

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

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

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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000019A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,526,600.72	ADJUSTMENTS	135,516.31
COVERED CHARGES	5,494,012.61	CONTRACTUAL ALLOW	3,362,111.85
NON-COVERD CHARGES	32,588.11	TOTAL MEDICAID LIAB	2,131,900.76
		LESS: COB	6,094.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,125,806.54

TOTAL NUMBER OF ADMISSIONS 347

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	707		0	361,459.00		12,291.00
ROUTINE NURSERY	146		0	67,506.00		1,416.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	853		0	428,965.00		13,707.00
SPECIAL CARE SERVICES						
CCU	148		0	208,340.00		0.00
ICU	105		0	69,615.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	253		0	277,955.00		0.00
TOTAL ACCOMODATIONS	1,106		0	706,920.00		13,707.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,021,832.39	0.00	OTHER LAB	17,478.79	0.00
MED/SURG SUPPLY	620,552.61	3,190.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	793,845.38	339.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	86,752.45	0.00	OTHER THERAPEUTIC SVC	0.00	252.39
CT SCAN	182,530.73	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	66,208.81	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	34,271.66	0.00	MRI SERVICES	23,373.65	0.00
IV THERAPY	40,803.69	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	456,896.33	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	71,247.33	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	278,842.43	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	96,870.81	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	218,196.10	2,075.97	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	54,285.66	0.00	DRUG-SPECIFIC/HOME IV	0.00	797.69
LABORATORY PATHOLOGIC	29,568.82	0.00	INJECTABLE DRUGS	183,794.97	0.00
RADIOLOGY THERAPEUTIC	458.81	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	14,506.19	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,383.29	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	73.28	855.82	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	231,100.21	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,846.67
OTHER IMAGING SERVICE	36,271.59	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	63,728.71	460.51			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,770.99	662.09			
AUDIOLOGY	4,642.80	0.00			
CARDIOLOGY	106,659.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,304.60	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,840.53	2,400.32			
			TOTAL ANCILLARY	4,787,092.61	18,881.11
			TOTAL ACCOMODATIONS	706,920.00	13,707.00
			TOTAL CHARGES	5,494,012.61	32,588.11

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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013191083045	06/28/13 - 07/03/13	07/15/13	0.00	2,070.02	0.00	0.00	0.00
614	2013196022392	06/10/13 - 06/12/13	07/22/13	0.00	3,030.09	0.00	0.00	0.00
614	2013218053523	07/24/13 - 07/31/13	08/12/13	0.00	2,746.56	0.00	0.00	0.00
TOTAL				0.00	7,846.67	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

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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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,208.49	ADJUSTMENTS	0.00
COVERED CHARGES	7,194.49	CONTRACTUAL ALLOW	7,194.49
NON-COVERD CHARGES	14.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1		0	511.00		14.00
ROUTINE NURSERY	0		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	511.00		14.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	511.00		14.00

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SUMMARY TYPE II  
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 126 US HWY 280 W  
 AMERICUS,GA 31719-8645

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 000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	660.61	0.00	OTHER LAB	117.39	0.00
MED/SURG SUPPLY	1,087.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	626.52	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,626.05	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	221.07	0.00	INJECTABLE DRUGS	344.56	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,683.49	0.00
			TOTAL ACCOMODATIONS	511.00	14.00
			TOTAL CHARGES	7,194.49	14.00

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

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

PROVIDER NUMBER  
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,331,015.38	ADJUSTMENTS	219,147.85
COVERED CHARGES	5,732,380.33	CONTRACTUAL ALLOW	4,224,237.19
NON-COVERD CHARGES	598,635.05	TOTAL MEDICAID LIAB	1,508,143.14
		LESS: COB	560.35
		LESS: COPAYMENT	5,373.40
		REIMBURSEMENT	1,502,209.39
		ALL OTHER	1,199,389.52
		FEE SCHEDULE-LAB	168,510.60
		INJECTABLE DRUGS	134,309.27
		TOTAL NUMBER OF CLAIMS	4,784

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 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
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PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	491,041.12	16,106.03	OTHER LAB	40,856.03	296.58
MED/SURG SUPPLY	369,665.38	6,219.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,052.40	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	331,504.63	4,715.83	OTHER THERAPEUTIC SVC	0.00	413.43
CT SCAN	485,569.91	49,094.34	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,132.41	21,500.03	FEE SCHEDULE LAB	811,273.87	122,750.71
EKG/ECG	65,524.91	5,403.32	MRI SERVICES	174,506.23	5,401.41
IV THERAPY	208,846.80	21,226.06	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	649,043.59	62,214.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,455.90	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,220.22	7,067.80	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	120,912.41	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	773,891.15	51,318.66	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	89,789.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	484,320.14	177,488.38
RADIOLOGY THERAPEUTIC	68,682.52	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,062.20	3,486.62	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,273.38	1,768.61	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	20.64
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	68,695.32	5,899.47	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	55,349.39	5,355.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	40.00
OTHER IMAGING SERVICE	181,309.56	15,931.16			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,785.46	921.02			
ONCOLOGY	2,848.69	0.00			
NUCLEAR MEDICINE	24,143.57	6,052.43			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	73,754.38	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,621.42	0.00			
ORGAN ACQUISITION	0.00	1,128.39			
TREATMENT/OBSERV. RM	33,300.04	4,842.29			
			TOTAL ANCILLARY	5,732,380.33	597,713.61
			TOTAL ACCOMODATIONS	0.00	921.44
			TOTAL CHARGES	5,732,380.33	598,635.05

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SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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

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SERVICE DATES 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8	2213111000153	03/04/13 - 03/04/13	04/29/13	0.00	40.00	0.00	0.00	0.00
TOTAL				0.00	40.00	0.00	0.00	0.00



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GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,512.85	ADJUSTMENTS	0.00
COVERED CHARGES	6,099.66	CONTRACTUAL ALLOW	4,614.88
NON-COVERD CHARGES	413.19	TOTAL MEDICAID LIAB	1,484.78
		LESS: COB	1,484.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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

PHOEBE SUMTER MEDICAL CENTER  
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PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	702.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	97.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	749.15	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	684.40	149.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	331.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,577.95	242.88	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	23.38	21.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,933.18	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,099.66	413.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,099.66	413.19

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

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

Run Date: 07/23/2014  
Run Time: 09:20:31  
Page: 11

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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	408,059.71	ADJUSTMENTS	738.59
COVERED CHARGES	392,886.82	CONTRACTUAL ALLOW	360,710.23
NON-COVERD CHARGES	15,172.89	TOTAL MEDICAID LIAB	32,176.59
		LESS: COB	54.43
		LESS: COPAYMENT	1,089.00
		REIMBURSEMENT	31,033.16
		TOTAL NUMBER OF CLAIMS	579

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,739.66	376.42	OTHER LAB	3,725.86	0.00
MED/SURG SUPPLY	18,237.59	551.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,764.77	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,199.71	1,413.48	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	190.70	FEE SCHEDULE LAB	49,242.73	2,001.00
EKG/ECG	5,516.38	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,196.98	462.49	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,342.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,534.78	81.39	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	575.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	172,665.67	7,482.78	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	546.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,177.19	756.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,069.76	191.99	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	708.44	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,657.82	1,661.32			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	986.42	0.00			
			TOTAL ANCILLARY	392,886.82	15,169.91
			TOTAL ACCOMODATIONS	0.00	2.98
			TOTAL CHARGES	392,886.82	15,172.89

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,145.44	ADJUSTMENTS	0.00
COVERED CHARGES	1,145.44	CONTRACTUAL ALLOW	485.59
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	659.85
		LESS: COB	659.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	385.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2.98	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	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	262.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	494.60	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,145.44	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,145.44	0.00

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000019A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,075,907.68	ADJUSTMENTS	79,216.65
COVERED CHARGES	1,053,106.41	CONTRACTUAL ALLOW	825,018.28
NON-COVERD CHARGES	22,801.27	TOTAL MEDICAID LIAB	228,088.13
		LESS: COB	0.00
		LESS: COPAYMENT	517.52
		REIMBURSEMENT	227,570.61
		TOTAL NUMBER OF CLAIMS	43

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,868.61	127.45	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	28,723.00	269.63	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,654.99	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,084.96	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	190.70	FEE SCHEDULE LAB	14,813.14	2,508.26
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,921.65	627.33	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,448.95	4,261.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	123.68	81.39	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,889.88	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	2,275.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	814,062.49	14,578.15
RADIOLOGY THERAPEUTIC	74,963.59	157.31	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,700.44	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,014.13	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	438.26	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,123.52	0.00			
			TOTAL ANCILLARY	1,053,106.41	22,801.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,053,106.41	22,801.27



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

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

Run Date: 07/23/2014  
Run Time: 09:20:41  
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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,738.38	ADJUSTMENTS	0.00
COVERED CHARGES	24,738.38	CONTRACTUAL ALLOW	1,404.61
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	23,333.77
		LESS: COB	23,327.77
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	467.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	258.12	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	334.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	21,640.18	0.00
RADIOLOGY THERAPEUTIC	1,835.17	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	203.74	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,738.38	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,738.38	0.00

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

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

Run Date: 07/23/2014  
 Run Time: 11:37:47  
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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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,045,595.96	ADJUSTMENTS	102,406.75
COVERED CHARGES	1,999,809.03	CONTRACTUAL ALLOW	990,641.19
NON-COVERD CHARGES	45,786.93	TOTAL MEDICAID LIAB	1,009,167.84
		LESS: COB	1,386.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,007,781.39

TOTAL NUMBER OF ADMISSIONS 209

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	671		0	334,158.00		27,606.00
ROUTINE NURSERY	70		0	16,348.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	741		0	350,506.00		27,606.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	81		0	84,750.00		0.00
NICU	1		0	648.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	85,398.00		0.00
TOTAL ACCOMODATIONS	823		0	435,904.00		27,606.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,498.44	0.00	OTHER LAB	5,864.00	0.00
MED/SURG SUPPLY	129,174.07	160.93	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	325,593.00	0.00	EDUCATION & TRAINING	280.00	0.00
RADIOLOGY-DIAGNOSTIC	30,024.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	98,779.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,954.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	22,720.00	0.00	MRI SERVICES	14,697.00	0.00
IV THERAPY	160,015.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	105,692.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	85,797.00	226.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,539.00	0.00	FREE STANDING CLINIC	0.00	368.00
ANESTHESIA	39,384.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,856.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	41,574.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,080.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	216,904.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,277.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,077.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,235.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	844.42	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	344.00
OTHER IMAGING SERVICE	4,848.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,042.00	17,082.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,166.00	0.00			
AUDIOLOGY	1,960.00	0.00			
CARDIOLOGY	17,505.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	836.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,690.00	0.00			
			TOTAL ANCILLARY	1,563,905.03	18,180.93
			TOTAL ACCOMODATIONS	435,904.00	27,606.00
			TOTAL CHARGES	1,999,809.03	45,786.93

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

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

Run Date: 07/23/2014  
Run Time: 11:37:47  
Page: 3

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

PROVIDER NUMBER  
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3005	2213105008594	04/04/13 - 04/09/13	04/22/13	0.00	116.00	0.00	0.00	0.00
7300	2213177010848	06/11/13 - 06/18/13	07/01/13	0.00	155.00	0.00	0.00	0.00
3	2213249007457	08/28/13 - 09/02/13	09/09/13	0.00	73.00	0.00	0.00	0.00
TOTAL				0.00	344.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
 Run Time: 11:37:51  
 Page: 4

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

PROVIDER NUMBER  
 000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,047.08	ADJUSTMENTS	0.00
COVERED CHARGES	13,047.08	CONTRACTUAL ALLOW	2,584.64
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	10,462.44
		LESS: COB	10,462.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	1,992.00		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	1,992.00		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	1,992.00		0.00

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	676.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	264.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,213.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	862.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	155.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	653.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	805.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,569.42	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,423.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	437.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,997.00	0.00			
			TOTAL ANCILLARY	11,055.08	0.00
			TOTAL ACCOMODATIONS	1,992.00	0.00
			TOTAL CHARGES	13,047.08	0.00

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

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

Run Date: 07/23/2014  
Run Time: 11:37:51  
Page: 6

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

PROVIDER NUMBER  
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,736,742.62	ADJUSTMENTS	102,512.20
COVERED CHARGES	2,349,739.78	CONTRACTUAL ALLOW	1,860,670.93
NON-COVERD CHARGES	387,002.84	TOTAL MEDICAID LIAB	489,068.85
		LESS: COB	1,177.11
		LESS: COPAYMENT	1,701.00
		REIMBURSEMENT	486,190.74
		ALL OTHER	383,536.40
		FEE SCHEDULE-LAB	83,022.86
		INJECTABLE DRUGS	19,631.48

TOTAL NUMBER OF CLAIMS 2,199



SUMMARY TYPE III  
 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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,508.25	10,932.22	OTHER LAB	12,795.00	200.00
MED/SURG SUPPLY	76,396.70	2,412.66	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	168.00
RADIOLOGY-DIAGNOSTIC	123,688.00	1,745.00	OTHER THERAPEUTIC SVC	0.00	119.00
CT SCAN	223,779.00	22,311.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,790.00	9,407.00	FEE SCHEDULE LAB	725,132.00	175,883.00
EKG/ECG	32,485.00	5,560.00	MRI SERVICES	108,853.00	6,958.00
IV THERAPY	161,240.00	28,038.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	74,892.00	24,242.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,116.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,195.00	9,887.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54,497.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	21,535.00	6,935.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	275,792.03	2,774.97	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	35,279.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	84,627.80	17,036.34
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,032.00	10,649.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,262.00	4,832.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,114.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	24,171.65
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	50,572.00	8,165.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,374.00	9,198.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	39,696.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	29,002.00	2,665.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,319.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	81,882.00	599.00			
			TOTAL ANCILLARY	2,349,739.78	387,002.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,349,739.78	387,002.84

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

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

Run Date: 07/23/2014  
Run Time: 11:38:19  
Page: 8

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,586.87	ADJUSTMENTS	0.00
COVERED CHARGES	17,613.14	CONTRACTUAL ALLOW	292.49
NON-COVERD CHARGES	6,973.73	TOTAL MEDICAID LIAB	17,320.65
		LESS: COB	17,320.65
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 16

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 09/01/12 THROUGH 08/31/13  
 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	91.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	574.21	33.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	822.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,365.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,040.00	902.00	FEE SCHEDULE LAB	5,058.00	665.00
EKG/ECG	155.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	120.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,986.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	639.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,649.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	923.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	190.93	87.43
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,980.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	2,115.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	191.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,613.14	6,973.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,613.14	6,973.73

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

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

Run Date: 07/23/2014  
Run Time: 11:38:19  
Page: 10

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212346010606	10/15/12 - 10/15/12	12/17/12	0.00	116.00	0.00	105.04	0.00
4200	2213123017573	02/14/13 - 02/14/13	05/06/13	0.00	75.00	0.00	6,909.29	0.00
TOTAL				0.00	191.00	0.00	7,014.33	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: 07/23/2014  
Run Time: 11:38:20  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	100,185.58	ADJUSTMENTS	323.64
COVERED CHARGES	95,645.03	CONTRACTUAL ALLOW	85,296.13
NON-COVERD CHARGES	4,540.55	TOTAL MEDICAID LIAB	10,348.90
		LESS: COB	23.95
		LESS: COPAYMENT	324.01
		REIMBURSEMENT	10,000.94
		TOTAL NUMBER OF CLAIMS	185

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,493.18	204.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,192.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,198.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,166.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,466.00	2,574.00
EKG/ECG	155.00	0.00	MRI SERVICES	3,401.00	0.00
IV THERAPY	4,963.00	991.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	292.00	87.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	47,390.00	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	1,708.05	291.55
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,054.00	163.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,166.00	0.00			
			TOTAL ANCILLARY	95,645.03	4,540.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	95,645.03	4,540.55

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

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

PROVIDER NUMBER  
000000052A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	492.00	ADJUSTMENTS	0.00
COVERED CHARGES	492.00	CONTRACTUAL ALLOW	98.40
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	393.60
		LESS: COB	393.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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

Run Date: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 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	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	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	324.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	492.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	492.00	0.00



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

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

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

PROVIDER NUMBER  
000000052A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
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

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

PROVIDER NUMBER  
000000052A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,316,526.67	ADJUSTMENTS	1,119,549.87
COVERED CHARGES	28,177,999.77	CONTRACTUAL ALLOW	18,766,428.22
NON-COVERD CHARGES	1,138,526.90	TOTAL MEDICAID LIAB	9,411,571.55
		LESS: COB	27,047.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,384,524.21

TOTAL NUMBER OF ADMISSIONS 1,173

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,102		3	4,132,579.00		379,862.00
ROUTINE NURSERY	129		0	65,702.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6,231		3	4,198,281.00		379,862.00
SPECIAL CARE SERVICES						
CCU	77		0	103,284.00		0.00
ICU	1,145		0	1,366,184.00		72,324.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		296	0.00		222,785.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,222		296	1,469,468.00		295,109.00
TOTAL ACCOMODATIONS	7,453		299	5,667,749.00		674,971.00

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,088,976.63	134,868.90	OTHER LAB	46,215.00	304.00
MED/SURG SUPPLY	2,143,360.00	40,257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,987,461.19	59,452.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	553,454.00	16,309.00	OTHER THERAPEUTIC SVC	0.00	1,199.00
CT SCAN	1,177,637.00	33,192.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	315,842.14	2,410.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	85,567.00	449.00	MRI SERVICES	343,506.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,874,376.00	3,356.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	110,972.00	615.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,063,426.00	50,285.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	121,865.00	290.00	AMBULANCE	0.00	0.00
GI SERVICES	124,457.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	901,887.00	10,703.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	132,659.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	143,497.81	0.00	INJECTABLE DRUGS	1,915.00	0.00
RADIOLOGY THERAPEUTIC	189,965.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	195,781.04	1,188.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	104,567.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	166,917.00	42,634.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	11,083.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	248.00	2,568.00	IMPL DEV CHARGE PATIENTS	1,662,281.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	63,272.00	14,547.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	298,753.96	34,914.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	67,263.00	0.00			
AUDIOLOGY	5,750.00	0.00			
CARDIOLOGY	466,908.00	1,336.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,843.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	38,628.00	1,596.00			
			TOTAL ANCILLARY	22,510,250.77	463,555.90
			TOTAL ACCOMODATIONS	5,667,749.00	674,971.00
			TOTAL CHARGES	28,177,999.77	1,138,526.90

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,343.00	ADJUSTMENTS	0.00
COVERED CHARGES	30,343.00	CONTRACTUAL ALLOW	4,974.30
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	25,368.70
		LESS: COB	25,368.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	3,458.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	3,458.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5		0	3,458.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000063A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,965.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,458.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,644.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	226.00	0.00	MRI SERVICES	10,238.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,968.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,541.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	332.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,179.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	614.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	280.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	404.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36.00	0.00			
			TOTAL ANCILLARY	26,885.00	0.00
			TOTAL ACCOMODATIONS	3,458.00	0.00
			TOTAL CHARGES	30,343.00	0.00

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:42:03  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,351,330.62	ADJUSTMENTS	706,455.98
COVERED CHARGES	15,336,788.22	CONTRACTUAL ALLOW	11,508,967.01
NON-COVERD CHARGES	2,014,542.40	TOTAL MEDICAID LIAB	3,827,821.21
		LESS: COB	1,820.13
		LESS: COPAYMENT	16,673.04
		REIMBURSEMENT	3,809,328.04
		ALL OTHER	2,999,693.75
		FEE SCHEDULE-LAB	284,000.64
		INJECTABLE DRUGS	525,633.65

