57,915.16	MRI SERVICES	463,342.31	67,075.75
IV THERAPY	525,204.15	34,638.51	PROFESSIONAL FEES	0.00	21,521.48
OPERATING ROOM	1,047,779.20	324,115.22	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,999.11	0.00	REHAB THERAPY	0.00	1,134.00
RESPIRATORY SERVICES	116,810.00	35,214.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	130,996.56	8,995.86	AMBULANCE	0.00	0.00
GI SERVICES	344,644.30	89,370.21	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,102,907.47	38,812.68	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	228,618.19	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,659,658.79	854,197.09
RADIOLOGY THERAPEUTIC	435,311.89	31,998.19	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,468.54	3,074.67	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,674.68	3,268.45	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	64,630.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	69,292.82	6,223.82	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	74,458.66	109,867.18
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	284.25
OTHER IMAGING SERVICE	651,410.93	95,610.54			
BLOOD	1,810.18	0.00			
BLOOD STORAGE & PRO.	170,828.25	79,881.44			
ONCOLOGY	7,208.40	0.00			
NUCLEAR MEDICINE	354,755.31	190,840.18			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	369,593.12	247,099.84			
AMBULATORY SURGERY	684.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,380.57	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	522,373.69	46,969.48			
			TOTAL ANCILLARY	19,103,457.00	4,895,938.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,103,457.00	4,895,938.12

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:27:14  
Page: 7

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015275020145	09/11/15 - 09/11/15	10/05/15	0.00	34.25	0.00	0.00	0.00
948	2015288016992	08/27/15 - 08/27/15	10/19/15	0.00	250.00	0.00	0.00	0.00
TOTAL				0.00	284.25	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

Run Date: 08/12/2016  
Run Time: 03:28:12  
Page: 8

SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR  
901 18TH ST E  
TIFTON,GA 31794-3648

PROVIDER NUMBER  
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	757,843.72	ADJUSTMENTS	0.00
COVERED CHARGES	514,790.91	CONTRACTUAL ALLOW	133,758.56
NON-COVERD CHARGES	243,052.81	TOTAL MEDICAID LIAB	381,032.35
		LESS: COB	380,704.00
		LESS: COPAYMENT	328.35
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 194

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,368.39	30,225.09	OTHER LAB	9,331.23	444.58
MED/SURG SUPPLY	28,197.30	1,117.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,707.32	450.90	OTHER THERAPEUTIC SVC	0.00	3,107.91
CT SCAN	29,143.28	47,349.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	675.33	9,457.50	FEE SCHEDULE LAB	123,839.89	16,458.05
EKG/ECG	8,455.49	1,942.56	MRI SERVICES	19,309.08	2,103.12
IV THERAPY	21,779.52	1,450.99	PROFESSIONAL FEES	0.00	59,829.76
OPERATING ROOM	66,457.84	8,345.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,205.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,824.33	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,364.72	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,449.33	461.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,829.09	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,967.65	27,575.00
RADIOLOGY THERAPEUTIC	4,573.68	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	8,430.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,333.22	126.37	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,792.31	2,906.87
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,798.33	4,696.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,260.28	1,810.18			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,940.23	2,091.69			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	9,810.72			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	713.26	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,838.69	496.64			
			TOTAL ANCILLARY	514,790.91	243,052.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	514,790.91	243,052.81

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: 08/12/2016  
Run Time: 03:28:16  
Page: 10

TIFT REGIONAL MEDICAL CTR  
901 18TH ST E  
TIFTON,GA 31794-3648

PROVIDER NUMBER  
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	710,684.45	ADJUSTMENTS	214.76
COVERED CHARGES	626,411.87	CONTRACTUAL ALLOW	584,230.40
NON-COVERD CHARGES	84,272.58	TOTAL MEDICAID LIAB	42,181.47
		LESS: COB	0.00
		LESS: COPAYMENT	1,671.00
		REIMBURSEMENT	40,510.47
		TOTAL NUMBER OF CLAIMS	760

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,075.50	32,584.40	OTHER LAB	4,223.93	0.00
MED/SURG SUPPLY	10,456.11	3,973.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,377.53	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	64,849.50	5,000.14	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	116,768.36	10,096.07
EKG/ECG	5,828.68	224.18	MRI SERVICES	0.00	0.00
IV THERAPY	8,060.78	277.51	PROFESSIONAL FEES	0.00	4,467.50
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	1,465.67	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	344,610.68	711.97	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	22,514.60
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	2,810.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,324.87	1,565.52			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	159.22	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	211.04	47.01			
			TOTAL ANCILLARY	626,411.87	84,272.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	626,411.87	84,272.58

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:28:21  
Page: 12

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,134.84	ADJUSTMENTS	0.00
COVERED CHARGES	41,912.49	CONTRACTUAL ALLOW	21,229.45
NON-COVERD CHARGES	17,222.35	TOTAL MEDICAID LIAB	20,683.04
		LESS: COB	20,641.04
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	25



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	510.15	1,752.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,146.08	299.76	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,097.54	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,179.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,085.09	397.06
EKG/ECG	896.72	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	519.11	0.00	PROFESSIONAL FEES	0.00	9,473.75
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,056.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,716.84	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	408.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,565.52	1,711.85			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	319.21	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	41,912.49	17,222.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	41,912.49	17,222.35

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 03:28:24  
Page: 14

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,126,251.61	ADJUSTMENTS	103,865.22
COVERED CHARGES	3,016,029.08	CONTRACTUAL ALLOW	2,641,147.81
NON-COVERD CHARGES	110,222.53	TOTAL MEDICAID LIAB	374,881.27
		LESS: COB	0.00
		LESS: COPAYMENT	612.00
		REIMBURSEMENT	374,269.27
		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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,026.93	29,934.06	OTHER LAB	190.06	0.00
MED/SURG SUPPLY	12,562.76	13,444.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	88.46	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,742.67	3,144.70	OTHER THERAPEUTIC SVC	0.00	12,692.78
CT SCAN	3,778.86	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,953.48	16,508.95
EKG/ECG	224.18	1,544.24	MRI SERVICES	0.00	0.00
IV THERAPY	65,405.65	5,363.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	64,665.81	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150.89	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	704.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,072.15	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,962.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,487,434.38	17,365.50
RADIOLOGY THERAPEUTIC	97,819.13	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,160.14	230.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	94,873.41	3,801.34
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.	14,203.22	5,430.54			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	55,052.73	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,046.23	673.82			
			TOTAL ANCILLARY	3,016,029.08	110,222.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,016,029.08	110,222.53

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:28:27  
Page: 16

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,235.52	ADJUSTMENTS	0.00
COVERED CHARGES	73,214.92	CONTRACTUAL ALLOW	13,358.18
NON-COVERD CHARGES	20.60	TOTAL MEDICAID LIAB	59,856.74
		LESS: COB	59,850.74
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR  
 901 18TH ST E  
 TIFTON,GA 31794-3648

PROVIDER NUMBER  
 000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	445.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	58.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	244.70	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	70,708.00	20.60
RADIOLOGY THERAPEUTIC	1,758.60	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	73,214.92	20.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	73,214.92	20.60

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:34:09  
 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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	112,140.12	ADJUSTMENTS	0.00
COVERED CHARGES	111,412.12	CONTRACTUAL ALLOW	58,317.78
NON-COVERD CHARGES	728.00	TOTAL MEDICAID LIAB	53,094.34
		LESS: COB	2,829.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	50,264.75

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	27		0	20,250.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	27		0	20,250.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	27		0	20,250.00		0.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL  
 PO BOX 509  
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER  
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,389.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,926.00	278.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,758.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,260.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,800.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	140.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,880.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,760.94	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,962.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	140.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	43.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,450.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	327.00	450.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,006.18	0.00			
			TOTAL ANCILLARY	91,162.12	728.00
			TOTAL ACCOMODATIONS	20,250.00	0.00
			TOTAL CHARGES	111,412.12	728.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	458,430.52	ADJUSTMENTS	9,668.49
COVERED CHARGES	388,544.37	CONTRACTUAL ALLOW	238,674.79
NON-COVERD CHARGES	69,886.15	TOTAL MEDICAID LIAB	149,869.58
		LESS: COB	133.22
		LESS: COPAYMENT	708.00
		REIMBURSEMENT	149,028.36
		ALL OTHER	131,489.50
		FEE SCHEDULE-LAB	16,732.22
		INJECTABLE DRUGS	806.64

TOTAL NUMBER OF CLAIMS 472

CHATUGE REGIONAL HOSPITAL  
 PO BOX 509  
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER  
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,953.00	10,658.00	OTHER LAB	4,080.00	0.00
MED/SURG SUPPLY	6,891.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,385.00	430.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,025.00	14,075.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	111,511.20	22,026.00
EKG/ECG	7,281.00	165.00	MRI SERVICES	14,200.00	4,500.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	300.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	585.00	145.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,100.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	107,069.17	2,951.94	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,222.00	3,343.00
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	215.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,790.00	1,400.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,602.00	1,392.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,150.00	55.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,500.00	175.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,300.00	6,955.21			
			TOTAL ANCILLARY	388,544.37	69,886.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	388,544.37	69,886.15

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,527.50	ADJUSTMENTS	0.00
COVERED CHARGES	2,400.66	CONTRACTUAL ALLOW	-219.36
NON-COVERD CHARGES	3,126.84	TOTAL MEDICAID LIAB	2,620.02
		LESS: COB	2,620.02
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL  
 PO BOX 509  
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER  
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	141.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	50.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	330.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	729.00	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	195.00	95.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	880.66	1,423.84	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	25.00	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	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	50.00	0.00			
			TOTAL ANCILLARY	2,400.66	3,126.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,400.66	3,126.84

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,352.14	ADJUSTMENTS	0.00
COVERED CHARGES	21,900.14	CONTRACTUAL ALLOW	19,700.14
NON-COVERD CHARGES	1,452.00	TOTAL MEDICAID LIAB	2,200.00
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	2,107.00
		TOTAL NUMBER OF CLAIMS	44

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	763.00	456.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	428.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,825.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,042.00	391.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,497.14	60.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	250.00	95.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	450.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	21,900.14	1,452.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,900.14	1,452.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:34:17  
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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	05/01/14	THROUGH	04/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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	05/01/14	THROUGH	04/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	05/01/14	THROUGH	04/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:29:16  
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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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	401,040.34	ADJUSTMENTS	6,316.76
COVERED CHARGES	391,570.34	CONTRACTUAL ALLOW	169,527.78
NON-COVERD CHARGES	9,470.00	TOTAL MEDICAID LIAB	222,042.56
		LESS: COB	7,387.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	214,654.68

TOTAL NUMBER OF ADMISSIONS 42

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	89		0	66,750.00		0.00
ROUTINE NURSERY	0		16	0.00		5,600.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	89		16	66,750.00		5,600.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	10		0	12,500.00		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	10		0	12,500.00		0.00
TOTAL ACCOMODATIONS	99		16	79,250.00		5,600.00

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

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,039.00	0.00	OTHER LAB	250.00	0.00
MED/SURG SUPPLY	6,283.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	49,843.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,823.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,975.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	190.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,736.00	0.00	MRI SERVICES	0.00	1,800.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	1,800.00
OPERATING ROOM	36,300.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,147.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28,095.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,800.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,268.47	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	224.70	60.00	INJECTABLE DRUGS	7,042.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,523.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,710.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,045.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,560.00	210.00			
AUDIOLOGY	1,600.00	0.00			
CARDIOLOGY	4,104.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,761.67	0.00			
			TOTAL ANCILLARY	312,320.34	3,870.00
			TOTAL ACCOMODATIONS	79,250.00	5,600.00
			TOTAL CHARGES	391,570.34	9,470.00

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,889.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,179.00	CONTRACTUAL ALLOW	1,479.50
NON-COVERD CHARGES	1,710.00	TOTAL MEDICAID LIAB	4,699.50
		LESS: COB	4,699.50
		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	1,500.00		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	2		0	1,500.00		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	2		0	1,500.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

UNION COUNTY HOSPITAL AUTHORITY  
 35 HOSPITAL RD  
 BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER  
 000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,302.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	242.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	1,710.00
OPERATING ROOM	1,500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	275.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	360.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,679.00	1,710.00
			TOTAL ACCOMODATIONS	1,500.00	0.00
			TOTAL CHARGES	6,179.00	1,710.00

Report : CLM-0804-0  
Process : CLMJ0800  
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 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,150,487.88	ADJUSTMENTS	155,629.26
COVERED CHARGES	2,018,661.03	CONTRACTUAL ALLOW	1,427,214.79
NON-COVERD CHARGES	131,826.85	TOTAL MEDICAID LIAB	591,446.24
		LESS: COB	583.78
		LESS: COPAYMENT	1,560.00
		REIMBURSEMENT	589,302.46
		ALL OTHER	525,628.26
		FEE SCHEDULE-LAB	45,883.96
		INJECTABLE DRUGS	17,790.24
		TOTAL NUMBER OF CLAIMS	1,479

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,294.15	0.00	OTHER LAB	30,564.00	0.00
MED/SURG SUPPLY	6,022.00	106.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	151,968.00	2,115.00	OTHER THERAPEUTIC SVC	0.00	2,033.00
CT SCAN	313,805.00	10,080.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,900.00	0.00	FEE SCHEDULE LAB	298,356.85	41,780.60
EKG/ECG	20,061.00	165.00	MRI SERVICES	81,565.00	7,440.00
IV THERAPY	123,482.99	10,840.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	180,000.00	8,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,227.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,312.00	1,666.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	16,150.00	850.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	344,084.42	6,965.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,250.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	185,489.00	11,085.25
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	185.00	191.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,660.00	386.40	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	101.00	1,500.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,648.00
OTHER IMAGING SERVICE	77,619.40	4,095.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,884.00	7,560.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	37,870.00	8,545.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,401.40	175.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,408.32	100.00			
			TOTAL ANCILLARY	2,018,661.03	131,826.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,018,661.03	131,826.85

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2214259000831	08/18/14 - 08/18/14	09/22/14	0.00	8.00	0.00	0.00	0.00
615	2015012032871	01/05/15 - 01/05/15	01/19/15	0.00	1,410.00	0.00	0.00	0.00
615	2015012032871	01/05/15 - 01/05/15	01/19/15	0.00	1,410.00	0.00	0.00	0.00
615	5915104001022	03/26/15 - 03/26/15	04/20/15	0.00	1,410.00	0.00	0.00	0.00
615	5915104001022	03/26/15 - 03/26/15	04/20/15	0.00	1,410.00	0.00	0.00	0.00
TOTAL				0.00	5,648.00	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	88,571.40	ADJUSTMENTS	0.00
COVERED CHARGES	64,887.78	CONTRACTUAL ALLOW	11,610.66
NON-COVERD CHARGES	23,683.62	TOTAL MEDICAID LIAB	53,277.12
		LESS: COB	53,232.12
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 43

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,649.00	0.00	OTHER LAB	1,500.00	0.00
MED/SURG SUPPLY	260.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,877.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,020.00	1,320.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,815.35	393.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,400.00	930.00	PROFESSIONAL FEES	0.00	925.00
OPERATING ROOM	17,200.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	220.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	394.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,357.81	828.42	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	900.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,287.00	18,902.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	55.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,344.40	330.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	663.22	0.00			
			TOTAL ANCILLARY	64,887.78	23,683.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,887.78	23,683.62

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:29:31  
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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 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	121,106.46	ADJUSTMENTS	1,023.86
COVERED CHARGES	118,136.26	CONTRACTUAL ALLOW	108,234.88
NON-COVERD CHARGES	2,970.20	TOTAL MEDICAID LIAB	9,901.38
		LESS: COB	37.83
		LESS: COPAYMENT	318.00
		REIMBURSEMENT	9,545.55
		TOTAL NUMBER OF CLAIMS	177

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,068.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	105.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,392.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,420.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,368.00	1,554.00
EKG/ECG	1,108.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,240.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	82.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,242.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,370.28	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,213.00	671.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,018.80	745.20			
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	508.68	0.00			
			TOTAL ANCILLARY	118,136.26	2,970.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	118,136.26	2,970.20

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,772.08	ADJUSTMENTS	0.00
COVERED CHARGES	4,764.08	CONTRACTUAL ALLOW	3,246.01
NON-COVERD CHARGES	8.00	TOTAL MEDICAID LIAB	1,518.07
		LESS: COB	1,515.07
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:29:32  
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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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,800.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	960.00	8.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	540.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,259.08	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	165.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,764.08	8.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,764.08	8.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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	05/01/14	THROUGH	04/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNION COUNTY HOSPITAL AUTHORITY  
35 HOSPITAL RD  
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER  
000001966A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/14	THROUGH	04/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:29:41  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA, GA 30901-2612

PROVIDER NUMBER 000001977A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,574,067.25	ADJUSTMENTS	2,800,849.75
COVERED CHARGES	41,222,701.15	CONTRACTUAL ALLOW	28,896,874.09
NON-COVERD CHARGES	351,366.10	TOTAL MEDICAID LIAB	12,325,827.06
		LESS: COB	165,099.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,160,727.89

TOTAL NUMBER OF ADMISSIONS 1,213

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,047		2	1,752,920.00		14,500.00
ROUTINE NURSERY	467		6	386,870.00		2,646.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,514		8	2,139,790.00		17,146.00
SPECIAL CARE SERVICES						
CCU	82		0	133,250.00		0.00
ICU	3,536		0	3,797,522.00		0.00
NICU	107		0	173,875.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,725		0	4,104,647.00		0.00
TOTAL ACCOMODATIONS	7,239		8	6,244,437.00		17,146.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,078,476.19	57,773.08	OTHER LAB	214,575.00	0.00
MED/SURG SUPPLY	6,356,663.85	67,291.01	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,040,439.62	14,565.07	EDUCATION & TRAINING	44,255.00	83.00
RADIOLOGY-DIAGNOSTIC	899,043.00	0.00	OTHER THERAPEUTIC SVC	45,961.40	10,703.00
CT SCAN	1,840,215.00	5,912.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	211,337.00	1,878.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	275,163.00	0.00	MRI SERVICES	486,292.00	0.00
IV THERAPY	248,539.38	1,945.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,432,849.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	101,041.00	0.00	REHAB THERAPY	2,850.00	0.00
RESPIRATORY SERVICES	1,894,640.00	735.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	206,131.00	151.00	AMBULANCE	0.00	0.00
GI SERVICES	237,883.00	4,484.00	CAST ROOM	71.00	0.00
EMERGENCY ROOM	922,868.00	0.00	SPECIAL SERVICES	0.00	198.00
RECOVERY ROOM	189,879.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,846.94
LABORATORY PATHOLOGIC	167,796.88	0.00	INJECTABLE DRUGS	2,722.87	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	83,293.00	1,780.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	59,556.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	379,358.00	31,336.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	40,110.38	6,993.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	795,558.58	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	37,034.00
OTHER IMAGING SERVICE	177,933.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	452,210.00	19,361.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	216,265.00	63,495.00			
AUDIOLOGY	23,280.00	0.00			
CARDIOLOGY	1,293,299.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,048.00	572.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	516,661.00	5,084.00			
			TOTAL ANCILLARY	34,978,264.15	334,220.10
			TOTAL ACCOMODATIONS	6,244,437.00	17,146.00
			TOTAL CHARGES	41,222,701.15	351,366.10

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015112039809	04/07/15 - 04/10/15	04/27/15	0.00	3,053.00	0.00	0.00	0.00
615	2315112000143	01/14/15 - 01/16/15	05/04/15	0.00	3,053.00	0.00	1,568.16	0.00
615	2015189024028	06/17/15 - 06/22/15	07/13/15	0.00	2,613.00	0.00	0.00	0.00
615	2215222008764	02/26/15 - 03/03/15	08/17/15	0.00	3,053.00	0.00	0.00	0.00
618	2215225001197	05/10/15 - 05/21/15	08/17/15	0.00	2,613.00	0.00	0.00	0.00
615	2215225012925	06/21/15 - 07/01/15	08/17/15	0.00	3,053.00	0.00	0.00	0.00
-1	2315267000201	06/16/15 - 06/21/15	10/26/15	0.00	3,478.00	0.00	683.80	0.00
615	2015321020293	11/05/15 - 11/12/15	11/23/15	0.00	2,613.00	0.00	0.00	0.00
615	2015362013094	05/21/15 - 05/30/15	01/04/16	0.00	2,613.00	0.00	0.00	0.00
615	5215363005037	10/09/15 - 10/14/15	02/22/16	0.00	2,613.00	0.00	0.00	0.00
615	2016075044500	12/21/15 - 12/28/15	03/21/16	0.00	3,053.00	0.00	0.00	0.00
615	2016096053667	06/23/15 - 06/25/15	04/11/16	0.00	2,613.00	0.00	0.00	0.00
615	2016120055753	12/13/15 - 02/22/16	05/02/16	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	37,034.00	0.00	2,251.96	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 03:30:02  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	953,262.13	ADJUSTMENTS	0.00
COVERED CHARGES	952,607.13	CONTRACTUAL ALLOW	453,610.50
NON-COVERD CHARGES	655.00	TOTAL MEDICAID LIAB	498,996.63
		LESS: COB	498,996.63
		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	31		0	17,980.00		0.00
ROUTINE NURSERY	92		0	110,216.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	123		0	128,196.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	43		0	56,263.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	43		0	56,263.00		0.00
TOTAL ACCOMODATIONS	166		0	184,459.00		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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	208,337.09	0.00	OTHER LAB	1,144.00	0.00
MED/SURG SUPPLY	162,565.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	83,669.88	0.00	EDUCATION & TRAINING	79.00	0.00
RADIOLOGY-DIAGNOSTIC	24,264.00	0.00	OTHER THERAPEUTIC SVC	406.00	175.00
CT SCAN	17,740.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,812.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,035.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	597.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	49,131.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,279.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	114,717.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,876.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,240.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,680.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,234.54	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,023.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,781.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,240.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	378.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,416.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,384.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,786.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,730.00	480.00			
AUDIOLOGY	608.00	0.00			
CARDIOLOGY	35,214.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,781.00	0.00			
			TOTAL ANCILLARY	768,148.13	655.00
			TOTAL ACCOMODATIONS	184,459.00	0.00
			TOTAL CHARGES	952,607.13	655.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:30:06  
Page: 6

UNIVERSITY HOSPITAL  
1350 WALTON WAY  
AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,410,261.77	ADJUSTMENTS	696,670.10
COVERED CHARGES	17,672,412.65	CONTRACTUAL ALLOW	14,275,276.09
NON-COVERD CHARGES	1,737,849.12	TOTAL MEDICAID LIAB	3,397,136.56
		LESS: COB	41,120.73
		LESS: COPAYMENT	13,986.00
		REIMBURSEMENT	3,342,029.83
		ALL OTHER	2,435,702.32
		FEE SCHEDULE-LAB	338,165.28
		INJECTABLE DRUGS	568,162.23

TOTAL NUMBER OF CLAIMS 10,575

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	820,021.31	1,282.15	OTHER LAB	304,990.00	0.00
MED/SURG SUPPLY	1,665,562.11	99,574.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	958.00	2,065.00
RADIOLOGY-DIAGNOSTIC	810,502.00	2,429.00	OTHER THERAPEUTIC SVC	1,182.00	457.00
CT SCAN	1,904,174.00	404,076.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,533.00	4,803.00	FEE SCHEDULE LAB	2,286,409.59	126,385.46
EKG/ECG	322,266.00	4,716.00	MRI SERVICES	458,755.00	38,598.00
IV THERAPY	996,145.00	8,850.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	733,136.86	141,038.48	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	75,491.00	970.00	REHAB THERAPY	90.00	1,955.00
RESPIRATORY SERVICES	308,584.00	32,776.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	79,538.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	126,963.00	18,037.00	CAST ROOM	8,840.00	0.00
EMERGENCY ROOM	2,456,305.00	3,469.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	138,699.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,560,238.40	369,512.03
RADIOLOGY THERAPEUTIC	21,634.00	394.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,970.00	5,574.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,442.00	2,994.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	281,967.00	16,534.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	100,187.38	44,567.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,851.00
OTHER IMAGING SERVICE	440,969.00	86,260.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	54,646.00	588.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	447,432.00	173,959.00			
AUDIOLOGY	3,833.00	0.00			
CARDIOLOGY	803,323.00	128,280.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,172.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	406,454.00	14,855.00			
			TOTAL ANCILLARY	17,672,412.65	1,737,849.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,672,412.65	1,737,849.12

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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Page: 8

UNIVERSITY HOSPITAL  
1350 WALTON WAY  
AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015264018080	05/21/15 - 05/21/15	09/28/15	0.00	238.00	0.00	0.00	0.00
615	2016195051020	09/08/15 - 09/08/15	07/18/16	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	2,851.00	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 03:31:32  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	230,059.06	ADJUSTMENTS	0.00
COVERED CHARGES	178,582.18	CONTRACTUAL ALLOW	116,208.86
NON-COVERD CHARGES	51,476.88	TOTAL MEDICAID LIAB	62,373.32
		LESS: COB	62,264.36
		LESS: COPAYMENT	108.96
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 88

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,717.23	0.00	OTHER LAB	4,903.00	0.00
MED/SURG SUPPLY	17,787.76	2,247.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,624.50	242.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,865.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,351.42	1,231.00
EKG/ECG	2,882.00	0.00	MRI SERVICES	2,722.00	0.00
IV THERAPY	9,069.00	1,225.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,064.50	2,674.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,398.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	150.00	440.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,325.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,242.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,168.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,498.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	21,357.77	35,921.88
RADIOLOGY THERAPEUTIC	788.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,009.00	378.00	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	0.00
OTHER IMAGING SERVICE	5,847.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,004.00	3,662.00			
AUDIOLOGY	1,076.00	1,076.00			
CARDIOLOGY	1,005.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	712.00	137.00			
			TOTAL ANCILLARY	178,582.18	51,476.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	178,582.18	51,476.88

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:31:36  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	314,853.72	ADJUSTMENTS	750.16
COVERED CHARGES	297,341.63	CONTRACTUAL ALLOW	272,565.79
NON-COVERD CHARGES	17,512.09	TOTAL MEDICAID LIAB	24,775.84
		LESS: COB	162.24
		LESS: COPAYMENT	876.00
		REIMBURSEMENT	23,737.60
		TOTAL NUMBER OF CLAIMS	440

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,127.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,294.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,617.00	451.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,352.00	11,024.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	48,732.98	612.52
EKG/ECG	4,454.00	0.00	MRI SERVICES	0.00	2,722.00
IV THERAPY	21,410.00	378.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	155,627.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,740.70	482.57
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	189.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,965.00	1,653.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20.00	0.00			
			TOTAL ANCILLARY	297,341.63	17,512.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	297,341.63	17,512.09

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:31:41  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,359.52	ADJUSTMENTS	0.00
COVERED CHARGES	1,339.52	CONTRACTUAL ALLOW	349.30
NON-COVERD CHARGES	20.00	TOTAL MEDICAID LIAB	990.22
		LESS: COB	987.22
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 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	50.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	355.52	20.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,339.52	20.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,339.52	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: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL  
1350 WALTON WAY  
AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,447,171.00	ADJUSTMENTS	113,546.29
COVERED CHARGES	1,518,036.93	CONTRACTUAL ALLOW	1,220,231.99
NON-COVERD CHARGES	929,134.07	TOTAL MEDICAID LIAB	297,804.94
		LESS: COB	0.00
		LESS: COPAYMENT	267.00
		REIMBURSEMENT	297,537.94