TOTAL NUMBER OF CLAIMS 9,324

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	279,040.68	143,743.60	OTHER LAB	68,091.00	0.00
MED/SURG SUPPLY	749,309.00	1,715.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	494.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	445,289.00	8,899.00	OTHER THERAPEUTIC SVC	0.00	114.00
CT SCAN	1,406,383.00	507,764.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	72,477.00	28,793.06	FEE SCHEDULE LAB	2,086,717.15	318,315.07
EKG/ECG	82,424.00	9,225.00	MRI SERVICES	474,564.00	23,554.00
IV THERAPY	569,168.00	114,675.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,215,459.72	182,248.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	43,161.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,770.00	24,481.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	103,224.00	9,796.00	AMBULANCE	0.00	0.00
GI SERVICES	215,674.46	37,726.54	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,200,034.80	7,581.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	234,216.00	762.00	DRUG-SPECIFIC/HOME IV	0.00	6,050.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,965,850.81	307,765.70
RADIOLOGY THERAPEUTIC	1,457,613.00	122,853.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	15,515.00	11,760.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,025.00	6,870.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	201,715.00	3,319.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	34,702.00	4,320.00	IMPL DEV CHARGE PATIENTS	107,793.00	0.00
LITHOTRIPSY	0.00	10,246.00	NO CC/INVALID REV CODE	0.00	430.00
OTHER IMAGING SERVICE	303,791.00	36,343.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	86,074.60	15,505.13			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	227,407.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	193,804.00	37,849.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	171,557.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	267,938.00	31,345.00			
			TOTAL ANCILLARY	15,336,788.22	2,014,542.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,336,788.22	2,014,542.40



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: 07/23/2014  
Run Time: 12:42:03  
Page: 7

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
906	5913350002062	06/07/13 - 06/07/13	12/23/13	0.00	430.00	0.00	0.00	0.00
TOTAL				0.00	430.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 12:43:05  
Page: 8

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	85,545.80	ADJUSTMENTS	0.00
COVERED CHARGES	57,390.80	CONTRACTUAL ALLOW	13,584.07
NON-COVERD CHARGES	28,155.00	TOTAL MEDICAID LIAB	43,806.73
		LESS: COB	43,732.21
		LESS: COPAYMENT	74.52
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 47

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

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,019.00	165.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,929.00	427.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	881.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,441.00	12,865.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,704.00	3,740.00
EKG/ECG	565.00	34.00	MRI SERVICES	0.00	1,625.00
IV THERAPY	884.00	966.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	336.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	52.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	270.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,854.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,977.00	51.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,971.80	128.00
RADIOLOGY THERAPEUTIC	3,472.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,201.00	87.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	201.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	600.00	4,070.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,033.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	3,997.00			
			TOTAL ANCILLARY	57,390.80	28,155.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	57,390.80	28,155.00

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

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

Run Date: 07/23/2014  
Run Time: 12:43:07  
Page: 10

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	392,232.63	ADJUSTMENTS	4,539.94
COVERED CHARGES	338,939.77	CONTRACTUAL ALLOW	315,058.36
NON-COVERD CHARGES	53,292.86	TOTAL MEDICAID LIAB	23,881.41
		LESS: COB	163.52
		LESS: COPAYMENT	807.09
		REIMBURSEMENT	22,910.80
		TOTAL NUMBER OF CLAIMS	427

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,236.00	901.00	OTHER LAB	304.00	0.00
MED/SURG SUPPLY	10,591.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,961.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,639.00	19,294.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	63,297.77	6,560.86
EKG/ECG	1,820.00	249.00	MRI SERVICES	3,836.00	0.00
IV THERAPY	27,240.00	5,277.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,187.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,524.00	388.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	270.00	290.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	176,780.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,164.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,057.00	18,484.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	289.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,608.00	1,849.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,136.00	0.00			
			TOTAL ANCILLARY	338,939.77	53,292.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	338,939.77	53,292.86

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

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

Run Date: 07/23/2014  
Run Time: 12:43:13  
Page: 12

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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 12:43:15  
Page: 13

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,903,487.76	ADJUSTMENTS	145,705.86
COVERED CHARGES	2,589,578.47	CONTRACTUAL ALLOW	2,127,569.70
NON-COVERD CHARGES	313,909.29	TOTAL MEDICAID LIAB	462,008.77
		LESS: COB	16,138.25
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	445,528.52
		TOTAL NUMBER OF CLAIMS	87

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,812.00	10,159.00	OTHER LAB	3,354.00	0.00
MED/SURG SUPPLY	365,401.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	80,027.00	13,952.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,803.00	1,331.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,184.10	FEE SCHEDULE LAB	42,878.92	8,780.59
EKG/ECG	1,763.00	1,119.00	MRI SERVICES	1,618.00	5,287.00
IV THERAPY	55,634.00	24,616.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	431,355.40	106,175.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,371.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,302.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,911.00	144.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	47,288.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	692,431.15	124,972.00
RADIOLOGY THERAPEUTIC	240,208.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,514.00	318.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	441,295.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	834.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,645.00	814.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,637.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	33,251.00	11,530.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,245.00	3,527.00			
			TOTAL ANCILLARY	2,589,578.47	313,909.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,589,578.47	313,909.29



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

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

Run Date: 07/23/2014  
Run Time: 12:43:18  
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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 11:34:11  
 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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,718,221.53	ADJUSTMENTS	2,973,136.78
COVERED CHARGES	58,522,572.92	CONTRACTUAL ALLOW	42,001,712.60
NON-COVERD CHARGES	1,195,648.61	TOTAL MEDICAID LIAB	16,520,860.32
		LESS: COB	167,937.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,352,923.09

TOTAL NUMBER OF ADMISSIONS 2,031

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,623		131	5,390,232.00		464,541.00
ROUTINE NURSERY	1,124		41	1,163,674.00		267,785.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		37.00
TOTAL ROUTINE	7,747		172	6,553,906.00		732,363.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,152		0	2,302,848.00		0.00
NICU	156		0	405,600.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,308		0	2,708,448.00		0.00
TOTAL ACCOMODATIONS	9,055		172	9,262,354.00		732,363.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,059,678.41	44,096.18	OTHER LAB	337,275.95	875.00
MED/SURG SUPPLY	3,429,276.15	92,360.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,827,401.38	73,501.80	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,112,027.96	4,193.20	OTHER THERAPEUTIC SVC	0.00	17,635.00
CT SCAN	2,175,630.24	22,292.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	182,813.65	6,953.01	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,652,692.86	6,054.00	MRI SERVICES	678,415.00	4,680.40
IV THERAPY	34,181.16	166.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,153,450.59	18,153.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,395,376.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,844,373.08	37,330.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	216,666.00	390.00	AMBULANCE	0.00	0.00
GI SERVICES	457,360.00	4,158.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,543,371.76	2,291.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	516,062.00	1,279.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	679,826.36	7,327.00	INJECTABLE DRUGS	1,674,341.00	21,962.32
RADIOLOGY THERAPEUTIC	230,745.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	103,628.75	3,108.70	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	103,426.03	2,636.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	390,422.72	17,878.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	18.00	11,981.00	TRAUMA RESPONSE	0.00	22,960.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,958,297.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	388,935.75	8,055.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	715,404.19	22,027.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	242,271.56	1,388.00			
AUDIOLOGY	88,264.80	0.00			
CARDIOLOGY	1,669,043.75	4,675.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	100,731.55	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	298,809.54	2,880.00			
			TOTAL ANCILLARY	49,260,218.92	463,285.61
			TOTAL ACCOMODATIONS	9,262,354.00	732,363.00
			TOTAL CHARGES	58,522,572.92	1,195,648.61

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

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

Run Date: 07/23/2014  
Run Time: 11:34:11  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9714090962095	05/01/13 - 05/03/13	04/07/14	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
 Run Time: 11:34:52  
 Page: 4

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	457,083.19	ADJUSTMENTS	0.00
COVERED CHARGES	449,589.19	CONTRACTUAL ALLOW	264,344.51
NON-COVERD CHARGES	7,494.00	TOTAL MEDICAID LIAB	185,244.68
		LESS: COB	185,244.68
		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	41		6	30,965.00		7,374.00
ROUTINE NURSERY	2		0	1,658.00		120.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	43		6	32,623.00		7,494.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	11		0	21,989.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	21,989.00		0.00
TOTAL ACCOMODATIONS	54		6	54,612.00		7,494.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,278.12	0.00	OTHER LAB	1,126.00	0.00
MED/SURG SUPPLY	69,823.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,519.98	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,668.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,954.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	820.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,836.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	69,367.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	50,705.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,291.23	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,785.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,644.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,250.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,639.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,671.00	0.00	INJECTABLE DRUGS	14,846.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	707.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,057.02	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	949.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,206.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	234.00	0.00			
CARDIOLOGY	3,600.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	394,977.19	0.00
			TOTAL ACCOMODATIONS	54,612.00	7,494.00
			TOTAL CHARGES	449,589.19	7,494.00

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

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

Run Date: 07/23/2014  
Run Time: 11:34:55  
Page: 6

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

PROVIDER NUMBER  
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,624,069.71	ADJUSTMENTS	1,776,502.46
COVERED CHARGES	30,740,499.40	CONTRACTUAL ALLOW	24,413,347.72
NON-COVERD CHARGES	2,883,570.31	TOTAL MEDICAID LIAB	6,327,151.68
		LESS: COB	13,915.63
		LESS: COPAYMENT	17,047.46
		REIMBURSEMENT	6,296,188.59
		ALL OTHER	5,227,813.11
		FEE SCHEDULE-LAB	651,464.84
		INJECTABLE DRUGS	416,910.64

TOTAL NUMBER OF CLAIMS 14,032

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	856,800.78	6,343.62	OTHER LAB	357,612.00	1,091.00
MED/SURG SUPPLY	1,055,484.43	7,534.01	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	119.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,290,404.00	19,360.88	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,098,543.00	128,023.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	39,228.00	15,309.09	FEE SCHEDULE LAB	5,286,897.74	1,432,193.58
EKG/ECG	665,829.00	89,792.00	MRI SERVICES	887,427.00	48,999.00
IV THERAPY	828,343.00	43,022.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,169,786.88	279,524.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	92,424.00	0.00	REHAB THERAPY	0.00	3,690.00
RESPIRATORY SERVICES	299,692.00	16,024.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	150,763.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	284,890.27	21,746.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,842,698.00	20,116.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	446,441.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,930,676.04	404,328.19
RADIOLOGY THERAPEUTIC	233,713.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,120.00	7,687.09	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,332.00	3,799.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	33,202.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	123,247.36	2,023.00	TRAUMA RESPONSE	0.00	18,368.00
PSYCHIATRIC SERVICES	1,022.00	0.00	IMPL DEV CHARGE PATIENTS	226,438.26	13,275.39
LITHOTRIPSY	34,750.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	821,426.02	44,724.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	163,688.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,329,249.00	33,439.17			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,044,430.00	179,019.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	435,393.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	716,750.42	10,817.93			
			TOTAL ANCILLARY	30,740,499.40	2,883,570.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,740,499.40	2,883,570.31



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

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

Run Date: 07/23/2014  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	534,697.79	ADJUSTMENTS	0.00
COVERED CHARGES	445,701.09	CONTRACTUAL ALLOW	229,581.08
NON-COVERD CHARGES	88,996.70	TOTAL MEDICAID LIAB	216,120.01
		LESS: COB	215,910.68
		LESS: COPAYMENT	209.33
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 192

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

ATHENS REGIONAL MEDICAL CTR	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1199 PRINCE AVE	000000074A	SERVICE DATES	10/01/12	THROUGH	09/30/13
ATHENS,GA 30606-2797		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,543.25	0.00	OTHER LAB	6,104.00	0.00
MED/SURG SUPPLY	7,628.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,683.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	49,525.00	8,840.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,915.00	1,989.00	FEE SCHEDULE LAB	92,899.27	11,937.86
EKG/ECG	3,796.00	2,386.00	MRI SERVICES	3,612.00	6,988.00
IV THERAPY	15,708.00	310.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,260.00	42,413.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,384.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	700.00	1,404.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,465.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	87,385.00	454.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,467.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,530.42	5,665.84
RADIOLOGY THERAPEUTIC	699.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,820.00	1,547.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,806.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,015.79	1,138.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,683.00	2,124.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,182.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	13,280.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,400.00	1,800.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,624.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,586.25	0.00			
			TOTAL ANCILLARY	445,701.09	88,996.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	445,701.09	88,996.70

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

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

Run Date: 07/23/2014  
Run Time: 11:37:18  
Page: 10

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,144,996.61	ADJUSTMENTS	2,673.98
COVERED CHARGES	1,090,562.51	CONTRACTUAL ALLOW	1,042,454.12
NON-COVERD CHARGES	54,434.10	TOTAL MEDICAID LIAB	48,108.39
		LESS: COB	0.00
		LESS: COPAYMENT	1,653.06
		REIMBURSEMENT	46,455.33
		TOTAL NUMBER OF CLAIMS	860

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,247.99	0.00	OTHER LAB	8,879.00	0.00
MED/SURG SUPPLY	9,209.82	809.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	70,733.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	56,759.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	209,941.16	35,388.72
EKG/ECG	11,680.00	584.00	MRI SERVICES	0.00	0.00
IV THERAPY	21,376.00	2,183.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,361.00	716.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,900.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	624,675.00	2,665.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,388.79	7,791.18
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	2,554.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	311.85	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,682.00	1,743.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,394.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,023.90	0.00			
			TOTAL ANCILLARY	1,090,562.51	54,434.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,090,562.51	54,434.10

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

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

Run Date: 07/23/2014  
Run Time: 11:37:27  
Page: 12

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

PROVIDER NUMBER  
000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,423.10	ADJUSTMENTS	0.00
COVERED CHARGES	25,328.07	CONTRACTUAL ALLOW	16,469.40
NON-COVERD CHARGES	2,095.03	TOTAL MEDICAID LIAB	8,858.67
		LESS: COB	8,846.67
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	12

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

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

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000074A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	321.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	494.18	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,655.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,210.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,426.00	1,296.00
EKG/ECG	292.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	554.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	393.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	175.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	740.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	380.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,950.00	170.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	859.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,679.39	201.03
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	198.75	428.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,328.07	2,095.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,328.07	2,095.03

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

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

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

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,919,346.60	ADJUSTMENTS	331,791.66
COVERED CHARGES	4,652,477.00	CONTRACTUAL ALLOW	3,921,655.26
NON-COVERD CHARGES	266,869.60	TOTAL MEDICAID LIAB	730,821.74
		LESS: COB	0.00
		LESS: COPAYMENT	1,347.00
		REIMBURSEMENT	729,474.74
		TOTAL NUMBER OF CLAIMS	137

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

ATHENS REGIONAL MEDICAL CTR	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1199 PRINCE AVE	000000074A	SERVICE DATES	10/01/12	THROUGH	09/30/13
ATHENS,GA 30606-2797		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88,072.31	0.00	OTHER LAB	2,771.00	0.00
MED/SURG SUPPLY	309,257.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,052.00	5,809.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	202,266.00	2,995.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	466.00	FEE SCHEDULE LAB	147,770.56	41,598.62
EKG/ECG	55,604.00	7,856.00	MRI SERVICES	3,494.00	0.00
IV THERAPY	51,273.00	310.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	792,375.00	38,196.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,375.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,035.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,265.00	90.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	54,650.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	804,245.46	74,130.33
RADIOLOGY THERAPEUTIC	534,011.00	2,902.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,754.00	123.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,162,044.22	22,286.81
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,028.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,271.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	26,445.00	466.84			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	272,613.00	65,809.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	54,805.45	3,831.00			
			TOTAL ANCILLARY	4,652,477.00	266,869.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,652,477.00	266,869.60



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

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,183,420.27	ADJUSTMENTS	3,985.14
COVERED CHARGES	1,146,141.38	CONTRACTUAL ALLOW	747,488.59
NON-COVERD CHARGES	37,278.89	TOTAL MEDICAID LIAB	398,652.79
		LESS: COB	9,892.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	388,760.19

TOTAL NUMBER OF ADMISSIONS 73

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	209		0	126,236.00		6,090.00
ROUTINE NURSERY	17		0	9,972.00		1,250.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	226		0	136,208.00		7,340.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	38		0	39,137.80		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	38		0	39,137.80		0.00
TOTAL ACCOMODATIONS	264		0	175,345.80		7,340.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	226,127.44	0.00	OTHER LAB	2,255.90	0.00
MED/SURG SUPPLY	140,854.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	172,420.20	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,054.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,221.50	6,888.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,318.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,053.80	0.00	MRI SERVICES	8,372.70	0.00
IV THERAPY	2,140.60	18,520.59	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	82,301.60	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,886.60	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,123.87	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,073.90	0.00	AMBULANCE	0.00	0.00
GI SERVICES	869.10	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,534.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,608.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,311.80	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	584.60	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	127,228.60	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,249.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,433.00	4,530.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,431.40	0.00			
AUDIOLOGY	1,372.00	0.00			
CARDIOLOGY	4,254.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,713.60	0.00			
			TOTAL ANCILLARY	970,795.58	29,938.89
			TOTAL ACCOMODATIONS	175,345.80	7,340.00
			TOTAL CHARGES	1,146,141.38	37,278.89

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 11:28:55  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,767,217.05	ADJUSTMENTS	5,714.38
COVERED CHARGES	1,367,040.88	CONTRACTUAL ALLOW	994,969.83
NON-COVERD CHARGES	400,176.17	TOTAL MEDICAID LIAB	372,071.05
		LESS: COB	0.00
		LESS: COPAYMENT	1,164.00
		REIMBURSEMENT	370,907.05
		ALL OTHER	331,504.87
		FEE SCHEDULE-LAB	39,402.18
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,380

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,088.13	88,736.27	OTHER LAB	11,787.40	0.00
MED/SURG SUPPLY	125,570.74	117.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,710.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	139,883.18	1,528.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	71,428.20	67,742.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,367.20	167.20	FEE SCHEDULE LAB	431,177.24	111,824.50
EKG/ECG	25,536.80	4,309.00	MRI SERVICES	84,452.20	4,562.40
IV THERAPY	4,183.90	21,876.30	PROFESSIONAL FEES	0.00	681.50
OPERATING ROOM	65,378.68	58,036.86	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,408.60	510.54	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	43,414.40	10,905.30	CAST ROOM	0.00	0.00
EMERGENCY ROOM	228,654.51	19,462.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,064.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	1,853.60	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	834.30	1,428.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,114.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,991.30	2,641.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	668.80	2,082.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,542.80	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,127.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,367.10	0.00			
			TOTAL ANCILLARY	1,367,040.88	400,176.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,367,040.88	400,176.17

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

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

Run Date: 07/23/2014  
Run Time: 11:29:10  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,581.26	ADJUSTMENTS	0.00
COVERED CHARGES	1,352.56	CONTRACTUAL ALLOW	266.36
NON-COVERD CHARGES	228.70	TOTAL MEDICAID LIAB	1,086.20
		LESS: COB	1,077.83
		LESS: COPAYMENT	8.37
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	195.30	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	106.66	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	312.10	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	656.60	33.40
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	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	277.20	0.00			
			TOTAL ANCILLARY	1,352.56	228.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,352.56	228.70



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

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

Run Date: 07/23/2014  
Run Time: 11:29:10  
Page: 8

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

PROVIDER NUMBER  
000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	128,400.17	ADJUSTMENTS	147.00
COVERED CHARGES	107,499.39	CONTRACTUAL ALLOW	98,499.39
NON-COVERD CHARGES	20,900.78	TOTAL MEDICAID LIAB	9,000.00
		LESS: COB	0.00
		LESS: COPAYMENT	321.00
		REIMBURSEMENT	8,679.00
		TOTAL NUMBER OF CLAIMS	180

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,285.77	6,660.67	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,692.12	10.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	81.90	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,289.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,071.40	4,644.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,070.60	4,487.30
EKG/ECG	859.00	171.80	MRI SERVICES	0.00	0.00
IV THERAPY	291.90	1,248.21	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	664.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,605.60	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,696.80	1,780.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	210.60	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	577.80	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	107,499.39	20,900.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	107,499.39	20,900.78

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

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

Run Date: 07/23/2014  
Run Time: 11:29:12  
Page: 10

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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Page: 11

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	58,043.72	ADJUSTMENTS	0.00
COVERED CHARGES	50,710.54	CONTRACTUAL ALLOW	41,757.16
NON-COVERD CHARGES	7,333.18	TOTAL MEDICAID LIAB	8,953.38
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	8,944.38

TOTAL NUMBER OF CLAIMS 2

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

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

PROVIDER NUMBER  
 000000118A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,060.30	2,944.41	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,241.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	59.20
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	318.07	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,011.50	4,011.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	246.10	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	768.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	24,382.80	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	50,710.54	7,333.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50,710.54	7,333.18