TOTAL NUMBER OF CLAIMS 54

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,016.22	0.00	OTHER LAB	455.00	0.00
MED/SURG SUPPLY	177,583.36	181,968.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	156.00	0.00
RADIOLOGY-DIAGNOSTIC	48,570.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,196.45	1,058.00
EKG/ECG	2,882.00	524.00	MRI SERVICES	0.00	0.00
IV THERAPY	16,261.00	280.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	739,168.78	62,553.22	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,058.00	1,633.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,369.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,385.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	222,462.12	9,608.85
RADIOLOGY THERAPEUTIC	189.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	402.00	189.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	104,576.00	576,491.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,280.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	97,427.00	94,829.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,600.00	0.00			
			TOTAL ANCILLARY	1,518,036.93	929,134.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,518,036.93	929,134.07



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: 08/12/2016  
Run Time: 03:31:47  
Page: 17

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,001.38	ADJUSTMENTS	0.00
COVERED CHARGES	43,093.58	CONTRACTUAL ALLOW	13,575.24
NON-COVERD CHARGES	33,907.80	TOTAL MEDICAID LIAB	29,518.34
		LESS: COB	29,515.34
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	524.32	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,117.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	468.00	20.00
EKG/ECG	262.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,548.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	631.26	213.80
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	33,674.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,543.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	43,093.58	33,907.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,093.58	33,907.80

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,474,377.84	ADJUSTMENTS	665,726.36
COVERED CHARGES	9,366,642.45	CONTRACTUAL ALLOW	6,497,533.73
NON-COVERD CHARGES	107,735.39	TOTAL MEDICAID LIAB	2,869,108.72
		LESS: COB	33,327.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,835,780.78

TOTAL NUMBER OF ADMISSIONS 325

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	932		0	916,488.00		31,924.00
ROUTINE NURSERY	42		1	31,458.00		749.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		3,051.00
TOTAL ROUTINE	974		1	947,946.00		35,724.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	478		0	864,346.00		4,922.00
NICU	13		0	13,910.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	491		0	878,256.00		4,922.00
TOTAL ACCOMODATIONS	1,465		1	1,826,202.00		40,646.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	350,512.80	1,094.69	OTHER LAB	18,857.00	0.00
MED/SURG SUPPLY	691,051.69	10,506.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	972,686.00	5,465.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	250,795.00	356.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	539,111.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	197,745.31	484.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	78,794.00	0.00	MRI SERVICES	96,336.00	0.00
IV THERAPY	188,199.00	515.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,008,634.00	6,728.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	53,811.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	873,213.00	12,834.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,972.00	109.00	AMBULANCE	0.00	0.00
GI SERVICES	102,416.00	3,407.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	350,658.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	129,440.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,166.00
LABORATORY PATHOLOGIC	38,963.00	0.00	INJECTABLE DRUGS	956,728.65	2,084.40
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,591.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,908.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	23,285.00	0.00	PATIENT CONVENIENCE	0.00	50.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,762.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	231,846.00	0.00
LITHOTRIPSY	18,693.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,553.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	112,086.00	12,781.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	26,266.00	6,469.00			
AUDIOLOGY	2,700.00	874.00			
CARDIOLOGY	99,004.00	1,166.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,734.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,089.00	0.00			
			TOTAL ANCILLARY	7,540,440.45	67,089.39
			TOTAL ACCOMODATIONS	1,826,202.00	40,646.00
			TOTAL CHARGES	9,366,642.45	107,735.39

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:32:30  
 Page: 3

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	83,047.84	ADJUSTMENTS	0.00
COVERED CHARGES	82,846.84	CONTRACTUAL ALLOW	46,647.96
NON-COVERD CHARGES	201.00	TOTAL MEDICAID LIAB	36,198.88
		LESS: COB	36,198.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6		0	5,901.00		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	6		0	5,901.00		201.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	9,095.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	9,095.00		0.00
TOTAL ACCOMODATIONS	11		0	14,996.00		201.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,884.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,282.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,276.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	796.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,427.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	351.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	377.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,324.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,327.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,928.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	414.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,334.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,565.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	406.00	0.00	INJECTABLE DRUGS	8,665.61	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	413.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,586.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	232.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,262.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	67,850.84	0.00
			TOTAL ACCOMODATIONS	14,996.00	201.00
			TOTAL CHARGES	82,846.84	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: 08/12/2016  
Run Time: 03:32:31  
Page: 5

UPSON REGIONAL MEDICAL CENTER  
801 W GORDON ST  
THOMASTON,GA 30286-3426

PROVIDER NUMBER  
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,708,788.74	ADJUSTMENTS	490,186.91
COVERED CHARGES	11,203,635.39	CONTRACTUAL ALLOW	9,282,450.02
NON-COVERD CHARGES	505,153.35	TOTAL MEDICAID LIAB	1,921,185.37
		LESS: COB	1,792.89
		LESS: COPAYMENT	4,599.00
		REIMBURSEMENT	1,914,793.48
		ALL OTHER	1,717,342.94
		FEE SCHEDULE-LAB	147,995.34
		INJECTABLE DRUGS	49,455.20

TOTAL NUMBER OF CLAIMS 4,116

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102,160.53	3,805.00	OTHER LAB	77,051.00	2,317.00
MED/SURG SUPPLY	348,068.76	8,115.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	630.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	627,283.00	10,365.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,901,729.00	71,612.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	210,529.00	37,356.00	FEE SCHEDULE LAB	1,576,179.00	118,375.00
EKG/ECG	197,272.00	7,371.00	MRI SERVICES	278,926.00	16,318.00
IV THERAPY	665,286.00	1,368.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,098,370.00	106,674.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	22,416.00	0.00	REHAB THERAPY	1,606.00	0.00
RESPIRATORY SERVICES	41,540.00	2,834.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54,145.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	122,500.00	1,526.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,117,993.00	2,316.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	271,705.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	346,478.20	46,834.35
RADIOLOGY THERAPEUTIC	4,334.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,380.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,969.00	3,450.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	98,643.90	6,434.00
LITHOTRIPSY	26,147.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	280,081.00	21,299.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,638.00	5,094.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	190,209.00	12,450.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	95,976.00	13,393.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	83,827.00	1,356.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	325,573.00	2,481.00			
			TOTAL ANCILLARY	11,203,635.39	505,153.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,203,635.39	505,153.35



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 03:33:05  
Page: 7

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	200,975.19	ADJUSTMENTS	0.00
COVERED CHARGES	168,744.25	CONTRACTUAL ALLOW	70,281.61
NON-COVERD CHARGES	32,230.94	TOTAL MEDICAID LIAB	98,462.64
		LESS: COB	98,438.64
		LESS: COPAYMENT	24.00
		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

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	703.20	76.00	OTHER LAB	2,578.00	0.00
MED/SURG SUPPLY	2,180.25	133.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,831.00	1,544.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,364.00	12,083.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,852.00	6,185.00	FEE SCHEDULE LAB	28,003.00	1,741.00
EKG/ECG	1,904.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,248.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,388.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	460.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,063.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,047.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,130.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,920.80	1,372.94
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	138.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	116.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,037.00	3,492.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	310.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,861.00	5,466.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,228.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,520.00	0.00			
			TOTAL ANCILLARY	168,744.25	32,230.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	168,744.25	32,230.94

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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Page: 9

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	905,420.54	ADJUSTMENTS	2,458.01
COVERED CHARGES	891,285.94	CONTRACTUAL ALLOW	856,043.74
NON-COVERD CHARGES	14,134.60	TOTAL MEDICAID LIAB	35,242.20
		LESS: COB	0.00
		LESS: COPAYMENT	1,421.01
		REIMBURSEMENT	33,821.19
		TOTAL NUMBER OF CLAIMS	630

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,179.05	119.00	OTHER LAB	2,856.00	0.00
MED/SURG SUPPLY	7,792.00	676.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,928.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	102,890.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	341.00	FEE SCHEDULE LAB	144,881.00	7,032.00
EKG/ECG	8,775.00	0.00	MRI SERVICES	3,308.00	0.00
IV THERAPY	51,248.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,454.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	824.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	414.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	437,813.00	668.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,565.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,655.89	2,478.60
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	8,173.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,292.00	2,820.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	464.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,774.00	0.00			
			TOTAL ANCILLARY	891,285.94	14,134.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	891,285.94	14,134.60

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:33:11  
Page: 11

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,912.70	ADJUSTMENTS	0.00
COVERED CHARGES	23,255.70	CONTRACTUAL ALLOW	10,884.57
NON-COVERD CHARGES	3,657.00	TOTAL MEDICAID LIAB	12,371.13
		LESS: COB	12,353.13
		LESS: COPAYMENT	18.00
		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: 08/12/2016  
 Run Time: 03:33:11  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	109.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,625.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,685.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,914.00	954.00
EKG/ECG	702.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	780.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,871.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,236.70	18.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	23,255.70	3,657.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,255.70	3,657.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CENTER  
801 W GORDON ST  
THOMASTON,GA 30286-3426

PROVIDER NUMBER  
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	854,581.40	ADJUSTMENTS	39,109.01
COVERED CHARGES	686,535.36	CONTRACTUAL ALLOW	574,813.80
NON-COVERD CHARGES	168,046.04	TOTAL MEDICAID LIAB	111,721.56
		LESS: COB	0.00
		LESS: COPAYMENT	142.42
		REIMBURSEMENT	111,579.14
		TOTAL NUMBER OF CLAIMS	20

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CENTER  
 801 W GORDON ST  
 THOMASTON,GA 30286-3426

PROVIDER NUMBER  
 000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,782.56	1,910.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	76,617.55	399.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,204.00	2,805.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,785.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,614.00	FEE SCHEDULE LAB	5,231.00	1,235.00
EKG/ECG	3,159.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,942.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	277,455.00	6.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,744.00	226.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,495.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,334.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,070.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	87,371.25	127,068.79
RADIOLOGY THERAPEUTIC	11,312.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	103,049.00	31,998.00
LITHOTRIPSY	37,386.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,389.00	784.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,209.00	0.00			
			TOTAL ANCILLARY	686,535.36	168,046.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	686,535.36	168,046.04



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 03:33:13  
Page: 15

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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 02:33:48  
 Page: 1

WELLSTAR WINDY HILL HOSPITAL  
 2540 WINDY HILL RD SE  
 MARIETTA,GA 30067-8605

PROVIDER NUMBER 000001999A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,673,281.31	ADJUSTMENTS	341,124.78
COVERED CHARGES	4,398,436.76	CONTRACTUAL ALLOW	3,579,668.51
NON-COVERD CHARGES	274,844.55	TOTAL MEDICAID LIAB	818,768.25
		LESS: COB	2,462.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	816,305.57

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	110		0	114,840.00		20,766.80
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	110		0	114,840.00		20,766.80
SPECIAL CARE SERVICES						
CCU	647		0	1,438,329.70		135,470.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	647		0	1,438,329.70		135,470.00
TOTAL ACCOMODATIONS	757		0	1,553,169.70		156,236.80

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	524,562.14	54,210.11	OTHER LAB	14,918.41	0.00
MED/SURG SUPPLY	139,150.78	15,893.72	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	291,544.12	5,099.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,154.00	1,999.00	OTHER THERAPEUTIC SVC	0.00	1,680.00
CT SCAN	50,076.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	94,907.00	4,420.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,208.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,044.00	12,897.99	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,233.30	1,232.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,312,670.16	3,254.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,124.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	238.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	33,298.00	4,729.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	69,386.00	4,785.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	155,687.55	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	888.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,373.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,953.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,948.00	6,739.93			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,135.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,724.00	1,668.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,044.00	0.00			
			TOTAL ANCILLARY	2,845,267.06	118,607.75
			TOTAL ACCOMODATIONS	1,553,169.70	156,236.80
			TOTAL CHARGES	4,398,436.76	274,844.55

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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Page: 3

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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:33:49  
Page: 4

WELLSTAR WINDY HILL HOSPITAL  
2540 WINDY HILL RD SE  
MARIETTA,GA 30067-8605

PROVIDER NUMBER  
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,758,569.62	ADJUSTMENTS	66,564.79
COVERED CHARGES	1,606,149.38	CONTRACTUAL ALLOW	1,279,241.98
NON-COVERD CHARGES	152,420.24	TOTAL MEDICAID LIAB	326,907.40
		LESS: COB	1,173.40
		LESS: COPAYMENT	867.00
		REIMBURSEMENT	324,867.00
		ALL OTHER	291,407.18
		FEE SCHEDULE-LAB	1,042.98
		INJECTABLE DRUGS	32,416.84

TOTAL NUMBER OF CLAIMS 350

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL  
 2540 WINDY HILL RD SE  
 MARIETTA,GA 30067-8605

PROVIDER NUMBER  
 000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,333.34	510.00	OTHER LAB	3,820.00	0.00
MED/SURG SUPPLY	61,735.48	6,436.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	77,229.94	1,125.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,534.00	29,572.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,861.00	2,040.00	FEE SCHEDULE LAB	13,870.00	686.00
EKG/ECG	2,676.00	0.00	MRI SERVICES	67,928.00	40,009.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	317,133.00	55,018.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	502.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	161,310.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	111,640.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	128,082.00	2,616.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	51,563.84	316.00
LITHOTRIPSY	143,844.08	0.00	NO CC/INVALID REV CODE	0.00	4,000.00
OTHER IMAGING SERVICE	61,336.20	3,880.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,390.50	4,426.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,610.00	1,785.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	324,895.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	855.00	0.00			
			TOTAL ANCILLARY	1,606,149.38	152,420.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,606,149.38	152,420.24

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014339054517	11/06/14 - 11/06/14	12/08/14	0.00	200.00	0.00	0.00	0.00
948	2014339054517	11/25/14 - 11/25/14	12/08/14	0.00	200.00	0.00	0.00	0.00
948	2014339054517	11/20/14 - 11/20/14	12/08/14	0.00	100.00	0.00	0.00	0.00
948	2014339054517	11/18/14 - 11/18/14	12/08/14	0.00	100.00	0.00	0.00	0.00
948	2014339054517	11/13/14 - 11/13/14	12/08/14	0.00	100.00	0.00	0.00	0.00
948	2014339054517	11/11/14 - 11/11/14	12/08/14	0.00	200.00	0.00	0.00	0.00
948	2015036049040	01/06/15 - 01/06/15	02/09/15	0.00	100.00	0.00	0.00	0.00
948	2015036049040	01/08/15 - 01/08/15	02/09/15	0.00	100.00	0.00	0.00	0.00
948	2015036049040	01/13/15 - 01/13/15	02/09/15	0.00	200.00	0.00	0.00	0.00
948	2015036049040	01/22/15 - 01/22/15	02/09/15	0.00	200.00	0.00	0.00	0.00
948	2015036049040	01/29/15 - 01/29/15	02/09/15	0.00	100.00	0.00	0.00	0.00
948	2015036049040	01/27/15 - 01/27/15	02/09/15	0.00	200.00	0.00	0.00	0.00
948	2015064050206	12/18/14 - 12/18/14	03/09/15	0.00	200.00	0.00	0.00	0.00
948	2015064050206	12/16/14 - 12/16/14	03/09/15	0.00	100.00	0.00	0.00	0.00
948	2015064050207	02/05/15 - 02/05/15	03/09/15	0.00	100.00	0.00	0.00	0.00
948	2015064050207	02/03/15 - 02/03/15	03/09/15	0.00	100.00	0.00	0.00	0.00
948	2015064050207	02/19/15 - 02/19/15	03/09/15	0.00	100.00	0.00	0.00	0.00
948	2015064050209	12/04/14 - 12/04/14	03/09/15	0.00	100.00	0.00	0.00	0.00
948	2015064050209	12/09/14 - 12/09/14	03/09/15	0.00	100.00	0.00	0.00	0.00
948	2015064050209	12/11/14 - 12/11/14	03/09/15	0.00	100.00	0.00	0.00	0.00
948	2015097046358	03/03/15 - 03/03/15	04/13/15	0.00	100.00	0.00	0.00	0.00
948	2015097046358	03/31/15 - 03/31/15	04/13/15	0.00	100.00	0.00	0.00	0.00
948	2015097046358	03/17/15 - 03/17/15	04/13/15	0.00	100.00	0.00	0.00	0.00
948	2015125048615	04/14/15 - 04/14/15	05/11/15	0.00	100.00	0.00	0.00	0.00
948	2015125048615	04/21/15 - 04/21/15	05/11/15	0.00	100.00	0.00	0.00	0.00
948	2015125048615	04/16/15 - 04/16/15	05/11/15	0.00	100.00	0.00	0.00	0.00
948	2015125048615	04/28/15 - 04/28/15	05/11/15	0.00	100.00	0.00	0.00	0.00
948	2015125048615	04/02/15 - 04/02/15	05/11/15	0.00	100.00	0.00	0.00	0.00
948	2015156047522	05/26/15 - 05/26/15	06/08/15	0.00	100.00	0.00	0.00	0.00
948	2015156047522	05/27/15 - 05/27/15	06/08/15	0.00	100.00	0.00	0.00	0.00
948	2015156047522	05/19/15 - 05/19/15	06/08/15	0.00	100.00	0.00	0.00	0.00
948	2015156047522	05/18/15 - 05/18/15	06/08/15	0.00	100.00	0.00	0.00	0.00
948	2015188019959	06/08/15 - 06/08/15	07/13/15	0.00	100.00	0.00	0.00	0.00
TOTAL				0.00	4,000.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL  
2540 WINDY HILL RD SE  
MARIETTA,GA 30067-8605

PROVIDER NUMBER  
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,958.42	ADJUSTMENTS	0.00
COVERED CHARGES	57,620.67	CONTRACTUAL ALLOW	28,609.72
NON-COVERD CHARGES	6,337.75	TOTAL MEDICAID LIAB	29,010.95
		LESS: COB	29,004.95
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR 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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	296.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,753.92	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	688.00	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	11,751.00	4,897.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,646.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,089.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,583.50	57.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,844.50	695.50			
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	5,656.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	57,620.67	6,337.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	57,620.67	6,337.75

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WINDY HILL HOSPITAL  
2540 WINDY HILL RD SE  
MARIETTA,GA 30067-8605

PROVIDER NUMBER  
000001999A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,638,612.74	ADJUSTMENTS	1,542,928.22
COVERED CHARGES	13,359,451.10	CONTRACTUAL ALLOW	8,489,712.69
NON-COVERD CHARGES	279,161.64	TOTAL MEDICAID LIAB	4,869,738.41
		LESS: COB	53,652.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,816,086.37

TOTAL NUMBER OF ADMISSIONS 706

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,420		0	762,899.00		131,587.90
ROUTINE NURSERY	318		0	162,392.60		549.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,738		0	925,291.60		132,136.90
SPECIAL CARE SERVICES						
CCU	821		0	767,607.28		3,752.92
ICU	361		0	470,744.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,182		0	1,238,351.28		3,752.92
TOTAL ACCOMODATIONS	2,920		0	2,163,642.88		135,889.82

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,354,283.88	13,260.30	OTHER LAB	54,355.10	839.40
MED/SURG SUPPLY	1,032,627.52	14,564.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,697,627.91	15,889.19	EDUCATION & TRAINING	4,594.90	0.00
RADIOLOGY-DIAGNOSTIC	199,235.60	1,030.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	720,380.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	94,834.70	8,445.90	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	82,890.50	215.30	MRI SERVICES	85,706.60	0.00
IV THERAPY	105,406.23	825.00	PROFESSIONAL FEES	0.00	2,146.80
OPERATING ROOM	937,787.10	5,508.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	161,865.80	2,678.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,171,130.40	4,119.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	156,681.80	1,327.80	AMBULANCE	0.00	0.00
GI SERVICES	171,107.40	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	385,923.20	712.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	103,136.60	576.80	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	68,279.50	0.00	INJECTABLE DRUGS	1,399,271.26	27,586.43
RADIOLOGY THERAPEUTIC	567.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,782.90	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,096.60	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	51,980.50	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	165.00	22,593.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	544,619.62	1,282.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	77,951.60	2,174.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	121,757.40	8,475.90			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	70,479.30	4,257.60			
AUDIOLOGY	16,230.60	0.00			
CARDIOLOGY	175,532.70	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,117.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	120,400.20	4,761.60			
			TOTAL ANCILLARY	11,195,808.22	143,271.82
			TOTAL ACCOMODATIONS	2,163,642.88	135,889.82
			TOTAL CHARGES	13,359,451.10	279,161.64

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 01:50:01  
 Page: 3

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,953.63	ADJUSTMENTS	0.00
COVERED CHARGES	18,322.43	CONTRACTUAL ALLOW	4,336.79
NON-COVERD CHARGES	631.20	TOTAL MEDICAID LIAB	13,985.64
		LESS: COB	13,985.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	2,228.00		631.20
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4		0	2,228.00		631.20
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	4		0	2,228.00		631.20



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,746.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,818.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,005.90	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,216.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,876.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	259.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	756.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,314.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	316.20	0.00	INJECTABLE DRUGS	1,345.63	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	437.80	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,094.43	0.00
			TOTAL ACCOMODATIONS	2,228.00	631.20
			TOTAL CHARGES	18,322.43	631.20

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 01:50:02  
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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,016,136.71	ADJUSTMENTS	455,986.94
COVERED CHARGES	8,298,911.65	CONTRACTUAL ALLOW	6,335,739.97
NON-COVERD CHARGES	717,225.06	TOTAL MEDICAID LIAB	1,963,171.68
		LESS: COB	1,451.36
		LESS: COPAYMENT	9,604.90
		REIMBURSEMENT	1,952,115.42
		ALL OTHER	1,568,887.63
		FEE SCHEDULE-LAB	214,281.27
		INJECTABLE DRUGS	168,946.52

TOTAL NUMBER OF CLAIMS 5,507

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	275,479.58	392.72	OTHER LAB	60,069.50	0.00
MED/SURG SUPPLY	322,607.85	10,194.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,047.20
RADIOLOGY-DIAGNOSTIC	296,884.50	7,904.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,269,919.70	81,174.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,004.40	11,150.56	FEE SCHEDULE LAB	961,022.26	131,405.36
EKG/ECG	89,454.40	2,153.00	MRI SERVICES	204,822.50	17,702.50
IV THERAPY	236,897.20	5,114.99	PROFESSIONAL FEES	0.00	1,052.00
OPERATING ROOM	670,409.07	34,921.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	135,214.00	11,927.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	109,672.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	185,993.60	5,490.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	939,337.00	6,946.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	79,187.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	874,796.41	195,690.60
RADIOLOGY THERAPEUTIC	64,537.60	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,869.20	5,149.30	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,560.40	871.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,051.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	229,713.10	24,514.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	69,239.10	28,140.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	244,090.90	23,918.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	25,512.70	16,737.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	367,788.80	53,515.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	238,679.10	34,908.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	104,763.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	195,385.58	152.40			
			TOTAL ANCILLARY	8,298,911.65	717,225.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,298,911.65	717,225.06

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
Run Time: 01:51:15  
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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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	211,114.73	ADJUSTMENTS	0.00
COVERED CHARGES	148,374.63	CONTRACTUAL ALLOW	11,537.31
NON-COVERD CHARGES	62,740.10	TOTAL MEDICAID LIAB	136,837.32
		LESS: COB	136,753.32
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 106

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,912.73	378.15	OTHER LAB	254.40	254.40
MED/SURG SUPPLY	9,877.63	659.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,359.90	472.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,106.20	10,814.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,001.10	3,549.10
EKG/ECG	753.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,673.70	319.83	PROFESSIONAL FEES	0.00	3,706.00
OPERATING ROOM	25,512.24	9,031.46	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,733.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,873.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,924.30	786.90	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,861.33	13,498.06
RADIOLOGY THERAPEUTIC	2,344.40	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,275.40	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,310.70	3,279.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,095.70	1,706.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,335.00	4,307.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,280.30	6,559.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,708.80	3,417.60			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,181.60	0.00			
			TOTAL ANCILLARY	148,374.63	62,740.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	148,374.63	62,740.10

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:51:17  
Page: 9

COLQUITT REGIONAL MEDICAL CTR  
3131 THOMASVILLE HWY  
MOULTRIE,GA 31776-6925

PROVIDER NUMBER  
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	348,571.31	ADJUSTMENTS	1,267.56
COVERED CHARGES	339,120.59	CONTRACTUAL ALLOW	315,681.73
NON-COVERD CHARGES	9,450.72	TOTAL MEDICAID LIAB	23,438.86
		LESS: COB	37.31
		LESS: COPAYMENT	867.31
		REIMBURSEMENT	22,534.24
		TOTAL NUMBER OF CLAIMS	419

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,480.66	0.00	OTHER LAB	3,357.60	0.00
MED/SURG SUPPLY	9,242.10	975.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,964.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,860.70	1,908.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,642.90	2,754.70
EKG/ECG	3,014.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,753.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	951.30	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	183,545.60	376.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,024.33	2,547.62
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	601.60	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	188.50	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	3,242.60	231.70			
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	1,852.80	0.00			
			TOTAL ANCILLARY	339,120.59	9,450.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	339,120.59	9,450.72

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:51:23  
Page: 11

COLQUITT REGIONAL MEDICAL CTR  
3131 THOMASVILLE HWY  
MOULTRIE,GA 31776-6925

PROVIDER NUMBER 000002021A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,227.15	ADJUSTMENTS	0.00
COVERED CHARGES	8,807.02	CONTRACTUAL ALLOW	838.49
NON-COVERD CHARGES	2,420.13	TOTAL MEDICAID LIAB	7,968.53
		LESS: COB	7,956.53
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 9



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	436.74	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	368.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	679.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,979.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,105.70	40.20
EKG/ECG	430.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	937.30	0.00	PROFESSIONAL FEES	0.00	390.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,688.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	161.78	10.23
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	534.60	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	463.20	0.00			
			TOTAL ANCILLARY	8,807.02	2,420.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,807.02	2,420.13

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
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Page: 13

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,432,245.05	ADJUSTMENTS	49,704.95
COVERED CHARGES	1,414,909.25	CONTRACTUAL ALLOW	1,186,720.69
NON-COVERD CHARGES	17,335.80	TOTAL MEDICAID LIAB	228,188.56
		LESS: COB	0.00
		LESS: COPAYMENT	234.63
		REIMBURSEMENT	227,953.93
		TOTAL NUMBER OF CLAIMS	41

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,957.66	0.00	OTHER LAB	2,521.44	0.00
MED/SURG SUPPLY	40,342.90	51.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,891.40	473.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,854.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	940.50	FEE SCHEDULE LAB	17,763.50	2,226.10
EKG/ECG	1,937.70	0.00	MRI SERVICES	2,717.10	0.00
IV THERAPY	21,398.10	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	61,791.33	1,687.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,091.40	205.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,448.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	268,546.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,134.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	773,952.67	6,999.97
RADIOLOGY THERAPEUTIC	33,410.10	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,677.80	47.40	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	65,237.55	457.70
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,610.80	257.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,023.60	2,153.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,835.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,600.70	0.00			
			TOTAL ANCILLARY	1,414,909.25	17,335.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,414,909.25	17,335.80

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,613,225.70	ADJUSTMENTS	91,807.15
COVERED CHARGES	14,147,410.31	CONTRACTUAL ALLOW	8,182,466.27
NON-COVERD CHARGES	465,815.39	TOTAL MEDICAID LIAB	5,964,944.04
		LESS: COB	23,091.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,941,852.97