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

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

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000129A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,135,793.43	ADJUSTMENTS	129,535.62
COVERED CHARGES	8,035,323.99	CONTRACTUAL ALLOW	5,067,026.32
NON-COVERD CHARGES	100,469.44	TOTAL MEDICAID LIAB	2,968,297.67
		LESS: COB	69,468.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,898,829.42

TOTAL NUMBER OF ADMISSIONS 369

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	924		0	681,070.94		37.18
ROUTINE NURSERY	103		0	61,310.75		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,027		0	742,381.69		37.18
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,002		0	1,358,289.26		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	1,358,289.26		0.00
TOTAL ACCOMODATIONS	2,029		0	2,100,670.95		37.18

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	915,039.59	0.00	OTHER LAB	18,325.75	0.00
MED/SURG SUPPLY	645,713.76	432.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,141,837.94	286.22	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	95,314.76	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	339,664.57	1,590.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,085.72	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	21,809.52	0.00	MRI SERVICES	31,761.69	0.00
IV THERAPY	27,432.68	255.01	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	197,327.91	243.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	56,594.99	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	375,821.61	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	81,785.88	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	177,105.12	406.49	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,545.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	29,016.02	0.00	INJECTABLE DRUGS	1,223,711.69	17.90
RADIOLOGY THERAPEUTIC	51,051.97	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,637.15	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,199.76	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	22,839.96	585.64	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,067.58	2,815.34	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	40,421.63	0.00
LITHOTRIPSY	9,548.17	0.00	NO CC/INVALID REV CODE	0.00	8,149.33
OTHER IMAGING SERVICE	31,331.80	6,035.29			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	176,752.56	78,832.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	46,196.28	0.00			
AUDIOLOGY	4,047.40	0.00			
CARDIOLOGY	111,399.71	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,052.19	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,211.88	782.61			
			TOTAL ANCILLARY	5,934,653.04	100,432.26
			TOTAL ACCOMODATIONS	2,100,670.95	37.18
			TOTAL CHARGES	8,035,323.99	100,469.44



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: 07/23/2014  
Run Time: 10:36:34  
Page: 3

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013009031604	12/24/12 - 12/31/12	01/14/13	0.00	3,259.75	0.00	0.00	0.00
615	2013032060842	01/16/13 - 01/17/13	02/04/13	0.00	3,259.75	0.00	0.00	0.00
615	2013165044684	04/29/13 - 05/01/13	06/17/13	0.00	1,629.83	0.00	0.00	0.00
TOTAL				0.00	8,149.33	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 10:36:43  
Page: 4

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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 10:36:45  
Page: 5

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

PROVIDER NUMBER  
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,920,865.48	ADJUSTMENTS	351,560.79
COVERED CHARGES	6,170,903.02	CONTRACTUAL ALLOW	4,722,367.29
NON-COVERD CHARGES	749,962.46	TOTAL MEDICAID LIAB	1,448,535.73
		LESS: COB	1,042.72
		LESS: COPAYMENT	5,841.00
		REIMBURSEMENT	1,441,652.01
		ALL OTHER	1,158,671.48
		FEE SCHEDULE-LAB	237,514.74
		INJECTABLE DRUGS	45,465.79

TOTAL NUMBER OF CLAIMS 5,229

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	146,398.08	2,658.07	OTHER LAB	34,924.96	0.00
MED/SURG SUPPLY	246,389.69	4,853.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	162.59	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	235,643.74	1,430.02	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,157,648.26	24,109.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	30,819.88	4,987.81	FEE SCHEDULE LAB	1,584,610.13	389,732.26
EKG/ECG	51,145.93	3,332.01	MRI SERVICES	130,126.85	3,376.56
IV THERAPY	154,792.89	30,437.28	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	237,494.87	8,793.21	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,228.11	8,541.18	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	152.97	0.00	AMBULANCE	0.00	0.00
GI SERVICES	159,928.25	2,941.68	CAST ROOM	0.00	0.00
EMERGENCY ROOM	693,568.34	12,648.39	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,636.19	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	202,345.77	105,276.41
RADIOLOGY THERAPEUTIC	332,454.21	3,878.78	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,354.00	906.35	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,602.35	2,163.38	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	585.64	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,837.04	3,742.43	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	40,174.59	1,923.11
LITHOTRIPSY	9,548.17	0.00	NO CC/INVALID REV CODE	0.00	1,875.11
OTHER IMAGING SERVICE	225,419.40	21,296.46			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,651.44	8,869.86			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	167,328.97	89,209.69			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	79,126.28	2,811.74			
AMBULATORY SURGERY	251.72	125.86			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,253.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	117,046.04	9,293.45			
			TOTAL ANCILLARY	6,170,903.02	749,962.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,170,903.02	749,962.46

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

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

Run Date: 07/23/2014  
Run Time: 10:36:45  
Page: 7

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
7741	5913156000373	05/07/13 - 05/07/13	06/10/13	0.00	863.24	0.00	0.00	0.00
7701	5913156000373	05/07/13 - 05/07/13	06/10/13	0.00	1,011.87	0.00	0.00	0.00
TOTAL				0.00	1,875.11	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 10:37:45  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,972.77	ADJUSTMENTS	0.00
COVERED CHARGES	10,024.77	CONTRACTUAL ALLOW	7,561.96
NON-COVERD CHARGES	7,948.00	TOTAL MEDICAID LIAB	2,462.81
		LESS: COB	2,456.81
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	226.32	1,265.75	OTHER LAB	273.12	0.00
MED/SURG SUPPLY	0.00	2,404.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	566.45	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	2,818.23	729.47
EKG/ECG	100.97	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,142.34	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,534.23	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	473.56	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	555.27	279.44	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	422.08	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	548.71	313.03
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	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	858.75	0.00			
			TOTAL ANCILLARY	10,024.77	7,948.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,024.77	7,948.00

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	310,997.22	ADJUSTMENTS	1,627.20
COVERED CHARGES	286,664.02	CONTRACTUAL ALLOW	257,015.82
NON-COVERD CHARGES	24,333.20	TOTAL MEDICAID LIAB	29,648.20
		LESS: COB	0.00
		LESS: COPAYMENT	813.06
		REIMBURSEMENT	28,835.14
		TOTAL NUMBER OF CLAIMS	530



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,475.04	0.00	OTHER LAB	1,291.39	0.00
MED/SURG SUPPLY	6,403.33	72.79	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,269.26	209.58	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,929.56	1,084.16	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	70,882.83	12,205.70
EKG/ECG	3,130.07	100.97	MRI SERVICES	0.00	0.00
IV THERAPY	6,699.52	1,589.36	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	542.31	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,014.60	264.56	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	124,083.35	397.03	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,203.46	3,567.72
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	450.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	644.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,696.35	3,746.83			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,042.95	0.00			
			TOTAL ANCILLARY	286,664.02	24,333.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	286,664.02	24,333.20

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

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

Run Date: 07/23/2014  
Run Time: 10:37:52  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,374.02	ADJUSTMENTS	0.00
COVERED CHARGES	2,279.48	CONTRACTUAL ALLOW	1,677.92
NON-COVERD CHARGES	94.54	TOTAL MEDICAID LIAB	601.56
		LESS: COB	598.56
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22.88	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	208.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	841.55	94.54
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	465.12	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17.90	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	711.93	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,279.48	94.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,279.48	94.54

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

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

Run Date: 07/23/2014  
Run Time: 10:37:54  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000129A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	333,966.00	ADJUSTMENTS	21,567.78
COVERED CHARGES	328,252.04	CONTRACTUAL ALLOW	269,103.49
NON-COVERD CHARGES	5,713.96	TOTAL MEDICAID LIAB	59,148.55
		LESS: COB	0.00
		LESS: COPAYMENT	372.00
		REIMBURSEMENT	58,776.55

TOTAL NUMBER OF CLAIMS 11

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	189.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	245.67	160.00	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	129,519.36	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,606.55	91.07
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,232.12
RADIOLOGY THERAPEUTIC	195,760.97	4,230.77	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	180.86	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	644.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	328,252.04	5,713.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	328,252.04	5,713.96

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: 07/23/2014  
Run Time: 10:37:55  
Page: 16

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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 11:33:31  
 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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	959,547.16	ADJUSTMENTS	45,486.44
COVERED CHARGES	871,118.59	CONTRACTUAL ALLOW	448,716.73
NON-COVERD CHARGES	88,428.57	TOTAL MEDICAID LIAB	422,401.86
		LESS: COB	6,048.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	416,353.06

TOTAL NUMBER OF ADMISSIONS 67

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	138		83	81,672.00		81,165.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	138		83	81,672.00		81,165.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	22		0	32,098.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	22		0	32,098.00		0.00
TOTAL ACCOMODATIONS	160		83	113,770.00		81,165.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	190,633.12	326.22	OTHER LAB	11,706.00	0.00
MED/SURG SUPPLY	70,433.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	153,748.20	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,676.61	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,472.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,190.02	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,383.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,628.46	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,825.88	468.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	30,320.87	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,898.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,047.92	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,404.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,152.38	0.00	INJECTABLE DRUGS	6,734.40	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,323.21	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	15,440.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,141.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,643.20	6,468.39			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,308.96	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,238.36	0.00			
			TOTAL ANCILLARY	757,348.59	7,263.57
			TOTAL ACCOMODATIONS	113,770.00	81,165.00
			TOTAL CHARGES	871,118.59	88,428.57



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

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

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
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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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,168,647.08	ADJUSTMENTS	67,443.03
COVERED CHARGES	1,851,140.39	CONTRACTUAL ALLOW	1,460,222.13
NON-COVERD CHARGES	317,506.69	TOTAL MEDICAID LIAB	390,918.26
		LESS: COB	485.96
		LESS: COPAYMENT	1,635.00
		REIMBURSEMENT	388,797.30
		ALL OTHER	343,424.88
		FEE SCHEDULE-LAB	42,765.83
		INJECTABLE DRUGS	2,606.59
		TOTAL NUMBER OF CLAIMS	1,558

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,308.39	18,676.03	OTHER LAB	29,230.00	0.00
MED/SURG SUPPLY	41,559.00	4,034.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	45.00	EDUCATION & TRAINING	0.00	352.75
RADIOLOGY-DIAGNOSTIC	128,320.49	5,630.65	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	243,382.00	11,842.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,670.00	8,925.87	FEE SCHEDULE LAB	399,125.69	118,746.31
EKG/ECG	32,766.00	1,419.00	MRI SERVICES	95,765.00	0.00
IV THERAPY	102,644.41	13,449.02	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,675.96	51,799.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,910.39	545.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,598.00	1,309.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	500,875.06	5,816.77	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,089.00	8,899.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,643.52	45,877.61
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	96.00	3,558.02	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,314.06	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	1,712.02	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	335.00	1,019.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	408.48
OTHER IMAGING SERVICE	33,909.44	1,908.17			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,304.30	10,061.94			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,685.00	597.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	49,632.06	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,301.62	875.00			
			TOTAL ANCILLARY	1,851,140.39	317,506.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,851,140.39	317,506.69

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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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
9928	2213266008801	06/23/13 - 06/23/13	09/30/13	0.00	408.48	0.00	0.00	0.00
TOTAL				0.00	408.48	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

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,295.70	ADJUSTMENTS	0.00
COVERED CHARGES	1,073.70	CONTRACTUAL ALLOW	668.79
NON-COVERD CHARGES	222.00	TOTAL MEDICAID LIAB	404.91
		LESS: COB	401.91
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 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	170.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	432.00	222.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	259.53	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	212.17	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,073.70	222.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,073.70	222.00

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

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

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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	310,265.59	ADJUSTMENTS	1,070.80
COVERED CHARGES	223,681.64	CONTRACTUAL ALLOW	204,606.10
NON-COVERD CHARGES	86,583.95	TOTAL MEDICAID LIAB	19,075.54
		LESS: COB	0.00
		LESS: COPAYMENT	690.02
		REIMBURSEMENT	18,385.52
		TOTAL NUMBER OF CLAIMS	341

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,949.44	453.38	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	570.00	21.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	80,048.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,403.00	170.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,217.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,192.37	3,819.73
EKG/ECG	516.00	0.00	MRI SERVICES	2,039.00	0.00
IV THERAPY	10,291.73	540.13	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	155,241.05	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	4,262.05	1,277.28
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	104.43	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	223,681.64	86,583.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	223,681.64	86,583.95



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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	601.48	ADJUSTMENTS	0.00
COVERED CHARGES	601.48	CONTRACTUAL ALLOW	370.30
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	231.18
		LESS: COB	231.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000151A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 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	193.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	408.48	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	601.48	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	601.48	0.00

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

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

Run Date: 07/23/2014  
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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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 11:34:03  
Page: 14

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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 11:38:32  
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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 07/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	104,194.00	ADJUSTMENTS	6,000.92
COVERED CHARGES	91,869.00	CONTRACTUAL ALLOW	51,369.33
NON-COVERD CHARGES	12,325.00	TOTAL MEDICAID LIAB	40,499.67
		LESS: COB	255.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	40,244.05

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	34		0	13,600.00		10,200.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	34		0	13,600.00		10,200.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	34		0	13,600.00		10,200.00

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

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

Run Date: 07/23/2014  
 Run Time: 11:38:32  
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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 07/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,807.00	0.00	OTHER LAB	666.00	0.00
MED/SURG SUPPLY	7,940.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,052.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,880.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,920.00	2,125.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,148.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	999.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,625.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,232.00	0.00			
			TOTAL ANCILLARY	78,269.00	2,125.00
			TOTAL ACCOMODATIONS	13,600.00	10,200.00
			TOTAL CHARGES	91,869.00	12,325.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 11:38:32  
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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 07/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	674,553.00	ADJUSTMENTS	32,867.72
COVERED CHARGES	612,452.00	CONTRACTUAL ALLOW	462,416.41
NON-COVERD CHARGES	62,101.00	TOTAL MEDICAID LIAB	150,035.59
		LESS: COB	267.98
		LESS: COPAYMENT	414.00
		REIMBURSEMENT	149,353.61
		ALL OTHER	127,221.88
		FEE SCHEDULE-LAB	22,022.16
		INJECTABLE DRUGS	109.57

TOTAL NUMBER OF CLAIMS 745



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 07/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	66,605.00	28.00	OTHER LAB	7,842.00	0.00
MED/SURG SUPPLY	18,436.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	103.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,980.00	1,450.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	79,055.00	12,220.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,207.00	2,202.00	FEE SCHEDULE LAB	142,842.00	38,843.00
EKG/ECG	15,616.00	874.00	MRI SERVICES	18,145.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,203.00	182.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,615.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	188,970.00	5,608.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,057.00	566.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	25.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	308.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,295.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,900.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,858.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,518.00	0.00			
			TOTAL ANCILLARY	612,452.00	62,101.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	612,452.00	62,101.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,209.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,440.00	CONTRACTUAL ALLOW	2,035.92
NON-COVERD CHARGES	1,769.00	TOTAL MEDICAID LIAB	5,404.08
		LESS: COB	5,401.08
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

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

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 07/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	537.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	60.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	320.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,620.00	1,700.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,149.00	69.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,754.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,440.00	1,769.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,440.00	1,769.00

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

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

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

PROVIDER NUMBER  
000000173A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,358.00	ADJUSTMENTS	161.82
COVERED CHARGES	72,610.00	CONTRACTUAL ALLOW	65,237.80
NON-COVERD CHARGES	748.00	TOTAL MEDICAID LIAB	7,372.20
		LESS: COB	26.28
		LESS: COPAYMENT	183.00
		REIMBURSEMENT	7,162.92
		TOTAL NUMBER OF CLAIMS	132

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 07/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,540.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	534.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,010.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,800.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,436.00	748.00
EKG/ECG	548.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	328.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,964.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	450.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	72,610.00	748.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	72,610.00	748.00

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

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

Run Date: 07/23/2014  
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Page: 10

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

PROVIDER NUMBER  
000000173A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 11:39:08  
Page: 11

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 07/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 11:39:08  
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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	07/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



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

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

Run Date: 07/23/2014  
 Run Time: 12:46:09  
 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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	236,691.75	ADJUSTMENTS	0.00
COVERED CHARGES	227,945.75	CONTRACTUAL ALLOW	50,314.18
NON-COVERD CHARGES	8,746.00	TOTAL MEDICAID LIAB	177,631.57
		LESS: COB	5,246.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	172,385.20

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	92		0	38,272.00		832.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	92		0	38,272.00		832.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	92		0	38,272.00		832.00

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,615.00	0.00	OTHER LAB	220.00	0.00
MED/SURG SUPPLY	14,509.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	46,876.90	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,743.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,562.00	7,480.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,376.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,100.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,118.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,725.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,143.50	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	100.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,462.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	434.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,111.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,012.00	0.00			
			TOTAL ANCILLARY	189,673.75	7,914.00
			TOTAL ACCOMODATIONS	38,272.00	832.00
			TOTAL CHARGES	227,945.75	8,746.00

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

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

Run Date: 07/23/2014  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 12:46:11  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	521,751.90	ADJUSTMENTS	17,738.09
COVERED CHARGES	444,339.90	CONTRACTUAL ALLOW	183,352.22
NON-COVERD CHARGES	77,412.00	TOTAL MEDICAID LIAB	260,987.68
		LESS: COB	1,874.59
		LESS: COPAYMENT	837.00
		REIMBURSEMENT	258,276.09
		ALL OTHER	222,265.35
		FEE SCHEDULE-LAB	26,680.15
		INJECTABLE DRUGS	9,330.59

TOTAL NUMBER OF CLAIMS 761

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,914.00	1,365.00	OTHER LAB	3,696.00	275.00
MED/SURG SUPPLY	15,596.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,590.00	5,096.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,478.00	4,488.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	165.00	462.00	FEE SCHEDULE LAB	163,065.53	47,960.50
EKG/ECG	10,811.00	2,100.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,556.30	1,883.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	91,740.62	1,470.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,005.95	11,344.50
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	50.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,244.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	671.00	868.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,074.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	29,600.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,132.00	50.00			
			TOTAL ANCILLARY	444,339.90	77,412.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	444,339.90	77,412.00

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

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

Run Date: 07/23/2014  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,179.79	ADJUSTMENTS	0.00
COVERED CHARGES	7,856.89	CONTRACTUAL ALLOW	3,965.94
NON-COVERD CHARGES	1,322.90	TOTAL MEDICAID LIAB	3,890.95
		LESS: COB	3,884.95
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

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

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

PROVIDER NUMBER  
 000000195A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	360.00	35.00	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	170.00	80.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,496.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,781.39	542.00
EKG/ECG	200.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,815.00	447.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	477.50	218.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	306.00	0.00			
			TOTAL ANCILLARY	7,856.89	1,322.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,856.89	1,322.90

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

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

Run Date: 07/23/2014  
Run Time: 12:46:31  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,252.02	ADJUSTMENTS	191.00
COVERED CHARGES	29,742.50	CONTRACTUAL ALLOW	25,442.50
NON-COVERD CHARGES	2,509.52	TOTAL MEDICAID LIAB	4,300.00
		LESS: COB	47.94
		LESS: COPAYMENT	162.00
		REIMBURSEMENT	4,090.06
		TOTAL NUMBER OF CLAIMS	86



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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	446.50	70.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	562.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,326.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,068.50	1,912.52
EKG/ECG	800.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	330.00	40.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,025.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,752.00	487.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	432.00	0.00			
			TOTAL ANCILLARY	29,742.50	2,509.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,742.50	2,509.52

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: 07/23/2014  
Run Time: 12:46:33  
Page: 10

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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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Page: 11

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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 12:46:33  
Page: 12

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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 12:45:18  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000239A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	300,456.58	ADJUSTMENTS	5,417.56
COVERED CHARGES	294,193.58	CONTRACTUAL ALLOW	158,325.77
NON-COVERD CHARGES	6,263.00	TOTAL MEDICAID LIAB	135,867.81
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	135,867.81

TOTAL NUMBER OF ADMISSIONS 29

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	104		0	56,842.00		2,560.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	104		0	56,842.00		2,560.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	104		0	56,842.00		2,560.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,272.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,963.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	84,765.74	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,079.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,974.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,931.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,352.00	0.00	MRI SERVICES	1,625.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,362.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,075.00	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,633.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	422.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	274.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,488.00	3,703.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,033.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	102.00	0.00			
			TOTAL ANCILLARY	237,351.58	3,703.00
			TOTAL ACCOMODATIONS	56,842.00	2,560.00
			TOTAL CHARGES	294,193.58	6,263.00

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

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

Run Date: 07/23/2014  
Run Time: 12:45:19  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 12:45:20  
Page: 4

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

PROVIDER NUMBER  
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,468,852.89	ADJUSTMENTS	41,536.32
COVERED CHARGES	1,269,741.29	CONTRACTUAL ALLOW	948,871.81
NON-COVERD CHARGES	199,111.60	TOTAL MEDICAID LIAB	320,869.48
		LESS: COB	0.00
		LESS: COPAYMENT	2,346.00
		REIMBURSEMENT	318,523.48
		ALL OTHER	254,327.30
		FEE SCHEDULE-LAB	62,442.34
		INJECTABLE DRUGS	1,753.84
		TOTAL NUMBER OF CLAIMS	1,835



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,519.08	23,914.00	OTHER LAB	4,544.00	0.00
MED/SURG SUPPLY	13,059.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	13,533.32	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	91,334.00	190.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	121,438.00	7,311.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,062.00	21,552.00	FEE SCHEDULE LAB	503,863.69	106,375.28
EKG/ECG	10,633.00	1,404.00	MRI SERVICES	39,130.00	0.00
IV THERAPY	40,996.00	4,002.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,293.00	1,668.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,133.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	194,891.00	597.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,091.00	3,845.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,183.00	13,110.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	355.00	1,182.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	203.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,797.00	326.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	938.52	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,528.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,750.00	36.00			
			TOTAL ANCILLARY	1,269,741.29	199,111.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,269,741.29	199,111.60

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,687.00	ADJUSTMENTS	0.00
COVERED CHARGES	762.00	CONTRACTUAL ALLOW	678.72
NON-COVERD CHARGES	2,925.00	TOTAL MEDICAID LIAB	83.28
		LESS: COB	83.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

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

PROVIDER NUMBER  
 000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	95.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	230.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,592.00	FEE SCHEDULE LAB	326.00	238.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	206.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	762.00	2,925.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	762.00	2,925.00

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

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

Run Date: 07/23/2014  
Run Time: 12:45:31  
Page: 8

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	86,163.92	ADJUSTMENTS	97.00
COVERED CHARGES	83,351.92	CONTRACTUAL ALLOW	75,901.92
NON-COVERD CHARGES	2,812.00	TOTAL MEDICAID LIAB	7,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	183.01
		REIMBURSEMENT	7,266.99
		TOTAL NUMBER OF CLAIMS	149

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	464.00	15.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	876.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,631.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,662.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,399.92	2,083.00
EKG/ECG	520.00	68.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,785.00	576.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	372.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,797.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,845.00	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	83,351.92	2,812.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	83,351.92	2,812.00

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

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

Run Date: 07/23/2014  
Run Time: 12:45:32  
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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	373.00	ADJUSTMENTS	0.00
COVERED CHARGES	373.00	CONTRACTUAL ALLOW	186.50
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	186.50
		LESS: COB	186.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	361.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	373.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	373.00	0.00

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

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

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000239A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	166,928.08	ADJUSTMENTS	8,539.58
COVERED CHARGES	160,325.08	CONTRACTUAL ALLOW	121,802.47
NON-COVERD CHARGES	6,603.00	TOTAL MEDICAID LIAB	38,522.61
		LESS: COB	0.00
		LESS: COPAYMENT	174.00
		REIMBURSEMENT	38,348.61

TOTAL NUMBER OF CLAIMS 9



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131,233.08	3,850.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	701.00	190.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,101.00	2,563.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,290.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	160,325.08	6,603.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	160,325.08	6,603.00

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

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

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000239A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 09:43:27  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000272A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,587,104.52	ADJUSTMENTS	341,859.12
COVERED CHARGES	26,330,935.34	CONTRACTUAL ALLOW	20,356,904.75
NON-COVERD CHARGES	256,169.18	TOTAL MEDICAID LIAB	5,974,030.59
		LESS: COB	76,934.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,897,096.25

TOTAL NUMBER OF ADMISSIONS 846

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,765		0	877,385.00		34,173.26
ROUTINE NURSERY	244		0	103,305.90		51.30
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		2,569.28
TOTAL ROUTINE	2,009		0	980,690.90		36,793.84
SPECIAL CARE SERVICES						
CCU	227		0	233,716.08		0.00
ICU	1,320		0	1,148,335.34		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,547		0	1,382,051.42		0.00
TOTAL ACCOMODATIONS	3,556		0	2,362,742.32		36,793.84

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

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

Run Date: 07/23/2014  
 Run Time: 09:43:27  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,859,520.91	0.00	OTHER LAB	119,795.10	0.00
MED/SURG SUPPLY	5,137,147.13	10,161.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,786,447.02	0.00	EDUCATION & TRAINING	14,389.69	0.00
RADIOLOGY-DIAGNOSTIC	609,037.63	31,064.44	OTHER THERAPEUTIC SVC	0.00	46,709.78
CT SCAN	1,472,926.22	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	193,756.15	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	131,116.23	0.00	MRI SERVICES	386,528.91	0.00
IV THERAPY	381.19	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,805,975.97	11,030.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	407,950.32	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	427,557.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	636,488.14	0.00	AMBULANCE	0.00	0.00
GI SERVICES	214,242.29	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,034,507.94	0.00	SPECIAL SERVICES	0.00	3,736.65
RECOVERY ROOM	116,113.93	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	185,496.95	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	21,646.99	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	22,797.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	50,164.30	967.36	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	412.28	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	495,058.72	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	53,318.07
OTHER IMAGING SERVICE	126,880.87	1,445.94			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	301,850.06	46,570.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	79,883.53	14,370.76			
AUDIOLOGY	4,128.00	0.00			
CARDIOLOGY	1,241,235.22	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	73,238.67	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,518.38	0.00			
			TOTAL ANCILLARY	23,968,193.02	219,375.34
			TOTAL ACCOMODATIONS	2,362,742.32	36,793.84
			TOTAL CHARGES	26,330,935.34	256,169.18

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012321046975	11/06/12 - 11/08/12	11/19/12	0.00	2,630.62	0.00	0.00	0.00
615	2012348048604	12/03/12 - 12/06/12	12/17/12	0.00	2,630.62	0.00	0.00	0.00
615	5912362000528	11/30/12 - 12/10/12	12/31/12	0.00	2,630.62	0.00	0.00	0.00
615	5913009001689	12/15/12 - 12/19/12	01/14/13	0.00	2,630.62	0.00	0.00	0.00
615	2013011040117	12/25/12 - 12/28/12	01/14/13	0.00	2,630.62	0.00	0.00	0.00
615	2013012027513	01/01/13 - 01/04/13	01/21/13	0.00	2,630.62	0.00	0.00	0.00
615	2013032063159	01/06/13 - 01/25/13	02/04/13	0.00	5,870.49	0.00	0.00	0.00
615	2013138025647	05/13/13 - 05/15/13	05/27/13	0.00	2,762.22	0.00	0.00	0.00
615	2213169009624	06/10/13 - 06/11/13	06/24/13	0.00	2,762.22	0.00	0.00	0.00
615	2013180026424	06/17/13 - 06/21/13	07/08/13	0.00	6,164.16	0.00	0.00	0.00
615	2213206016224	06/07/13 - 06/12/13	07/29/13	0.00	2,762.22	0.00	0.00	0.00
615	2013239030838	08/14/13 - 08/17/13	09/02/13	0.00	2,762.22	0.00	0.00	0.00
615	2013275046689	08/16/13 - 08/23/13	10/07/13	0.00	2,762.22	0.00	0.00	0.00
615	2013323032438	05/13/13 - 05/14/13	11/25/13	0.00	6,164.16	0.00	0.00	0.00
615	2214059015904	06/19/13 - 06/24/13	03/03/14	0.00	2,762.22	0.00	0.00	0.00
615	9114111008781	06/15/13 - 06/18/13	05/26/14	0.00	2,762.22	0.00	1,770.95	0.00
TOTAL				0.00	53,318.07	0.00	1,770.95	0.00

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

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

Run Date: 07/23/2014  
 Run Time: 09:43:58  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000272A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	318,024.62	ADJUSTMENTS	0.00
COVERED CHARGES	316,576.08	CONTRACTUAL ALLOW	159,828.74
NON-COVERD CHARGES	1,448.54	TOTAL MEDICAID LIAB	156,747.34
		LESS: COB	156,747.34
		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	31		0	15,395.00		512.60
ROUTINE NURSERY	8		0	3,403.06		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	39		0	18,798.06		512.60
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	6		0	6,331.68		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	6		0	6,331.68		0.00
TOTAL ACCOMODATIONS	45		0	25,129.74		512.60

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,177.37	0.00	OTHER LAB	526.33	0.00
MED/SURG SUPPLY	69,313.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,812.18	0.00	EDUCATION & TRAINING	150.46	0.00
RADIOLOGY-DIAGNOSTIC	3,125.43	0.00	OTHER THERAPEUTIC SVC	0.00	124.42
CT SCAN	13,449.73	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,468.91	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	614.27	0.00	MRI SERVICES	6,929.53	0.00
IV THERAPY	72.77	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	63,856.13	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,447.97	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11.24	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,373.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,999.32	0.00	SPECIAL SERVICES	0.00	182.70
RECOVERY ROOM	1,679.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,303.25	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	4,306.45	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,137.48	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,579.60	268.97			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,306.32	359.85			
AUDIOLOGY	124.00	0.00			
CARDIOLOGY	4,195.53	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,486.44	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	291,446.34	935.94
			TOTAL ACCOMODATIONS	25,129.74	512.60
			TOTAL CHARGES	316,576.08	1,448.54

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: 07/23/2014  
Run Time: 09:44:01  
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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,027,614.01	ADJUSTMENTS	925,666.72
COVERED CHARGES	17,588,449.51	CONTRACTUAL ALLOW	14,199,639.11
NON-COVERD CHARGES	2,439,164.50	TOTAL MEDICAID LIAB	3,388,810.40
		LESS: COB	14,395.56
		LESS: COPAYMENT	6,342.00
		REIMBURSEMENT	3,368,072.84
		ALL OTHER	3,189,627.12
		FEE SCHEDULE-LAB	150,209.68
		INJECTABLE DRUGS	28,236.04

TOTAL NUMBER OF CLAIMS 5,839



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	131,055.48	122,534.13	OTHER LAB	620,228.61	22,476.27
MED/SURG SUPPLY	1,839,598.95	60,487.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	98.51	EDUCATION & TRAINING	329.81	485.04
RADIOLOGY-DIAGNOSTIC	879,005.74	43,482.52	OTHER THERAPEUTIC SVC	0.00	70,590.95
CT SCAN	2,196,700.27	172,967.14	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	622.89	6,160.75	FEE SCHEDULE LAB	2,550,270.07	637,552.92
EKG/ECG	96,591.68	6,764.69	MRI SERVICES	782,940.91	77,618.85
IV THERAPY	41,797.73	10,384.03	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	707,885.13	298,283.69	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,467.10	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	739,998.52	104,624.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	473,291.09	31,149.94	AMBULANCE	0.00	0.00
GI SERVICES	255,623.67	42,651.54	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,332,409.80	27,385.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	207,295.90	2,504.86	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	726,491.35	152,111.48
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	282.34	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	4,684.43	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,757.40	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	8,348.41	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	38,543.38	66,503.76
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,883.82
OTHER IMAGING SERVICE	464,817.20	86,151.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	122,529.18	9,208.99			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	114,281.19	26,667.47			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	704,904.06	324,571.53			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,428.94	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	535,340.86	13,791.25			
			TOTAL ANCILLARY	17,588,449.51	2,439,164.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,588,449.51	2,439,164.50

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012300071165	10/17/12 - 10/17/12	11/05/12	0.00	6,883.82	0.00	0.00	0.00
TOTAL				0.00	6,883.82	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 09:45:45  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	585,959.82	ADJUSTMENTS	0.00
COVERED CHARGES	461,384.60	CONTRACTUAL ALLOW	176,877.30
NON-COVERD CHARGES	124,575.22	TOTAL MEDICAID LIAB	284,507.30
		LESS: COB	284,426.30
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 145

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,593.25	6,120.56	OTHER LAB	10,601.13	2,948.46
MED/SURG SUPPLY	112,215.90	506.83	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,233.94	0.00	OTHER THERAPEUTIC SVC	0.00	3,834.52
CT SCAN	3,899.12	16,009.89	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	79,753.71	12,121.29
EKG/ECG	1,084.46	159.26	MRI SERVICES	9,883.29	11,124.16
IV THERAPY	95.84	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,997.86	27,221.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	391.89	365.84	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	36,157.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,701.34	3,325.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	74,812.86	2,326.62	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,911.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,183.11	3,429.57
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	1,887.45	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,866.91	12,651.22			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,517.68	131.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,995.65	21,133.32			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,600.16	1,165.51			
			TOTAL ANCILLARY	461,384.60	124,575.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	461,384.60	124,575.22

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,788,153.14	ADJUSTMENTS	4,295.16
COVERED CHARGES	1,665,391.61	CONTRACTUAL ALLOW	1,621,758.44
NON-COVERD CHARGES	122,761.53	TOTAL MEDICAID LIAB	43,633.17
		LESS: COB	20.90
		LESS: COPAYMENT	1,416.13
		REIMBURSEMENT	42,196.14
		TOTAL NUMBER OF CLAIMS	780

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,740.15	22,284.12	OTHER LAB	19,230.33	5,026.94
MED/SURG SUPPLY	80,246.56	2,250.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	98,730.49	0.00	OTHER THERAPEUTIC SVC	0.00	1,340.28
CT SCAN	165,585.28	25,109.63	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	296.46	FEE SCHEDULE LAB	293,700.76	42,203.86
EKG/ECG	8,182.72	159.26	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	646.72	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	599.79	2,215.59	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	355.73	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	865,127.26	2,370.84	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	79,853.64	11,515.30
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	196.32	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	475.81
OTHER IMAGING SERVICE	33,410.04	5,905.29			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,547.78	268.97			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,995.65	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	4,441.16	139.92			
			TOTAL ANCILLARY	1,665,391.61	122,761.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,665,391.61	122,761.53

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
428	5912313001136	10/11/12 - 10/11/12	11/12/12	0.00	475.81	0.00	0.00	0.00
TOTAL				0.00	475.81	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: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,598.67	ADJUSTMENTS	0.00
COVERED CHARGES	64,138.33	CONTRACTUAL ALLOW	30,180.19
NON-COVERD CHARGES	12,460.34	TOTAL MEDICAID LIAB	33,958.14
		LESS: COB	33,934.14
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	28



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69.56	1,357.69	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,709.99	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,480.36	0.00	OTHER THERAPEUTIC SVC	0.00	72.77
CT SCAN	3,832.90	5,603.59	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,940.99	2,473.45
EKG/ECG	629.45	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	11.80	91.77	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,469.85	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	2,993.43	131.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	2,730.01			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	64,138.33	12,460.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,138.33	12,460.34

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,467,314.98	ADJUSTMENTS	366,965.62
COVERED CHARGES	6,717,643.39	CONTRACTUAL ALLOW	5,879,418.81
NON-COVERD CHARGES	749,671.59	TOTAL MEDICAID LIAB	838,224.58
		LESS: COB	17,321.61
		LESS: COPAYMENT	564.00
		REIMBURSEMENT	820,338.97

TOTAL NUMBER OF CLAIMS 162

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

EAST GA REGIONAL MEDICAL CTR., LLC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1499 FAIR RD	000000272A	SERVICE DATES	10/01/12	THROUGH	09/30/13
STATESBORO,GA 30458-1683		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,391.33	54,050.63	OTHER LAB	13,519.52	0.00
MED/SURG SUPPLY	2,376,847.42	1,847.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	173.72
RADIOLOGY-DIAGNOSTIC	19,778.97	11,871.25	OTHER THERAPEUTIC SVC	0.00	10,460.66
CT SCAN	21,230.60	20,221.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,274.93	FEE SCHEDULE LAB	151,460.85	36,061.35
EKG/ECG	2,760.42	5,862.13	MRI SERVICES	25,020.27	0.00
IV THERAPY	307.08	820.95	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,935,248.06	374,587.51	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,158.82	716.68	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	473,858.32	355.73	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,111.42	3,969.67	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	181,080.86	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	179,342.14	69,438.70
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	1,894.84	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	313,703.71	77,126.52
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,294.92	11,315.99			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,495.86	781.29			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	881,594.76	64,669.60			
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	27,438.06	2,169.74			
			TOTAL ANCILLARY	6,717,643.39	749,671.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,717,643.39	749,671.59

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: 07/23/2014  
Run Time: 09:46:10  
Page: 18

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	125,319.70	ADJUSTMENTS	0.00
COVERED CHARGES	92,954.35	CONTRACTUAL ALLOW	13,208.62
NON-COVERD CHARGES	32,365.35	TOTAL MEDICAID LIAB	79,745.73
		LESS: COB	79,733.73
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	874.05	2,075.97	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	52,881.41	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	414.33	849.90	OTHER THERAPEUTIC SVC	0.00	202.75
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,096.71	940.31
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,332.14	27,217.55	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,745.81	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,525.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,118.01	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,290.96	1,078.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,675.93	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	92,954.35	32,365.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,954.35	32,365.35

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

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

Run Date: 07/23/2014  
 Run Time: 12:45:40  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000283A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/12 THROUGH 05/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	392,154.23	ADJUSTMENTS	2,568.66
COVERED CHARGES	390,706.98	CONTRACTUAL ALLOW	128,834.97
NON-COVERD CHARGES	1,447.25	TOTAL MEDICAID LIAB	261,872.01
		LESS: COB	1,573.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	260,298.79

TOTAL NUMBER OF ADMISSIONS 68

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	128		0	40,234.00		15.00
ROUTINE NURSERY	30		0	5,550.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	158		0	45,784.00		15.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	158		0	45,784.00		15.00

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

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

Run Date: 07/23/2014  
 Run Time: 12:45:40  
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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 06/01/12 THROUGH 05/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,777.94	0.00	OTHER LAB	912.50	0.00
MED/SURG SUPPLY	65,572.32	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	55,161.23	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,192.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,678.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,486.95	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,380.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,845.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,990.53	429.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,795.11	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,261.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,436.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,469.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,359.90	1,003.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,599.50	0.00			
CARDIOLOGY	7,003.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	344,922.98	1,432.25
			TOTAL ACCOMODATIONS	45,784.00	15.00
			TOTAL CHARGES	390,706.98	1,447.25

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

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

Run Date: 07/23/2014  
 Run Time: 12:45:42  
 Page: 3

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 06/01/12 THROUGH 05/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,294.09	ADJUSTMENTS	0.00
COVERED CHARGES	4,294.09	CONTRACTUAL ALLOW	2,678.09
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,616.00
		LESS: COB	1,616.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		0	640.00		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	640.00		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	640.00		0.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/12 THROUGH 05/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	306.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	756.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	364.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	942.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	804.38	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	481.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,654.09	0.00
			TOTAL ACCOMODATIONS	640.00	0.00
			TOTAL CHARGES	4,294.09	0.00

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

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

Run Date: 07/23/2014  
Run Time: 12:45:43  
Page: 5

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

PROVIDER NUMBER  
000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/12 THROUGH 05/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	913,403.48	ADJUSTMENTS	49,233.00
COVERED CHARGES	838,863.45	CONTRACTUAL ALLOW	448,828.58
NON-COVERD CHARGES	74,540.03	TOTAL MEDICAID LIAB	390,034.87
		LESS: COB	257.14
		LESS: COPAYMENT	951.00
		REIMBURSEMENT	388,826.73
		ALL OTHER	362,782.98
		FEE SCHEDULE-LAB	25,754.56
		INJECTABLE DRUGS	289.19