TOTAL NUMBER OF ADMISSIONS 1,304

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,540		0	7,487,220.00		449,870.00
ROUTINE NURSERY	110		0	71,500.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7,650		0	7,558,720.00		449,870.00
SPECIAL CARE SERVICES						
CCU	193		0	325,205.00		0.00
ICU	125		0	312,500.00		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		4	0.00		4,200.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	318		4	637,705.00		4,200.00
TOTAL ACCOMODATIONS	7,968		4	8,196,425.00		454,070.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,488,755.04	0.00	OTHER LAB	32,343.00	0.00
MED/SURG SUPPLY	206,341.58	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,530,288.00	0.00	EDUCATION & TRAINING	1,235.00	0.00
RADIOLOGY-DIAGNOSTIC	80,368.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	244,259.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	31,462.38	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	55,757.00	0.00	MRI SERVICES	61,433.00	0.00
IV THERAPY	150,846.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	236,352.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	131,424.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	339,352.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	40,740.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	22,804.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	524,767.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,652.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	535.39
LABORATORY PATHOLOGIC	21,058.00	0.00	INJECTABLE DRUGS	244,541.11	0.00
RADIOLOGY THERAPEUTIC	6,025.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	295.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,518.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	27,048.00	3,864.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,385.00	237.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,450.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,109.00
OTHER IMAGING SERVICE	25,481.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	103,119.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	64,014.00	0.00			
AUDIOLOGY	4,080.00	0.00			
CARDIOLOGY	184,839.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,422.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	67,531.00	0.00			
			TOTAL ANCILLARY	5,950,985.31	11,745.39
			TOTAL ACCOMODATIONS	8,196,425.00	454,070.00
			TOTAL CHARGES	14,147,410.31	465,815.39

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
Run Time: 03:24:31  
Page: 3

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2315205000242	04/14/15 - 04/20/15	08/17/15	0.00	3,873.00	0.00	0.00	0.00
615	2315205000242	04/14/15 - 04/20/15	08/17/15	0.00	3,236.00	0.00	0.00	0.00
TOTAL				0.00	7,109.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:24:41  
 Page: 4

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,207.06	ADJUSTMENTS	0.00
COVERED CHARGES	10,033.06	CONTRACTUAL ALLOW	6,357.00
NON-COVERD CHARGES	174.00	TOTAL MEDICAID LIAB	3,676.06
		LESS: COB	3,676.06
		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	1,986.00		174.00
ROUTINE NURSERY	0		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	1,986.00		174.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,986.00		174.00



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:24:41  
 Page: 5

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,096.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,707.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	4,769.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	405.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	70.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,047.06	0.00
			TOTAL ACCOMODATIONS	1,986.00	174.00
			TOTAL CHARGES	10,033.06	174.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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TANNER MEDICAL CENTER VILLA RICA  
601 DALLAS HWY  
VILLA RICA,GA 30180-1202

PROVIDER NUMBER  
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,715,205.95	ADJUSTMENTS	391,079.09
COVERED CHARGES	10,232,558.61	CONTRACTUAL ALLOW	7,336,743.15
NON-COVERD CHARGES	482,647.34	TOTAL MEDICAID LIAB	2,895,815.46
		LESS: COB	2,776.77
		LESS: COPAYMENT	5,922.00
		REIMBURSEMENT	2,887,116.69
		ALL OTHER	2,174,955.07
		FEE SCHEDULE-LAB	100,227.28
		INJECTABLE DRUGS	611,934.34
		TOTAL NUMBER OF CLAIMS	3,822

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	377,001.76	4,642.97	OTHER LAB	53,192.00	0.00
MED/SURG SUPPLY	126,498.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	730.00
RADIOLOGY-DIAGNOSTIC	439,215.00	2,886.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,345,235.00	79,407.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	425.00	6,990.00	FEE SCHEDULE LAB	1,189,103.30	182,552.80
EKG/ECG	101,175.00	1,687.00	MRI SERVICES	267,798.00	20,053.00
IV THERAPY	656,300.00	21,330.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	416,251.00	31,713.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,927.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	61,784.05	1,775.85	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	112,468.00	1,040.00	AMBULANCE	0.00	0.00
GI SERVICES	128,104.00	6,548.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,817,517.00	15,890.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,798.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	931,782.63	40,893.72
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	2,256.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,864.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	26,122.00	3,975.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,335,840.00	1,210.00	IMPL DEV CHARGE PATIENTS	25,227.07	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,190.00
OTHER IMAGING SERVICE	212,680.00	16,968.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	47,174.00	1,604.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	167,121.00	15,780.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	166,974.00	16,551.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	70,938.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142,907.00	110.00			
			TOTAL ANCILLARY	10,232,558.61	482,647.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,232,558.61	482,647.34

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

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TANNER MEDICAL CENTER VILLA RICA  
601 DALLAS HWY  
VILLA RICA,GA 30180-1202

PROVIDER NUMBER  
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015148077600	05/11/15 - 05/11/15	06/01/15	0.00	365.00	0.00	0.00	0.00
905	2015148077600	05/08/15 - 05/08/15	06/01/15	0.00	365.00	0.00	0.00	0.00
905	2015148077600	05/07/15 - 05/07/15	06/01/15	0.00	365.00	0.00	0.00	0.00
905	2015148077600	05/06/15 - 05/06/15	06/01/15	0.00	365.00	0.00	0.00	0.00
905	2015148077600	05/01/15 - 05/01/15	06/01/15	0.00	365.00	0.00	0.00	0.00
905	2015156045457	05/20/15 - 05/20/15	06/08/15	0.00	365.00	0.00	0.00	0.00
TOTAL				0.00	2,190.00	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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,315.96	ADJUSTMENTS	0.00
COVERED CHARGES	26,983.25	CONTRACTUAL ALLOW	11,325.84
NON-COVERD CHARGES	18,332.71	TOTAL MEDICAID LIAB	15,657.41
		LESS: COB	15,618.41
		LESS: COPAYMENT	39.00
		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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	928.30	273.26	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,455.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	286.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	578.00	21.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,260.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,257.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,194.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,720.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42.00	13,658.45
RADIOLOGY THERAPEUTIC	1,150.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	6,655.00	0.00	IMPL DEV CHARGE PATIENTS	1,750.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,380.00
OTHER IMAGING SERVICE	707.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,983.25	18,332.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,983.25	18,332.71

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014308056652	08/18/14 - 08/18/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/29/14 - 08/29/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/22/14 - 08/22/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/25/14 - 08/25/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/27/14 - 08/27/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/04/14 - 08/04/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/06/14 - 08/06/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/08/14 - 08/08/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/11/14 - 08/11/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/13/14 - 08/13/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/15/14 - 08/15/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
905	2014308056652	08/20/14 - 08/20/14	11/10/14	0.00	365.00	0.00	4,577.60	0.00
TOTAL				0.00	4,380.00	0.00	54,931.20	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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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	481,906.93	ADJUSTMENTS	211.76
COVERED CHARGES	470,431.89	CONTRACTUAL ALLOW	448,111.83
NON-COVERD CHARGES	11,475.04	TOTAL MEDICAID LIAB	22,320.06
		LESS: COB	0.00
		LESS: COPAYMENT	789.00
		REIMBURSEMENT	21,531.06
		TOTAL NUMBER OF CLAIMS	399



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,226.87	0.00	OTHER LAB	1,825.00	0.00
MED/SURG SUPPLY	1,027.17	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,261.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,154.00	1,823.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	815.00	FEE SCHEDULE LAB	79,297.00	7,605.00
EKG/ECG	5,302.00	0.00	MRI SERVICES	3,236.00	0.00
IV THERAPY	31,550.00	480.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,730.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	245,424.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,058.85	92.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	210.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,120.00	450.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	220.00	0.00			
			TOTAL ANCILLARY	470,431.89	11,475.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	470,431.89	11,475.04

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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TANNER MEDICAL CENTER VILLA RICA  
601 DALLAS HWY  
VILLA RICA,GA 30180-1202

PROVIDER NUMBER  
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,090.73	ADJUSTMENTS	0.00
COVERED CHARGES	6,497.73	CONTRACTUAL ALLOW	5,612.65
NON-COVERD CHARGES	593.00	TOTAL MEDICAID LIAB	885.08
		LESS: COB	882.08
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	146.73	11.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	250.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,219.00	42.00
EKG/ECG	241.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	460.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,700.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,481.00	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	0.00	0.00			
			TOTAL ANCILLARY	6,497.73	593.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,497.73	593.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER VILLA RICA  
601 DALLAS HWY  
VILLA RICA,GA 30180-1202

PROVIDER NUMBER  
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,055,198.64	ADJUSTMENTS	27,542.10
COVERED CHARGES	1,001,109.59	CONTRACTUAL ALLOW	791,521.36
NON-COVERD CHARGES	54,089.05	TOTAL MEDICAID LIAB	209,588.23
		LESS: COB	0.00
		LESS: COPAYMENT	390.00
		REIMBURSEMENT	209,198.23
		TOTAL NUMBER OF CLAIMS	38

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	120,902.62	695.00	OTHER LAB	1,118.00	0.00
MED/SURG SUPPLY	178,978.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,734.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,823.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	45,274.00	4,022.00
EKG/ECG	2,892.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	56,580.00	1,045.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	228,739.17	34,077.83	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,696.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,716.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,999.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	92,386.14	1,189.22
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	210.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	100,430.00	0.00	IMPL DEV CHARGE PATIENTS	79,473.12	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,470.00	550.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,432.00	12,300.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,466.00	0.00			
			TOTAL ANCILLARY	1,001,109.59	54,089.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,001,109.59	54,089.05

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 02:57:20  
 Page: 1

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	665,743.94	ADJUSTMENTS	23,169.09
COVERED CHARGES	651,812.69	CONTRACTUAL ALLOW	340,977.67
NON-COVERD CHARGES	13,931.25	TOTAL MEDICAID LIAB	310,835.02
		LESS: COB	1,123.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	309,711.03

TOTAL NUMBER OF ADMISSIONS 49

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	125		0	32,500.00		11,205.25
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	125		0	32,500.00		11,205.25
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	44		0	46,222.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	46,222.00		0.00
TOTAL ACCOMODATIONS	169		0	78,722.00		11,205.25

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	183,908.40	0.00	OTHER LAB	2,170.50	0.00
MED/SURG SUPPLY	51,959.63	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	118,523.96	0.00	EDUCATION & TRAINING	746.00	0.00
RADIOLOGY-DIAGNOSTIC	21,014.25	0.00	OTHER THERAPEUTIC SVC	0.00	598.50
CT SCAN	30,705.00	2,127.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,959.75	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,231.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	30,873.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	49,019.75	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	49,822.75	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	8,544.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,073.75	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	207.50	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	553.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,865.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	912.00	0.00			
			TOTAL ANCILLARY	573,090.69	2,726.00
			TOTAL ACCOMODATIONS	78,722.00	11,205.25
			TOTAL CHARGES	651,812.69	13,931.25



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:57:20  
Page: 4

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,425,123.35	ADJUSTMENTS	27,932.27
COVERED CHARGES	1,367,091.95	CONTRACTUAL ALLOW	1,052,058.75
NON-COVERD CHARGES	58,031.40	TOTAL MEDICAID LIAB	315,033.20
		LESS: COB	360.16
		LESS: COPAYMENT	1,271.44
		REIMBURSEMENT	313,401.60
		ALL OTHER	275,493.00
		FEE SCHEDULE-LAB	37,773.54
		INJECTABLE DRUGS	135.06
		TOTAL NUMBER OF CLAIMS	1,202

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,507.17	1,185.80	OTHER LAB	14,764.75	0.00
MED/SURG SUPPLY	73,319.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	179.50
RADIOLOGY-DIAGNOSTIC	100,114.50	85.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	73,350.95	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	247,294.34	45,558.10
EKG/ECG	49,199.05	204.75	MRI SERVICES	13,620.25	3,211.00
IV THERAPY	49,864.25	840.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	94,185.20	2,126.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,560.50	442.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,529.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	370,009.00	249.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,382.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,913.45	589.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18,727.25	542.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,551.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,575.00	756.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,864.25	326.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	39,040.75	1,735.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,405.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,312.75	0.00			
			TOTAL ANCILLARY	1,367,091.95	58,031.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,367,091.95	58,031.40

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: 08/12/2016  
Run Time: 02:57:27  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,891.27	ADJUSTMENTS	0.00
COVERED CHARGES	10,877.77	CONTRACTUAL ALLOW	6,067.98
NON-COVERD CHARGES	1,013.50	TOTAL MEDICAID LIAB	4,809.79
		LESS: COB	4,794.79
		LESS: COPAYMENT	15.00
		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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 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	212.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,418.00	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	3,892.52	808.75
EKG/ECG	586.75	204.75	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,224.75	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	3,543.75	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	10,877.77	1,013.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,877.77	1,013.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:57:28  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	125,946.50	ADJUSTMENTS	370.58
COVERED CHARGES	122,863.12	CONTRACTUAL ALLOW	114,975.58
NON-COVERD CHARGES	3,083.38	TOTAL MEDICAID LIAB	7,887.54
		LESS: COB	0.00
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	7,605.54
		TOTAL NUMBER OF CLAIMS	141

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,572.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,955.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,779.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,513.35	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,763.32	2,962.38
EKG/ECG	2,169.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,154.50	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	715.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	80,235.75	83.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,468.40	38.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	536.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	122,863.12	3,083.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	122,863.12	3,083.38

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: 08/12/2016  
Run Time: 02:57:29  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 02:57:29  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY,GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	290,642.90	ADJUSTMENTS	5,625.15
COVERED CHARGES	285,254.70	CONTRACTUAL ALLOW	240,229.50
NON-COVERD CHARGES	5,388.20	TOTAL MEDICAID LIAB	45,025.20
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	45,001.20
		TOTAL NUMBER OF CLAIMS	8

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,989.99	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	85,862.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,464.25	500.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	423.00	FEE SCHEDULE LAB	2,070.28	171.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,680.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	79,446.65	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	157.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	74,943.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,050.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	625.20	135.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	4,159.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	505.75	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	460.00	0.00			
			TOTAL ANCILLARY	285,254.70	5,388.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	285,254.70	5,388.20

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 02:57:29  
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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	07/01/14	THROUGH	06/30/15
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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,646,175.38	ADJUSTMENTS	104,675.93
COVERED CHARGES	4,590,770.38	CONTRACTUAL ALLOW	3,007,504.86
NON-COVERD CHARGES	55,405.00	TOTAL MEDICAID LIAB	1,583,265.52
		LESS: COB	37,569.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,545,695.53

TOTAL NUMBER OF ADMISSIONS 239

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	783		0	375,840.00		47,595.00
ROUTINE NURSERY	66		0	21,120.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	849		0	396,960.00		47,595.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	154		0	193,732.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	154		0	193,732.00		0.00
TOTAL ACCOMODATIONS	1,003		0	590,692.00		47,595.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:34:00  
 Page: 2

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,022,016.40	0.00	OTHER LAB	13,643.00	0.00
MED/SURG SUPPLY	938,342.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	639,940.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,821.00	0.00	OTHER THERAPEUTIC SVC	0.00	15.00
CT SCAN	212,566.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	35,763.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	31,464.00	0.00	MRI SERVICES	21,992.00	0.00
IV THERAPY	73,097.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	305,904.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,021.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	158,434.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,364.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,096.00	1,630.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,492.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	789.00	0.00	INJECTABLE DRUGS	20,184.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,773.03	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,373.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,320.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,140.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,565.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,334.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,773.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,556.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	72,582.00	0.00			
AMBULATORY SURGERY	3,522.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	101,350.98	2,025.00			
			TOTAL ANCILLARY	4,000,078.38	7,810.00
			TOTAL ACCOMODATIONS	590,692.00	47,595.00
			TOTAL CHARGES	4,590,770.38	55,405.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:34:05  
 Page: 3

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,896.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,774.00	CONTRACTUAL ALLOW	3,531.93
NON-COVERD CHARGES	122.00	TOTAL MEDICAID LIAB	11,242.07
		LESS: COB	11,242.07
		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	960.00		122.00
ROUTINE NURSERY	0		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	960.00		122.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	960.00		122.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,511.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,308.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	768.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,942.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	268.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	657.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	360.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,814.00	0.00
			TOTAL ACCOMODATIONS	960.00	122.00
			TOTAL CHARGES	14,774.00	122.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:34:06  
Page: 5

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,624,172.96	ADJUSTMENTS	294,622.16
COVERED CHARGES	4,040,645.65	CONTRACTUAL ALLOW	3,029,985.83
NON-COVERD CHARGES	583,527.31	TOTAL MEDICAID LIAB	1,010,659.82
		LESS: COB	2,017.33
		LESS: COPAYMENT	2,634.00
		REIMBURSEMENT	1,006,008.49
		ALL OTHER	914,724.69
		FEE SCHEDULE-LAB	78,545.39
		INJECTABLE DRUGS	12,738.41
		TOTAL NUMBER OF CLAIMS	2,618



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	260,119.00	1,625.00	OTHER LAB	18,971.00	0.00
MED/SURG SUPPLY	522,510.47	696.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	173,275.00	3,840.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	667,714.06	83,497.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	366.00	3,710.03	FEE SCHEDULE LAB	688,396.90	145,819.10
EKG/ECG	48,827.00	5,480.00	MRI SERVICES	125,825.00	9,176.00
IV THERAPY	120,502.00	43,014.97	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	256,265.50	40,206.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,395.00	536.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,520.00	118.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,155.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	538,797.00	6,224.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	29,016.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	85,438.25	134,034.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,520.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,209.00	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	25,198.00	525.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	12,495.00
LITHOTRIPSY	70,639.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	100,220.00	24,978.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,550.00	1,214.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	50,290.00	13,640.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	53,130.00	26,560.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	114,525.47	22,408.96			
			TOTAL ANCILLARY	4,040,645.65	583,527.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,040,645.65	583,527.31

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	99,243.17	ADJUSTMENTS	0.00
COVERED CHARGES	79,345.17	CONTRACTUAL ALLOW	28,834.94
NON-COVERD CHARGES	19,898.00	TOTAL MEDICAID LIAB	50,510.23
		LESS: COB	50,486.23
		LESS: COPAYMENT	24.00
		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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,954.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,862.17	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,886.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,001.00	2,724.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,693.00	2,168.00
EKG/ECG	608.00	0.00	MRI SERVICES	0.00	5,636.00
IV THERAPY	3,897.00	666.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,059.00	4,112.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,761.00	268.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	442.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,241.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,104.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	588.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,209.00	1,520.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	1,813.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,051.00	958.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,176.00	1,846.00			
			TOTAL ANCILLARY	79,345.17	19,898.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	79,345.17	19,898.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	363,256.51	ADJUSTMENTS	1,326.50
COVERED CHARGES	332,926.01	CONTRACTUAL ALLOW	308,256.47
NON-COVERD CHARGES	30,330.50	TOTAL MEDICAID LIAB	24,669.54
		LESS: COB	51.77
		LESS: COPAYMENT	930.00
		REIMBURSEMENT	23,687.77
		TOTAL NUMBER OF CLAIMS	441

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,611.00	0.00	OTHER LAB	2,160.00	0.00
MED/SURG SUPPLY	14,356.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	18,713.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,150.00	11,617.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	69,299.00	8,935.00
EKG/ECG	3,496.00	0.00	MRI SERVICES	0.00	2,818.00
IV THERAPY	19,909.00	3,870.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	609.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	134,817.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,981.50	1,762.50
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	5,260.00	1,328.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	564.00	0.00			
			TOTAL ANCILLARY	332,926.01	30,330.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	332,926.01	30,330.50

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

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,165.25	ADJUSTMENTS	0.00
COVERED CHARGES	7,731.25	CONTRACTUAL ALLOW	3,566.16
NON-COVERD CHARGES	2,434.00	TOTAL MEDICAID LIAB	4,165.09
		LESS: COB	4,156.09
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	327.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	313.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	438.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,788.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,469.00	580.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	325.00	66.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,162.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.25	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	697.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,731.25	2,434.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,731.25	2,434.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEMORIAL HOSPITAL  
865 S 1ST ST  
JESUP,GA 31545-0210

PROVIDER NUMBER  
000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	362,184.17	ADJUSTMENTS	17,572.95
COVERED CHARGES	356,044.17	CONTRACTUAL ALLOW	268,104.42
NON-COVERD CHARGES	6,140.00	TOTAL MEDICAID LIAB	87,939.75
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	87,867.75
		TOTAL NUMBER OF CLAIMS	15



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,038.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41,232.17	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	635.00	210.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,041.00	239.00
EKG/ECG	1,368.00	456.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	492.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,097.00	2,191.00	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	9,845.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,203.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,789.00	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	1,052.00
LITHOTRIPSY	258,752.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	356,044.17	6,140.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	356,044.17	6,140.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEMORIAL HOSPITAL  
865 S 1ST ST  
JESUP,GA 31545-0210

PROVIDER NUMBER  
000002054A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:36:32  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR WEST GEORGIA MEDICAL CENTER  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER 000002065A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,706,060.36	ADJUSTMENTS	1,580,840.40
COVERED CHARGES	14,557,557.22	CONTRACTUAL ALLOW	9,332,140.82
NON-COVERD CHARGES	148,503.14	TOTAL MEDICAID LIAB	5,225,416.40
		LESS: COB	69,726.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,155,689.72

TOTAL NUMBER OF ADMISSIONS 632

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,428		4	1,256,990.00		77,200.00
ROUTINE NURSERY	168		0	103,740.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,596		4	1,360,730.00		77,200.00
SPECIAL CARE SERVICES						
CCU	712		0	1,124,595.00		0.00
ICU	313		0	647,165.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,025		0	1,771,760.00		0.00
TOTAL ACCOMODATIONS	2,621		4	3,132,490.00		77,200.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR WEST GEORGIA MEDICAL CENTER  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,610,444.95	0.00	OTHER LAB	57,840.90	0.00
MED/SURG SUPPLY	646,402.34	3,265.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,877,853.22	0.00	EDUCATION & TRAINING	13,584.10	0.00
RADIOLOGY-DIAGNOSTIC	298,737.15	0.00	OTHER THERAPEUTIC SVC	0.00	525.25
CT SCAN	760,611.85	1,485.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	132,047.40	0.14	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	104,438.00	0.00	MRI SERVICES	129,106.30	0.00
IV THERAPY	8,586.35	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,768,243.60	26,326.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	225,434.65	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	627,298.65	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	401,566.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	176,224.80	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	735,093.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	144,062.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	69,311.60	0.00	INJECTABLE DRUGS	135.75	0.00
RADIOLOGY THERAPEUTIC	50,466.25	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,355.60	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	75,592.00	1,576.60	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	132.35	4,163.35	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	339,802.46	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	95,241.65	12,968.40			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	236,982.10	16,115.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	80,850.25	4,876.30			
AUDIOLOGY	12,910.20	0.00			
CARDIOLOGY	716,622.95	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,360.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,726.90	0.00			
			TOTAL ANCILLARY	11,425,067.22	71,303.14
			TOTAL ACCOMODATIONS	3,132,490.00	77,200.00
			TOTAL CHARGES	14,557,557.22	148,503.14

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
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WELLSTAR WEST GEORGIA MEDICAL CENTER  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	203,681.75	ADJUSTMENTS	0.00
COVERED CHARGES	202,526.45	CONTRACTUAL ALLOW	85,078.63
NON-COVERD CHARGES	1,155.30	TOTAL MEDICAID LIAB	117,447.82
		LESS: COB	117,447.82
		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	20		0	17,930.00		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	20		0	17,930.00		660.00
SPECIAL CARE SERVICES						
CCU	6		0	9,120.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6		0	9,120.00		0.00
TOTAL ACCOMODATIONS	26		0	27,050.00		660.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR WEST GEORGIA MEDICAL CENTER  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,984.33	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,346.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,602.80	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	938.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,970.70	495.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	358.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	295.80	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	53,686.95	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,776.95	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	209.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,503.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,077.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,590.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,780.65	0.00	INJECTABLE DRUGS	6,547.22	0.00
RADIOLOGY THERAPEUTIC	8,890.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,060.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,125.20	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	730.65	0.00			
			TOTAL ANCILLARY	175,476.45	495.30
			TOTAL ACCOMODATIONS	27,050.00	660.00
			TOTAL CHARGES	202,526.45	1,155.30

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:36:40  
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WELLSTAR WEST GEORGIA MEDICAL CENTER  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,459,600.59	ADJUSTMENTS	310,088.31
COVERED CHARGES	12,317,338.71	CONTRACTUAL ALLOW	10,021,819.58
NON-COVERD CHARGES	1,142,261.88	TOTAL MEDICAID LIAB	2,295,519.13
		LESS: COB	2,285.92
		LESS: COPAYMENT	7,741.03
		REIMBURSEMENT	2,285,492.18
		ALL OTHER	1,933,811.39
		FEE SCHEDULE-LAB	250,592.37
		INJECTABLE DRUGS	101,088.42

TOTAL NUMBER OF CLAIMS 6,851

WELLSTAR WEST GEORGIA MEDICAL CENTER  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	279,284.02	1,048.50	OTHER LAB	183,277.90	0.00
MED/SURG SUPPLY	277,619.75	124,954.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	4,757.28	EDUCATION & TRAINING	0.00	3,418.90
RADIOLOGY-DIAGNOSTIC	423,033.65	14,247.45	OTHER THERAPEUTIC SVC	0.00	510.35
CT SCAN	1,040,980.45	77,994.65	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	37,880.90	7,156.46	FEE SCHEDULE LAB	2,161,257.25	214,631.95
EKG/ECG	120,515.70	8,519.40	MRI SERVICES	123,492.25	2,262.50
IV THERAPY	395,104.70	14,537.90	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,204,004.70	115,533.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,117.15	451.65	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	258,104.35	12,434.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	366,403.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	176,773.98	20,789.47	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,127,722.25	57,724.35	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	167,914.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	341,242.86	94,820.67
RADIOLOGY THERAPEUTIC	340,600.90	257,380.20	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,883.70	437.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,809.35	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	43,867.40	431.15	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	409,265.10	26,455.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	26,568.50	1,074.35			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	53,333.70	27,175.85			
AUDIOLOGY	892.30	318.05			
CARDIOLOGY	331,497.80	44,064.75			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,656.15	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	381,043.10	6,321.15			
			TOTAL ANCILLARY	12,317,338.71	1,142,261.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,317,338.71	1,142,261.88



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WEST GEORGIA MEDICAL CENTER  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	440,576.80	ADJUSTMENTS	0.00
COVERED CHARGES	343,615.57	CONTRACTUAL ALLOW	88,684.01
NON-COVERD CHARGES	96,961.23	TOTAL MEDICAID LIAB	254,931.56
		LESS: COB	254,711.04
		LESS: COPAYMENT	220.52
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 189