TOTAL NUMBER OF CLAIMS 1,191

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

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

Run Date: 07/23/2014  
 Run Time: 12:45:43  
 Page: 6

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

PROVIDER NUMBER  
 000000283A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/12 THROUGH 05/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	41,878.26	2,100.75	OTHER LAB	7,627.75	841.75
MED/SURG SUPPLY	55,561.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,564.25	660.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	85,940.00	5,598.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	133,647.47	32,580.50
EKG/ECG	13,769.10	400.25	MRI SERVICES	0.00	0.00
IV THERAPY	41,497.75	6,100.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,570.25	5,602.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,030.00	150.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,082.35	8,235.10	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,724.32	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,412.00	5,354.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	213,779.92	659.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,480.00	130.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,804.68	2,789.68
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	396.50	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	16,804.85	227.50	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	62,385.50	1,688.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,461.90	1,024.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	174.20	0.00			
CARDIOLOGY	7,029.50	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	49,638.25	0.00			
			TOTAL ANCILLARY	838,863.45	74,540.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	838,863.45	74,540.03

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

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

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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	06/01/12	THROUGH	05/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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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 06/01/12 THROUGH 05/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	51,291.20	ADJUSTMENTS	164.82
COVERED CHARGES	48,888.30	CONTRACTUAL ALLOW	41,504.22
NON-COVERD CHARGES	2,402.90	TOTAL MEDICAID LIAB	7,384.08
		LESS: COB	0.00
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	7,168.08
		TOTAL NUMBER OF CLAIMS	132

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 06/01/12 THROUGH 05/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,030.29	48.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,314.79	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,247.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,056.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,535.22	2,007.45
EKG/ECG	401.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,058.50	117.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	179.10	147.45	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,868.95	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	946.50	83.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	249.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	48,888.30	2,402.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,888.30	2,402.90

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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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	06/01/12	THROUGH	05/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

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

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

PROVIDER NUMBER  
000000283A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	06/01/12	THROUGH	05/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



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

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

Run Date: 07/23/2014  
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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	06/01/12	THROUGH	05/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	63,915,089.25	ADJUSTMENTS	3,907,037.40
COVERED CHARGES	60,670,313.25	CONTRACTUAL ALLOW	37,072,292.58
NON-COVERD CHARGES	3,244,776.00	TOTAL MEDICAID LIAB	23,598,020.67
		LESS: COB	289,435.97
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	23,308,584.70

TOTAL NUMBER OF ADMISSIONS 3,475

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,185		31	7,596,817.00		2,383,396.00
ROUTINE NURSERY	2,193		7	1,568,786.00		3,493.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10,378		38	9,165,603.00		2,386,889.00
SPECIAL CARE SERVICES						
CCU	77		0	285,600.00		0.00
ICU	1,998		0	4,547,296.00		0.00
NICU	2,217		0	4,987,230.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,292		0	9,820,126.00		0.00
TOTAL ACCOMODATIONS	14,670		38	18,985,729.00		2,386,889.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,914,008.25	15,241.00	OTHER LAB	474,667.00	0.00
MED/SURG SUPPLY	364,037.00	40,329.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,896,188.00	16,717.00	EDUCATION & TRAINING	12,043.00	638.00
RADIOLOGY-DIAGNOSTIC	2,169,207.00	0.00	OTHER THERAPEUTIC SVC	0.00	11,047.00
CT SCAN	3,567,295.00	159,635.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	296,795.00	2,797.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	435,154.00	0.00	MRI SERVICES	781,181.00	0.00
IV THERAPY	73,575.00	4,208.00	PROFESSIONAL FEES	0.00	688.00
OPERATING ROOM	6,381,290.00	15,025.00	DURABLE MED. EQUIP.	0.00	15.00
LABOR/DELIVERY ROOM	334,386.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,660,130.00	23,771.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,058,004.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	329,551.00	2,100.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,761,575.00	28,565.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,479,299.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	454,799.00	0.00	INJECTABLE DRUGS	3,161,565.00	2,807.00
RADIOLOGY THERAPEUTIC	5,548.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	81,571.00	1,357.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	56,055.00	326.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	65,700.00	344,159.00	PATIENT CONVENIENCE	0.00	68.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,086.00	0.00	TRAUMA RESPONSE	0.00	50,592.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,425,485.00	2,093.00
LITHOTRIPSY	20,000.00	0.00	NO CC/INVALID REV CODE	0.00	103,188.00
OTHER IMAGING SERVICE	434,330.00	13,092.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	500,550.00	15,579.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	401,914.00	0.00			
AUDIOLOGY	75,831.00	0.00			
CARDIOLOGY	1,679,426.00	3,850.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	78,341.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	252,998.00	0.00			
			TOTAL ANCILLARY	41,684,584.25	857,887.00
			TOTAL ACCOMODATIONS	18,985,729.00	2,386,889.00
			TOTAL CHARGES	60,670,313.25	3,244,776.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012285049700	09/26/12 - 09/29/12	10/15/12	0.00	2,625.00	0.00	0.00	0.00
615	5212331000097	09/21/12 - 10/04/12	12/03/12	0.00	4,830.00	0.00	0.00	0.00
30	2212339005882	10/09/12 - 10/11/12	12/10/12	0.00	25.00	0.00	0.00	0.00
615	2313007000018	09/14/12 - 09/20/12	02/11/13	0.00	2,625.00	0.00	0.00	0.00
615	2013010076564	10/26/12 - 10/29/12	01/14/13	0.00	2,625.00	0.00	0.00	0.00
615	2213015000774	08/21/12 - 08/31/12	01/21/13	0.00	2,625.00	0.00	0.00	0.00
615	2013032006418	11/03/12 - 11/09/12	02/04/13	0.00	4,830.00	0.00	0.00	0.00
615	2013044046332	11/23/12 - 11/27/12	02/18/13	0.00	2,625.00	0.00	0.00	0.00
615	2013084051814	12/14/12 - 12/18/12	04/01/13	0.00	2,625.00	0.00	0.00	0.00
615	2013086088507	11/27/12 - 11/29/12	04/01/13	0.00	4,830.00	0.00	0.00	0.00
615	2013107082242	01/17/13 - 01/19/13	04/22/13	0.00	2,625.00	0.00	0.00	0.00
615	2013115082090	03/31/13 - 04/03/13	04/29/13	0.00	4,830.00	0.00	0.00	0.00
615	2213119000212	03/16/13 - 03/19/13	05/06/13	0.00	2,625.00	0.00	0.00	0.00
615	2013121081569	03/05/13 - 03/12/13	05/06/13	0.00	2,625.00	0.00	0.00	0.00
615	9113099004500	09/15/12 - 09/21/12	05/13/13	0.00	4,830.00	0.00	2,436.58	0.00
615	2013148040577	04/07/13 - 04/09/13	06/03/13	0.00	2,625.00	0.00	0.00	0.00
615	2013169048181	04/18/13 - 04/23/13	06/24/13	0.00	4,830.00	0.00	0.00	0.00
615	2313192000079	01/26/13 - 01/30/13	08/26/13	0.00	4,830.00	0.00	0.00	0.00
615	2013204047540	04/10/13 - 04/21/13	07/29/13	0.00	4,830.00	0.00	0.00	0.00
615	5213212000156	11/17/12 - 12/03/12	08/05/13	0.00	2,625.00	0.00	0.00	0.00
615	2013227061591	10/21/12 - 10/30/12	08/19/13	0.00	2,625.00	0.00	0.00	0.00
615	2013248087803	05/17/13 - 05/19/13	09/09/13	0.00	4,830.00	0.00	0.00	0.00
615	2213266000302	09/16/12 - 09/19/12	09/30/13	0.00	2,625.00	0.00	0.00	0.00
615	2013270062265	06/15/13 - 06/19/13	10/07/13	0.00	2,625.00	0.00	0.00	0.00
615	2013315035783	05/05/13 - 05/08/13	11/18/13	0.00	2,625.00	0.00	0.00	0.00
615	2213329007413	03/28/13 - 04/03/13	12/02/13	0.00	4,830.00	0.00	0.00	0.00
615	9113281002159	03/03/13 - 03/07/13	12/16/13	0.00	2,625.00	0.00	1,733.66	0.00
615	5213347000132	01/09/13 - 02/03/13	12/23/13	0.00	2,625.00	0.00	0.00	0.00
615	2014076037883	06/28/13 - 07/05/13	03/24/14	0.00	2,363.00	0.00	0.00	0.00
615	2214133005779	12/31/12 - 01/11/13	05/19/14	0.00	2,625.00	0.00	0.00	0.00
615	5214150000197	01/05/13 - 02/04/13	06/09/14	0.00	5,250.00	0.00	0.00	0.00
TOTAL				0.00	103,188.00	0.00	4,170.24	0.00

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

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

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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	181,197.00	ADJUSTMENTS	0.00
COVERED CHARGES	151,591.00	CONTRACTUAL ALLOW	73,210.69
NON-COVERD CHARGES	29,606.00	TOTAL MEDICAID LIAB	78,380.31
		LESS: COB	78,380.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 11

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	21		0	19,614.00		27,927.00
ROUTINE NURSERY	11		0	13,000.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	32		0	32,614.00		27,927.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	17,356.00		0.00
NICU	12		0	26,640.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	16		0	43,996.00		0.00
TOTAL ACCOMODATIONS	48		0	76,610.00		27,927.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,090.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	719.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,991.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,856.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	600.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,961.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,465.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,995.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,633.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,994.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,172.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,288.00	0.00	INJECTABLE DRUGS	5,070.00	98.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	76.00	0.00	TRAUMA RESPONSE	0.00	1,581.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,005.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	386.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	207.00	0.00			
CARDIOLOGY	1,790.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	654.00	0.00			
			TOTAL ANCILLARY	74,981.00	1,679.00
			TOTAL ACCOMODATIONS	76,610.00	27,927.00
			TOTAL CHARGES	151,591.00	29,606.00

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

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

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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,393,161.42	ADJUSTMENTS	496,934.52
COVERED CHARGES	21,901,981.42	CONTRACTUAL ALLOW	17,486,405.76
NON-COVERD CHARGES	4,491,180.00	TOTAL MEDICAID LIAB	4,415,575.66
		LESS: COB	2,235.72
		LESS: COPAYMENT	10,612.48
		REIMBURSEMENT	4,402,727.46
		ALL OTHER	3,567,777.52
		FEE SCHEDULE-LAB	300,608.88
		INJECTABLE DRUGS	534,341.06

TOTAL NUMBER OF CLAIMS 9,529

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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	609,626.00	21,040.00	OTHER LAB	305,839.00	26,453.00
MED/SURG SUPPLY	73,369.00	59,228.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	4,108.00	EDUCATION & TRAINING	69.00	567.00
RADIOLOGY-DIAGNOSTIC	1,218,398.00	41,823.00	OTHER THERAPEUTIC SVC	0.00	24,367.00
CT SCAN	1,939,048.00	1,146,916.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,354.00	6,442.00	FEE SCHEDULE LAB	2,746,022.34	444,980.00
EKG/ECG	274,578.00	30,300.00	MRI SERVICES	374,698.00	134,166.00
IV THERAPY	498,606.00	73,325.00	PROFESSIONAL FEES	0.00	50.00
OPERATING ROOM	1,739,089.00	790,124.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,828.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	61,807.00	37,913.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	570,526.00	1,613.00	AMBULANCE	0.00	0.00
GI SERVICES	215,782.00	53,705.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,578,570.08	166,283.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	740,626.00	3,642.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,228,157.00	451,208.00
RADIOLOGY THERAPEUTIC	98,099.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,342.00	465.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	306.00	2,267.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	26,100.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	21,173.00	2,340.00	TRAUMA RESPONSE	0.00	30,039.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,034.00	383,972.00
LITHOTRIPSY	40,000.00	0.00	NO CC/INVALID REV CODE	0.00	18,103.00
OTHER IMAGING SERVICE	1,014,821.00	125,461.00			
BLOOD	184.00	0.00			
BLOOD STORAGE & PRO.	63,761.00	35,245.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	497,423.00	159,346.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	484,336.00	179,645.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,619.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	400,891.00	7,813.00			
			TOTAL ANCILLARY	21,901,981.42	4,489,049.00
			TOTAL ACCOMODATIONS	0.00	2,131.00
			TOTAL CHARGES	21,901,981.42	4,491,180.00



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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012331045683	10/19/12 - 10/19/12	12/03/12	0.00	2,625.00	0.00	0.00	0.00
618	2013081009144	03/14/13 - 03/14/13	03/25/13	0.00	3,035.00	0.00	0.00	0.00
615	2013081085271	03/15/13 - 03/15/13	04/01/13	0.00	2,625.00	0.00	0.00	0.00
615	2313157000023	12/21/12 - 12/21/12	07/22/13	0.00	2,625.00	0.00	0.00	0.00
615	2313157000023	12/21/12 - 12/21/12	07/22/13	0.00	2,205.00	0.00	0.00	0.00
615	2213203006486	11/14/12 - 11/14/12	07/29/13	0.00	2,625.00	0.00	0.00	0.00
615	2213217000479	07/01/13 - 07/01/13	08/12/13	0.00	2,363.00	0.00	0.00	0.00
TOTAL				0.00	18,103.00	0.00	0.00	0.00

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	323,533.50	ADJUSTMENTS	0.00
COVERED CHARGES	249,749.00	CONTRACTUAL ALLOW	210,774.86
NON-COVERD CHARGES	73,784.50	TOTAL MEDICAID LIAB	38,974.14
		LESS: COB	38,827.82
		LESS: COPAYMENT	146.32
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,443.00	160.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	99.00	12.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	195.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,662.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,447.00	14,762.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,364.00	3,872.50
EKG/ECG	4,200.00	0.00	MRI SERVICES	10,019.00	3,971.00
IV THERAPY	9,782.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,886.00	1,853.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	66.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,962.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,825.00	2,586.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,379.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	83,137.00	37,723.00
RADIOLOGY THERAPEUTIC	6,732.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	178.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	261.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,678.00	1,146.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,338.00	6,417.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,552.00	826.00			
			TOTAL ANCILLARY	249,749.00	73,784.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	249,749.00	73,784.50

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

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

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

PROVIDER NUMBER  
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	899,551.00	ADJUSTMENTS	1,038.86
COVERED CHARGES	801,615.00	CONTRACTUAL ALLOW	760,163.47
NON-COVERD CHARGES	97,936.00	TOTAL MEDICAID LIAB	41,451.53
		LESS: COB	45.50
		LESS: COPAYMENT	747.04
		REIMBURSEMENT	40,658.99
		TOTAL NUMBER OF CLAIMS	741

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

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

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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,123.00	515.00	OTHER LAB	3,796.00	3,390.00
MED/SURG SUPPLY	915.00	1,174.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	424.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,496.00	389.00	OTHER THERAPEUTIC SVC	0.00	130.00
CT SCAN	30,967.00	25,171.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	116,413.00	17,206.00
EKG/ECG	10,800.00	0.00	MRI SERVICES	3,045.00	0.00
IV THERAPY	4,837.00	1,238.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,430.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,122.00	678.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	496,568.00	9,103.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	400.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	25,420.00	29,305.00
RADIOLOGY THERAPEUTIC	666.00	840.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	76.00	TRAUMA RESPONSE	0.00	1,581.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,577.00	1,191.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	25,414.00	4,518.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	726.00	1,007.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,900.00	0.00			
			TOTAL ANCILLARY	801,615.00	97,936.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	801,615.00	97,936.00



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

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

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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	162.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	417.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,765.00	233.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	301.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,493.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	200.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,338.00	233.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,338.00	233.00

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

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

Run Date: 07/23/2014  
Run Time: 12:22:01  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000294A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,163,390.00	ADJUSTMENTS	139,390.14
COVERED CHARGES	3,946,988.00	CONTRACTUAL ALLOW	3,231,077.83
NON-COVERD CHARGES	216,402.00	TOTAL MEDICAID LIAB	715,910.17
		LESS: COB	0.00
		LESS: COPAYMENT	794.29
		REIMBURSEMENT	715,115.88
		TOTAL NUMBER OF CLAIMS	138



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	104,230.00	1,293.00	OTHER LAB	1,130.00	8,054.00
MED/SURG SUPPLY	13,430.00	12,105.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	98.00	EDUCATION & TRAINING	0.00	70.00
RADIOLOGY-DIAGNOSTIC	20,538.00	676.00	OTHER THERAPEUTIC SVC	0.00	1,950.00
CT SCAN	32,163.00	13,838.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	962.00	FEE SCHEDULE LAB	92,953.00	28,363.00
EKG/ECG	4,800.00	1,800.00	MRI SERVICES	0.00	0.00
IV THERAPY	137,600.00	1,282.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	500,196.00	1,804.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,920.00	628.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	123,112.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,469.00	4,000.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	126,422.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,084,712.00	79,307.00
RADIOLOGY THERAPEUTIC	65,387.00	288.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	216.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	89.00	228.00	TRAUMA RESPONSE	0.00	7,905.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	83,411.00	30,888.00
LITHOTRIPSY	300,000.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,895.00	1,560.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	163,350.00	4,028.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,130.00	2,412.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	21,737.00	9,608.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	2,766.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,314.00	273.00			
			TOTAL ANCILLARY	3,946,988.00	216,402.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,946,988.00	216,402.00

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

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

Run Date: 07/23/2014  
Run Time: 12:22:05  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000294A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 09:20:56  
 Page: 1

CALHOUN MEMORIAL HOSP  
 PO BOX R  
 ARLINGTON,GA 39813-0496

PROVIDER NUMBER 000000305A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 01/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	243,263.00	ADJUSTMENTS	4,893.61
COVERED CHARGES	242,329.00	CONTRACTUAL ALLOW	117,622.10
NON-COVERD CHARGES	934.00	TOTAL MEDICAID LIAB	124,706.90
		LESS: COB	6,308.98
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	118,397.92
		TOTAL NUMBER OF ADMISSIONS	26

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	87		0	39,411.00		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	87		0	39,411.00		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	87		0	39,411.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP  
 PO BOX R  
 ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
 000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 01/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,003.00	0.00	OTHER LAB	1,934.00	0.00
MED/SURG SUPPLY	41,503.00	156.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,585.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,563.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,948.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,157.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,853.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,762.00	0.00	PROFESSIONAL FEES	0.00	276.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,212.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,290.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	76.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,077.00	0.00			
BLOOD	2,080.00	0.00			
BLOOD STORAGE & PRO.	0.00	278.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,775.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,100.00	224.00			
			TOTAL ANCILLARY	202,918.00	934.00
			TOTAL ACCOMODATIONS	39,411.00	0.00
			TOTAL CHARGES	242,329.00	934.00

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

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

Run Date: 07/23/2014  
Run Time: 09:20:59  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

CALHOUN MEMORIAL HOSP  
PO BOX R  
ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
000000305A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	01/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 09:20:59  
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CALHOUN MEMORIAL HOSP  
PO BOX R  
ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 01/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	219,630.50	ADJUSTMENTS	10,710.91
COVERED CHARGES	180,954.00	CONTRACTUAL ALLOW	102,248.81
NON-COVERD CHARGES	38,676.50	TOTAL MEDICAID LIAB	78,705.19
		LESS: COB	1,083.92
		LESS: COPAYMENT	321.00
		REIMBURSEMENT	77,300.27
		ALL OTHER	69,490.00
		FEE SCHEDULE-LAB	7,664.86
		INJECTABLE DRUGS	145.41

TOTAL NUMBER OF CLAIMS 285

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

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

Run Date: 07/23/2014  
 Run Time: 09:20:59  
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CALHOUN MEMORIAL HOSP  
 PO BOX R  
 ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
 000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 01/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,365.00	4,480.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,718.00	5,052.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,810.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,250.00	7,462.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,048.00	93.00	FEE SCHEDULE LAB	52,491.00	14,657.50
EKG/ECG	3,270.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	209.00	4,598.00	PROFESSIONAL FEES	0.00	477.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,420.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,116.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	21,060.00	500.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	636.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	251.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,641.00	1,357.00			
BLOOD	3,606.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,550.00	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	13,513.00	0.00			
			TOTAL ANCILLARY	180,954.00	38,676.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	180,954.00	38,676.50

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: 07/23/2014  
Run Time: 09:21:08  
Page: 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CALHOUN MEMORIAL HOSP  
PO BOX R  
ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 01/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	266.00	ADJUSTMENTS	0.00
COVERED CHARGES	266.00	CONTRACTUAL ALLOW	141.64
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	124.36
		LESS: COB	124.36
		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

CALHOUN MEMORIAL HOSP  
 PO BOX R  
 ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
 000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 01/31/13  
 ADMISSION DATES 00/00/00 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	120.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	146.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	266.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	266.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 09:21:08  
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CALHOUN MEMORIAL HOSP  
PO BOX R  
ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 01/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,625.00	ADJUSTMENTS	147.00
COVERED CHARGES	24,085.00	CONTRACTUAL ALLOW	20,935.00
NON-COVERD CHARGES	3,540.00	TOTAL MEDICAID LIAB	3,150.00
		LESS: COB	0.00
		LESS: COPAYMENT	126.00
		REIMBURSEMENT	3,024.00
		TOTAL NUMBER OF CLAIMS	63

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

CALHOUN MEMORIAL HOSP  
 PO BOX R  
 ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
 000000305A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 01/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,106.00	1,583.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	254.00	374.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,602.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,648.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,899.00	956.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	627.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	10,028.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	108.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,200.00	0.00			
			TOTAL ANCILLARY	24,085.00	3,540.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,085.00	3,540.00

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

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

Run Date: 07/23/2014  
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CALHOUN MEMORIAL HOSP  
PO BOX R  
ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
000000305A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	01/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP  
PO BOX R  
ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
000000305A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	01/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CALHOUN MEMORIAL HOSP  
PO BOX R  
ARLINGTON,GA 39813-0496

PROVIDER NUMBER  
000000305A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	01/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

PROVIDER NUMBER 000000316A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	677,023.83	ADJUSTMENTS	5,953.81
COVERED CHARGES	633,924.10	CONTRACTUAL ALLOW	418,768.13
NON-COVERD CHARGES	43,099.73	TOTAL MEDICAID LIAB	215,155.97
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	215,155.97
		TOTAL NUMBER OF ADMISSIONS	37

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	91		0	74,835.00		24,961.00
ROUTINE NURSERY	0		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	74,835.00		24,961.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	48		0	88,489.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	48		0	88,489.00		0.00
TOTAL ACCOMODATIONS	139		0	163,324.00		24,961.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,766.51	0.00	OTHER LAB	1,788.00	0.00
MED/SURG SUPPLY	39,855.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	139,778.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,873.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	61,022.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,254.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,884.00	0.00	MRI SERVICES	3,352.00	0.00
IV THERAPY	8,355.94	7,878.73	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	2,662.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	69,552.00	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	27,877.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	480.00	0.00	INJECTABLE DRUGS	18,697.00	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	624.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,704.00
OTHER IMAGING SERVICE	8,700.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,680.00	894.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,701.00	0.00			
			TOTAL ANCILLARY	470,600.10	18,138.73
			TOTAL ACCOMODATIONS	163,324.00	24,961.00
			TOTAL CHARGES	633,924.10	43,099.73



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

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

Run Date: 07/23/2014  
Run Time: 09:21:17  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013128038193	04/11/13 - 04/12/13	05/13/13	0.00	3,352.00	0.00	0.00	0.00
615	2213287005149	09/19/13 - 10/01/13	10/21/13	0.00	3,352.00	0.00	0.00	0.00
TOTAL				0.00	6,704.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 09:21:19  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,017,221.24	ADJUSTMENTS	81,979.43
COVERED CHARGES	2,555,365.80	CONTRACTUAL ALLOW	1,943,364.09
NON-COVERD CHARGES	461,855.44	TOTAL MEDICAID LIAB	612,001.71
		LESS: COB	328.33
		LESS: COPAYMENT	2,111.68
		REIMBURSEMENT	609,561.70
		ALL OTHER	569,717.96
		FEE SCHEDULE-LAB	38,335.56
		INJECTABLE DRUGS	1,508.18
		TOTAL NUMBER OF CLAIMS	1,430

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

PROVIDER NUMBER  
 000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,853.60	719.00	OTHER LAB	7,152.00	447.00
MED/SURG SUPPLY	156,067.10	21.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,333.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	140,592.00	1,788.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	286,564.00	117,581.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,665.00	3,257.00	FEE SCHEDULE LAB	533,304.00	89,324.80
EKG/ECG	48,648.00	8,649.00	MRI SERVICES	69,243.00	0.00
IV THERAPY	1,288.00	4,460.22	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	393,523.00	84,486.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,076.00	7,991.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	165,000.00	70,346.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	435,309.00	10,235.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	129,438.00	3,312.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,395.10	25,540.42
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	1,955.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,552.00	4,819.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,442.00
OTHER IMAGING SERVICE	38,268.00	3,912.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	670.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,364.00	1,734.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	34,394.00	14,503.00			
			TOTAL ANCILLARY	2,555,365.80	461,855.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,555,365.80	461,855.44

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

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

Run Date: 07/23/2014  
Run Time: 09:21:19  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213219002773	05/29/13 - 05/29/13	08/12/13	0.00	3,352.00	0.00	0.00	0.00
4501	2213283005487	05/26/13 - 05/26/13	10/14/13	0.00	90.00	0.00	0.00	0.00
TOTAL				0.00	3,442.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,820.00	ADJUSTMENTS	0.00
COVERED CHARGES	7,734.00	CONTRACTUAL ALLOW	3,717.93
NON-COVERD CHARGES	6,086.00	TOTAL MEDICAID LIAB	4,016.07
		LESS: COB	4,013.07
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 7

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

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

PROVIDER NUMBER  
 000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 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	25.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,236.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,157.00	FEE SCHEDULE LAB	6,282.00	2,693.00
EKG/ECG	175.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,252.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,734.00	6,086.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,734.00	6,086.00

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

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

Run Date: 07/23/2014  
Run Time: 09:22:00  
Page: 10

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

PROVIDER NUMBER  
000000316A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	154,817.43	ADJUSTMENTS	394.00
COVERED CHARGES	145,537.84	CONTRACTUAL ALLOW	137,037.84
NON-COVERD CHARGES	9,279.59	TOTAL MEDICAID LIAB	8,500.00
		LESS: COB	0.00
		LESS: COPAYMENT	294.00
		REIMBURSEMENT	8,206.00
		TOTAL NUMBER OF CLAIMS	170



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,160.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,377.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,376.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,649.00	2,236.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,443.00	4,299.90
EKG/ECG	814.00	289.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	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	388.00	191.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	95,467.00	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	693.00	1,345.69
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,170.00	0.00			
			TOTAL ANCILLARY	145,537.84	9,279.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	145,537.84	9,279.59

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

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

Run Date: 07/23/2014  
Run Time: 09:22:04  
Page: 12

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

PROVIDER NUMBER  
000000316A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,411.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,388.00	CONTRACTUAL ALLOW	848.00
NON-COVERD CHARGES	23.00	TOTAL MEDICAID LIAB	1,540.00
		LESS: COB	1,537.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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

Run Date: 07/23/2014  
 Run Time: 09:22:04  
 Page: 13

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 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	16.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	875.00	23.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,320.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,388.00	23.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,388.00	23.00

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

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

Run Date: 07/23/2014  
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Page: 14

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,940.50	ADJUSTMENTS	4,473.66
COVERED CHARGES	69,738.50	CONTRACTUAL ALLOW	51,843.86
NON-COVERD CHARGES	13,202.00	TOTAL MEDICAID LIAB	17,894.64
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	17,888.64
		TOTAL NUMBER OF CLAIMS	4

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,057.50	667.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	32,827.00	504.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,566.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,023.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	741.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25.00	202.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,717.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,316.00	4,998.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,157.00	366.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,196.00	720.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33.00	303.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	5,442.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
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	69,738.50	13,202.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	69,738.50	13,202.00

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

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

Run Date: 07/23/2014  
Run Time: 09:22:05  
Page: 16

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	01/01/13	THROUGH	12/31/13
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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,971,478.94	ADJUSTMENTS	1,567,939.81
COVERED CHARGES	29,397,050.00	CONTRACTUAL ALLOW	21,081,692.28
NON-COVERD CHARGES	574,428.94	TOTAL MEDICAID LIAB	8,315,357.72
		LESS: COB	143,431.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,171,926.12

TOTAL NUMBER OF ADMISSIONS 875

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,451		0	2,985,855.00		0.00
ROUTINE NURSERY	482		0	487,100.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,933		0	3,472,955.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,763		0	3,291,774.00		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	1,763		0	3,291,774.00		0.00
TOTAL ACCOMODATIONS	5,696		0	6,764,729.00		0.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,251,839.00	68.00	OTHER LAB	69,038.00	0.00
MED/SURG SUPPLY	1,179,342.00	8,337.94	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,184,625.00	33,235.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,146,307.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,190,660.00	33,165.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	218,644.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	76,902.00	0.00	MRI SERVICES	253,994.00	0.00
IV THERAPY	250,650.00	8,763.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,201,574.00	53,359.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	506,720.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,585,706.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	569,527.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	130,096.00	8,304.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	597,497.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	278,261.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	192,881.00	0.00	INJECTABLE DRUGS	3,868,595.00	0.00
RADIOLOGY THERAPEUTIC	238,270.00	731.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	62,178.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	95,251.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	78,977.00	12,200.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	214.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	218,042.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	153,795.00	14,378.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	751,661.00	307,545.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	74,462.00	94,343.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	123,980.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	23,914.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	58,719.00	0.00			
			TOTAL ANCILLARY	22,632,321.00	574,428.94
			TOTAL ACCOMODATIONS	6,764,729.00	0.00
			TOTAL CHARGES	29,397,050.00	574,428.94



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

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

Run Date: 07/23/2014  
 Run Time: 11:41:21  
 Page: 3

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	135,818.00	ADJUSTMENTS	0.00
COVERED CHARGES	135,818.00	CONTRACTUAL ALLOW	50,837.74
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	84,980.26
		LESS: COB	84,980.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	23		0	19,895.00		0.00
ROUTINE NURSERY	19		0	27,626.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	42		0	47,521.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	42		0	47,521.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CANDLER HOSPITAL  
 5353 REYNOLDS ST  
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,034.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,445.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,878.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	792.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	11,772.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	28,680.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,360.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,569.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	598.00	0.00	INJECTABLE DRUGS	12,169.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	88,297.00	0.00
			TOTAL ACCOMODATIONS	47,521.00	0.00
			TOTAL CHARGES	135,818.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 11:41:23  
Page: 5

CANDLER HOSPITAL  
5353 REYNOLDS ST  
SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,006,132.47	ADJUSTMENTS	628,090.13
COVERED CHARGES	14,650,200.68	CONTRACTUAL ALLOW	11,587,248.36
NON-COVERD CHARGES	1,355,931.79	TOTAL MEDICAID LIAB	3,062,952.32
		LESS: COB	36,453.69
		LESS: COPAYMENT	7,790.01
		REIMBURSEMENT	3,018,708.62
		ALL OTHER	2,462,370.71
		FEE SCHEDULE-LAB	360,483.16
		INJECTABLE DRUGS	195,854.75

TOTAL NUMBER OF CLAIMS 8,206

CANDLER HOSPITAL  
 5353 REYNOLDS ST  
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	554,214.00	195,423.00	OTHER LAB	62,140.00	889.00
MED/SURG SUPPLY	602,571.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	884,677.00	52,213.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,313,503.00	42,080.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	60,122.00	22,808.00	FEE SCHEDULE LAB	2,391,887.89	445,608.40
EKG/ECG	64,092.00	2,232.00	MRI SERVICES	207,709.00	14,355.00
IV THERAPY	848,890.00	41,536.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,923,761.62	89,209.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	120,560.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	47,865.00	58,629.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	389,697.80	199.00	AMBULANCE	0.00	0.00
GI SERVICES	63,753.32	9,226.68	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,742,334.67	145.33	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	398,984.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	985,668.00	95,426.00
RADIOLOGY THERAPEUTIC	456,537.00	97,177.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,486.00	11,594.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,040.00	816.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,555.00	3,253.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	74,246.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	801,851.00	72,373.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	194,713.00	66,458.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	58,512.00	31,650.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,496.00	1,568.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	73,135.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	296,198.48	1,063.00			
			TOTAL ANCILLARY	14,650,200.68	1,355,931.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,650,200.68	1,355,931.79

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

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

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CANDLER HOSPITAL  
5353 REYNOLDS ST  
SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	280,530.00	ADJUSTMENTS	0.00
COVERED CHARGES	197,359.00	CONTRACTUAL ALLOW	127,731.48
NON-COVERD CHARGES	83,171.00	TOTAL MEDICAID LIAB	69,627.52
		LESS: COB	69,534.52
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 119

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

CANDLER HOSPITAL  
 5353 REYNOLDS ST  
 SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
 000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,036.00	3,867.00	OTHER LAB	895.00	456.00
MED/SURG SUPPLY	13,799.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,726.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,222.00	3,318.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	528.00	0.00	FEE SCHEDULE LAB	36,952.00	12,265.00
EKG/ECG	1,566.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	18,448.00	2,186.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,930.00	17,784.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,264.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	1,908.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,502.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,384.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,286.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,121.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,450.00	20,844.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	408.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	258.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,910.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,664.00	18,751.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,707.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,095.00	0.00			
			TOTAL ANCILLARY	197,359.00	83,171.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	197,359.00	83,171.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	937,439.00	ADJUSTMENTS	2,583.03
COVERED CHARGES	907,912.00	CONTRACTUAL ALLOW	861,873.48
NON-COVERD CHARGES	29,527.00	TOTAL MEDICAID LIAB	46,038.52
		LESS: COB	0.00
		LESS: COPAYMENT	1,515.10
		REIMBURSEMENT	44,523.42
		TOTAL NUMBER OF CLAIMS	823

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,930.00	1,249.00	OTHER LAB	12,385.00	433.00
MED/SURG SUPPLY	1,261.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	74,043.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,614.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	512.00	FEE SCHEDULE LAB	95,782.00	10,378.00
EKG/ECG	6,572.00	0.00	MRI SERVICES	4,165.00	0.00
IV THERAPY	78,009.00	6,867.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,717.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,088.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,678.00	396.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	482,715.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,472.00	1,250.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	214.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,944.00	8,228.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,537.00	0.00			
			TOTAL ANCILLARY	907,912.00	29,527.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	907,912.00	29,527.00





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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	540.00	57.00	OTHER LAB	439.00	0.00
MED/SURG SUPPLY	71.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,228.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,978.00	1,092.00
EKG/ECG	248.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,890.00	259.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,546.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	850.00	200.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,842.00	848.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	26,632.00	2,456.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,632.00	2,456.00

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER HOSPITAL  
5353 REYNOLDS ST  
SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
000000327A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,307,506.89	ADJUSTMENTS	139,578.57
COVERED CHARGES	3,207,778.89	CONTRACTUAL ALLOW	2,731,554.37
NON-COVERD CHARGES	99,728.00	TOTAL MEDICAID LIAB	476,224.52
		LESS: COB	7,315.15
		LESS: COPAYMENT	1,319.94
		REIMBURSEMENT	467,589.43
		TOTAL NUMBER OF CLAIMS	92

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	248,962.44	48,891.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	235,459.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,371.00	3,621.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,029.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	314.00	1,535.00	FEE SCHEDULE LAB	37,218.00	1,162.00
EKG/ECG	1,488.00	124.00	MRI SERVICES	0.00	0.00
IV THERAPY	154,893.00	259.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	492,954.00	22,669.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	65,213.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	127,653.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	654.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	70,265.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	696,722.45	4,170.00
RADIOLOGY THERAPEUTIC	907,349.00	5,932.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	45,720.00	0.00
LITHOTRIPSY	74,415.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,232.00	910.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,056.00	6,363.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,697.00	4,092.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,114.00	0.00			
			TOTAL ANCILLARY	3,207,778.89	99,728.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,207,778.89	99,728.00

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

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

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CANDLER HOSPITAL  
5353 REYNOLDS ST  
SAVANNAH,GA 31405-6005

PROVIDER NUMBER  
000000327A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000338A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	52,100.26	ADJUSTMENTS	5,212.48
COVERED CHARGES	50,836.26	CONTRACTUAL ALLOW	12,705.34
NON-COVERD CHARGES	1,264.00	TOTAL MEDICAID LIAB	38,130.92
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	38,130.92

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	23		0	12,512.00		1,264.00
ROUTINE NURSERY	0		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	12,512.00		1,264.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	23		0	12,512.00		1,264.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,728.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	44.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,517.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,236.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,221.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	510.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,416.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	672.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,962.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,370.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	604.01	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	620.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	424.00	0.00			
			TOTAL ANCILLARY	38,324.26	0.00
			TOTAL ACCOMODATIONS	12,512.00	1,264.00
			TOTAL CHARGES	50,836.26	1,264.00

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*



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

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

Run Date: 07/23/2014  
Run Time: 11:39:17  
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CHARLTON MEMORIAL HOSPITAL  
2449 THIRD ST  
FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	600,525.42	ADJUSTMENTS	55,300.24
COVERED CHARGES	501,724.54	CONTRACTUAL ALLOW	331,967.13
NON-COVERD CHARGES	98,800.88	TOTAL MEDICAID LIAB	169,757.41
		LESS: COB	514.47
		LESS: COPAYMENT	1,014.00
		REIMBURSEMENT	168,228.94
		ALL OTHER	139,216.47
		FEE SCHEDULE-LAB	25,152.50
		INJECTABLE DRUGS	3,859.97

TOTAL NUMBER OF CLAIMS 764

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

PROVIDER NUMBER  
 000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,975.51	0.00	OTHER LAB	4,113.00	0.00
MED/SURG SUPPLY	1,293.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,416.00	589.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	71,283.00	5,631.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,413.00	6,696.00	FEE SCHEDULE LAB	189,354.00	65,226.00
EKG/ECG	6,150.00	708.00	MRI SERVICES	14,131.00	0.00
IV THERAPY	13,902.00	5,053.00	PROFESSIONAL FEES	0.00	3,681.00
OPERATING ROOM	16,164.00	1,197.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,706.00	1,288.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,800.00	AMBULANCE	0.00	0.00
GI SERVICES	246.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	109,762.00	4,625.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,839.03	950.88
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,809.00	1,356.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	720.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,391.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,057.00	0.00			
			TOTAL ANCILLARY	501,724.54	98,800.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	501,724.54	98,800.88

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: 07/23/2014  
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Page: 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,155.92	ADJUSTMENTS	0.00
COVERED CHARGES	2,574.92	CONTRACTUAL ALLOW	2,574.92
NON-COVERD CHARGES	1,581.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 1

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

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

PROVIDER NUMBER  
 000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	321.03	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	105.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	951.00	839.00
EKG/ECG	0.00	118.00	MRI SERVICES	0.00	0.00
IV THERAPY	174.00	447.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	82.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	838.00	177.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53.89	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	2,574.92	1,581.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,574.92	1,581.00

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

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

Run Date: 07/23/2014  
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CHARLTON MEMORIAL HOSPITAL  
2449 THIRD ST  
FOLKSTON,GA 31537-8919

PROVIDER NUMBER  
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,996.13	ADJUSTMENTS	435.00
COVERED CHARGES	35,166.13	CONTRACTUAL ALLOW	31,766.13
NON-COVERD CHARGES	1,830.00	TOTAL MEDICAID LIAB	3,400.00
		LESS: COB	0.00
		LESS: COPAYMENT	120.00
		REIMBURSEMENT	3,280.00
		TOTAL NUMBER OF CLAIMS	68

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	921.33	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	23.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,677.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,199.00	1,267.00
EKG/ECG	118.00	0.00	MRI SERVICES	1,856.00	0.00
IV THERAPY	1,063.00	212.00	PROFESSIONAL FEES	0.00	233.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,224.00	118.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	406.80	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	678.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	35,166.13	1,830.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	35,166.13	1,830.00

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

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

Run Date: 07/23/2014  
Run Time: 11:39:34  
Page: 10

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

PROVIDER NUMBER  
000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,169.65	ADJUSTMENTS	0.00
COVERED CHARGES	10,153.65	CONTRACTUAL ALLOW	10,103.65
NON-COVERD CHARGES	5,016.00	TOTAL MEDICAID LIAB	50.00
		LESS: COB	0.00
		LESS: COPAYMENT	50.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000338A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,425.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,080.00	FEE SCHEDULE LAB	1,689.00	144.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,694.00	2,792.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	161.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,170.65	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,153.65	5,016.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,153.65	5,016.00