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WEST GEORGIA MEDICAL CENTER  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,827.63	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,156.65	7,911.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	62.35
RADIOLOGY-DIAGNOSTIC	7,472.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,408.50	18,872.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	358.10	942.90	FEE SCHEDULE LAB	58,315.40	4,725.50
EKG/ECG	2,950.90	147.90	MRI SERVICES	2,509.35	4,857.80
IV THERAPY	15,505.20	121.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	45,223.42	11,933.18	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,831.80	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	649.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,883.40	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	69,013.35	1,095.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,191.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,723.42	19,717.30
RADIOLOGY THERAPEUTIC	22,900.35	11,272.20	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,083.80	124.85	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,604.25	11,272.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,041.40	1,074.35			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,160.10			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,756.10	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	941.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,267.05	670.10			
			TOTAL ANCILLARY	343,615.57	96,961.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	343,615.57	96,961.23

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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WELLSTAR WEST GEORGIA MEDICAL CENTER  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	712,788.95	ADJUSTMENTS	644.28
COVERED CHARGES	691,895.13	CONTRACTUAL ALLOW	646,304.03
NON-COVERD CHARGES	20,893.82	TOTAL MEDICAID LIAB	45,591.10
		LESS: COB	0.00
		LESS: COPAYMENT	1,632.48
		REIMBURSEMENT	43,958.62
		TOTAL NUMBER OF CLAIMS	815

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR WEST GEORGIA MEDICAL CENTER  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,255.22	10.25	OTHER LAB	1,610.45	0.00
MED/SURG SUPPLY	5,384.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,591.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,676.30	7,109.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	111,630.20	5,138.05
EKG/ECG	6,621.90	0.00	MRI SERVICES	0.00	5,018.70
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,955.45	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,218.75	119.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,962.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	479,016.43	1,709.82	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,309.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,836.58	244.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,825.90	463.35			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,080.05			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	691,895.13	20,893.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	691,895.13	20,893.82

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

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WELLSTAR WEST GEORGIA MEDICAL CENTER  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,242.75	ADJUSTMENTS	0.00
COVERED CHARGES	18,082.00	CONTRACTUAL ALLOW	7,390.53
NON-COVERD CHARGES	1,160.75	TOTAL MEDICAID LIAB	10,691.47
		LESS: COB	10,676.47
		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

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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR WEST GEORGIA MEDICAL CENTER  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110.50	0.00	OTHER LAB	547.15	0.00
MED/SURG SUPPLY	227.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,212.65	366.40
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,310.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	295.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	379.60	794.35			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,082.00	1,160.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,082.00	1,160.75

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WEST GEORGIA MEDICAL CENTER  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,483,814.91	ADJUSTMENTS	103,231.91
COVERED CHARGES	1,338,266.60	CONTRACTUAL ALLOW	1,029,937.43
NON-COVERD CHARGES	145,548.31	TOTAL MEDICAID LIAB	308,329.17
		LESS: COB	0.00
		LESS: COPAYMENT	739.30
		REIMBURSEMENT	307,589.87
		TOTAL NUMBER OF CLAIMS	56

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WEST GEORGIA MEDICAL CENTER  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,214.70	722.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,733.21	97,784.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	187.05
RADIOLOGY-DIAGNOSTIC	21,680.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,310.30	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	418.55	358.12	FEE SCHEDULE LAB	41,751.75	4,284.10
EKG/ECG	1,035.30	1,035.30	MRI SERVICES	7,562.70	0.00
IV THERAPY	211,378.30	3,977.95	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	148,025.79	6,762.16	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	59,259.95	192.15	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,449.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,155.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,745.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	564,596.55	20,380.00
RADIOLOGY THERAPEUTIC	77,665.10	6,953.70	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	481.23	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,184.35	319.95	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,749.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,339.05	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	776.60	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	94,886.55	1,663.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,347.15	445.85			
			TOTAL ANCILLARY	1,338,266.60	145,548.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,338,266.60	145,548.31



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

WELLSTAR WEST GEORGIA MEDICAL CENTER  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,481.05	ADJUSTMENTS	0.00
COVERED CHARGES	27,284.55	CONTRACTUAL ALLOW	9,817.34
NON-COVERD CHARGES	196.50	TOTAL MEDICAID LIAB	17,467.21
		LESS: COB	17,446.21
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

WELLSTAR WEST GEORGIA MEDICAL CENTER  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	673.96	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,512.05	121.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,767.55	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,810.29	75.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	520.70	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,284.55	196.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,284.55	196.50

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
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 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WILLS MEMORIAL HOSPITAL  
 120 GORDON ST  
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER 000002087A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	340,610.00	ADJUSTMENTS	9,555.02
COVERED CHARGES	336,110.00	CONTRACTUAL ALLOW	156,661.41
NON-COVERD CHARGES	4,500.00	TOTAL MEDICAID LIAB	179,448.59
		LESS: COB	5,723.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	173,725.05

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	134		0	64,320.00		4,320.00
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	134		0	64,320.00		4,320.00
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	134		0	64,320.00		4,320.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WILLS MEMORIAL HOSPITAL  
 120 GORDON ST  
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,942.00	0.00	OTHER LAB	3,295.00	0.00
MED/SURG SUPPLY	37,566.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,753.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,624.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,840.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,075.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,365.00	0.00	MRI SERVICES	19,800.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,904.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,273.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	84.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,822.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,905.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,032.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,170.00	180.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,279.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,061.00	0.00			
			TOTAL ANCILLARY	271,790.00	180.00
			TOTAL ACCOMODATIONS	64,320.00	4,320.00
			TOTAL CHARGES	336,110.00	4,500.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:37:24  
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WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	501,472.50	ADJUSTMENTS	19,478.28
COVERED CHARGES	427,453.20	CONTRACTUAL ALLOW	210,747.35
NON-COVERD CHARGES	74,019.30	TOTAL MEDICAID LIAB	216,705.85
		LESS: COB	200.84
		LESS: COPAYMENT	1,191.00
		REIMBURSEMENT	215,314.01
		ALL OTHER	191,242.71
		FEE SCHEDULE-LAB	22,628.38
		INJECTABLE DRUGS	1,442.92

TOTAL NUMBER OF CLAIMS 785

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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WILLS MEMORIAL HOSPITAL  
 120 GORDON ST  
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,646.00	524.00	OTHER LAB	3,983.00	0.00
MED/SURG SUPPLY	22,530.00	311.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,512.00	404.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,053.00	2,236.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,725.00	7,245.00	FEE SCHEDULE LAB	132,120.00	29,283.30
EKG/ECG	7,948.00	315.00	MRI SERVICES	5,600.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,690.00	2,715.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,266.00	2,581.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	450.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	88,570.00	17,316.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,454.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,175.20	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	1,755.00	1,085.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,145.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	390.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,057.00	1,167.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,200.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,634.00	8,387.00			
			TOTAL ANCILLARY	427,453.20	74,019.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	427,453.20	74,019.30

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,452.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,377.00	CONTRACTUAL ALLOW	120.27
NON-COVERD CHARGES	5,075.00	TOTAL MEDICAID LIAB	3,256.73
		LESS: COB	3,250.05
		LESS: COPAYMENT	6.68
		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

WILLS MEMORIAL HOSPITAL  
 120 GORDON ST  
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	320.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	144.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	78.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	956.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	853.00	3,597.00
EKG/ECG	315.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	170.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	352.00			
			TOTAL ANCILLARY	3,377.00	5,075.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,377.00	5,075.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,213.50	ADJUSTMENTS	0.00
COVERED CHARGES	21,232.50	CONTRACTUAL ALLOW	17,857.50
NON-COVERD CHARGES	981.00	TOTAL MEDICAID LIAB	3,375.00
		LESS: COB	0.00
		LESS: COPAYMENT	126.00
		REIMBURSEMENT	3,249.00
		TOTAL NUMBER OF CLAIMS	69

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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	729.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	286.00	6.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	892.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,895.00	340.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,956.00	635.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	340.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	134.00	0.00			
			TOTAL ANCILLARY	21,232.50	981.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,232.50	981.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 03:37:32  
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WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/14	THROUGH	04/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
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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 05/01/14 THROUGH 04/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,138.00	ADJUSTMENTS	4,991.16
COVERED CHARGES	8,128.00	CONTRACTUAL ALLOW	3,136.84
NON-COVERD CHARGES	10.00	TOTAL MEDICAID LIAB	4,991.16
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,991.16

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 05/01/14 THROUGH 04/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	121.00	0.00	OTHER LAB	659.00	0.00
MED/SURG SUPPLY	201.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,378.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	956.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	338.00	10.00
EKG/ECG	105.00	0.00	MRI SERVICES	2,800.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	445.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	389.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	736.00	0.00			
			TOTAL ANCILLARY	8,128.00	10.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,128.00	10.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/14	THROUGH	04/30/15
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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,007,941.54	ADJUSTMENTS	484,384.28
COVERED CHARGES	6,698,323.09	CONTRACTUAL ALLOW	5,267,491.82
NON-COVERD CHARGES	309,618.45	TOTAL MEDICAID LIAB	1,430,831.27
		LESS: COB	9,395.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,421,435.79

TOTAL NUMBER OF ADMISSIONS 189

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	174		242	86,975.97		236,569.56
ROUTINE NURSERY	13		0	5,341.02		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	187		242	92,316.99		236,569.56
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	293		6	386,095.82		8,711.52
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	293		6	386,095.82		8,711.52
TOTAL ACCOMODATIONS	480		248	478,412.81		245,281.08



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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,353,072.21	0.00	OTHER LAB	38,871.17	0.00
MED/SURG SUPPLY	229,004.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,135,695.44	0.00	EDUCATION & TRAINING	2,431.76	0.00
RADIOLOGY-DIAGNOSTIC	238,270.43	5,167.53	OTHER THERAPEUTIC SVC	0.00	28,156.05
CT SCAN	872,783.73	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	87,212.58	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	75,482.53	0.00	MRI SERVICES	95,533.10	0.00
IV THERAPY	1,939.95	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	417,953.82	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,194.30	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	394,603.78	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	161,439.92	0.00	AMBULANCE	0.00	0.00
GI SERVICES	73,663.09	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	476,485.05	1,398.32	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,902.62	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,657.71	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	31,809.13	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	419.74	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	164,241.53	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,614.64
OTHER IMAGING SERVICE	98,537.00	2,283.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,244.89	13,721.64			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	92,598.90	8,995.59			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	114,144.32	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,717.21	0.00			
			TOTAL ANCILLARY	6,219,910.28	64,337.37
			TOTAL ACCOMODATIONS	478,412.81	245,281.08
			TOTAL CHARGES	6,698,323.09	309,618.45

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
Run Time: 01:26:54  
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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5215362001145	07/16/15 - 07/18/15	02/22/16	0.00	4,614.64	0.00	0.00	0.00
TOTAL				0.00	4,614.64	0.00	0.00	0.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 01:27:01  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 01:27:01  
Page: 5

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,855,746.84	ADJUSTMENTS	266,067.37
COVERED CHARGES	12,110,854.47	CONTRACTUAL ALLOW	11,188,719.51
NON-COVERD CHARGES	1,744,892.37	TOTAL MEDICAID LIAB	922,134.96
		LESS: COB	3,009.05
		LESS: COPAYMENT	3,336.00
		REIMBURSEMENT	915,789.91
		ALL OTHER	820,650.89
		FEE SCHEDULE-LAB	81,461.07
		INJECTABLE DRUGS	13,677.95
		TOTAL NUMBER OF CLAIMS	3,000

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,810.58	179,821.51	OTHER LAB	59,294.00	0.00
MED/SURG SUPPLY	66,850.07	2,770.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	421.27	EDUCATION & TRAINING	0.00	1,379.35
RADIOLOGY-DIAGNOSTIC	790,295.15	16,246.68	OTHER THERAPEUTIC SVC	0.00	9,157.36
CT SCAN	2,363,906.69	678,384.54	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	106,536.00	6,528.62	FEE SCHEDULE LAB	1,418,853.05	119,269.58
EKG/ECG	133,694.71	9,177.41	MRI SERVICES	326,663.18	17,873.39
IV THERAPY	53,744.49	4,122.72	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	659,205.84	22,320.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	64,564.05	38,593.99	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	264,182.21	182,152.84	AMBULANCE	0.00	0.00
GI SERVICES	252,589.15	53,706.17	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,067,551.84	86,340.54	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	120,914.42	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	331,690.95	145,323.09
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	292.10	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,642.42	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	51.70	7,437.69
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	193,903.33	47,051.27			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,947.95	1,215.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	180,031.42	75,488.58			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	71,449.19	18,600.20			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,130.66	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	566,993.84	16,575.54			
			TOTAL ANCILLARY	12,110,854.47	1,744,892.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,110,854.47	1,744,892.37

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	139,750.93	ADJUSTMENTS	0.00
COVERED CHARGES	105,782.29	CONTRACTUAL ALLOW	77,767.25
NON-COVERD CHARGES	33,968.64	TOTAL MEDICAID LIAB	28,015.04
		LESS: COB	28,014.75
		LESS: COPAYMENT	0.29
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 36

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	2,200.90	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	198.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,295.65	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,967.46	26,684.53	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,681.09	1,396.86
EKG/ECG	781.04	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,728.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	524.80	145.89	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,544.97	211.50	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	3,112.54	600.86
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,676.54	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	105,782.29	33,968.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	105,782.29	33,968.64

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:27:55  
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BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,058,709.90	ADJUSTMENTS	1,170.68
COVERED CHARGES	995,465.06	CONTRACTUAL ALLOW	972,529.68
NON-COVERD CHARGES	63,244.84	TOTAL MEDICAID LIAB	22,935.38
		LESS: COB	0.00
		LESS: COPAYMENT	732.37
		REIMBURSEMENT	22,203.01
		TOTAL NUMBER OF CLAIMS	410



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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27.73	17,031.76	OTHER LAB	1,451.87	0.00
MED/SURG SUPPLY	1,597.73	7.28	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,281.94	131.65	OTHER THERAPEUTIC SVC	0.00	92.00
CT SCAN	113,785.74	33,719.57	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	80,688.14	4,859.95
EKG/ECG	6,777.91	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	740.99	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,165.51	1,854.35	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,313.14	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	704,544.11	1,361.99	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,534.57	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,490.64	2,186.26
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	263.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,353.55	1,736.23			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,711.49	0.00			
			TOTAL ANCILLARY	995,465.06	63,244.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	995,465.06	63,244.84

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: 08/12/2016  
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BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,255.39	ADJUSTMENTS	0.00
COVERED CHARGES	34,992.86	CONTRACTUAL ALLOW	24,140.01
NON-COVERD CHARGES	7,262.53	TOTAL MEDICAID LIAB	10,852.85
		LESS: COB	10,837.85
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:28:01  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	270.41	OTHER LAB	764.04	0.00
MED/SURG SUPPLY	95.62	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,236.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,840.95	3,967.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,870.02	520.76
EKG/ECG	382.58	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	253.19	145.89	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,457.33	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	781.78	6.94
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	931.32	2,351.07			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	379.48	0.00			
			TOTAL ANCILLARY	34,992.86	7,262.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,992.86	7,262.53

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 01:28:02  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:19:17  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PHOEBE WORTH MEDICAL CENTER  
 807 S ISABELLA ST  
 SYLVESTER,GA 31791-7554

PROVIDER NUMBER 000002109A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	184,002.12	ADJUSTMENTS	4,077.86
COVERED CHARGES	183,882.12	CONTRACTUAL ALLOW	83,109.48
NON-COVERD CHARGES	120.00	TOTAL MEDICAID LIAB	100,772.64
		LESS: COB	1,015.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	99,756.86

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	66		0	34,980.00		120.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	66		0	34,980.00		120.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	66		0	34,980.00		120.00

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,441.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	36,876.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	33,221.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,941.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,293.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,640.00	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	1,937.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,941.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,326.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	749.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,537.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	148,902.12	0.00
			TOTAL ACCOMODATIONS	34,980.00	120.00
			TOTAL CHARGES	183,882.12	120.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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	08/01/14	THROUGH	07/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:19:17  
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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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,134,859.84	ADJUSTMENTS	33,064.84
COVERED CHARGES	1,053,389.82	CONTRACTUAL ALLOW	670,210.00
NON-COVERD CHARGES	81,470.02	TOTAL MEDICAID LIAB	383,179.82
		LESS: COB	3,759.41
		LESS: COPAYMENT	570.00
		REIMBURSEMENT	378,850.41
		ALL OTHER	352,055.15
		FEE SCHEDULE-LAB	22,014.93
		INJECTABLE DRUGS	4,780.33
		TOTAL NUMBER OF CLAIMS	1,007

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,630.82	115.00	OTHER LAB	7,283.00	0.00
MED/SURG SUPPLY	53,355.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,738.00	825.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	110,106.00	22,828.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	954.00	2,632.02	FEE SCHEDULE LAB	223,172.00	38,455.00
EKG/ECG	15,840.00	1,320.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,355.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,311.00	915.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,089.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	473,587.00	8,987.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,237.00	200.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	495.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,596.00	2,161.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,074.00	2,537.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,062.00	0.00			
			TOTAL ANCILLARY	1,053,389.82	81,470.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,053,389.82	81,470.02

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,244.00	ADJUSTMENTS	0.00
COVERED CHARGES	5,879.00	CONTRACTUAL ALLOW	2,542.52
NON-COVERD CHARGES	365.00	TOTAL MEDICAID LIAB	3,336.48
		LESS: COB	3,336.48
		LESS: COPAYMENT	0.00
		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

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	273.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	220.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,418.00	365.00
EKG/ECG	440.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,518.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,879.00	365.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,879.00	365.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	137,114.00	ADJUSTMENTS	100.00
COVERED CHARGES	133,841.00	CONTRACTUAL ALLOW	124,091.00
NON-COVERD CHARGES	3,273.00	TOTAL MEDICAID LIAB	9,750.00
		LESS: COB	0.00
		LESS: COPAYMENT	393.00
		REIMBURSEMENT	9,357.00
		TOTAL NUMBER OF CLAIMS	195

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 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,121.00	98.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,962.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,922.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,298.00	1,442.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,745.00	1,447.00
EKG/ECG	220.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	198.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	99,094.00	190.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,057.00	96.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	133,841.00	3,273.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	133,841.00	3,273.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 08/01/14 THROUGH 07/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,525.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,461.00	CONTRACTUAL ALLOW	657.96
NON-COVERD CHARGES	64.00	TOTAL MEDICAID LIAB	803.04
		LESS: COB	803.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PHOEBE WORTH MEDICAL CENTER  
 807 S ISABELLA ST  
 SYLVESTER,GA 31791-7554

PROVIDER NUMBER  
 000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/14 THROUGH 07/31/15  
 ADMISSION DATES 00/00/00 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	419.00	64.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,042.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,461.00	64.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,461.00	64.00



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH MEDICAL CENTER  
807 S ISABELLA ST  
SYLVESTER,GA 31791-7554

PROVIDER NUMBER  
000002109A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/14	THROUGH	07/31/15
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

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	08/01/14	THROUGH	07/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER 000020677A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,696,182.64	ADJUSTMENTS	361,393.30
COVERED CHARGES	7,614,147.13	CONTRACTUAL ALLOW	5,899,705.18
NON-COVERD CHARGES	82,035.51	TOTAL MEDICAID LIAB	1,714,441.95
		LESS: COB	19,018.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,695,423.65

TOTAL NUMBER OF ADMISSIONS 246

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	350		0	192,395.38		18,961.52
ROUTINE NURSERY	78		0	22,946.52		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	428		0	215,341.90		18,961.52
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	454		1	576,094.69		1,713.28
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	454		1	576,094.69		1,713.28
TOTAL ACCOMODATIONS	882		1	791,436.59		20,674.80

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
INPATIENT PAID CLAIMS

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,257,891.46	0.00	OTHER LAB	67,639.70	0.00
MED/SURG SUPPLY	215,259.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,110,889.84	0.00	EDUCATION & TRAINING	1,155.70	0.00
RADIOLOGY-DIAGNOSTIC	223,077.10	15,396.49	OTHER THERAPEUTIC SVC	0.00	6,529.03
CT SCAN	539,628.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	59,404.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	75,167.86	0.00	MRI SERVICES	65,664.53	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	936,749.23	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	38,246.24	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	273,901.21	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	559,965.63	0.00	AMBULANCE	0.00	0.00
GI SERVICES	115,425.13	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	486,761.47	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	163,340.35	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	17,426.90	0.00	INJECTABLE DRUGS	2,601.91	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	26,831.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	11,248.19	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	23,728.64	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	47,557.39	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,894.86
OTHER IMAGING SERVICE	69,196.72	0.00			
BLOOD	4,261.98	0.00			
BLOOD STORAGE & PRO.	31,212.39	27,831.54			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	40,642.13	6,708.79			
AUDIOLOGY	6,117.63	0.00			
CARDIOLOGY	336,148.73	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,568.71	0.00			
			TOTAL ANCILLARY	6,822,710.54	61,360.71
			TOTAL ACCOMODATIONS	791,436.59	20,674.80
			TOTAL CHARGES	7,614,147.13	82,035.51

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

Run Date: 08/12/2016  
Run Time: 01:45:14  
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MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014352045781	12/12/14 - 12/14/14	12/22/14	0.00	4,894.86	0.00	0.00	0.00
TOTAL				0.00	4,894.86	0.00	0.00	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,662.34	ADJUSTMENTS	0.00
COVERED CHARGES	30,662.34	CONTRACTUAL ALLOW	15,316.48
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	15,345.86
		LESS: COB	15,345.86
		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	3,567.20		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	7		0	3,567.20		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	7		0	3,567.20		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,343.58	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	667.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,037.26	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,684.17	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,320.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,343.79	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	331.19	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,123.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	244.24	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,095.14	0.00
			TOTAL ACCOMODATIONS	3,567.20	0.00
			TOTAL CHARGES	30,662.34	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 01:45:23  
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MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,423,736.43	ADJUSTMENTS	313,772.32
COVERED CHARGES	14,474,668.75	CONTRACTUAL ALLOW	13,053,965.84
NON-COVERD CHARGES	1,949,067.68	TOTAL MEDICAID LIAB	1,420,702.91
		LESS: COB	4,594.42
		LESS: COPAYMENT	3,933.00
		REIMBURSEMENT	1,412,175.49
		ALL OTHER	1,287,637.60
		FEE SCHEDULE-LAB	114,409.15
		INJECTABLE DRUGS	10,128.74

TOTAL NUMBER OF CLAIMS 4,107



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,136.00	268,829.61	OTHER LAB	162,251.71	0.00
MED/SURG SUPPLY	168,929.57	21,805.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	441.36	EDUCATION & TRAINING	0.00	706.40
RADIOLOGY-DIAGNOSTIC	605,527.07	16,169.48	OTHER THERAPEUTIC SVC	0.00	88,077.73
CT SCAN	1,971,466.68	412,903.14	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,720.00	2,238.77	FEE SCHEDULE LAB	1,682,102.08	143,738.39
EKG/ECG	236,223.42	10,043.54	MRI SERVICES	270,633.28	28,167.50
IV THERAPY	21,955.16	6,142.66	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	765,323.48	219,658.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	82,357.28	21,838.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	618,554.95	859.47	AMBULANCE	0.00	0.00
GI SERVICES	280,274.56	20,629.78	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,288,111.12	161,159.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	433,078.86	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	825.79	INJECTABLE DRUGS	279,148.92	158,383.22
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	1,562.55	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,119.48	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,763.78	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,392.08	67,812.15
LITHOTRIPSY	86,754.54	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	379,822.79	144,271.18			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,609.52	2,941.48			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	112,725.39	52,390.18			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	218,980.99	41,725.11			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	756,589.30	50,863.25			
			TOTAL ANCILLARY	14,474,668.75	1,949,067.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,474,668.75	1,949,067.68

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	210,532.27	ADJUSTMENTS	0.00
COVERED CHARGES	162,055.23	CONTRACTUAL ALLOW	112,931.79
NON-COVERD CHARGES	48,477.04	TOTAL MEDICAID LIAB	49,123.44
		LESS: COB	49,102.44
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 51

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3.66	3,440.59	OTHER LAB	2,702.09	0.00
MED/SURG SUPPLY	835.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	64.90
RADIOLOGY-DIAGNOSTIC	7,370.76	291.65	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,228.48	19,860.21	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,190.72	863.28
EKG/ECG	2,532.22	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	768.20	287.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	859.47	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	81,449.02	1,759.66	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	3,239.95	1,102.21
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	219.06	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,484.68	7,849.23			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,249.81	11,879.26			
			TOTAL ANCILLARY	162,055.23	48,477.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	162,055.23	48,477.04

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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Page: 10

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,209,072.67	ADJUSTMENTS	1,441.38
COVERED CHARGES	1,115,855.44	CONTRACTUAL ALLOW	1,078,040.00
NON-COVERD CHARGES	93,217.23	TOTAL MEDICAID LIAB	37,815.44
		LESS: COB	0.00
		LESS: COPAYMENT	1,335.94
		REIMBURSEMENT	36,479.50
		TOTAL NUMBER OF CLAIMS	676

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19.28	20,905.19	OTHER LAB	5,387.00	0.00
MED/SURG SUPPLY	822.42	1,359.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	131.75
RADIOLOGY-DIAGNOSTIC	44,577.78	0.00	OTHER THERAPEUTIC SVC	0.00	555.60
CT SCAN	91,140.96	43,487.29	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	124,636.04	5,760.85
EKG/ECG	18,383.04	491.58	MRI SERVICES	0.00	4,068.89
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,575.06	463.50	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	782,075.02	2,553.76	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,009.15	4,086.75
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	109.53	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,180.35	9,242.58			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	49.34	0.00			
			TOTAL ANCILLARY	1,115,855.44	93,217.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,115,855.44	93,217.23

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,171.02	ADJUSTMENTS	0.00
COVERED CHARGES	15,182.31	CONTRACTUAL ALLOW	7,933.93
NON-COVERD CHARGES	2,988.71	TOTAL MEDICAID LIAB	7,248.38
		LESS: COB	7,239.38
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	274.23	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	447.79	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,553.81	16.40
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	153.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,824.33	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	574.27	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	628.21	2,698.08			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,182.31	2,988.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,182.31	2,988.71

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/14 THROUGH 09/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	511,312.30	ADJUSTMENTS	10,921.52
COVERED CHARGES	457,591.56	CONTRACTUAL ALLOW	424,818.00
NON-COVERD CHARGES	53,720.74	TOTAL MEDICAID LIAB	32,773.56
		LESS: COB	0.00
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	32,743.56
		TOTAL NUMBER OF CLAIMS	6



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 10/01/14 THROUGH 09/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	2,068.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25,899.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,006.90	1,188.73	OTHER THERAPEUTIC SVC	0.00	1,027.79
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,114.88	233.66
EKG/ECG	511.24	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	255,936.75	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	117,772.52	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,593.56	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,329.36	30,246.20
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	18,342.01
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,427.00	612.25			
			TOTAL ANCILLARY	457,591.56	53,720.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	457,591.56	53,720.74

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	10/01/14	THROUGH	09/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:34:24  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER 000081232A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,593,652.57	ADJUSTMENTS	39,249.66
COVERED CHARGES	1,561,500.57	CONTRACTUAL ALLOW	1,078,961.37
NON-COVERD CHARGES	32,152.00	TOTAL MEDICAID LIAB	482,539.20
		LESS: COB	5,011.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	477,528.12