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

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

PROVIDER NUMBER  
000000338A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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Page: 13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000338A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,546,770.66	ADJUSTMENTS	3,732,842.92
COVERED CHARGES	53,873,976.71	CONTRACTUAL ALLOW	38,008,997.18
NON-COVERD CHARGES	3,672,793.95	TOTAL MEDICAID LIAB	15,864,979.53
		LESS: COB	161,537.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	15,703,441.60

TOTAL NUMBER OF ADMISSIONS 2,486

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,085		12	6,426,338.00		1,331,960.00
ROUTINE NURSERY	1,860		6	2,590,100.00		53,814.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		70,823.25
TOTAL ROUTINE	9,945		18	9,016,438.00		1,456,597.25
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,468		0	3,666,657.00		41,472.00
NICU	686		53	2,084,424.00		165,148.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		14	0.00		20,510.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,154		67	5,751,081.00		227,130.00
TOTAL ACCOMODATIONS	12,099		85	14,767,519.00		1,683,727.25

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,843,236.44	341,094.74	OTHER LAB	304,392.80	4,971.29
MED/SURG SUPPLY	2,653,660.56	75,487.91	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,407,233.19	487,631.36	EDUCATION & TRAINING	78,367.64	476.86
RADIOLOGY-DIAGNOSTIC	661,230.40	15,599.69	OTHER THERAPEUTIC SVC	222.83	1,087.88
CT SCAN	1,168,797.26	468,971.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	188,144.40	20,615.86	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	279,494.56	711.76	MRI SERVICES	871,336.48	28,610.14
IV THERAPY	682,047.73	41,071.03	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,667,180.17	15,444.53	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,479,653.76	0.00	REHAB THERAPY	249.02	0.00
RESPIRATORY SERVICES	3,305,607.46	249,303.08	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	685,513.17	14,223.41	AMBULANCE	0.00	0.00
GI SERVICES	453,196.63	15,629.24	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,863,033.18	9,225.01	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	516,864.45	6,305.65	DRUG-SPECIFIC/HOME IV	0.00	3.18
LABORATORY PATHOLOGIC	384,608.91	1,881.18	INJECTABLE DRUGS	21,965.12	6.36
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	65,032.93	4,790.27	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	103,550.96	9,374.57	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	169,877.22	16,508.98	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,339.82	4,390.99	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	606,336.81	1,287.55
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	529,625.82	3,642.22			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	898,070.54	44,963.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	331,052.96	88,322.02			
AUDIOLOGY	616,613.66	997.27			
CARDIOLOGY	1,842,263.01	7,387.51			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	27,894.34	853.46			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	398,763.48	8,197.35			
			TOTAL ANCILLARY	39,106,457.71	1,989,066.70
			TOTAL ACCOMODATIONS	14,767,519.00	1,683,727.25
			TOTAL CHARGES	53,873,976.71	3,672,793.95

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	460,667.12	ADJUSTMENTS	0.00
COVERED CHARGES	452,520.30	CONTRACTUAL ALLOW	416,586.31
NON-COVERD CHARGES	8,146.82	TOTAL MEDICAID LIAB	35,933.99
		LESS: COB	35,933.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	61		0	51,484.00		4,676.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	61		0	51,484.00		4,676.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	28		0	68,460.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	28		0	68,460.00		0.00
TOTAL ACCOMODATIONS	89		0	119,944.00		4,676.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,375.32	0.00	OTHER LAB	5,579.16	0.00
MED/SURG SUPPLY	21,896.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	64,844.38	0.00	EDUCATION & TRAINING	520.27	0.00
RADIOLOGY-DIAGNOSTIC	8,417.72	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,338.37	3,328.52	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,372.93	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,628.20	0.00	MRI SERVICES	6,522.24	0.00
IV THERAPY	1,711.41	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,684.11	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,444.72	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	72,025.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,559.77	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,067.71	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,553.84	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,901.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	6.36
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,306.41	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,074.75	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	75.94	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	202.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	794.19	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	794.61	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	760.98	60.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,712.59	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	487.26	0.00			
			TOTAL ANCILLARY	332,576.30	3,470.82
			TOTAL ACCOMODATIONS	119,944.00	4,676.00
			TOTAL CHARGES	452,520.30	8,146.82

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

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

Run Date: 07/23/2014  
Run Time: 09:06:15  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,606,268.06	ADJUSTMENTS	632,790.35
COVERED CHARGES	21,199,402.18	CONTRACTUAL ALLOW	16,313,087.01
NON-COVERD CHARGES	3,406,865.88	TOTAL MEDICAID LIAB	4,886,315.17
		LESS: COB	25,001.44
		LESS: COPAYMENT	5,078.02
		REIMBURSEMENT	4,856,235.71
		ALL OTHER	4,336,159.35
		FEE SCHEDULE-LAB	360,198.14
		INJECTABLE DRUGS	159,878.22

TOTAL NUMBER OF CLAIMS 9,253

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303,961.47	13,342.93	OTHER LAB	232,753.10	3,186.90
MED/SURG SUPPLY	902,183.61	15,254.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	958.15	EDUCATION & TRAINING	176.76	1,041.35
RADIOLOGY-DIAGNOSTIC	885,162.21	7,882.27	OTHER THERAPEUTIC SVC	0.00	3,409.73
CT SCAN	1,586,526.28	189,032.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,592.51	22,906.20	FEE SCHEDULE LAB	3,507,095.91	976,563.42
EKG/ECG	218,576.18	15,319.16	MRI SERVICES	355,813.05	37,107.35
IV THERAPY	859,678.20	204,526.98	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,207,422.69	170,732.44	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	225,651.81	2,117.12	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	114,504.14	129,797.38	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	516,208.55	116,380.68	AMBULANCE	0.00	0.00
GI SERVICES	495,321.49	121,717.26	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,090,771.04	23,135.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	435,369.76	1,139.93	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	811.32	INJECTABLE DRUGS	1,175,301.09	641,093.36
RADIOLOGY THERAPEUTIC	3,149.61	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,060.17	23,547.57	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,613.98	6,523.41	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	21,136.96	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	303,355.37	13,006.17	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	70,039.51	6,058.31
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	51,263.64
OTHER IMAGING SERVICE	1,447,184.90	207,848.95			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	93,685.98	18,206.85			
ONCOLOGY	644.54	0.00			
NUCLEAR MEDICINE	247,492.85	124,455.28			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	323,442.44	234,991.16			
AMBULATORY SURGERY	25,698.21	2,328.14			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,424.09	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	495,540.68	0.00			
			TOTAL ANCILLARY	21,199,402.18	3,406,822.46
			TOTAL ACCOMODATIONS	0.00	43.42
			TOTAL CHARGES	21,199,402.18	3,406,865.88



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: 07/23/2014  
 Run Time: 09:06:15  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013066068220	02/28/13 - 02/28/13	03/11/13	0.00	5,695.96	0.00	0.00	0.00
614	2013084049192	03/15/13 - 03/15/13	04/01/13	0.00	5,695.96	0.00	0.00	0.00
614	2013092067708	03/27/13 - 03/27/13	04/08/13	0.00	5,695.96	0.00	0.00	0.00
614	2013119032648	04/24/13 - 04/24/13	05/06/13	0.00	5,695.96	0.00	0.00	0.00
614	2013128081411	05/02/13 - 05/02/13	05/13/13	0.00	5,695.96	0.00	0.00	0.00
614	2013142079897	05/15/13 - 05/15/13	05/27/13	0.00	5,695.96	0.00	0.00	0.00
614	2013144069939	05/17/13 - 05/17/13	06/03/13	0.00	5,695.96	0.00	0.00	0.00
614	2013182037391	06/25/13 - 06/25/13	07/08/13	0.00	5,695.96	0.00	0.00	0.00
614	5913191000279	05/21/13 - 05/21/13	07/15/13	0.00	5,695.96	0.00	0.00	0.00
TOTAL				0.00	51,263.64	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: 07/23/2014  
Run Time: 09:08:40  
Page: 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000404A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	157,093.47	ADJUSTMENTS	0.00
COVERED CHARGES	72,711.65	CONTRACTUAL ALLOW	-12,927.55
NON-COVERD CHARGES	84,381.82	TOTAL MEDICAID LIAB	85,639.20
		LESS: COB	85,613.88
		LESS: COPAYMENT	25.32
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 37

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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	845.25	343.33	OTHER LAB	1,335.31	0.00
MED/SURG SUPPLY	4,093.16	4,743.79	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	236.04	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,825.07	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,309.90	1,148.27	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,287.58	2,161.02
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	5,397.26
IV THERAPY	3,296.77	147.97	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,946.42	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	747.87	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,635.05	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,110.37	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,987.58	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	618.91	558.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	352.32	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	6,075.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,917.51	18,968.96			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,099.52			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	41,292.43			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	402.58	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	72,711.65	84,172.46
			TOTAL ACCOMODATIONS	0.00	209.36
			TOTAL CHARGES	72,711.65	84,381.82

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: 07/23/2014  
Run Time: 09:08:43  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,839,170.11	ADJUSTMENTS	2,779.77
COVERED CHARGES	1,691,512.78	CONTRACTUAL ALLOW	1,597,620.33
NON-COVERD CHARGES	147,657.33	TOTAL MEDICAID LIAB	93,892.45
		LESS: COB	6,849.88
		LESS: COPAYMENT	2,490.24
		REIMBURSEMENT	84,552.33
		TOTAL NUMBER OF CLAIMS	1,556

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,161.74	1,478.34	OTHER LAB	16,491.89	0.00
MED/SURG SUPPLY	25,101.87	1,656.12	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	100.62	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	74,593.70	357.32	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,090.64	14,184.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	275,029.66	85,786.03
EKG/ECG	19,892.12	711.76	MRI SERVICES	2,551.95	9,929.86
IV THERAPY	49,609.90	7,582.15	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,123.21	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,380.59	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,599.58	111.37	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,733.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,004,480.76	1,468.19	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,112.62	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,885.08	5,954.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	75.94	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	641.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	61,795.52	17,084.29			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,543.35	1,065.91			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,102.08	0.00			
AMBULATORY SURGERY	3,418.84	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	656.37	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,516.91	0.00			
			TOTAL ANCILLARY	1,691,512.78	147,546.66
			TOTAL ACCOMODATIONS	0.00	110.67
			TOTAL CHARGES	1,691,512.78	147,657.33

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

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

Run Date: 07/23/2014  
Run Time: 09:09:01  
Page: 12

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,446.15	ADJUSTMENTS	0.00
COVERED CHARGES	4,167.25	CONTRACTUAL ALLOW	2,415.58
NON-COVERD CHARGES	278.90	TOTAL MEDICAID LIAB	1,751.67
		LESS: COB	1,745.67
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	47.98	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	51.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	28.38	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	562.49	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	887.68	202.54
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,665.87	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,167.25	278.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,167.25	278.90

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

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

Run Date: 07/23/2014  
Run Time: 09:09:04  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,397,662.44	ADJUSTMENTS	105,111.30
COVERED CHARGES	2,830,325.64	CONTRACTUAL ALLOW	2,352,297.80
NON-COVERD CHARGES	567,336.80	TOTAL MEDICAID LIAB	478,027.84
		LESS: COB	12,162.94
		LESS: COPAYMENT	471.56
		REIMBURSEMENT	465,393.34

TOTAL NUMBER OF CLAIMS 93



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85,391.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	214,617.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	180.24
RADIOLOGY-DIAGNOSTIC	46,967.84	0.00	OTHER THERAPEUTIC SVC	0.00	155.26
CT SCAN	6,343.43	3,233.96	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,001.67	FEE SCHEDULE LAB	95,552.52	22,350.49
EKG/ECG	4,051.92	1,437.48	MRI SERVICES	16,885.12	1,866.92
IV THERAPY	50,737.97	3,743.39	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	526,049.63	46,508.17	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,223.99	24,781.51	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	92,766.61	45,197.36	AMBULANCE	0.00	0.00
GI SERVICES	3,253.82	2,990.28	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,438.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	77,524.26	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	946,708.86	162,216.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	236.83	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,690.78	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,341.16	1,820.38	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	393,153.54	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,495.16	3,167.39			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,657.62	2,472.93			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,228.85	2,692.57			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	47,273.69	237,592.23			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	114,662.55	0.00			
			TOTAL ANCILLARY	2,830,325.64	567,336.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,830,325.64	567,336.80

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

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

Run Date: 07/23/2014  
Run Time: 09:09:07  
Page: 16

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 09:28:51  
 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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	231,009.90	ADJUSTMENTS	0.00
COVERED CHARGES	231,009.90	CONTRACTUAL ALLOW	116,897.42
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	114,112.48
		LESS: COB	6,650.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	107,462.10

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	80		0	23,360.00		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	80		0	23,360.00		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	80		0	23,360.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	82,855.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25,922.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	37,574.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,234.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,299.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	144.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,438.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	650.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,093.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,429.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	112.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14.80	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	360.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,083.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	440.00	0.00			
			TOTAL ANCILLARY	207,649.90	0.00
			TOTAL ACCOMODATIONS	23,360.00	0.00
			TOTAL CHARGES	231,009.90	0.00

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 09:28:52  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	674,622.14	ADJUSTMENTS	3,441.21
COVERED CHARGES	585,298.42	CONTRACTUAL ALLOW	297,509.85
NON-COVERD CHARGES	89,323.72	TOTAL MEDICAID LIAB	287,788.57
		LESS: COB	0.00
		LESS: COPAYMENT	1,476.00
		REIMBURSEMENT	286,312.57
		ALL OTHER	256,317.80
		FEE SCHEDULE-LAB	29,994.77
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,002

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

PROVIDER NUMBER  
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,809.77	0.00	OTHER LAB	1,403.00	0.00
MED/SURG SUPPLY	20,393.65	102.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,937.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	79,687.50	9,240.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,883.00	530.00	FEE SCHEDULE LAB	223,861.50	66,932.80
EKG/ECG	17,090.00	2,106.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	338.00
OPERATING ROOM	6,110.00	1,656.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,343.00	179.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	88,247.00	6,132.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,120.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,472.00	31.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	53.00
OTHER IMAGING SERVICE	12,183.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,498.00	1,083.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,320.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	940.00	940.00			
			TOTAL ANCILLARY	585,298.42	89,323.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	585,298.42	89,323.72

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013037045038	01/11/13 - 01/11/13	02/11/13	0.00	53.00	0.00	0.00	0.00
TOTAL				0.00	53.00	0.00	0.00	0.00



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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,084.00	ADJUSTMENTS	0.00
COVERED CHARGES	120.00	CONTRACTUAL ALLOW	117.00
NON-COVERD CHARGES	964.00	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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

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

PROVIDER NUMBER  
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	56.00	964.00	FEE SCHEDULE LAB	64.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	120.00	964.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	120.00	964.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,479.08	ADJUSTMENTS	150.00
COVERED CHARGES	67,010.08	CONTRACTUAL ALLOW	56,487.54
NON-COVERD CHARGES	2,469.00	TOTAL MEDICAID LIAB	10,522.54
		LESS: COB	0.00
		LESS: COPAYMENT	375.00
		REIMBURSEMENT	10,147.54
		TOTAL NUMBER OF CLAIMS	208

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,863.23	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,190.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,743.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,676.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,816.33	1,815.00
EKG/ECG	1,042.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	74.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	996.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,553.00	470.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	130.00	110.00			
			TOTAL ANCILLARY	67,010.08	2,469.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,010.08	2,469.00

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

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

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,132.01	ADJUSTMENTS	0.00
COVERED CHARGES	31,526.01	CONTRACTUAL ALLOW	13,551.85
NON-COVERD CHARGES	2,606.00	TOTAL MEDICAID LIAB	17,974.16
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	17,974.16

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

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

PROVIDER NUMBER  
 000000415A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,078.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,418.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	848.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,866.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	305.00	FEE SCHEDULE LAB	5,556.00	1,860.00
EKG/ECG	2,691.00	116.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,897.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,208.00	245.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,083.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	880.00	80.00			
			TOTAL ANCILLARY	31,526.01	2,606.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,526.01	2,606.00

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

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

Run Date: 07/23/2014  
Run Time: 09:29:16  
Page: 14

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	07/01/12	THROUGH	06/30/13
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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	72,146,944.87	ADJUSTMENTS	7,086,640.26
COVERED CHARGES	67,339,974.59	CONTRACTUAL ALLOW	48,582,576.20
NON-COVERD CHARGES	4,806,970.28	TOTAL MEDICAID LIAB	18,757,398.39
		LESS: COB	81,667.84
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	18,675,730.55
		TOTAL NUMBER OF ADMISSIONS	2,392

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,826		693	5,815,692.00		2,697,056.00
ROUTINE NURSERY	1,031		32	494,505.00		109,368.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6,857		725	6,310,197.00		2,806,424.00
SPECIAL CARE SERVICES						
CCU	2,408		101	3,354,593.00		176,652.00
ICU	911		23	2,184,694.00		59,214.00
NICU	1,507		0	3,722,233.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		284	0.00		382,634.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,826		408	9,261,520.00		618,500.00
TOTAL ACCOMODATIONS	11,683		1,133	15,571,717.00		3,424,924.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,238,735.59	196,875.54	OTHER LAB	604,829.00	6,068.00
MED/SURG SUPPLY	1,881,052.00	62,440.74	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,255,852.69	103,358.00	EDUCATION & TRAINING	41,467.00	373.00
RADIOLOGY-DIAGNOSTIC	1,436,730.00	17,242.00	OTHER THERAPEUTIC SVC	0.00	7,331.00
CT SCAN	2,791,402.00	23,259.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	439,091.00	5,715.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	400,443.00	969.00	MRI SERVICES	1,063,271.00	0.00
IV THERAPY	741,694.00	139,290.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,353,824.00	77,103.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,186,111.00	30,802.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,589,008.00	94,372.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,103,461.00	15,057.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,532,310.00	4,093.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,041,263.00	9,865.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	255,362.70	1,510.00	INJECTABLE DRUGS	3,159.50	234.00
RADIOLOGY THERAPEUTIC	22,725.00	1,548.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	267,032.00	2,270.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	152,960.00	7,505.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,625,589.00	256,905.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	56,209.00	13,303.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	231,485.00	10,383.00	IMPL DEV CHARGE PATIENTS	1,391,805.10	8,106.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	47,903.00
OTHER IMAGING SERVICE	532,154.00	2,111.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	517,983.72	199,312.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	614,674.00	18,963.00			
AUDIOLOGY	12,689.00	0.00			
CARDIOLOGY	2,059,920.00	10,930.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	181,973.00	2,862.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	141,992.29	3,988.00			
			TOTAL ANCILLARY	51,768,257.59	1,382,046.28
			TOTAL ACCOMODATIONS	15,571,717.00	3,424,924.00
			TOTAL CHARGES	67,339,974.59	4,806,970.28