TOTAL NUMBER OF ADMISSIONS 69

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	221		0	146,965.00		31,186.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	221		0	146,965.00		31,186.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	45		0	55,730.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	45		0	55,730.00		0.00
TOTAL ACCOMODATIONS	266		0	202,695.00		31,186.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	286,415.00	0.00	OTHER LAB	2,119.00	0.00
MED/SURG SUPPLY	121,173.90	275.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	219,814.00	0.00	EDUCATION & TRAINING	150.00	0.00
RADIOLOGY-DIAGNOSTIC	23,672.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	81,074.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,052.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,679.00	0.00	MRI SERVICES	2,423.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	75,771.98	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	121,929.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	40,131.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	81,421.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,775.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,373.72	0.00	INJECTABLE DRUGS	154,027.78	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	934.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	91,337.19	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,213.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,628.00	421.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,084.00	270.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,250.00	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	5,358.00	0.00			
			TOTAL ANCILLARY	1,358,805.57	966.00
			TOTAL ACCOMODATIONS	202,695.00	31,186.00
			TOTAL CHARGES	1,561,500.57	32,152.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,686,701.72	ADJUSTMENTS	87,922.21
COVERED CHARGES	1,592,930.54	CONTRACTUAL ALLOW	1,277,404.52
NON-COVERD CHARGES	93,771.18	TOTAL MEDICAID LIAB	315,526.02
		LESS: COB	868.54
		LESS: COPAYMENT	1,284.00
		REIMBURSEMENT	313,373.48
		ALL OTHER	286,418.13
		FEE SCHEDULE-LAB	22,182.79
		INJECTABLE DRUGS	4,772.56

TOTAL NUMBER OF CLAIMS 916

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,911.00	296.00	OTHER LAB	9,752.00	0.00
MED/SURG SUPPLY	98,003.87	292.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	104,943.00	4,663.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	210,554.00	10,806.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	440.00	FEE SCHEDULE LAB	296,744.60	47,317.20
EKG/ECG	19,776.00	0.00	MRI SERVICES	9,360.00	0.00
IV THERAPY	15,168.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	105,396.00	6,152.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,125.00	2,073.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	79,029.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	373,156.00	2,034.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,539.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	57,987.96	14,460.98
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	30.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,608.00	611.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	33,433.00	1,304.00	IMPL DEV CHARGE PATIENTS	7,981.11	264.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,101.00	2,242.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,608.00	561.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,707.00	203.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,750.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,267.00	52.00			
			TOTAL ANCILLARY	1,592,930.54	93,771.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,592,930.54	93,771.18

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

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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,368.00	ADJUSTMENTS	0.00
COVERED CHARGES	24,047.00	CONTRACTUAL ALLOW	12,670.33
NON-COVERD CHARGES	321.00	TOTAL MEDICAID LIAB	11,376.67
		LESS: COB	11,280.67
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	433.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	436.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	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	5,206.00	248.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,326.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,109.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,064.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	413.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	73.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,867.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,382.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,047.00	321.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,047.00	321.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,742.00	ADJUSTMENTS	376.58
COVERED CHARGES	64,523.00	CONTRACTUAL ALLOW	60,460.14
NON-COVERD CHARGES	2,219.00	TOTAL MEDICAID LIAB	4,062.86
		LESS: COB	0.00
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	3,891.86
		TOTAL NUMBER OF CLAIMS	76

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,020.00	0.00	OTHER LAB	448.00	0.00
MED/SURG SUPPLY	1,526.00	164.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,613.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,544.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,605.00	1,939.00
EKG/ECG	206.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	211.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	368.00	116.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,489.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,339.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	660.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	494.00	0.00			
			TOTAL ANCILLARY	64,523.00	2,219.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,523.00	2,219.00

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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CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,059.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,728.00	CONTRACTUAL ALLOW	1,477.89
NON-COVERD CHARGES	331.00	TOTAL MEDICAID LIAB	250.11
		LESS: COB	244.11
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	94.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	495.00	165.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,139.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	166.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,728.00	331.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,728.00	331.00

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

CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP  
 2855 OLD HIGHWAY 5  
 BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER 000134406A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,331,327.55	ADJUSTMENTS	147,210.98
COVERED CHARGES	4,213,103.39	CONTRACTUAL ALLOW	3,498,757.41
NON-COVERD CHARGES	118,224.16	TOTAL MEDICAID LIAB	714,345.98
		LESS: COB	10,431.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	703,914.36
		TOTAL NUMBER OF ADMISSIONS	180

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	193		105	173,547.00		110,637.70
ROUTINE NURSERY	138		0	96,676.32		4,044.88
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	331		105	270,223.32		114,682.58
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	56		0	79,760.06		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	56		0	79,760.06		0.00
TOTAL ACCOMODATIONS	387		105	349,983.38		114,682.58



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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	403,560.02	0.00	OTHER LAB	849.14	0.00
MED/SURG SUPPLY	109,658.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	702,135.91	0.00	EDUCATION & TRAINING	2,552.78	0.00
RADIOLOGY-DIAGNOSTIC	31,165.59	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	80,619.45	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,685.94	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	20,216.56	0.00	MRI SERVICES	4,069.00	0.00
IV THERAPY	1,027.09	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	691,968.69	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	449,707.91	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	107,227.43	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	128,120.66	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,971.55	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	104,069.84	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,643.61	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	22,050.35	0.00	INJECTABLE DRUGS	810,123.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,737.65	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,528.98	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	3,652.98	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	49,975.41	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,930.61	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,698.77	3,050.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,196.90	491.46			
AUDIOLOGY	10,802.82	0.00			
CARDIOLOGY	13,106.18	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,066.16	0.00			
			TOTAL ANCILLARY	3,863,120.01	3,541.58
			TOTAL ACCOMODATIONS	349,983.38	114,682.58
			TOTAL CHARGES	4,213,103.39	118,224.16

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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Page: 4

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,237,356.72	ADJUSTMENTS	126,191.05
COVERED CHARGES	4,653,764.61	CONTRACTUAL ALLOW	4,175,514.93
NON-COVERD CHARGES	583,592.11	TOTAL MEDICAID LIAB	478,249.68
		LESS: COB	3,652.62
		LESS: COPAYMENT	1,077.00
		REIMBURSEMENT	473,520.06
		ALL OTHER	420,654.52
		FEE SCHEDULE-LAB	47,674.38
		INJECTABLE DRUGS	5,191.16
		TOTAL NUMBER OF CLAIMS	1,324

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	181,993.25	23,035.14	OTHER LAB	154,273.56	0.00
MED/SURG SUPPLY	22,171.31	476.76	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	144,708.65	5,380.16	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	440,656.94	103,879.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,122.60	6,069.29	FEE SCHEDULE LAB	1,368,369.42	137,733.44
EKG/ECG	68,837.92	1,772.32	MRI SERVICES	32,987.05	2,882.42
IV THERAPY	8,693.78	413.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	419,637.14	103,864.46	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,079.27	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,984.91	1,586.58	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	136,832.19	0.00	AMBULANCE	0.00	0.00
GI SERVICES	82,675.90	11,973.18	CAST ROOM	0.00	0.00
EMERGENCY ROOM	885,794.13	6,763.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	90,946.21	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	237,230.43	122,469.51
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	968.14	101.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	505.51	1,334.13	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,942.34	877.19	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	17,991.24
LITHOTRIPSY	100,819.32	0.00	NO CC/INVALID REV CODE	0.00	2,660.45
OTHER IMAGING SERVICE	53,807.14	13,186.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,755.52	2,147.58			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,939.66	9,104.96			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	62,201.77	3,712.80			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,238.78	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,591.77	4,175.75			
			TOTAL ANCILLARY	4,653,764.61	583,592.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,653,764.61	583,592.11

Report : CLM-0804-0  
Process : CLMJ0800  
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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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5916176000255	09/10/15 - 09/10/15	06/27/16	0.00	2,660.45	0.00	0.00	0.00
TOTAL				0.00	2,660.45	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: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP  
2855 OLD HIGHWAY 5  
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER  
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,890.86	ADJUSTMENTS	0.00
COVERED CHARGES	36,390.29	CONTRACTUAL ALLOW	29,878.48
NON-COVERD CHARGES	13,500.57	TOTAL MEDICAID LIAB	6,511.81
		LESS: COB	6,511.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 13

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FANNIN REGIONAL HOSP  
 2855 OLD HIGHWAY 5  
 BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER  
 000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,028.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	570.73	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,060.64	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,276.23	363.14
EKG/ECG	704.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,531.10	1,617.16	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	292.65	1,312.95
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	1,958.93	5,672.60			
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	2,027.20	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	474.08			
			TOTAL ANCILLARY	36,390.29	13,500.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,390.29	13,500.57

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	150,305.86	ADJUSTMENTS	320.64
COVERED CHARGES	137,593.38	CONTRACTUAL ALLOW	132,353.60
NON-COVERD CHARGES	12,712.48	TOTAL MEDICAID LIAB	5,239.78
		LESS: COB	0.00
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	5,068.78
		TOTAL NUMBER OF CLAIMS	94



Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,518.81	312.88	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,776.02	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,719.72	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,565.07	9,744.48
EKG/ECG	1,771.28	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,009.58	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	243.02	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	64,973.76	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,328.32	2,655.12
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,687.80	0.00			
			TOTAL ANCILLARY	137,593.38	12,712.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	137,593.38	12,712.48

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:10:50  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP  
2855 OLD HIGHWAY 5  
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER  
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	641,606.69	ADJUSTMENTS	22,109.61
COVERED CHARGES	576,954.33	CONTRACTUAL ALLOW	516,211.14
NON-COVERD CHARGES	64,652.36	TOTAL MEDICAID LIAB	60,743.19
		LESS: COB	0.00
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	60,698.19
		TOTAL NUMBER OF CLAIMS	11

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,522.02	5,261.33	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	13,698.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	769.43	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,434.24	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,864.83	433.05
EKG/ECG	352.35	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	379,624.40	16,589.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	200.66	401.32	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	75,606.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	30,007.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,975.27	18,925.56
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	21,780.45
LITHOTRIPSY	20,274.07	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,624.77	1,260.81			
			TOTAL ANCILLARY	576,954.33	64,652.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	576,954.33	64,652.36

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: 08/12/2016  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:09:56  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PREMIER HEALTHCARE INVESTMENTS  
 509 SUMTER STREET  
 MONTEZUMA,GA 31063-2502

PROVIDER NUMBER 000149487A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,959,348.94	ADJUSTMENTS	1,453,975.48
COVERED CHARGES	6,982,308.94	CONTRACTUAL ALLOW	2,948,027.64
NON-COVERD CHARGES	977,040.00	TOTAL MEDICAID LIAB	4,034,281.30
		LESS: COB	386.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,033,894.75

TOTAL NUMBER OF ADMISSIONS 985

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,917		6	2,139,400.00		977,040.00
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	3,917		6	2,139,400.00		977,040.00
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	3,917		6	2,139,400.00		977,040.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PREMIER HEALTHCARE INVESTMENTS  
 509 SUMTER STREET  
 MONTEZUMA,GA 31063-2502

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,291,951.94	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	443,674.02	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,663.03	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	847.99	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	3,067,771.96	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,842,908.94	0.00
			TOTAL ACCOMODATIONS	2,139,400.00	977,040.00
			TOTAL CHARGES	6,982,308.94	977,040.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

PREMIER HEALTHCARE INVESTMENTS  
509 SUMTER STREET  
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER  
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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PREMIER HEALTHCARE INVESTMENTS  
509 SUMTER STREET  
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	153,199.44	ADJUSTMENTS	186.47
COVERED CHARGES	143,864.51	CONTRACTUAL ALLOW	84,781.51
NON-COVERD CHARGES	9,334.93	TOTAL MEDICAID LIAB	59,083.00
		LESS: COB	0.00
		LESS: COPAYMENT	483.00
		REIMBURSEMENT	58,600.00
		ALL OTHER	53,971.64
		FEE SCHEDULE-LAB	4,426.18
		INJECTABLE DRUGS	202.18

TOTAL NUMBER OF CLAIMS 221

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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PREMIER HEALTHCARE INVESTMENTS  
 509 SUMTER STREET  
 MONTEZUMA,GA 31063-2502

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 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	16,980.58	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	97.24	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	67,165.60	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	37,757.62	6,678.69
EKG/ECG	899.08	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	352.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,388.62	2,559.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,321.01	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	0.00	0.00			
			TOTAL ANCILLARY	143,864.51	9,334.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	143,864.51	9,334.93

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: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PREMIER HEALTHCARE INVESTMENTS  
509 SUMTER STREET  
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	138.51	ADJUSTMENTS	0.00
COVERED CHARGES	118.56	CONTRACTUAL ALLOW	25.53
NON-COVERD CHARGES	19.95	TOTAL MEDICAID LIAB	93.03
		LESS: COB	90.03
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PREMIER HEALTHCARE INVESTMENTS  
 509 SUMTER STREET  
 MONTEZUMA,GA 31063-2502

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 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	118.56	19.95
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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	118.56	19.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	118.56	19.95

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:10:26  
Page: 8

PREMIER HEALTHCARE INVESTMENTS  
509 SUMTER STREET  
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER  
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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PREMIER HEALTHCARE INVESTMENTS  
509 SUMTER STREET  
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER  
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 01:10:26  
Page: 10

SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PREMIER HEALTHCARE INVESTMENTS  
509 SUMTER STREET  
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER  
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 01:10:26  
Page: 11

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PREMIER HEALTHCARE INVESTMENTS  
509 SUMTER STREET  
MONTEZUMA,GA 31063-2502

PROVIDER NUMBER  
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER 000182388A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,283,506.86	ADJUSTMENTS	484,519.98
COVERED CHARGES	28,032,811.53	CONTRACTUAL ALLOW	21,091,266.55
NON-COVERD CHARGES	1,250,695.33	TOTAL MEDICAID LIAB	6,941,544.98
		LESS: COB	74,587.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,866,957.50

TOTAL NUMBER OF ADMISSIONS 811

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,197		0	1,969,329.00		763,143.00
ROUTINE NURSERY	704		2	1,197,651.00		630.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,901		2	3,166,980.00		763,773.00
SPECIAL CARE SERVICES						
CCU	386		0	901,240.00		0.00
ICU	286		0	665,769.00		0.00
NICU	346		0	976,066.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,018		0	2,543,075.00		0.00
TOTAL ACCOMODATIONS	4,919		2	5,710,055.00		763,773.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,874,108.06	241,457.72	OTHER LAB	155,134.00	0.00
MED/SURG SUPPLY	805,089.94	10,757.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,256,427.00	41,890.00	EDUCATION & TRAINING	600.00	0.00
RADIOLOGY-DIAGNOSTIC	530,356.00	1,127.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	917,383.00	4,124.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	128,220.15	10,990.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	135,531.00	333.00	MRI SERVICES	301,837.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,074,122.00	10,588.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	543,406.00	2,385.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,477,269.00	5,396.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	367,262.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	221,077.00	3,665.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,172,853.00	1,928.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	437,444.00	827.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	112,222.00	0.00	INJECTABLE DRUGS	360.00	0.00
RADIOLOGY THERAPEUTIC	32,086.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	58,918.02	8,415.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	51,097.00	4,489.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	152,390.00	8,130.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	35,588.00	17,867.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	671,570.16	45,984.36
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	307,597.00	174.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	545,993.00	35,366.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	199,475.00	31,029.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	657,225.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	38,852.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	61,264.20	0.00			
			TOTAL ANCILLARY	22,322,756.53	486,922.33
			TOTAL ACCOMODATIONS	5,710,055.00	763,773.00
			TOTAL CHARGES	28,032,811.53	1,250,695.33

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER 000182388A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	255,692.78	ADJUSTMENTS	0.00
COVERED CHARGES	243,224.78	CONTRACTUAL ALLOW	139,827.63
NON-COVERD CHARGES	12,468.00	TOTAL MEDICAID LIAB	103,397.15
		LESS: COB	103,397.15
		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	34		0	21,726.00		10,938.00
ROUTINE NURSERY	8		0	11,480.00		630.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	42		0	33,206.00		11,568.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,309.00		0.00
NICU	2		0	5,642.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3		0	7,951.00		0.00
TOTAL ACCOMODATIONS	45		0	41,157.00		11,568.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,047.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,965.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	37,849.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,225.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,889.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	533.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	666.00	0.00	MRI SERVICES	2,900.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,124.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	48,301.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,867.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,351.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,967.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,014.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	406.00	0.00	INJECTABLE DRUGS	431.38	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	346.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	692.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	987.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,446.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,920.00	900.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,140.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	202,067.78	900.00
			TOTAL ACCOMODATIONS	41,157.00	11,568.00
			TOTAL CHARGES	243,224.78	12,468.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:21:43  
Page: 5

PIEDMONT HENRY HOSPITAL, INC.  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,896,064.14	ADJUSTMENTS	339,328.41
COVERED CHARGES	15,883,751.26	CONTRACTUAL ALLOW	13,712,021.87
NON-COVERD CHARGES	3,012,312.88	TOTAL MEDICAID LIAB	2,171,729.39
		LESS: COB	66,230.62
		LESS: COPAYMENT	5,283.00
		REIMBURSEMENT	2,100,215.77
		ALL OTHER	1,913,560.99
		FEE SCHEDULE-LAB	169,755.45
		INJECTABLE DRUGS	16,899.33

TOTAL NUMBER OF CLAIMS 6,323

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	390,196.65	19,546.60	OTHER LAB	177,150.00	41,184.00
MED/SURG SUPPLY	396,878.58	68,285.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	484.00	EDUCATION & TRAINING	0.00	150.00
RADIOLOGY-DIAGNOSTIC	1,175,453.00	27,821.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,235,444.00	461,673.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,502.00	8,817.07	FEE SCHEDULE LAB	2,840,861.80	475,223.60
EKG/ECG	252,747.00	4,995.00	MRI SERVICES	130,104.00	62,943.00
IV THERAPY	8,737.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,782,115.00	613,667.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	94,768.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,049.00	14,570.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	295,203.00	1,202.00	AMBULANCE	0.00	0.00
GI SERVICES	177,173.00	52,267.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,930,487.00	41,834.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	437,027.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	202,291.16	174,712.92
RADIOLOGY THERAPEUTIC	489,868.00	277,960.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,032.00	3,236.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	4,122.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,756.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	141,263.00	7,536.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,073.83	101,610.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	586,617.00	243,880.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	60,358.00	16,952.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	139,939.00	156,645.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	351,202.00	112,291.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	81,348.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	403,863.24	8,949.00			
			TOTAL ANCILLARY	15,883,751.26	3,012,312.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,883,751.26	3,012,312.88

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:22:16  
Page: 7

SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HENRY HOSPITAL, INC.  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	251,680.91	ADJUSTMENTS	0.00
COVERED CHARGES	197,156.24	CONTRACTUAL ALLOW	132,092.76
NON-COVERD CHARGES	54,524.67	TOTAL MEDICAID LIAB	65,063.48
		LESS: COB	64,994.75
		LESS: COPAYMENT	68.73
		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

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,942.98	416.00	OTHER LAB	2,001.00	1,474.00
MED/SURG SUPPLY	5,918.06	462.24	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,160.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	29,870.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	38,254.00	5,193.00
EKG/ECG	3,663.00	0.00	MRI SERVICES	3,853.00	0.00
IV THERAPY	493.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,761.00	9,334.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,828.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,638.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	557.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,632.00	387.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,337.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,691.88	2,403.43
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	2,456.00	157.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	112.32	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,865.00	4,363.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,947.00	465.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,412.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,634.00	0.00			
			TOTAL ANCILLARY	197,156.24	54,524.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	197,156.24	54,524.67



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:22:17  
Page: 9

PIEDMONT HENRY HOSPITAL, INC.  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	987,704.36	ADJUSTMENTS	2,047.72
COVERED CHARGES	865,828.70	CONTRACTUAL ALLOW	826,446.94
NON-COVERD CHARGES	121,875.66	TOTAL MEDICAID LIAB	39,381.76
		LESS: COB	13.12
		LESS: COPAYMENT	1,251.00
		REIMBURSEMENT	38,117.64
		TOTAL NUMBER OF CLAIMS	704

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,307.04	287.17	OTHER LAB	2,948.00	4,422.00
MED/SURG SUPPLY	14,089.63	853.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	712.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,994.00	887.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,110.00	28,080.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	207,207.00	30,738.00
EKG/ECG	11,988.00	333.00	MRI SERVICES	9,680.00	4,035.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,399.00	27,466.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	555.00	430.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,785.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,331.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	455,654.00	693.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,255.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,553.03	5,172.69
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	222.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,751.00	17,766.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	865,828.70	121,875.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	865,828.70	121,875.66

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,684.77	ADJUSTMENTS	0.00
COVERED CHARGES	14,522.17	CONTRACTUAL ALLOW	8,725.54
NON-COVERD CHARGES	3,162.60	TOTAL MEDICAID LIAB	5,796.63
		LESS: COB	5,784.63
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	14

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:22:21  
 Page: 12

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	150.11	0.00	OTHER LAB	1,474.00	0.00
MED/SURG SUPPLY	190.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,654.00	359.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,245.00	258.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47.06	845.60
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	762.00	1,700.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,522.17	3,162.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,522.17	3,162.60

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HENRY HOSPITAL, INC.  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,604,909.24	ADJUSTMENTS	85,647.00
COVERED CHARGES	2,269,573.81	CONTRACTUAL ALLOW	1,996,428.09
NON-COVERD CHARGES	335,335.43	TOTAL MEDICAID LIAB	273,145.72
		LESS: COB	4,044.12
		LESS: COPAYMENT	294.00
		REIMBURSEMENT	268,807.60

TOTAL NUMBER OF CLAIMS 48

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,253.23	2,770.40	OTHER LAB	2,196.00	0.00
MED/SURG SUPPLY	170,532.83	23,375.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,502.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	39,792.00	8,816.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	52,680.00	5,713.00
EKG/ECG	2,664.00	666.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	989,911.00	39,170.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,205.00	1,158.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	90,231.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,820.00	1,902.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	112,074.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,081.01	18,226.27
RADIOLOGY THERAPEUTIC	202,271.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,252.00	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	303,333.34	110,206.15
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,325.00	3,483.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,646.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	428.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	143,170.00	116,169.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,766.40	0.00			
			TOTAL ANCILLARY	2,269,573.81	335,335.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,269,573.81	335,335.43

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: 08/12/2016  
Run Time: 02:22:25  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT HENRY HOSPITAL, INC.  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EASTSIDE MEDICAL CENTER LLC  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER 000190088A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	52,341,112.58	ADJUSTMENTS	2,558,998.69
COVERED CHARGES	45,034,267.27	CONTRACTUAL ALLOW	37,507,745.72
NON-COVERD CHARGES	7,306,845.31	TOTAL MEDICAID LIAB	7,526,521.55
		LESS: COB	171,100.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,355,421.35

TOTAL NUMBER OF ADMISSIONS 958

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,207		12	5,984,114.92		6,073,334.06
ROUTINE NURSERY	320		7	462,621.00		4,554.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,527		19	6,446,735.92		6,077,888.06
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,169		2	2,798,562.68		99,481.32
NICU	208		0	608,608.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,377		2	3,407,170.68		99,481.32
TOTAL ACCOMODATIONS	6,904		21	9,853,906.60		6,177,369.38



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EASTSIDE MEDICAL CENTER LLC  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,600,428.07	26,811.99	OTHER LAB	315,881.12	1,492.41
MED/SURG SUPPLY	2,533,856.70	51,558.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,680,646.71	164,969.36	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	786,355.51	14,819.26	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,167,597.95	42,019.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	404,759.64	17,817.87	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	400,923.76	1,268.82	MRI SERVICES	469,166.74	3,053.19
IV THERAPY	2,666.40	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,325,458.35	21,017.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	386,227.65	0.00	REHAB THERAPY	492.03	0.00
RESPIRATORY SERVICES	2,741,728.34	109,378.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	554,912.02	9,236.37	AMBULANCE	0.00	0.00
GI SERVICES	310,869.92	19,764.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,564,029.12	1,904.41	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	475,320.02	3,872.00	DRUG-SPECIFIC/HOME IV	0.00	4,298.64
LABORATORY PATHOLOGIC	197,807.17	1,646.00	INJECTABLE DRUGS	4,942,413.81	300,378.42
RADIOLOGY THERAPEUTIC	439.71	39,019.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	220,437.29	12,153.39	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	198,617.53	235.20	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	265,541.19	128,555.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,341.38	5,306.69	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	145,208.32	0.00	IMPL DEV CHARGE PATIENTS	1,535,943.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	323,319.70	880.12			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	113,473.37	124,459.37			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	559,511.49	9,371.31			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	746,728.36	1,779.93			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	79,995.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	114,262.80	12,408.60			
			TOTAL ANCILLARY	35,180,360.67	1,129,475.93
			TOTAL ACCOMODATIONS	9,853,906.60	6,177,369.38
			TOTAL CHARGES	45,034,267.27	7,306,845.31

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:02:45  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EASTSIDE MEDICAL CENTER LLC  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER 000190088A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	307,693.04	ADJUSTMENTS	0.00
COVERED CHARGES	302,550.78	CONTRACTUAL ALLOW	193,510.45
NON-COVERD CHARGES	5,142.26	TOTAL MEDICAID LIAB	109,040.33
		LESS: COB	109,040.33
		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	34		0	38,778.00		3,388.00
ROUTINE NURSERY	7		0	7,629.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	41		0	46,407.00		3,388.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	6,378.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	6,378.00		0.00
TOTAL ACCOMODATIONS	44		0	52,785.00		3,388.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EASTSIDE MEDICAL CENTER LLC  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,409.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,165.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	66,843.85	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,676.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,267.72	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,903.23	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,681.47	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,579.83	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	880.77	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,380.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,820.67	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,218.47	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	618.56	0.00	INJECTABLE DRUGS	28,109.76	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	375.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,704.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,129.08	1,754.26			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	249,765.78	1,754.26
			TOTAL ACCOMODATIONS	52,785.00	3,388.00
			TOTAL CHARGES	302,550.78	5,142.26

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:02:46  
Page: 5

EASTSIDE MEDICAL CENTER LLC  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,668,642.66	ADJUSTMENTS	164,620.45
COVERED CHARGES	15,905,871.25	CONTRACTUAL ALLOW	14,435,766.33
NON-COVERD CHARGES	1,762,771.41	TOTAL MEDICAID LIAB	1,470,104.92
		LESS: COB	2,044.71
		LESS: COPAYMENT	3,042.66
		REIMBURSEMENT	1,465,017.55
		ALL OTHER	1,352,257.77
		FEE SCHEDULE-LAB	93,853.48
		INJECTABLE DRUGS	18,906.30

TOTAL NUMBER OF CLAIMS 3,618

EASTSIDE MEDICAL CENTER LLC  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	411,962.30	902.10	OTHER LAB	251,447.25	4,439.50
MED/SURG SUPPLY	398,993.00	28,697.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	763,008.85	6,073.34	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,104,469.06	346,027.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,026.61	13,400.32	FEE SCHEDULE LAB	3,221,737.65	423,400.22
EKG/ECG	331,326.62	2,443.66	MRI SERVICES	192,888.96	37,592.08
IV THERAPY	610,558.21	24,826.13	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	799,442.33	127,985.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	45,746.72	6,473.84	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,465.48	6,244.14	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	317,932.43	0.00	AMBULANCE	0.00	0.00
GI SERVICES	17,172.00	5,724.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,762,700.10	51,244.84	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	627,214.77	0.00	DRUG-SPECIFIC/HOME IV	0.00	683.28
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	179,888.22	40,539.41
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,531.44	8,260.54	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,153.16	18,246.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	27,507.42	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	132,002.23	7,978.78	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	86,849.28	0.00	IMPL DEV CHARGE PATIENTS	215,593.75	10,944.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	464,919.11	128,666.59			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,613.24	22,740.41			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	527,355.52	85,099.17			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	93,192.13	146,311.49			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	66,452.28	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	204,228.55	180,320.94			
			TOTAL ANCILLARY	15,905,871.25	1,762,771.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,905,871.25	1,762,771.41

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:03:03  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EASTSIDE MEDICAL CENTER LLC  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	352,601.09	ADJUSTMENTS	0.00
COVERED CHARGES	265,072.71	CONTRACTUAL ALLOW	180,426.66
NON-COVERD CHARGES	87,528.38	TOTAL MEDICAID LIAB	84,646.05
		LESS: COB	84,583.05
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 93

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EASTSIDE MEDICAL CENTER LLC  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,791.46	0.00	OTHER LAB	4,125.94	0.00
MED/SURG SUPPLY	2,068.25	6,825.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,650.93	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,990.97	20,049.64	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,692.91	FEE SCHEDULE LAB	73,597.56	11,678.58
EKG/ECG	6,931.52	634.41	MRI SERVICES	0.00	0.00
IV THERAPY	8,863.75	919.54	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,444.09	3,324.30	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,876.41	987.85	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	983.26	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,761.08	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,857.68	7,939.09	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,352.02	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,599.00	543.22
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,159.52	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	537.57	2,465.61	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,945.44	76.28	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,432.68	8,693.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	14,198.74			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,561.25	5,339.79			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,701.85	0.00			
			TOTAL ANCILLARY	265,072.71	87,528.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	265,072.71	87,528.38

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:03:05  
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EASTSIDE MEDICAL CENTER LLC  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,299,299.55	ADJUSTMENTS	379.58
COVERED CHARGES	1,184,044.84	CONTRACTUAL ALLOW	1,157,081.76
NON-COVERD CHARGES	115,254.71	TOTAL MEDICAID LIAB	26,963.08
		LESS: COB	0.00
		LESS: COPAYMENT	1,011.00
		REIMBURSEMENT	25,952.08
		TOTAL NUMBER OF CLAIMS	482



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

EASTSIDE MEDICAL CENTER LLC  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,065.95	0.00	OTHER LAB	8,174.07	0.00
MED/SURG SUPPLY	2,015.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,700.77	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	81,073.26	20,077.94	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	284,538.48	85,187.82
EKG/ECG	16,400.68	0.00	MRI SERVICES	3,053.19	0.00
IV THERAPY	59,272.81	1,329.72	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	913.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	618,403.40	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	11,417.59	677.63
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	21,015.30	7,981.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,184,044.84	115,254.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,184,044.84	115,254.71

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:03:07  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EASTSIDE MEDICAL CENTER LLC  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,938.22	ADJUSTMENTS	0.00
COVERED CHARGES	35,933.41	CONTRACTUAL ALLOW	19,312.44
NON-COVERD CHARGES	9,004.81	TOTAL MEDICAID LIAB	16,620.97
		LESS: COB	16,611.97
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:03:07  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EASTSIDE MEDICAL CENTER LLC  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	770.47	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	640.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,240.51	7,257.78
EKG/ECG	1,903.23	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	492.15	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,108.59	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20.72	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	1,757.64	1,747.03			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	35,933.41	9,004.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,933.41	9,004.81

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 02:03:08  
Page: 13

SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EASTSIDE MEDICAL CENTER LLC  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	85,765.40	ADJUSTMENTS	0.00
COVERED CHARGES	81,715.24	CONTRACTUAL ALLOW	75,931.17
NON-COVERD CHARGES	4,050.16	TOTAL MEDICAID LIAB	5,784.07
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	5,781.07

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EASTSIDE MEDICAL CENTER LLC  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,909.31	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,980.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	8,100.33	4,050.16	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	4,297.74	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,332.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53.09	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	48,353.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	689.62	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	81,715.24	4,050.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	81,715.24	4,050.16

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EASTSIDE MEDICAL CENTER LLC  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,287,202.24	ADJUSTMENTS	7,859.30
COVERED CHARGES	1,236,398.24	CONTRACTUAL ALLOW	695,515.96
NON-COVERD CHARGES	50,804.00	TOTAL MEDICAID LIAB	540,882.28
		LESS: COB	7,963.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	532,919.14

TOTAL NUMBER OF ADMISSIONS 129

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	335		0	206,025.00		49,634.00
ROUTINE NURSERY	46		0	28,290.00		874.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	381		0	234,315.00		50,508.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	381		0	234,315.00		50,508.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:57:05  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	442,124.24	0.00	OTHER LAB	1,354.00	0.00
MED/SURG SUPPLY	176,551.00	296.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	126,999.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,978.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,313.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,933.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,360.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	72,534.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,972.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,397.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,400.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,238.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,404.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,581.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	741.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,504.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,062.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	4,686.00	0.00			
CARDIOLOGY	4,076.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,876.00	0.00			
			TOTAL ANCILLARY	1,002,083.24	296.00
			TOTAL ACCOMODATIONS	234,315.00	50,508.00
			TOTAL CHARGES	1,236,398.24	50,804.00



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,264.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,800.00	CONTRACTUAL ALLOW	4,134.38
NON-COVERD CHARGES	2,464.00	TOTAL MEDICAID LIAB	10,665.62
		LESS: COB	10,665.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	2,460.00		2,464.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4		0	2,460.00		2,464.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	4		0	2,460.00		2,464.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,802.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	927.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	908.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	207.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,736.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,760.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,340.00	0.00
			TOTAL ACCOMODATIONS	2,460.00	2,464.00
			TOTAL CHARGES	14,800.00	2,464.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,474,275.00	ADJUSTMENTS	39.34
COVERED CHARGES	1,228,414.80	CONTRACTUAL ALLOW	1,007,912.94
NON-COVERD CHARGES	245,860.20	TOTAL MEDICAID LIAB	220,501.86
		LESS: COB	136.43
		LESS: COPAYMENT	789.00
		REIMBURSEMENT	219,576.43
		ALL OTHER	180,941.41
		FEE SCHEDULE-LAB	38,605.64
		INJECTABLE DRUGS	29.38
		TOTAL NUMBER OF CLAIMS	1,149

DONALSONVILLE HOSPITAL INC  
 102 HOSPITAL CIR  
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
 000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	151,714.00	0.00	OTHER LAB	9,984.00	0.00
MED/SURG SUPPLY	107,346.00	446.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	83,966.00	0.00	OTHER THERAPEUTIC SVC	0.00	128.00
CT SCAN	49,499.00	9,279.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,870.00	7,341.00	FEE SCHEDULE LAB	450,763.80	88,536.20
EKG/ECG	9,815.00	0.00	MRI SERVICES	15,191.00	0.00
IV THERAPY	0.00	73,417.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	94,642.00	21,759.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,540.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,421.00	1,107.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	118,894.00	485.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,056.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	427.00	8,356.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	135.00	804.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	55,981.00	3,816.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	329.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,438.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,019.00	5,081.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,713.00	24,976.00			
			TOTAL ANCILLARY	1,228,414.80	245,860.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,228,414.80	245,860.20

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: 08/12/2016  
Run Time: 01:57:24  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC  
102 HOSPITAL CIR  
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,752.00	ADJUSTMENTS	0.00
COVERED CHARGES	28,303.00	CONTRACTUAL ALLOW	8,568.49
NON-COVERD CHARGES	2,449.00	TOTAL MEDICAID LIAB	19,734.51
		LESS: COB	19,734.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 28

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,899.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	583.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	426.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,878.00	1,195.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	954.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,431.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	1,340.00	814.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,660.00	440.00			
			TOTAL ANCILLARY	28,303.00	2,449.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,303.00	2,449.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:57:24  
Page: 9

DONALSONVILLE HOSPITAL INC  
102 HOSPITAL CIR  
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	81,130.00	ADJUSTMENTS	0.00
COVERED CHARGES	76,118.00	CONTRACTUAL ALLOW	69,573.02
NON-COVERD CHARGES	5,012.00	TOTAL MEDICAID LIAB	6,544.98
		LESS: COB	0.00
		LESS: COPAYMENT	222.00
		REIMBURSEMENT	6,322.98
		TOTAL NUMBER OF CLAIMS	117

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:57:24  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,114.00	18.00	OTHER LAB	842.00	0.00
MED/SURG SUPPLY	673.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,075.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,864.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,592.00	2,026.00
EKG/ECG	210.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	2,608.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	43,098.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	299.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	360.00			
			TOTAL ANCILLARY	76,118.00	5,012.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	76,118.00	5,012.00



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:57:25  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	597.00	ADJUSTMENTS	0.00
COVERED CHARGES	573.00	CONTRACTUAL ALLOW	165.72
NON-COVERD CHARGES	24.00	TOTAL MEDICAID LIAB	407.28
		LESS: COB	407.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 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	282.00	24.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	291.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	573.00	24.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	573.00	24.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 01:57:26  
Page: 13

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,696.00	ADJUSTMENTS	0.00
COVERED CHARGES	52,749.00	CONTRACTUAL ALLOW	42,131.66
NON-COVERD CHARGES	947.00	TOTAL MEDICAID LIAB	10,617.34
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	10,611.34
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,804.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21,787.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	994.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	681.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	392.00	FEE SCHEDULE LAB	857.00	25.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,522.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40.00	530.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,064.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	52,749.00	947.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,749.00	947.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 01:57:26  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 03:16:01  
 Page: 1

SHEPHERD CENTER  
 2020 PEACHTREE RD NW  
 ATLANTA,GA 30309-1426

PROVIDER NUMBER 000248069A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,745,436.22	ADJUSTMENTS	1,712,634.03
COVERED CHARGES	13,670,864.26	CONTRACTUAL ALLOW	9,082,451.79
NON-COVERD CHARGES	1,074,571.96	TOTAL MEDICAID LIAB	4,588,412.47
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,588,412.47

TOTAL NUMBER OF ADMISSIONS 89

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,238		0	4,032,889.00		417,291.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,238		0	4,032,889.00		417,291.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	25		0	63,112.00		5,488.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		22	0.00		30,184.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	25		22	63,112.00		35,672.00
TOTAL ACCOMODATIONS	3,263		22	4,096,001.00		452,963.00

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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,353,177.00	44,419.70	OTHER LAB	148,450.00	6,036.00
MED/SURG SUPPLY	2,166,133.91	126,190.00	RECREATIONAL THERAPY	2,446.00	0.00
LABORATORY-GENERAL	360,447.00	23,681.00	EDUCATION & TRAINING	56,127.00	6,059.00
RADIOLOGY-DIAGNOSTIC	156,946.66	3,448.00	OTHER THERAPEUTIC SVC	7,218.00	6,166.00
CT SCAN	55,914.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	874,992.00	67,241.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,962.00	586.00	MRI SERVICES	6,968.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,234,677.09	76,091.21	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,167,393.00	104,374.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	833,065.25	35,974.05
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	839,634.35	58,186.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	244,843.00	40,375.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	1,517.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	9,791.00
OTHER IMAGING SERVICE	2,594.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,564.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,276.00	0.00			
AMBULATORY SURGERY	42,500.00	11,474.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,351.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	184.00	0.00			
			TOTAL ANCILLARY	9,574,863.26	621,608.96
			TOTAL ACCOMODATIONS	4,096,001.00	452,963.00
			TOTAL CHARGES	13,670,864.26	1,074,571.96

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: 08/12/2016  
 Run Time: 03:16:01  
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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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014261083032	07/16/14 - 09/10/14	09/22/14	0.00	642.00	0.00	0.00	0.00
952	5214337000114	05/29/14 - 08/05/14	12/08/14	0.00	1,708.00	0.00	0.00	0.00
952	2014349027042	08/20/14 - 09/30/14	12/22/14	0.00	1,220.00	0.00	0.00	0.00
952	5915008001554	09/17/14 - 12/19/14	01/12/15	0.00	244.00	0.00	0.00	0.00
952	5215061000020	08/06/14 - 09/25/14	03/09/15	0.00	1,733.00	0.00	0.00	0.00
952	2015110032266	08/27/14 - 12/02/14	04/27/15	0.00	1,586.00	0.00	0.00	0.00
952	9715345957014	05/20/14 - 06/25/14	12/14/15	0.00	2,414.00	0.00	0.00	0.00
952	2016195006291	07/30/14 - 09/17/14	07/18/16	0.00	244.00	0.00	0.00	0.00
TOTAL				0.00	9,791.00	0.00	0.00	0.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 03:16:03  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:16:03  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,999,298.98	ADJUSTMENTS	175,503.14
COVERED CHARGES	2,994,795.00	CONTRACTUAL ALLOW	1,960,079.16
NON-COVERD CHARGES	1,004,503.98	TOTAL MEDICAID LIAB	1,034,715.84
		LESS: COB	630.76
		LESS: COPAYMENT	5,256.00
		REIMBURSEMENT	1,028,829.08
		ALL OTHER	471,984.37
		FEE SCHEDULE-LAB	27,631.16
		INJECTABLE DRUGS	529,213.55
		TOTAL NUMBER OF CLAIMS	1,627

SHEPHERD CENTER  
 2020 PEACHTREE RD NW  
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 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,601.15	12,828.15	OTHER LAB	11,984.00	7,740.00
MED/SURG SUPPLY	42,696.00	0.00	RECREATIONAL THERAPY	0.00	5,928.00
LABORATORY-GENERAL	0.00	79.00	EDUCATION & TRAINING	4,122.00	4,701.00
RADIOLOGY-DIAGNOSTIC	31,736.00	2,045.00	OTHER THERAPEUTIC SVC	0.00	1,788.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	138,246.00	157,475.00	FEE SCHEDULE LAB	234,127.00	12,723.00
EKG/ECG	1,758.00	2,344.00	MRI SERVICES	366,650.00	31,216.00
IV THERAPY	12,989.00	282.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	487.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	1,492,794.85	531,418.70
RADIOLOGY THERAPEUTIC	89,865.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	102,341.00	139,883.11	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	23,542.00	47,402.02	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	355.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	237,517.00	1,976.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	4,572.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	18,912.00
OTHER IMAGING SERVICE	15,818.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	9,022.00	2,484.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	152,499.00	18,352.00			
			TOTAL ANCILLARY	2,994,795.00	1,004,503.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,994,795.00	1,004,503.98

SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER  
2020 PEACHTREE RD NW  
ATLANTA,GA 30309-1426

PROVIDER NUMBER  
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2015055063201	12/22/14 - 12/22/14	03/02/15	0.00	61.00	0.00	0.00	0.00
952	2015055063201	01/02/15 - 01/02/15	03/02/15	0.00	61.00	0.00	0.00	0.00
952	2015055063201	11/24/14 - 11/24/14	03/02/15	0.00	183.00	0.00	0.00	0.00
952	2015055063201	12/01/14 - 12/01/14	03/02/15	0.00	183.00	0.00	0.00	0.00
952	2015055063201	12/10/14 - 12/10/14	03/02/15	0.00	183.00	0.00	0.00	0.00
952	2015055063201	12/22/14 - 12/22/14	03/02/15	0.00	122.00	0.00	0.00	0.00
952	2015055063201	01/02/15 - 01/02/15	03/02/15	0.00	122.00	0.00	0.00	0.00
952	2015055063201	01/14/15 - 01/14/15	03/02/15	0.00	183.00	0.00	0.00	0.00
952	2015055063201	01/19/15 - 01/19/15	03/02/15	0.00	183.00	0.00	0.00	0.00
952	2015055063201	01/07/15 - 01/07/15	03/02/15	0.00	183.00	0.00	0.00	0.00
952	5915062002297	12/03/14 - 12/03/14	03/09/15	0.00	120.00	0.00	0.00	0.00
952	5915062002297	12/05/14 - 12/05/14	03/09/15	0.00	40.00	0.00	0.00	0.00
952	5915062002297	12/12/14 - 12/12/14	03/09/15	0.00	160.00	0.00	0.00	0.00
952	5915062002297	12/15/14 - 12/15/14	03/09/15	0.00	160.00	0.00	0.00	0.00
952	5915062002297	12/17/14 - 12/17/14	03/09/15	0.00	120.00	0.00	0.00	0.00
952	5915062002297	12/18/14 - 12/18/14	03/09/15	0.00	160.00	0.00	0.00	0.00
952	5915062002297	12/19/14 - 12/19/14	03/09/15	0.00	120.00	0.00	0.00	0.00
952	5915062002297	12/05/14 - 12/05/14	03/09/15	0.00	183.00	0.00	0.00	0.00
952	5915062002297	12/08/14 - 12/08/14	03/09/15	0.00	244.00	0.00	0.00	0.00
952	5915062002297	12/11/14 - 12/11/14	03/09/15	0.00	122.00	0.00	0.00	0.00
952	5915062002297	12/15/14 - 12/15/14	03/09/15	0.00	244.00	0.00	0.00	0.00
952	5915062002297	12/17/14 - 12/17/14	03/09/15	0.00	244.00	0.00	0.00	0.00
952	5915062002297	12/22/14 - 12/22/14	03/09/15	0.00	183.00	0.00	0.00	0.00
952	5915062002297	12/26/14 - 12/26/14	03/09/15	0.00	244.00	0.00	0.00	0.00
952	5915062002297	12/29/14 - 12/29/14	03/09/15	0.00	183.00	0.00	0.00	0.00
952	2015083061476	10/03/14 - 10/03/14	03/30/15	0.00	160.00	0.00	0.00	0.00
952	2015083061476	10/10/14 - 10/10/14	03/30/15	0.00	120.00	0.00	0.00	0.00
952	2015083061476	10/14/14 - 10/14/14	03/30/15	0.00	160.00	0.00	0.00	0.00
952	2015083061476	10/17/14 - 10/17/14	03/30/15	0.00	160.00	0.00	0.00	0.00
952	2015083061476	10/22/14 - 10/22/14	03/30/15	0.00	320.00	0.00	0.00	0.00
952	2015083061476	10/24/14 - 10/24/14	03/30/15	0.00	160.00	0.00	0.00	0.00
952	2015083061476	10/20/14 - 10/20/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015083061476	10/21/14 - 10/21/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015083061476	10/27/14 - 10/27/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015083061509	10/21/14 - 10/21/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015083061509	10/06/14 - 10/06/14	03/30/15	0.00	80.00	0.00	0.00	0.00
952	2015083061509	10/23/14 - 10/23/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015083061509	10/10/14 - 10/10/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015085095123	10/17/14 - 10/17/14	03/30/15	0.00	160.00	0.00	0.00	0.00
952	2015085095123	10/20/14 - 10/20/14	03/30/15	0.00	80.00	0.00	0.00	0.00
952	2015085095123	10/24/14 - 10/24/14	03/30/15	0.00	160.00	0.00	0.00	0.00
952	2015085095123	10/27/14 - 10/27/14	03/30/15	0.00	160.00	0.00	0.00	0.00

SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

SHEPHERD CENTER  
2020 PEACHTREE RD NW  
ATLANTA,GA 30309-1426

PROVIDER NUMBER  
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM#	CLM#	DATE	DATE	PROV#	AMOUNT	PAY#	AMOUNT	THRU#	AMOUNT
952	2015085095123	10/29/14	10/29/14	03/30/15	0.00	120.00	0.00	0.00	0.00
952	2015085095123	11/05/14	11/05/14	03/30/15	0.00	120.00	0.00	0.00	0.00
952	2015085095123	11/07/14	11/07/14	03/30/15	0.00	160.00	0.00	0.00	0.00
952	2015085095123	11/14/14	11/14/14	03/30/15	0.00	160.00	0.00	0.00	0.00
952	2015085095123	10/27/14	10/27/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015085095123	10/28/14	10/28/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015085095123	11/12/14	11/12/14	03/30/15	0.00	488.00	0.00	0.00	0.00
952	2015085095123	10/15/14	10/15/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015085095123	10/31/14	10/31/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015085095123	11/06/14	11/06/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015085095123	11/19/14	11/19/14	03/30/15	0.00	244.00	0.00	0.00	0.00
952	2015111055979	03/03/15	03/03/15	04/27/15	0.00	122.00	0.00	0.00	0.00
952	2015111055979	03/03/15	03/03/15	04/27/15	0.00	61.00	0.00	0.00	0.00
952	2015124032853	03/12/15	03/12/15	05/11/15	0.00	183.00	0.00	0.00	0.00
952	2015124032853	02/20/15	02/20/15	05/11/15	0.00	160.00	0.00	0.00	0.00
952	2015124032853	02/26/15	02/26/15	05/11/15	0.00	320.00	0.00	0.00	0.00
952	2015124032853	02/27/15	02/27/15	05/11/15	0.00	160.00	0.00	0.00	0.00
952	2015124032853	03/03/15	03/03/15	05/11/15	0.00	160.00	0.00	0.00	0.00
952	2015124032853	03/06/15	03/06/15	05/11/15	0.00	120.00	0.00	0.00	0.00
952	2015124032853	03/13/15	03/13/15	05/11/15	0.00	160.00	0.00	0.00	0.00
952	2015124032853	03/03/15	03/03/15	05/11/15	0.00	244.00	0.00	0.00	0.00
952	2015124032853	03/13/15	03/13/15	05/11/15	0.00	244.00	0.00	0.00	0.00
952	2015124032853	02/23/15	02/23/15	05/11/15	0.00	244.00	0.00	0.00	0.00
952	2015124032853	03/11/15	03/11/15	05/11/15	0.00	244.00	0.00	0.00	0.00
952	5915126000697	01/05/15	01/05/15	05/11/15	0.00	122.00	0.00	0.00	0.00
952	5915126000697	12/03/14	12/03/14	05/11/15	0.00	120.00	0.00	0.00	0.00
952	5915126000697	11/24/14	11/24/14	05/11/15	0.00	183.00	0.00	0.00	0.00
952	5915126000697	12/31/14	12/31/14	05/11/15	0.00	183.00	0.00	0.00	0.00
952	5915126000697	01/05/15	01/05/15	05/11/15	0.00	61.00	0.00	0.00	0.00
952	2015127133138	01/30/15	01/30/15	05/11/15	0.00	160.00	0.00	0.00	0.00
952	2015127133138	02/09/15	02/09/15	05/11/15	0.00	120.00	0.00	0.00	0.00
952	2015127133138	02/19/15	02/19/15	05/11/15	0.00	160.00	0.00	0.00	0.00
952	2015127133138	02/20/15	02/20/15	05/11/15	0.00	80.00	0.00	0.00	0.00
952	2015127133138	01/27/15	01/27/15	05/11/15	0.00	244.00	0.00	0.00	0.00
952	2015127133138	01/28/15	01/28/15	05/11/15	0.00	244.00	0.00	0.00	0.00
952	2015127133138	02/12/15	02/12/15	05/11/15	0.00	244.00	0.00	0.00	0.00
952	2015127133138	02/02/15	02/02/15	05/11/15	0.00	244.00	0.00	0.00	0.00
952	2015134077125	04/15/15	04/15/15	05/18/15	0.00	123.00	0.00	0.00	0.00
952	2015134077125	04/17/15	04/17/15	05/18/15	0.00	246.00	0.00	0.00	0.00
952	2015134077125	04/20/15	04/20/15	05/18/15	0.00	164.00	0.00	0.00	0.00
952	2015134077125	04/21/15	04/21/15	05/18/15	0.00	41.00	0.00	0.00	0.00
952	2015134077125	04/24/15	04/24/15	05/18/15	0.00	123.00	0.00	0.00	0.00
952	2015134077125	04/07/15	04/07/15	05/18/15	0.00	252.00	0.00	0.00	0.00
952	2015134077125	04/13/15	04/13/15	05/18/15	0.00	126.00	0.00	0.00	0.00
952	2015134077125	04/15/15	04/15/15	05/18/15	0.00	63.00	0.00	0.00	0.00
952	2015134077125	04/16/15	04/16/15	05/18/15	0.00	252.00	0.00	0.00	0.00

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM	CLM	DATE	DATE	DATE	AMOUNT	PAYMENT	THROUGH	AMOUNT
952	2015134077125	04/17/15	-	04/17/15	05/18/15	0.00	252.00	0.00
952	2015134077125	04/02/15	-	04/02/15	05/18/15	0.00	252.00	0.00
952	2015134077125	04/03/15	-	04/03/15	05/18/15	0.00	567.00	0.00
952	2015134077125	04/06/15	-	04/06/15	05/18/15	0.00	410.00	0.00
952	2015134077125	04/07/15	-	04/07/15	05/18/15	0.00	82.00	0.00
952	2015134077125	04/10/15	-	04/10/15	05/18/15	0.00	328.00	0.00
952	2015134077125	04/13/15	-	04/13/15	05/18/15	0.00	82.00	0.00
952	5915142001260	12/17/14	-	12/17/14	05/25/15	0.00	122.00	0.00
952	5915142001260	12/03/14	-	12/03/14	05/25/15	0.00	183.00	0.00
952	5915142001260	12/12/14	-	12/12/14	05/25/15	0.00	183.00	0.00
952	5915142001260	12/17/14	-	12/17/14	05/25/15	0.00	61.00	0.00
952	5915323000916	01/15/15	-	01/15/15	11/23/15	0.00	120.00	0.00
952	5915323000916	01/22/15	-	01/22/15	11/23/15	0.00	120.00	0.00
952	5915323000916	01/29/15	-	01/29/15	11/23/15	0.00	120.00	0.00
952	5915323000916	01/08/15	-	01/08/15	11/23/15	0.00	183.00	0.00
952	5915323000916	01/12/15	-	01/12/15	11/23/15	0.00	183.00	0.00

TOTAL 0.00 18,912.00 0.00 0.00 0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	86,433.35	ADJUSTMENTS	0.00
COVERED CHARGES	73,524.35	CONTRACTUAL ALLOW	37,009.79
NON-COVERD CHARGES	12,909.00	TOTAL MEDICAID LIAB	36,514.56
		LESS: COB	36,472.56
		LESS: COPAYMENT	42.00
		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

SHEPHERD CENTER  
 2020 PEACHTREE RD NW  
 ATLANTA,GA 30309-1426

PROVIDER NUMBER  
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	316.00	OTHER LAB	0.00	154.00
MED/SURG SUPPLY	434.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	166.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	606.00	4,747.00	FEE SCHEDULE LAB	604.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	210.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	64,521.35	0.00
RADIOLOGY THERAPEUTIC	1,984.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	633.00	4,747.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	303.00	2,727.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	356.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,873.00	52.00			
			TOTAL ANCILLARY	73,524.35	12,909.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	73,524.35	12,909.00



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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SHEPHERD CENTER  
2020 PEACHTREE RD NW  
ATLANTA,GA 30309-1426

PROVIDER NUMBER  
000248069A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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	04/01/14	THROUGH	03/31/15
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

SHEPHERD CENTER  
2020 PEACHTREE RD NW  
ATLANTA,GA 30309-1426

PROVIDER NUMBER  
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,196.00	ADJUSTMENTS	0.00
COVERED CHARGES	28,854.00	CONTRACTUAL ALLOW	17,710.89
NON-COVERD CHARGES	17,342.00	TOTAL MEDICAID LIAB	11,143.11
		LESS: COB	0.00
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	11,053.11
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SHEPHERD CENTER  
 2020 PEACHTREE RD NW  
 ATLANTA,GA 30309-1426

PROVIDER NUMBER  
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 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	48.00	0.00	RECREATIONAL THERAPY	444.00	740.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	303.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	384.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,697.00	8,297.00	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	9,362.00	5,874.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	105.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,942.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,854.00	17,342.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,854.00	17,342.00

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2016205006224	10/10/14 - 10/10/14	08/01/16	0.00	244.00	0.00	0.00	0.00
952	2016205006224	10/03/14 - 10/03/14	08/01/16	0.00	120.00	0.00	0.00	0.00
952	2016205006224	10/06/14 - 10/06/14	08/01/16	0.00	80.00	0.00	0.00	0.00
952	2016205006224	10/15/14 - 10/15/14	08/01/16	0.00	160.00	0.00	0.00	0.00
952	2016205006224	10/17/14 - 10/17/14	08/01/16	0.00	80.00	0.00	0.00	0.00
952	2016205006224	10/24/14 - 10/24/14	08/01/16	0.00	160.00	0.00	0.00	0.00
952	2016205006224	10/20/14 - 10/20/14	08/01/16	0.00	244.00	0.00	0.00	0.00
952	2016205006224	10/30/14 - 10/30/14	08/01/16	0.00	122.00	0.00	0.00	0.00
952	2016205006224	10/01/14 - 10/01/14	08/01/16	0.00	244.00	0.00	0.00	0.00
952	2016205006224	10/13/14 - 10/13/14	08/01/16	0.00	244.00	0.00	0.00	0.00
952	2016205006224	10/29/14 - 10/29/14	08/01/16	0.00	244.00	0.00	0.00	0.00
TOTAL				0.00	1,942.00	0.00	0.00	0.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:56:42  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR NORTH FULTON HOSPITAL, INC  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,710,462.55	ADJUSTMENTS	3,319,941.46
COVERED CHARGES	39,751,983.94	CONTRACTUAL ALLOW	34,252,156.44
NON-COVERD CHARGES	958,478.61	TOTAL MEDICAID LIAB	5,499,827.50
		LESS: COB	79,600.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,420,227.21

TOTAL NUMBER OF ADMISSIONS 751

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,409		2	1,796,397.00		171,747.00
ROUTINE NURSERY	801		13	1,142,555.00		19,899.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,210		15	2,938,952.00		191,646.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	988		0	3,868,174.00		0.00
NICU	9		0	45,693.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		38	0.00		73,720.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	997		38	3,913,867.00		73,720.00
TOTAL ACCOMODATIONS	3,207		53	6,852,819.00		265,366.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR NORTH FULTON HOSPITAL, INC  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,226,063.80	119,421.70	OTHER LAB	102,615.60	3,343.20
MED/SURG SUPPLY	4,033,685.27	154,220.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,088,083.63	42,792.29	EDUCATION & TRAINING	77.00	0.00
RADIOLOGY-DIAGNOSTIC	477,893.10	1,050.80	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,464,208.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	266,461.30	14,818.54	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	144,560.40	0.00	MRI SERVICES	253,987.50	0.00
IV THERAPY	40,712.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,863,455.80	55,509.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,600,997.50	0.00	REHAB THERAPY	240.00	0.00
RESPIRATORY SERVICES	2,137,389.80	17,421.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	422,152.10	1,297.40	AMBULANCE	0.00	0.00
GI SERVICES	185,047.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	814,433.30	10,708.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	457,572.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	182,565.00	0.00	INJECTABLE DRUGS	3,713.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	130,323.06	7,362.10	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	181,390.98	2,744.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	46,040.10	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38,990.70	295.50	TRAUMA RESPONSE	0.00	58,933.80
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	601,281.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	210,880.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	201,664.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	139,150.30	0.00			
AUDIOLOGY	105,894.60	0.00			
CARDIOLOGY	551,636.50	1,419.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,453.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	101,206.70	109.80			
			TOTAL ANCILLARY	32,899,164.94	693,112.61
			TOTAL ACCOMODATIONS	6,852,819.00	265,366.00
			TOTAL CHARGES	39,751,983.94	958,478.61



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:56:51  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR NORTH FULTON HOSPITAL, INC  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	64,959.90	ADJUSTMENTS	0.00
COVERED CHARGES	64,443.90	CONTRACTUAL ALLOW	55,504.59
NON-COVERD CHARGES	516.00	TOTAL MEDICAID LIAB	8,939.31
		LESS: COB	8,939.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6		0	7,818.00		516.00
ROUTINE NURSERY	4		0	2,868.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	10,686.00		516.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	10,686.00		516.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR NORTH FULTON HOSPITAL, INC  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,748.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,460.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,208.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,574.70	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,821.40	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,526.50	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	2,857.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,556.30	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	208.30	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	796.20	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	53,757.90	0.00
			TOTAL ACCOMODATIONS	10,686.00	516.00
			TOTAL CHARGES	64,443.90	516.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:56:52  
Page: 5

WELLSTAR NORTH FULTON HOSPITAL, INC  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,919,811.85	ADJUSTMENTS	166,872.78
COVERED CHARGES	8,077,737.01	CONTRACTUAL ALLOW	7,473,128.60
NON-COVERD CHARGES	842,074.84	TOTAL MEDICAID LIAB	604,608.41
		LESS: COB	1,826.58
		LESS: COPAYMENT	1,455.00
		REIMBURSEMENT	601,326.83
		ALL OTHER	540,163.85
		FEE SCHEDULE-LAB	50,696.06
		INJECTABLE DRUGS	10,466.92

TOTAL NUMBER OF CLAIMS 1,703

WELLSTAR NORTH FULTON HOSPITAL, INC  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	563,762.40	2,885.20	OTHER LAB	63,031.50	1,635.80
MED/SURG SUPPLY	653,661.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	264,827.80	3,099.20	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	872,568.20	122,886.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	539.50	5,348.07	FEE SCHEDULE LAB	1,369,952.99	160,874.51
EKG/ECG	105,891.30	4,844.70	MRI SERVICES	161,430.30	23,051.00
IV THERAPY	519,741.70	10,205.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	442,505.71	62,834.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,894.50	6,560.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	109,390.80	0.00	AMBULANCE	0.00	1,226.10
GI SERVICES	38,735.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,495,318.70	13,750.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	72,931.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,320.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	443,159.10	209,131.60
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	4,425.46	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,093.10	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,477.20	1,666.40	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	84,112.59	12,753.60
LITHOTRIPSY	42,287.85	14,095.95	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	172,871.80	26,306.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	85,726.00	15,396.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	78,949.10	74,489.40			
AMBULATORY SURGERY	170,828.44	50,060.06			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	47,847.40	2,482.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	178,293.70	6,651.50			
			TOTAL ANCILLARY	8,077,737.01	842,074.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,077,737.01	842,074.84

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR NORTH FULTON HOSPITAL, INC  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,975.60	ADJUSTMENTS	0.00
COVERED CHARGES	26,975.60	CONTRACTUAL ALLOW	23,403.24
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3,572.36
		LESS: COB	3,569.36
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR NORTH FULTON HOSPITAL, INC  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,367.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,780.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,428.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,397.70	0.00
EKG/ECG	692.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	866.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,562.90	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	887.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,291.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,014.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	223.60	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	1,499.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	963.20	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	26,975.60	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,975.60	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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WELLSTAR NORTH FULTON HOSPITAL, INC  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	391,536.50	ADJUSTMENTS	373.58
COVERED CHARGES	361,418.40	CONTRACTUAL ALLOW	353,754.62
NON-COVERD CHARGES	30,118.10	TOTAL MEDICAID LIAB	7,663.78
		LESS: COB	0.00
		LESS: COPAYMENT	210.00
		REIMBURSEMENT	7,453.78
		TOTAL NUMBER OF CLAIMS	137

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR NORTH FULTON HOSPITAL, INC  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,761.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,666.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,788.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,344.40	12,002.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	72,138.70	3,080.10
EKG/ECG	6,228.90	0.00	MRI SERVICES	0.00	10,861.00
IV THERAPY	15,732.40	770.80	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	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	153,581.70	793.60	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	11,567.50	1,371.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	98.50	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	4,585.90	1,140.10			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,022.50	0.00			
			TOTAL ANCILLARY	361,418.40	30,118.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	361,418.40	30,118.10



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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WELLSTAR NORTH FULTON HOSPITAL, INC  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR NORTH FULTON HOSPITAL, INC  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	516,693.28	ADJUSTMENTS	16,480.59
COVERED CHARGES	401,698.14	CONTRACTUAL ALLOW	374,271.42
NON-COVERD CHARGES	114,995.14	TOTAL MEDICAID LIAB	27,426.72
		LESS: COB	0.00
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	27,354.72
		TOTAL NUMBER OF CLAIMS	5

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR NORTH FULTON HOSPITAL, INC  
 3000 HOSPITAL BLVD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,393.00	0.00	OTHER LAB	1,356.70	0.00
MED/SURG SUPPLY	64,737.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,657.00	1,547.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,097.10	3,849.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	21,087.50	12,582.20
EKG/ECG	692.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	28,659.00	894.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,471.86	9,422.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,282.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,041.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,475.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47,761.80	16,190.70
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	3,237.60
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	50,746.68	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	29,754.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	33,155.10	36,039.60			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,083.20	1,476.90			
			TOTAL ANCILLARY	401,698.14	114,995.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	401,698.14	114,995.14

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR NORTH FULTON HOSPITAL, INC  
3000 HOSPITAL BLVD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:49:19  
 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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,765,968.09	ADJUSTMENTS	15,529.98
COVERED CHARGES	2,652,505.84	CONTRACTUAL ALLOW	2,004,051.37
NON-COVERD CHARGES	113,462.25	TOTAL MEDICAID LIAB	648,454.47
		LESS: COB	9,333.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	639,121.27

TOTAL NUMBER OF ADMISSIONS 81

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	249		0	218,373.00		77,011.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	249		0	218,373.00		77,011.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	57		0	155,370.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	57		0	155,370.00		0.00
TOTAL ACCOMODATIONS	306		0	373,743.00		77,011.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	192,604.50	0.00	OTHER LAB	9,852.25	0.00
MED/SURG SUPPLY	81,104.75	170.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	446,789.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	79,976.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	179,365.75	29,128.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,008.32	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,468.75	0.00	MRI SERVICES	44,876.00	0.00
IV THERAPY	18,538.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	237,179.25	952.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	85,830.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	90,949.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,247.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	104,112.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,719.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	6,020.00
LABORATORY PATHOLOGIC	9,324.25	0.00	INJECTABLE DRUGS	368,050.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	21,147.66	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,358.11	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	15,390.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	643.75	180.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	107,627.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,800.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,475.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,166.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	53,157.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,278,762.84	36,451.25
			TOTAL ACCOMODATIONS	373,743.00	77,011.00
			TOTAL CHARGES	2,652,505.84	113,462.25

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 01:49:20  
 Page: 3

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	189,720.35	ADJUSTMENTS	0.00
COVERED CHARGES	188,890.35	CONTRACTUAL ALLOW	126,392.74
NON-COVERD CHARGES	830.00	TOTAL MEDICAID LIAB	62,497.61
		LESS: COB	62,497.61
		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	1,754.00		830.00
ROUTINE NURSERY	0		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	1,754.00		830.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	11		0	27,923.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	27,923.00		0.00
TOTAL ACCOMODATIONS	13		0	29,677.00		830.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,098.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,101.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	26,894.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,404.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,859.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,457.04	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	704.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,510.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,607.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75,124.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	776.04	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	519.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	3,078.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,616.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,466.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	159,213.35	0.00
			TOTAL ACCOMODATIONS	29,677.00	830.00
			TOTAL CHARGES	188,890.35	830.00



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 01:49:21  
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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,842,355.94	ADJUSTMENTS	18,932.78
COVERED CHARGES	4,419,911.96	CONTRACTUAL ALLOW	3,939,664.46
NON-COVERD CHARGES	422,443.98	TOTAL MEDICAID LIAB	480,247.50
		LESS: COB	227.46
		LESS: COPAYMENT	874.73
		REIMBURSEMENT	479,145.31
		ALL OTHER	436,569.66
		FEE SCHEDULE-LAB	40,197.62
		INJECTABLE DRUGS	2,378.03
		TOTAL NUMBER OF CLAIMS	1,624

COLISEUM NORTHSIDE HOSPITAL  
 400 CHARTER BLVD  
 MACON,GA 31210-4831

PROVIDER NUMBER  
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	100,656.75	0.00	OTHER LAB	58,177.25	0.00
MED/SURG SUPPLY	44,719.25	173.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	5,571.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	501,732.25	704.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	532,834.00	193,988.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,101.00	9,541.07	FEE SCHEDULE LAB	867,119.00	76,903.50
EKG/ECG	65,906.25	712.50	MRI SERVICES	54,803.50	17,488.00
IV THERAPY	154,579.25	5,862.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	313,206.46	21,427.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,925.75	4,038.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	130,197.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	19,107.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,152,058.00	22,342.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	67,717.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	2,224.50	INJECTABLE DRUGS	24,663.00	17,324.34
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,500.50	3,984.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,943.75	1,012.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,251.25	1,785.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	53,877.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	51,738.75	19,806.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,675.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,596.25	8,305.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,015.00	6,617.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	151,971.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,837.75	2,633.00			
			TOTAL ANCILLARY	4,419,911.96	422,443.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,419,911.96	422,443.98

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
Run Time: 01:49:33  
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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	97,173.25	ADJUSTMENTS	0.00
COVERED CHARGES	72,184.75	CONTRACTUAL ALLOW	36,760.44
NON-COVERD CHARGES	24,988.50	TOTAL MEDICAID LIAB	35,424.31
		LESS: COB	35,416.42
		LESS: COPAYMENT	7.89
		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

COLISEUM NORTHSIDE HOSPITAL  
 400 CHARTER BLVD  
 MACON,GA 31210-4831

PROVIDER NUMBER  
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,096.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	154.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,503.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	18,506.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,099.25	0.00	FEE SCHEDULE LAB	15,923.25	626.25
EKG/ECG	1,068.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,899.25	679.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,799.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,644.00	268.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	336.25	85.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,460.00	1,024.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	72,184.75	24,988.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	72,184.75	24,988.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 01:49:34  
Page: 9

COLISEUM NORTHSIDE HOSPITAL  
400 CHARTER BLVD  
MACON,GA 31210-4831

PROVIDER NUMBER  
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	586,751.25	ADJUSTMENTS	209.82
COVERED CHARGES	566,781.00	CONTRACTUAL ALLOW	544,923.98
NON-COVERD CHARGES	19,970.25	TOTAL MEDICAID LIAB	21,857.02
		LESS: COB	0.00
		LESS: COPAYMENT	801.00
		REIMBURSEMENT	21,056.02
		TOTAL NUMBER OF CLAIMS	391

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,657.00	0.00	OTHER LAB	2,061.50	0.00
MED/SURG SUPPLY	582.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	42.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,074.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,340.25	10,490.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	100,712.25	6,848.25
EKG/ECG	4,987.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	26,893.00	287.50	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	708.00	498.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	304,479.50	883.50	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	2,962.25	921.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,323.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	566,781.00	19,970.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	566,781.00	19,970.25

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

COLISEUM NORTHSIDE HOSPITAL  
400 CHARTER BLVD  
MACON,GA 31210-4831

PROVIDER NUMBER  
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,941.50	ADJUSTMENTS	0.00
COVERED CHARGES	4,941.50	CONTRACTUAL ALLOW	2,328.50
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,613.00
		LESS: COB	2,607.00
		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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 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	19.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,951.25	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,970.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,941.50	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,941.50	0.00



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM NORTHSIDE HOSPITAL  
400 CHARTER BLVD  
MACON,GA 31210-4831

PROVIDER NUMBER  
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,749.00	ADJUSTMENTS	0.00
COVERED CHARGES	63,392.75	CONTRACTUAL ALLOW	57,572.34
NON-COVERD CHARGES	356.25	TOTAL MEDICAID LIAB	5,820.41
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	5,814.41
		TOTAL NUMBER OF CLAIMS	1

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,374.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,025.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,481.00	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	1,551.00	0.00
EKG/ECG	0.00	356.25	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,693.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,715.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,067.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	131.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,355.50	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	63,392.75	356.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	63,392.75	356.25

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

COLISEUM NORTHSIDE HOSPITAL  
400 CHARTER BLVD  
MACON,GA 31210-4831

PROVIDER NUMBER  
000295358A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
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NORTHSIDE MEDICAL CENTER  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER 000315642A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	925,679.73	ADJUSTMENTS	0.00
COVERED CHARGES	924,072.48	CONTRACTUAL ALLOW	669,068.68
NON-COVERD CHARGES	1,607.25	TOTAL MEDICAID LIAB	255,003.80
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	255,003.80

TOTAL NUMBER OF ADMISSIONS 16

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	42		0	37,800.00		1,584.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	42		0	37,800.00		1,584.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,815.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	1,815.00		0.00
TOTAL ACCOMODATIONS	43		0	39,615.00		1,584.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,121.00	0.00	OTHER LAB	2,006.25	0.00
MED/SURG SUPPLY	62,537.70	23.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,640.28	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,017.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,639.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,348.76	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	612.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	216,580.21	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,710.22	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,597.86	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	28,600.43	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	300.00	0.00	INJECTABLE DRUGS	50,786.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,326.27	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	416,453.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,181.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	884,457.48	23.25
			TOTAL ACCOMODATIONS	39,615.00	1,584.00
			TOTAL CHARGES	924,072.48	1,607.25

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 03:02:52  
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NORTHSIDE MEDICAL CENTER  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	300,917.56	ADJUSTMENTS	0.00
COVERED CHARGES	241,198.59	CONTRACTUAL ALLOW	195,831.46
NON-COVERD CHARGES	59,718.97	TOTAL MEDICAID LIAB	45,367.13
		LESS: COB	0.00
		LESS: COPAYMENT	213.00
		REIMBURSEMENT	45,154.13
		ALL OTHER	43,564.82
		FEE SCHEDULE-LAB	1,416.32
		INJECTABLE DRUGS	172.99

TOTAL NUMBER OF CLAIMS 54

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
 Run Time: 03:02:52  
 Page: 5

NORTHSIDE MEDICAL CENTER  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,186.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,141.25	21,639.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,726.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,811.45	1,272.76	FEE SCHEDULE LAB	14,968.83	1,124.88
EKG/ECG	2,244.00	408.00	MRI SERVICES	4,468.00	8,331.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	98,439.41	22,666.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,790.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,876.21	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,044.50	328.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,703.48	677.56	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,046.73	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,930.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,868.51	223.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	241,198.59	59,718.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	241,198.59	59,718.97



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

NORTHSIDE MEDICAL CENTER  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,106.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,106.00	CONTRACTUAL ALLOW	3,689.52
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	416.48
		LESS: COB	413.48
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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

NORTHSIDE MEDICAL CENTER  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 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	4,106.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	4,106.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,106.00	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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NORTHSIDE MEDICAL CENTER  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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NORTHSIDE MEDICAL CENTER  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE MEDICAL CENTER  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,157.25	ADJUSTMENTS	0.00
COVERED CHARGES	59,856.66	CONTRACTUAL ALLOW	53,127.44
NON-COVERD CHARGES	9,300.59	TOTAL MEDICAID LIAB	6,729.22
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	6,720.22

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE MEDICAL CENTER  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	246.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,263.25	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	163.00	FEE SCHEDULE LAB	1,262.75	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	10,690.66	5,345.34	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,648.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,479.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	641.00	81.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	21,425.50	3,711.25
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	59,856.66	9,300.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,856.66	9,300.59

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE MEDICAL CENTER  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
 1355 INDEPENDENCE DR  
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
 000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,284,055.43	ADJUSTMENTS	9,420.23
COVERED CHARGES	755,518.95	CONTRACTUAL ALLOW	346,259.82
NON-COVERD CHARGES	528,536.48	TOTAL MEDICAID LIAB	409,259.13
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	409,259.13

TOTAL NUMBER OF ADMISSIONS 47

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	71		549	62,622.00		511,208.00
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	71		549	62,622.00		511,208.00
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	71		549	62,622.00		511,208.00



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

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
 1355 INDEPENDENCE DR  
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
 000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	281,369.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,588.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,985.04	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,149.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	160,642.90	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,550.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	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	150,722.20	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	43,889.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,328.48	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	692,896.95	17,328.48
			TOTAL ACCOMODATIONS	62,622.00	511,208.00
			TOTAL CHARGES	755,518.95	528,536.48

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

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,142.00	ADJUSTMENTS	247.83
COVERED CHARGES	2,476.00	CONTRACTUAL ALLOW	1,192.58
NON-COVERD CHARGES	1,666.00	TOTAL MEDICAID LIAB	1,283.42
		LESS: COB	0.00
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	1,259.42
		ALL OTHER	1,259.42
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
 1355 INDEPENDENCE DR  
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
 000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/14 THROUGH 03/31/15  
 ADMISSION DATES 00/00/00 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	938.00	538.00	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	866.00	598.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	672.00	530.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,476.00	1,666.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,476.00	1,666.00

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

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/14 THROUGH 03/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
1355 INDEPENDENCE DR  
AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
000368387A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/14	THROUGH	03/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,045,538.81	ADJUSTMENTS	708,603.15
COVERED CHARGES	13,637,298.11	CONTRACTUAL ALLOW	9,850,072.01
NON-COVERD CHARGES	8,408,240.70	TOTAL MEDICAID LIAB	3,787,226.10
		LESS: COB	34,721.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,752,505.06

TOTAL NUMBER OF ADMISSIONS 100

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	931		2,070	840,024.00		5,135,070.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	931		2,070	840,024.00		5,135,070.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	697		0	1,724,760.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	697		0	1,724,760.00		0.00
TOTAL ACCOMODATIONS	1,628		2,070	2,564,784.00		5,135,070.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

KINDRED HOSPITAL ATLANTA  
 705 JUNIPER ST NE  
 ATLANTA,GA 30308-1307

PROVIDER NUMBER  
 000472513A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,459,229.41	78,762.05	OTHER LAB	20,618.00	0.00
MED/SURG SUPPLY	1,820,221.76	16,110.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,787,533.00	99,669.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	226,345.00	314.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,175.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	172,477.41	1,560.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	31,653.00	0.00	MRI SERVICES	2,696.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	409,548.19	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,084,909.00	3,069,856.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	77,230.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,182.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	144,794.57	1,320.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	237,076.35	5,579.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	311,095.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,310.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	100,444.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,434.84	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,714.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,827.58	0.00			
			TOTAL ANCILLARY	11,072,514.11	3,273,170.70
			TOTAL ACCOMODATIONS	2,564,784.00	5,135,070.00
			TOTAL CHARGES	13,637,298.11	8,408,240.70

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 02:33:58  
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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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,382,217.10	ADJUSTMENTS	543,058.29
COVERED CHARGES	10,233,311.10	CONTRACTUAL ALLOW	7,744,259.10
NON-COVERD CHARGES	148,906.00	TOTAL MEDICAID LIAB	2,489,052.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,489,052.00

TOTAL NUMBER OF ADMISSIONS 366

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,160		1	1,358,848.00		120,266.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,160		1	1,358,848.00		120,266.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,160		1	1,358,848.00		120,266.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	885,965.00	0.00	OTHER LAB	10,440.00	0.00
MED/SURG SUPPLY	92,713.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	636,970.20	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	167,412.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,901.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,147.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,879.00	0.00	MRI SERVICES	37,637.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	782.00
OPERATING ROOM	105,196.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,930,900.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	812,469.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	58.00	0.00
RADIOLOGY THERAPEUTIC	208.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,149.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	24,218.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	51,446.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	89,781.00	3,640.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,176.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,015.90	0.00			
			TOTAL ANCILLARY	8,874,463.10	28,640.00
			TOTAL ACCOMODATIONS	1,358,848.00	120,266.00
			TOTAL CHARGES	10,233,311.10	148,906.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
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HUGHES SPALDING CHILDRENS HOSP  
 35 JESSE HILL JR DR SE  
 ATLANTA,GA 30303-3032

PROVIDER NUMBER  
 000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,331.00	ADJUSTMENTS	0.00
COVERED CHARGES	29,728.00	CONTRACTUAL ALLOW	160.58
NON-COVERD CHARGES	603.00	TOTAL MEDICAID LIAB	29,567.42
		LESS: COB	29,567.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	3,219.00		603.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	3,219.00		603.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	3		0	3,219.00		603.00

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,411.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	753.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	15,469.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,876.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,509.00	0.00
			TOTAL ACCOMODATIONS	3,219.00	603.00
			TOTAL CHARGES	29,728.00	603.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 01:40:33  
Page: 5

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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,552,917.39	ADJUSTMENTS	614,755.80
COVERED CHARGES	18,668,731.29	CONTRACTUAL ALLOW	14,102,897.70
NON-COVERD CHARGES	884,186.10	TOTAL MEDICAID LIAB	4,565,833.59
		LESS: COB	9,627.23
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	4,556,194.36
		ALL OTHER	4,065,691.56
		FEE SCHEDULE-LAB	148,429.71
		INJECTABLE DRUGS	342,073.09
		TOTAL NUMBER OF CLAIMS	11,596

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	257,925.25	143.00	OTHER LAB	449,570.00	0.00
MED/SURG SUPPLY	360,210.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	607,836.00	469.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,807.00	19,230.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,386,778.29	296,435.30
EKG/ECG	41,400.00	267.00	MRI SERVICES	0.00	0.00
IV THERAPY	806.00	0.00	PROFESSIONAL FEES	0.00	993.30
OPERATING ROOM	112,132.00	3,144.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,361,225.75	145,797.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,812,475.00	269,076.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,049,100.50	32,266.25
RADIOLOGY THERAPEUTIC	3,952.00	624.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,149.00	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	3,369,893.00	91,870.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	951.75
OTHER IMAGING SERVICE	110,428.00	1,660.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	577,397.00	11,088.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	250.00	0.00			
CARDIOLOGY	58,786.00	9,022.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	64,759.50	0.00			
			TOTAL ANCILLARY	18,668,731.29	884,186.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,668,731.29	884,186.10



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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HUGHES SPALDING CHILDRENS HOSP  
35 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3032

PROVIDER NUMBER  
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
970	2015279075865	04/16/15 - 04/16/15	10/12/15	0.00	951.75	0.00	0.00	0.00
TOTAL				0.00	951.75	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUGHES SPALDING CHILDRENS HOSP  
35 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3032

PROVIDER NUMBER  
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	80,762.50	ADJUSTMENTS	0.00
COVERED CHARGES	75,983.00	CONTRACTUAL ALLOW	49,899.66
NON-COVERD CHARGES	4,779.50	TOTAL MEDICAID LIAB	26,083.34
		LESS: COB	26,083.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 41

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	519.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,772.00	131.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,814.00	469.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,301.50	514.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	292.50
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	4,054.00	1,304.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,665.00	1,981.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,077.00	88.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,780.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	75,983.00	4,779.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	75,983.00	4,779.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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HUGHES SPALDING CHILDRENS HOSP  
35 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3032

PROVIDER NUMBER  
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,668,026.35	ADJUSTMENTS	1,957.90
COVERED CHARGES	1,657,187.60	CONTRACTUAL ALLOW	1,579,654.76
NON-COVERD CHARGES	10,838.75	TOTAL MEDICAID LIAB	77,532.84
		LESS: COB	30.18
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	77,493.66
		TOTAL NUMBER OF CLAIMS	1,386

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,785.50	0.00	OTHER LAB	3,677.00	0.00
MED/SURG SUPPLY	30,893.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,167.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	113,394.00	9,243.00
EKG/ECG	2,721.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	192.00
OPERATING ROOM	6,566.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,754.00	1,388.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,426,733.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,213.50	15.75
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	1,476.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,635.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,172.60	0.00			
			TOTAL ANCILLARY	1,657,187.60	10,838.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,657,187.60	10,838.75

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP  
35 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3032

PROVIDER NUMBER  
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,603.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,166.00	CONTRACTUAL ALLOW	5,946.00
NON-COVERD CHARGES	437.00	TOTAL MEDICAID LIAB	220.00
		LESS: COB	220.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HUGHES SPALDING CHILDRENS HOSP  
 35 JESSE HILL JR DR SE  
 ATLANTA,GA 30303-3032

PROVIDER NUMBER  
 000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,642.50	437.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	369.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,511.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	621.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,166.00	437.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,166.00	437.00

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

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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 01:42:05  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP  
35 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3032

PROVIDER NUMBER  
000679808A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:53:46  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL  
 1077 S MAIN ST  
 MADISON,GA 30650-2073

PROVIDER NUMBER 000694229A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	127,544.31	ADJUSTMENTS	9,799.98
COVERED CHARGES	125,053.31	CONTRACTUAL ALLOW	66,897.33
NON-COVERD CHARGES	2,491.00	TOTAL MEDICAID LIAB	58,155.98
		LESS: COB	2,994.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	55,161.83

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	23		0	12,213.00		2,187.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	23		0	12,213.00		2,187.00
SPECIAL CARE SERVICES						
CCU	6		0	3,960.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	3,960.00		0.00
TOTAL ACCOMODATIONS	29		0	16,173.00		2,187.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL  
 1077 S MAIN ST  
 MADISON,GA 30650-2073

PROVIDER NUMBER  
 000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,916.87	0.00	OTHER LAB	500.00	0.00
MED/SURG SUPPLY	13,464.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	22,247.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,171.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,600.00	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	22,045.42	304.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,927.80	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	774.19	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,108.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,486.00	0.00			
			TOTAL ANCILLARY	108,880.31	304.00
			TOTAL ACCOMODATIONS	16,173.00	2,187.00
			TOTAL CHARGES	125,053.31	2,491.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL  
1077 S MAIN ST  
MADISON,GA 30650-2073

PROVIDER NUMBER  
000694229A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:53:46  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	746,289.82	ADJUSTMENTS	45,975.73
COVERED CHARGES	691,585.05	CONTRACTUAL ALLOW	409,822.26
NON-COVERD CHARGES	54,704.77	TOTAL MEDICAID LIAB	281,762.79
		LESS: COB	406.33
		LESS: COPAYMENT	474.00
		REIMBURSEMENT	280,882.46
		ALL OTHER	261,349.31
		FEE SCHEDULE-LAB	18,902.61
		INJECTABLE DRUGS	630.54

TOTAL NUMBER OF CLAIMS 779

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,592.90	8,002.64	OTHER LAB	9,227.99	0.00
MED/SURG SUPPLY	13,533.96	33.81	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	52,182.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	136,682.00	9,228.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	364.00	0.00	FEE SCHEDULE LAB	146,842.15	19,193.70
EKG/ECG	6,624.00	128.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	448.00
OPERATING ROOM	11,494.72	3,078.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,161.81	2,935.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,391.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	251,002.80	1,472.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,866.72	6,533.71
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	1,230.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,525.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,054.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,810.00	3,650.00			
			TOTAL ANCILLARY	691,585.05	54,704.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	691,585.05	54,704.77

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,516.57	ADJUSTMENTS	0.00
COVERED CHARGES	3,431.89	CONTRACTUAL ALLOW	1,436.09
NON-COVERD CHARGES	84.68	TOTAL MEDICAID LIAB	1,995.80
		LESS: COB	1,995.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	55.04	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	93.49	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	290.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	925.00	17.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,029.80	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	93.60	12.64
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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,431.89	84.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,431.89	84.68



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,568.60	ADJUSTMENTS	282.00
COVERED CHARGES	47,347.49	CONTRACTUAL ALLOW	42,547.49
NON-COVERD CHARGES	4,221.11	TOTAL MEDICAID LIAB	4,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	198.00
		REIMBURSEMENT	4,602.00
		TOTAL NUMBER OF CLAIMS	96

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	209.92	1,560.19	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	469.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,722.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,170.00	1,607.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,669.00	709.00
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	178.29	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	31,784.04	65.88	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	888.84	279.04
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	47,347.49	4,221.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	47,347.49	4,221.11

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL  
1077 S MAIN ST  
MADISON,GA 30650-2073

PROVIDER NUMBER  
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,473.20	ADJUSTMENTS	0.00
COVERED CHARGES	1,317.20	CONTRACTUAL ALLOW	501.69
NON-COVERD CHARGES	156.00	TOTAL MEDICAID LIAB	815.51
		LESS: COB	809.51
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:53:51  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MORGAN MEMORIAL HOSPITAL  
 1077 S MAIN ST  
 MADISON,GA 30650-2073

PROVIDER NUMBER  
 000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	530.00	144.00
EKG/ECG	128.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	654.20	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	12.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,317.20	156.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,317.20	156.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MORGAN MEMORIAL HOSPITAL  
1077 S MAIN ST  
MADISON,GA 30650-2073

PROVIDER NUMBER  
000694229A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:20:40  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL  
 1255 HIGHWAY 54 W  
 FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER 000755323A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,560,840.91	ADJUSTMENTS	434,681.56
COVERED CHARGES	19,169,573.48	CONTRACTUAL ALLOW	13,838,158.48
NON-COVERD CHARGES	391,267.43	TOTAL MEDICAID LIAB	5,331,415.00
		LESS: COB	69,680.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,261,734.48

TOTAL NUMBER OF ADMISSIONS 604

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,778		5	1,632,752.00		158,501.00
ROUTINE NURSERY	403		0	414,783.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,181		5	2,047,535.00		158,501.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	553		0	1,373,408.00		28,620.00
NICU	117		0	275,301.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	670		0	1,648,709.00		28,620.00
TOTAL ACCOMODATIONS	2,851		5	3,696,244.00		187,121.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,675,384.83	49,982.21	OTHER LAB	101,486.00	0.00
MED/SURG SUPPLY	484,780.32	4,333.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,534,916.00	12,212.00	EDUCATION & TRAINING	4,424.00	0.00
RADIOLOGY-DIAGNOSTIC	453,255.00	934.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,326,589.00	13,378.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	149,130.39	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	166,378.00	0.00	MRI SERVICES	301,769.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,313,481.00	14,132.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	325,260.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,096,666.00	43,815.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	204,130.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	148,432.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	986,308.00	4,127.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	306,960.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	138,878.50	0.00	INJECTABLE DRUGS	673.26	0.00
RADIOLOGY THERAPEUTIC	34,524.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	88,067.06	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	32,487.08	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	118,616.00	21,812.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38,913.00	9,430.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	171,260.24	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	192,566.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	352,652.00	15,727.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	99,455.00	12,269.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	530,626.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,635.00	1,176.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	62,626.80	819.00			
			TOTAL ANCILLARY	15,473,329.48	204,146.43
			TOTAL ACCOMODATIONS	3,696,244.00	187,121.00
			TOTAL CHARGES	19,169,573.48	391,267.43



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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	369,835.24	ADJUSTMENTS	0.00
COVERED CHARGES	364,799.24	CONTRACTUAL ALLOW	201,766.25
NON-COVERD CHARGES	5,036.00	TOTAL MEDICAID LIAB	163,032.99
		LESS: COB	163,032.99
		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	54		0	49,180.00		5,036.00
ROUTINE NURSERY	13		0	18,018.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	67		0	67,198.00		5,036.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	7,155.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3		0	7,155.00		0.00
TOTAL ACCOMODATIONS	70		0	74,353.00		5,036.00

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,988.92	0.00	OTHER LAB	2,503.00	0.00
MED/SURG SUPPLY	10,326.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,293.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,358.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,355.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,174.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,457.00	0.00	MRI SERVICES	12,839.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,900.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	72,569.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,605.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,055.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,011.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	24,158.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,218.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,326.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,208.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,277.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,723.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,028.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,074.00	0.00			
			TOTAL ANCILLARY	290,446.24	0.00
			TOTAL ACCOMODATIONS	74,353.00	5,036.00
			TOTAL CHARGES	364,799.24	5,036.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:20:49  
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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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,633,101.20	ADJUSTMENTS	389,466.85
COVERED CHARGES	12,351,848.88	CONTRACTUAL ALLOW	10,403,555.72
NON-COVERD CHARGES	2,281,252.32	TOTAL MEDICAID LIAB	1,948,293.16
		LESS: COB	75,949.08
		LESS: COPAYMENT	3,500.27
		REIMBURSEMENT	1,868,843.81
		ALL OTHER	1,720,279.30
		FEE SCHEDULE-LAB	112,543.50
		INJECTABLE DRUGS	36,021.01
		TOTAL NUMBER OF CLAIMS	3,820

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
 Run Time: 02:20:49  
 Page: 6

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	257,782.71	27,501.91	OTHER LAB	125,325.00	2,606.00
MED/SURG SUPPLY	259,963.74	42,127.41	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	265.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	797,480.00	28,127.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,990,792.00	610,505.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	669.00	FEE SCHEDULE LAB	1,695,537.30	277,824.90
EKG/ECG	242,079.00	6,537.00	MRI SERVICES	188,846.00	31,056.00
IV THERAPY	77,948.00	416.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	658,307.00	116,965.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	98,271.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	58,822.00	26,306.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	110,268.00	587.00	AMBULANCE	0.00	0.00
GI SERVICES	411,259.00	132,392.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,086,530.00	72,221.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	216,316.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	295,183.34	269,321.28
RADIOLOGY THERAPEUTIC	236,666.00	73,253.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	443.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	7,984.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	50,782.00	6,157.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	41,357.34	33,146.82
LITHOTRIPSY	48,782.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	497,722.00	313,855.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	49,943.00	18,836.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	129,526.00	48,232.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	348,131.00	122,402.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	62,968.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	315,261.45	11,516.00			
			TOTAL ANCILLARY	12,351,848.88	2,281,252.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,351,848.88	2,281,252.32

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: 08/12/2016  
Run Time: 02:21:18  
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT FAYETTE HOSPITAL  
1255 HIGHWAY 54 W  
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER  
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	367,607.88	ADJUSTMENTS	0.00
COVERED CHARGES	272,393.56	CONTRACTUAL ALLOW	190,439.82
NON-COVERD CHARGES	95,214.32	TOTAL MEDICAID LIAB	81,953.74
		LESS: COB	81,889.62
		LESS: COPAYMENT	64.12
		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

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,434.38	1,590.00	OTHER LAB	4,879.00	0.00
MED/SURG SUPPLY	13,457.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,123.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,636.00	45,613.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,556.00	9,665.00
EKG/ECG	6,774.00	0.00	MRI SERVICES	4,423.00	3,432.00
IV THERAPY	416.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,559.00	10,285.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,018.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	610.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,375.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,980.00	4,252.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,159.00	4,788.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,005.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,147.67	4,369.72
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,591.00	395.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	112.32	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,426.00	7,974.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,482.00	1,461.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,744.00	618.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,148.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,337.80	771.60			
			TOTAL ANCILLARY	272,393.56	95,214.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	272,393.56	95,214.32

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:21:20  
Page: 9

PIEDMONT FAYETTE HOSPITAL  
1255 HIGHWAY 54 W  
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER  
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	856,949.71	ADJUSTMENTS	623.28
COVERED CHARGES	742,591.87	CONTRACTUAL ALLOW	707,362.04
NON-COVERD CHARGES	114,357.84	TOTAL MEDICAID LIAB	35,229.83
		LESS: COB	7,995.41
		LESS: COPAYMENT	897.00
		REIMBURSEMENT	26,337.42
		TOTAL NUMBER OF CLAIMS	488

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,813.09	496.00	OTHER LAB	10,400.00	0.00
MED/SURG SUPPLY	5,204.15	411.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	77,677.00	1,026.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,617.00	52,984.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	145,716.00	21,393.00
EKG/ECG	17,448.00	0.00	MRI SERVICES	0.00	4,023.00
IV THERAPY	4,576.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,990.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,168.00	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	390,885.00	3,130.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,854.83	4,145.52
RADIOLOGY THERAPEUTIC	1,614.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	343.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,139.00	23,743.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,203.00	163.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,843.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	943.80	0.00			
			TOTAL ANCILLARY	742,591.87	114,357.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	742,591.87	114,357.84



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: 08/12/2016  
Run Time: 02:21:23  
Page: 11

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,677.31	ADJUSTMENTS	0.00
COVERED CHARGES	22,312.11	CONTRACTUAL ALLOW	14,319.69
NON-COVERD CHARGES	12,365.20	TOTAL MEDICAID LIAB	7,992.42
		LESS: COB	7,977.42
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108.51	83.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	91.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,059.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	8,622.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,796.00	1,243.00
EKG/ECG	834.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,023.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15.60	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	2,385.00	2,417.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,312.11	12,365.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,312.11	12,365.20

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 08/12/2016  
Run Time: 02:21:24  
Page: 13

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 07/01/14 THROUGH 06/30/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	545,003.33	ADJUSTMENTS	26,898.80
COVERED CHARGES	507,750.80	CONTRACTUAL ALLOW	436,197.12
NON-COVERD CHARGES	37,252.53	TOTAL MEDICAID LIAB	71,553.68
		LESS: COB	0.00
		LESS: COPAYMENT	156.00
		REIMBURSEMENT	71,397.68

TOTAL NUMBER OF CLAIMS 13

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 07/01/14 THROUGH 06/30/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,315.91	1,112.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	17,071.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	467.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,614.00	3,796.00
EKG/ECG	1,623.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	34,416.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,150.00	27,322.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	172.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,953.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,795.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,458.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	273,055.50	3,248.73
RADIOLOGY THERAPEUTIC	20,839.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	343.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	40,481.48	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,414.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,482.00	1,461.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,120.00	312.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,980.80	0.00			
			TOTAL ANCILLARY	507,750.80	37,252.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	507,750.80	37,252.53

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
Run Time: 02:21:26  
Page: 15

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	07/01/14	THROUGH	06/30/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:34:04  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL  
 320 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER 000886179A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,400,476.50	ADJUSTMENTS	201,480.85
COVERED CHARGES	3,932,148.50	CONTRACTUAL ALLOW	3,094,667.79
NON-COVERD CHARGES	3,468,328.00	TOTAL MEDICAID LIAB	837,480.71
		LESS: COB	7,871.88
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	829,608.83

TOTAL NUMBER OF ADMISSIONS 39

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	81		1,071	56,133.00		3,128,330.00
ROUTINE NURSERY	0		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		1,071	56,133.00		3,128,330.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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		1,071	56,133.00		3,128,330.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:34:04  
 Page: 2

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL  
 320 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER  
 000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	985,370.10	0.00	OTHER LAB	8,280.00	0.00
MED/SURG SUPPLY	645,721.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	649,555.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	49,076.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,263.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	426,172.03	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,223.00	0.00	MRI SERVICES	13,465.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	197,562.72	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	603,525.00	339,998.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	18,405.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	662.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	111,870.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	64,733.02	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	30,624.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,090.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,661.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,790.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,439.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,225.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,302.00	0.00			
			TOTAL ANCILLARY	3,876,015.50	339,998.00
			TOTAL ACCOMODATIONS	56,133.00	3,128,330.00
			TOTAL CHARGES	3,932,148.50	3,468,328.00

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 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/14	THROUGH	08/31/15
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	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 03:15:23  
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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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,237,634.45	ADJUSTMENTS	0.00
COVERED CHARGES	1,104,463.55	CONTRACTUAL ALLOW	936,027.64
NON-COVERD CHARGES	133,170.90	TOTAL MEDICAID LIAB	168,435.91
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	168,435.91

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	234		0	237,510.00		120,928.86
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	234		0	237,510.00		120,928.86
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	234		0	237,510.00		120,928.86

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 01/01/15 THROUGH 12/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	213,848.75	0.00	OTHER LAB	2,845.58	0.00
MED/SURG SUPPLY	105,806.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	41,531.98	0.00	EDUCATION & TRAINING	4,009.20	0.00
RADIOLOGY-DIAGNOSTIC	5,210.10	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	12,242.04	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,989.69	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	39,487.47	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,005.49	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	409,276.68	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	119.03	0.00	INJECTABLE DRUGS	439.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,716.32	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,504.61	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	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	721.72	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,415.80	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,026.08	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	0.00	0.00			
			TOTAL ANCILLARY	866,953.55	12,242.04
			TOTAL ACCOMODATIONS	237,510.00	120,928.86
			TOTAL CHARGES	1,104,463.55	133,170.90



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
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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 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 08/12/2016  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SELECT SPECIALTY HOSPITAL ATLANTA  
550 PEACHTREE ST NE 7TH FL  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000916781A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/15 THROUGH 12/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
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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	01/01/15	THROUGH	12/31/15
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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 08/12/2016  
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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	01/01/15	THROUGH	12/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 08/12/2016  
 Run Time: 02:04:41  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 6325 HOSPITAL PARKWAY  
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER 344886600A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,754,285.42	ADJUSTMENTS	328,578.89
COVERED CHARGES	7,448,286.41	CONTRACTUAL ALLOW	4,828,449.50
NON-COVERD CHARGES	305,999.01	TOTAL MEDICAID LIAB	2,619,836.91
		LESS: COB	75,631.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,544,205.36

TOTAL NUMBER OF ADMISSIONS 292

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,198		0	1,462,550.00		154,900.00
ROUTINE NURSERY	71		8	76,825.00		7,925.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,269		8	1,539,375.00		162,825.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	101		0	459,445.00		0.00
NICU	23		1	71,520.00		2,980.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	124		1	530,965.00		2,980.00
TOTAL ACCOMODATIONS	1,393		9	2,070,340.00		165,805.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 6325 HOSPITAL PARKWAY  
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	243,810.82	3,670.91	OTHER LAB	25,361.00	0.00
MED/SURG SUPPLY	364,489.00	2,103.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	779,487.19	7,029.64	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	146,415.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	473,236.00	1,638.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	141,486.88	8,536.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	24,874.00	0.00	MRI SERVICES	179,175.00	0.00
IV THERAPY	844.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	655,313.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	157,034.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	135,156.00	9,311.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	134,784.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	68,281.00	5,694.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	304,406.00	805.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	98,044.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	32,038.26	0.00	INJECTABLE DRUGS	634,850.42	8,241.46
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	82,257.58	3,336.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,813.26	4,286.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,648.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	199,512.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	74,344.00
OTHER IMAGING SERVICE	30,113.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	64,994.00	302.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	49,281.00	9,163.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	281,496.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,396.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,350.00	1,734.00			
			TOTAL ANCILLARY	5,377,946.41	140,194.01
			TOTAL ACCOMODATIONS	2,070,340.00	165,805.00
			TOTAL CHARGES	7,448,286.41	305,999.01

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 08/12/2016  
 Run Time: 02:04:41  
 Page: 3

EMORY JOHNS CREEK HOSPITAL  
 6325 HOSPITAL PARKWAY  
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014292000377	09/21/14 - 10/13/14	10/27/14	0.00	6,597.00	0.00	0.00	0.00
615	2014360051653	12/02/14 - 12/20/14	12/29/14	0.00	11,790.00	0.00	0.00	0.00
614	9115009002035	10/23/14 - 10/27/14	01/19/15	0.00	6,597.00	0.00	1,417.92	0.00
615	2015041019631	09/08/14 - 09/16/14	02/16/15	0.00	11,790.00	0.00	0.00	0.00
615	9115064001977	10/23/14 - 10/25/14	03/16/15	0.00	11,790.00	0.00	689.43	0.00
614	2015135028125	11/01/14 - 11/18/14	05/18/15	0.00	13,194.00	0.00	0.00	0.00
614	2315181000214	04/13/15 - 04/19/15	08/03/15	0.00	2,974.00	0.00	3,331.15	0.00
615	2315345000103	05/22/15 - 05/24/15	12/21/15	0.00	3,015.00	0.00	0.00	0.00
614	9816070001658	08/08/15 - 08/13/15	03/14/16	0.00	6,597.00	0.00	1,413.17	0.00
TOTAL				0.00	74,344.00	0.00	6,851.67	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 6325 HOSPITAL PARKWAY  
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	179,662.38	ADJUSTMENTS	0.00
COVERED CHARGES	176,162.38	CONTRACTUAL ALLOW	115,201.94
NON-COVERD CHARGES	3,500.00	TOTAL MEDICAID LIAB	60,960.44
		LESS: COB	60,960.44
		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	33		0	41,050.00		3,500.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	33		0	41,050.00		3,500.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	33		0	41,050.00		3,500.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 6325 HOSPITAL PARKWAY  
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,868.61	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,116.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,375.99	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,579.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,488.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,837.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	6,597.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,514.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	52,097.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,192.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,134.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,229.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,143.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,584.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,344.00	0.00	INJECTABLE DRUGS	10,526.78	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	581.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,563.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,609.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
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	135,112.38	0.00
			TOTAL ACCOMODATIONS	41,050.00	3,500.00
			TOTAL CHARGES	176,162.38	3,500.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
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Page: 6

EMORY JOHNS CREEK HOSPITAL  
6325 HOSPITAL PARKWAY  
JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,657,135.78	ADJUSTMENTS	43,999.15
COVERED CHARGES	2,040,878.03	CONTRACTUAL ALLOW	1,594,789.98
NON-COVERD CHARGES	616,257.75	TOTAL MEDICAID LIAB	446,088.05
		LESS: COB	329.89
		LESS: COPAYMENT	1,509.00
		REIMBURSEMENT	444,249.16
		ALL OTHER	409,417.62
		FEE SCHEDULE-LAB	26,575.87
		INJECTABLE DRUGS	8,255.67

TOTAL NUMBER OF CLAIMS 923

EMORY JOHNS CREEK HOSPITAL  
 6325 HOSPITAL PARKWAY  
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,306.60	44,693.86	OTHER LAB	48,599.00	0.00
MED/SURG SUPPLY	76,254.00	6,067.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	159.00
RADIOLOGY-DIAGNOSTIC	108,512.00	24,754.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	291,202.00	157,258.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,309.00	13,070.02	FEE SCHEDULE LAB	240,920.64	20,099.13
EKG/ECG	13,800.00	1,104.00	MRI SERVICES	183,962.00	15,805.00
IV THERAPY	5,662.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	158,419.00	55,967.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,178.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,147.00	1,414.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,568.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	50,404.00	16,494.00	CAST ROOM	256.00	0.00
EMERGENCY ROOM	338,638.00	5,339.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	44,007.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,116.79	48,767.69
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	430.00	5,838.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,869.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,282.00	126.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,088.00	22,241.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	16,756.00
OTHER IMAGING SERVICE	76,762.00	34,297.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,255.00	302.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	42,395.00	33,309.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	119,960.00	90,528.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,157.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	66,288.00	0.00			
			TOTAL ANCILLARY	2,040,878.03	616,257.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,040,878.03	616,257.75

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 08/12/2016  
Run Time: 02:04:46  
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EMORY JOHNS CREEK HOSPITAL  
6325 HOSPITAL PARKWAY  
JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014323031522	11/10/14 - 11/10/14	11/24/14	0.00	3,562.00	0.00	0.00	0.00
614	2215023002913	12/16/14 - 12/16/14	01/26/15	0.00	6,597.00	0.00	0.00	0.00
614	2215023002913	12/16/14 - 12/16/14	01/26/15	0.00	6,597.00	0.00	0.00	0.00
TOTAL				0.00	16,756.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL  
6325 HOSPITAL PARKWAY  
JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,587.45	ADJUSTMENTS	0.00
COVERED CHARGES	28,962.13	CONTRACTUAL ALLOW	8,229.82
NON-COVERD CHARGES	31,625.32	TOTAL MEDICAID LIAB	20,732.31
		LESS: COB	20,726.31
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 22



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL  
 6325 HOSPITAL PARKWAY  
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68.46	958.12	OTHER LAB	830.00	0.00
MED/SURG SUPPLY	851.00	45.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,574.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,363.00	17,958.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,104.00	692.00
EKG/ECG	276.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	966.00	966.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	504.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,869.00	453.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	703.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	129.67	1,313.20
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	465.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	259.00	8,563.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	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	0.00	0.00			
			TOTAL ANCILLARY	28,962.13	31,625.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,962.13	31,625.32

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 08/12/2016  
Run Time: 02:04:54  
Page: 11

EMORY JOHNS CREEK HOSPITAL  
6325 HOSPITAL PARKWAY  
JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,554.25	ADJUSTMENTS	211.76
COVERED CHARGES	42,514.52	CONTRACTUAL ALLOW	40,276.92
NON-COVERD CHARGES	5,039.73	TOTAL MEDICAID LIAB	2,237.60
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	2,144.60
		TOTAL NUMBER OF CLAIMS	40

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL  
 6325 HOSPITAL PARKWAY  
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13.86	0.00	OTHER LAB	1,120.00	0.00
MED/SURG SUPPLY	227.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,128.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,638.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	371.03	FEE SCHEDULE LAB	7,237.00	993.00
EKG/ECG	276.00	0.00	MRI SERVICES	2,907.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	318.00	122.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,149.00	345.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	215.66	899.67
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	623.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	259.00	1,686.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,026.00	0.00			
			TOTAL ANCILLARY	42,514.52	5,039.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,514.52	5,039.73

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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EMORY JOHNS CREEK HOSPITAL  
6325 HOSPITAL PARKWAY  
JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,382.74	ADJUSTMENTS	0.00
COVERED CHARGES	5,975.71	CONTRACTUAL ALLOW	2,520.25
NON-COVERD CHARGES	407.03	TOTAL MEDICAID LIAB	3,455.46
		LESS: COB	3,449.46
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL  
 6325 HOSPITAL PARKWAY  
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 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	1,826.74	325.00
EKG/ECG	276.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,776.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	96.97	82.03
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,975.71	407.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,975.71	407.03

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

EMORY JOHNS CREEK HOSPITAL  
6325 HOSPITAL PARKWAY  
JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/14 THROUGH 08/31/15  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	178,582.72	ADJUSTMENTS	11,971.98
COVERED CHARGES	104,400.33	CONTRACTUAL ALLOW	86,424.36
NON-COVERD CHARGES	74,182.39	TOTAL MEDICAID LIAB	17,975.97
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	17,963.97

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL  
 6325 HOSPITAL PARKWAY  
 JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/14 THROUGH 08/31/15  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,339.59	94.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	37,471.00	14.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,116.00	388.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	371.00	FEE SCHEDULE LAB	1,327.00	941.20
EKG/ECG	138.00	276.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,977.00	47,848.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,994.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,387.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	438.74	2,368.69
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	8,817.00	6,339.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	93.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,666.00	15,542.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	594.00	0.00			
			TOTAL ANCILLARY	104,400.33	74,182.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	104,400.33	74,182.39

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

EMORY JOHNS CREEK HOSPITAL  
6325 HOSPITAL PARKWAY  
JONES CREEK,GA 30097-5775

PROVIDER NUMBER  
344886600A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/14	THROUGH	08/31/15
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*