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

PROVIDER NUMBER  
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012209036998	07/09/12 - 07/13/12	08/06/12	0.00	6,533.00	0.00	0.00	0.00
615	2012264066317	08/31/12 - 09/14/12	09/24/12	0.00	6,533.00	0.00	0.00	0.00
615	2012277049605	08/04/12 - 08/07/12	10/08/12	0.00	2,947.00	0.00	0.00	0.00
615	2012318035372	07/15/12 - 07/27/12	11/19/12	0.00	5,781.00	0.00	0.00	0.00
615	5212335000133	08/12/12 - 08/30/12	12/10/12	0.00	5,781.00	0.00	0.00	0.00
905	2013003051267	12/12/12 - 12/18/12	01/07/13	0.00	465.00	0.00	0.00	0.00
906	2013003051267	12/12/12 - 12/18/12	01/07/13	0.00	233.00	0.00	0.00	0.00
615	2013035041570	01/25/13 - 01/29/13	02/11/13	0.00	5,781.00	0.00	0.00	0.00
615	2013085069478	03/09/13 - 03/20/13	04/01/13	0.00	6,533.00	0.00	0.00	0.00
905	2013189027225	06/27/13 - 07/01/13	07/15/13	0.00	233.00	0.00	0.00	0.00
905	2013190043829	06/28/13 - 07/03/13	07/15/13	0.00	550.00	0.00	0.00	0.00
615	2013224028452	04/28/13 - 04/30/13	08/19/13	0.00	6,533.00	0.00	0.00	0.00
TOTAL				0.00	47,903.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
 Run Time: 12:17:21  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	400,227.75	ADJUSTMENTS	0.00
COVERED CHARGES	365,208.75	CONTRACTUAL ALLOW	140,699.46
NON-COVERD CHARGES	35,019.00	TOTAL MEDICAID LIAB	224,509.29
		LESS: COB	224,509.29
		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	29		5	29,406.00		5,070.00
ROUTINE NURSERY	4		0	1,332.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	33		5	30,738.00		5,070.00
SPECIAL CARE SERVICES						
CCU	2		0	2,804.00		0.00
ICU	16		0	35,610.00		0.00
NICU	12		0	28,195.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	30		0	66,609.00		0.00
TOTAL ACCOMODATIONS	63		5	97,347.00		5,070.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,909.00	8,545.00	OTHER LAB	1,686.00	0.00
MED/SURG SUPPLY	13,026.00	2,579.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	36,762.00	0.00	EDUCATION & TRAINING	1,010.00	0.00
RADIOLOGY-DIAGNOSTIC	6,139.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,635.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,006.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	323.00	0.00	MRI SERVICES	8,466.00	0.00
IV THERAPY	3,127.00	434.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,571.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,314.00	12,292.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,806.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,997.00	1,763.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,567.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,873.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	672.00	INJECTABLE DRUGS	1,279.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	338.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	174.00	318.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,174.00	878.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	574.00	1,632.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	269.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	836.00	836.00			
			TOTAL ANCILLARY	267,861.75	29,949.00
			TOTAL ACCOMODATIONS	97,347.00	5,070.00
			TOTAL CHARGES	365,208.75	35,019.00

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

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

Run Date: 07/23/2014  
Run Time: 12:17:25  
Page: 6

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

PROVIDER NUMBER  
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,999,393.76	ADJUSTMENTS	1,285,082.42
COVERED CHARGES	25,655,609.00	CONTRACTUAL ALLOW	20,519,942.31
NON-COVERD CHARGES	2,343,784.76	TOTAL MEDICAID LIAB	5,135,666.69
		LESS: COB	14,408.20
		LESS: COPAYMENT	7,454.43
		REIMBURSEMENT	5,113,804.06
		ALL OTHER	4,628,192.18
		FEE SCHEDULE-LAB	356,700.64
		INJECTABLE DRUGS	128,911.24

TOTAL NUMBER OF CLAIMS 10,581

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	699,537.47	42,738.50	OTHER LAB	246,018.00	13,814.00
MED/SURG SUPPLY	433,544.03	60,552.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	154.00	EDUCATION & TRAINING	1,400.00	3,360.00
RADIOLOGY-DIAGNOSTIC	1,439,053.00	15,424.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,167,661.00	584,680.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	65,641.00	38,307.01	FEE SCHEDULE LAB	4,213,776.10	501,793.61
EKG/ECG	352,315.00	14,858.00	MRI SERVICES	634,250.00	90,946.00
IV THERAPY	1,018,809.00	3,066.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,654,162.00	281,098.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	400,481.00	4,588.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	250,946.00	68,604.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	774,750.00	2,781.00	AMBULANCE	0.00	0.00
GI SERVICES	5,946.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,566,150.00	66,805.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	945,937.00	1,596.00	DRUG-SPECIFIC/HOME IV	0.00	1,045.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	635,224.47	214,061.25
RADIOLOGY THERAPEUTIC	79,214.00	3,696.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,518.00	27,242.01	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,581.00	5,732.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	65,394.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	321,555.00	42,219.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	143,384.00	1,656.00	IMPL DEV CHARGE PATIENTS	92,435.00	38,268.99
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,860.00
OTHER IMAGING SERVICE	708,383.00	98,681.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,234.00	9,882.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	699,226.00	6,063.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	574,000.00	25,404.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,780.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	476,697.93	5,414.89			
			TOTAL ANCILLARY	25,655,609.00	2,343,784.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,655,609.00	2,343,784.76

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

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

Run Date: 07/23/2014  
Run Time: 12:17:25  
Page: 8

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

PROVIDER NUMBER  
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012305038845	10/16/12 - 10/16/12	11/05/12	0.00	233.00	0.00	0.00	0.00
905	2012305038845	10/18/12 - 10/18/12	11/05/12	0.00	932.00	0.00	0.00	0.00
905	2012305038845	10/19/12 - 10/19/12	11/05/12	0.00	932.00	0.00	0.00	0.00
32	5913059000251	01/10/13 - 01/10/13	03/04/13	0.00	61.00	0.00	0.00	0.00
453	1113071001483	02/13/13 - 02/13/13	03/25/13	0.00	1,679.00	0.00	4,611.00	0.00
3066	5913113000204	04/02/13 - 04/02/13	04/29/13	0.00	23.00	0.00	0.00	0.00
TOTAL				0.00	3,860.00	0.00	4,611.00	0.00



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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	429,109.00	ADJUSTMENTS	0.00
COVERED CHARGES	335,740.22	CONTRACTUAL ALLOW	102,416.75
NON-COVERD CHARGES	93,368.78	TOTAL MEDICAID LIAB	233,323.47
		LESS: COB	233,243.35
		LESS: COPAYMENT	80.12
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 180

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

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

PROVIDER NUMBER  
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,035.75	1,445.00	OTHER LAB	4,308.00	1,084.00
MED/SURG SUPPLY	2,605.11	2,015.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	114.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	17,772.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,212.00	6,732.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	299.00	7,820.00	FEE SCHEDULE LAB	71,516.47	7,402.28
EKG/ECG	5,168.00	0.00	MRI SERVICES	4,198.00	0.00
IV THERAPY	16,080.00	384.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,093.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	35,372.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,504.00	959.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	97,538.00	3,778.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,983.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,418.25	54,609.50
RADIOLOGY THERAPEUTIC	1,390.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	521.00	344.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,198.00	593.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	402.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,985.00	6,089.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,231.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,135.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,775.64	0.00			
			TOTAL ANCILLARY	335,740.22	93,368.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	335,740.22	93,368.78

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

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

Run Date: 07/23/2014  
Run Time: 12:18:53  
Page: 11

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

PROVIDER NUMBER  
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,525,746.30	ADJUSTMENTS	3,325.31
COVERED CHARGES	2,365,406.80	CONTRACTUAL ALLOW	2,268,170.10
NON-COVERD CHARGES	160,339.50	TOTAL MEDICAID LIAB	97,236.70
		LESS: COB	36.00
		LESS: COPAYMENT	2,373.14
		REIMBURSEMENT	94,827.56
		TOTAL NUMBER OF CLAIMS	1,739

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,490.75	1,534.50	OTHER LAB	14,491.00	6,504.00
MED/SURG SUPPLY	5,210.00	387.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	131,525.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,547.00	44,929.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	472,504.00	31,164.00
EKG/ECG	26,809.00	0.00	MRI SERVICES	7,439.00	0.00
IV THERAPY	93,783.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,244.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,996.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,034.00	4,083.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,366,736.00	5,459.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,417.75	4,266.00
RADIOLOGY THERAPEUTIC	378.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	32,697.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	206.00	87.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,608.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	71,146.00	29,229.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,785.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,057.30	0.00			
			TOTAL ANCILLARY	2,365,406.80	160,339.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,365,406.80	160,339.50



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,308.50	0.00	OTHER LAB	0.00	1,084.00
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	2,076.00	422.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,244.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,355.00	0.00
EKG/ECG	969.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,263.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	220.00	611.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,738.00	210.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	454.75	15.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,125.00	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	0.00	0.00			
			TOTAL ANCILLARY	57,625.25	7,456.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	57,625.25	7,456.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,544,842.68	ADJUSTMENTS	191,470.82
COVERED CHARGES	3,233,110.93	CONTRACTUAL ALLOW	2,720,179.04
NON-COVERD CHARGES	311,731.75	TOTAL MEDICAID LIAB	512,931.89
		LESS: COB	250.00
		LESS: COPAYMENT	558.00
		REIMBURSEMENT	512,123.89
		TOTAL NUMBER OF CLAIMS	101

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,340.75	90.00	OTHER LAB	7,061.00	0.00
MED/SURG SUPPLY	104,662.05	221.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,715.00	396.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,029.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	89,645.00	10,272.00
EKG/ECG	6,783.00	3,230.00	MRI SERVICES	14,163.00	0.00
IV THERAPY	64,152.00	128.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	278,574.00	23,090.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,585.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	114,640.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,530.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,139.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,774,449.00	192,862.75
RADIOLOGY THERAPEUTIC	94,964.00	12,936.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,671.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,857.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	200,679.20	61,425.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,955.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	57,538.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	150,779.00	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	29,202.93	2,410.00			
			TOTAL ANCILLARY	3,233,110.93	311,731.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,233,110.93	311,731.75



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: 07/23/2014  
Run Time: 12:19:16  
Page: 17

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	113,231.50	ADJUSTMENTS	0.00
COVERED CHARGES	83,886.50	CONTRACTUAL ALLOW	21,711.99
NON-COVERD CHARGES	29,345.00	TOTAL MEDICAID LIAB	62,174.51
		LESS: COB	62,162.51
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
 000000426A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	649.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	124.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	850.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,204.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	78,245.50	29,345.00
RADIOLOGY THERAPEUTIC	2,814.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	83,886.50	29,345.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	83,886.50	29,345.00

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

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

Run Date: 07/23/2014  
 Run Time: 09:27:29  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER 000000437A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,876,957.04	ADJUSTMENTS	76,982.57
COVERED CHARGES	2,854,876.04	CONTRACTUAL ALLOW	1,748,175.54
NON-COVERD CHARGES	22,081.00	TOTAL MEDICAID LIAB	1,106,700.50
		LESS: COB	18,134.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,088,566.35

TOTAL NUMBER OF ADMISSIONS 217

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	502		0	209,939.00		10,000.00
ROUTINE NURSERY	109		0	26,967.00		53.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	611		0	236,906.00		10,053.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	103		0	102,557.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	103		0	102,557.00		0.00
TOTAL ACCOMODATIONS	714		0	339,463.00		10,053.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	318,317.36	0.00	OTHER LAB	4,886.00	0.00
MED/SURG SUPPLY	237,837.30	141.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	422,546.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	53,382.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	168,791.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	35,798.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	19,360.00	0.00	MRI SERVICES	15,095.00	0.00
IV THERAPY	1,512.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	61,948.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	137,214.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	370,717.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	13,059.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	155,106.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,262.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	6,694.00	0.00	INJECTABLE DRUGS	325,158.38	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,179.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,073.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	146.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,924.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,004.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,034.00	9,874.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,735.00	2,013.00			
AUDIOLOGY	2,021.00	0.00			
CARDIOLOGY	34,468.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,825.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,321.00	0.00			
			TOTAL ANCILLARY	2,515,413.04	12,028.00
			TOTAL ACCOMODATIONS	339,463.00	10,053.00
			TOTAL CHARGES	2,854,876.04	22,081.00

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,460.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,460.00	CONTRACTUAL ALLOW	3,002.40
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	3,457.60
		LESS: COB	3,457.60
		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	1		0	439.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1		0	439.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1		0	439.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	742.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	572.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	467.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,734.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	506.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,021.00	0.00
			TOTAL ACCOMODATIONS	439.00	0.00
			TOTAL CHARGES	6,460.00	0.00

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

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

Run Date: 07/23/2014  
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TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,227,606.95	ADJUSTMENTS	210,377.67
COVERED CHARGES	3,744,905.22	CONTRACTUAL ALLOW	2,729,423.68
NON-COVERD CHARGES	482,701.73	TOTAL MEDICAID LIAB	1,015,481.54
		LESS: COB	1,157.67
		LESS: COPAYMENT	2,962.97
		REIMBURSEMENT	1,011,360.90
		ALL OTHER	918,629.54
		FEE SCHEDULE-LAB	86,015.80
		INJECTABLE DRUGS	6,715.56
		TOTAL NUMBER OF CLAIMS	2,629

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,186.57	95,216.36	OTHER LAB	42,127.00	935.00
MED/SURG SUPPLY	154,671.77	29,587.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	190,410.00	3,408.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	554,618.00	19,386.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,084.00	11,456.00	FEE SCHEDULE LAB	696,983.70	120,731.60
EKG/ECG	44,041.00	3,200.00	MRI SERVICES	94,499.00	1,408.00
IV THERAPY	125,464.00	19,192.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	159,577.33	8,007.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	254.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,754.00	15,995.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	531.00	AMBULANCE	0.00	0.00
GI SERVICES	159,289.00	16,049.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	747,144.00	20,908.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,005.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	148,425.45	60,692.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	266.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,822.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	4,380.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,068.40	0.00
LITHOTRIPSY	7,500.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	134,088.00	2,696.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,334.00	13,167.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	122,153.00	26,535.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	89,145.00	5,690.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	75,038.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	74,045.00	1,442.00			
			TOTAL ANCILLARY	3,744,905.22	482,701.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,744,905.22	482,701.73



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

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

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

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,118.59	ADJUSTMENTS	0.00
COVERED CHARGES	58,984.59	CONTRACTUAL ALLOW	15,334.47
NON-COVERD CHARGES	14,134.00	TOTAL MEDICAID LIAB	43,650.12
		LESS: COB	43,608.12
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 54

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

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51.00	2,205.00	OTHER LAB	441.00	441.00
MED/SURG SUPPLY	3,672.59	461.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,644.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,710.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,182.00	1,434.00
EKG/ECG	160.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,581.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,866.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	310.00	532.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,559.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	550.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,265.00	764.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,946.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,052.00	4,587.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	965.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,740.00	0.00			
			TOTAL ANCILLARY	58,984.59	14,134.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,984.59	14,134.00

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

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

Run Date: 07/23/2014  
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TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	244,818.85	ADJUSTMENTS	1,076.80
COVERED CHARGES	226,975.00	CONTRACTUAL ALLOW	208,291.05
NON-COVERD CHARGES	17,843.85	TOTAL MEDICAID LIAB	18,683.95
		LESS: COB	0.00
		LESS: COPAYMENT	627.02
		REIMBURSEMENT	18,056.93
		TOTAL NUMBER OF CLAIMS	334

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	710.00	6,042.85	OTHER LAB	883.00	0.00
MED/SURG SUPPLY	2,307.00	80.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,260.00	247.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,807.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	42,987.00	9,172.00
EKG/ECG	2,880.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,203.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	222.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	134,015.00	823.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,931.00	1,257.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,467.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	525.00	0.00			
			TOTAL ANCILLARY	226,975.00	17,843.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	226,975.00	17,843.85

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,939.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,770.00	CONTRACTUAL ALLOW	3,437.86
NON-COVERD CHARGES	2,169.00	TOTAL MEDICAID LIAB	5,332.14
		LESS: COB	5,326.14
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TY COBB REGIONAL MEDICAL CENTER LLC  
 367 CLEAR CREEK PARKWAY  
 LAVONIA,GA 30553-4173

PROVIDER NUMBER  
 000000437A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32.00	138.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	37.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	299.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,050.00	1,676.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,580.00	245.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	772.00	110.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,770.00	2,169.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,770.00	2,169.00

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

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

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

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TY COBB REGIONAL MEDICAL CENTER LLC  
367 CLEAR CREEK PARKWAY  
LAVONIA,GA 30553-4173

PROVIDER NUMBER  
000000437A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,841,070.03	ADJUSTMENTS	649,473.63
COVERED CHARGES	12,568,172.37	CONTRACTUAL ALLOW	7,822,555.30
NON-COVERD CHARGES	272,897.66	TOTAL MEDICAID LIAB	4,745,617.07
		LESS: COB	81,789.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,663,827.28

TOTAL NUMBER OF ADMISSIONS 641

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,836		14	1,140,683.00		57,417.00
ROUTINE NURSERY	83		0	44,153.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,919		14	1,184,836.00		57,417.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	305		0	359,287.00		0.00
NICU	2		0	1,300.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	307		0	360,587.00		0.00
TOTAL ACCOMODATIONS	2,226		14	1,545,423.00		57,417.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,659,187.08	1,371.00	OTHER LAB	60,799.00	0.00
MED/SURG SUPPLY	515,670.00	5,405.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,346,132.00	5,891.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	273,702.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	707,846.00	6,546.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	105,373.12	2,109.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	317,161.00	0.00	MRI SERVICES	121,469.00	0.00
IV THERAPY	249,638.00	4,970.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,444,329.00	11,344.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	46,417.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	870,660.00	9,745.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	158,028.00	1,352.00	AMBULANCE	0.00	1,006.66
GI SERVICES	181,127.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	339,066.00	128.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	49,764.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	23,768.00
LABORATORY PATHOLOGIC	31,837.00	30.00	INJECTABLE DRUGS	57,335.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,736.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	51,114.00	5,543.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	234.00	1,283.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	594,151.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,591.00
OTHER IMAGING SERVICE	56,401.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,077.00	72,828.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	158,307.00	7,171.00			
AUDIOLOGY	3,285.00	0.00			
CARDIOLOGY	384,952.00	52,241.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,220.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	173,730.17	158.00			
			TOTAL ANCILLARY	11,022,749.37	215,480.66
			TOTAL ACCOMODATIONS	1,545,423.00	57,417.00
			TOTAL CHARGES	12,568,172.37	272,897.66

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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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013267067068	09/18/13 - 09/19/13	09/30/13	0.00	2,591.00	0.00	0.00	0.00
TOTAL				0.00	2,591.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	74,395.34	ADJUSTMENTS	0.00
COVERED CHARGES	72,086.34	CONTRACTUAL ALLOW	21,670.99
NON-COVERD CHARGES	2,309.00	TOTAL MEDICAID LIAB	50,415.35
		LESS: COB	50,415.35
		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	23		0	14,375.00		575.00
ROUTINE NURSERY	2		0	1,056.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	25		0	15,431.00		575.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	25		0	15,431.00		575.00

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

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

Run Date: 07/23/2014  
 Run Time: 09:25:52  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,347.00	0.00	OTHER LAB	521.00	0.00
MED/SURG SUPPLY	3,328.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,247.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	886.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,769.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	253.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	513.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	707.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,383.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	248.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,340.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,768.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,240.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	572.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	241.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	968.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	814.00	1,734.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	73.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,437.34	0.00			
			TOTAL ANCILLARY	56,655.34	1,734.00
			TOTAL ACCOMODATIONS	15,431.00	575.00
			TOTAL CHARGES	72,086.34	2,309.00

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

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

Run Date: 07/23/2014  
Run Time: 09:25:54  
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COFFEE REGIONAL MEDICAL CENTER  
1101 OCILLA RD  
DOUGLAS,GA 31533-2207

PROVIDER NUMBER  
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,482,350.23	ADJUSTMENTS	807,294.30
COVERED CHARGES	8,936,754.40	CONTRACTUAL ALLOW	7,032,760.22
NON-COVERD CHARGES	545,595.83	TOTAL MEDICAID LIAB	1,903,994.18
		LESS: COB	21,654.59
		LESS: COPAYMENT	5,200.12
		REIMBURSEMENT	1,877,139.47
		ALL OTHER	1,699,514.50
		FEE SCHEDULE-LAB	149,376.02
		INJECTABLE DRUGS	28,248.95
		TOTAL NUMBER OF CLAIMS	4,956

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	351,651.00	2,597.00	OTHER LAB	64,894.00	0.00
MED/SURG SUPPLY	227,186.00	424.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	921.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	381,556.00	2,379.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	959,490.00	34,353.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	38,102.00	2,409.00	FEE SCHEDULE LAB	1,659,185.80	260,729.20
EKG/ECG	135,196.00	7,524.00	MRI SERVICES	210,460.00	7,509.00
IV THERAPY	437,143.00	93,627.00	PROFESSIONAL FEES	0.00	86.00
OPERATING ROOM	1,155,206.80	58,603.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	20,580.00	26.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	126,863.00	25,079.00	FREE STANDING CLINIC	276.00	0.00
ANESTHESIA	270,689.00	1,950.00	AMBULANCE	0.00	0.00
GI SERVICES	144,352.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,258,312.00	328.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	59,488.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	129,010.00	17,732.00
RADIOLOGY THERAPEUTIC	463.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	675.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	91,120.00	2,663.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,563.00	624.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	186,578.00	10,793.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,085.00	9,537.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	308,158.00	236.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	271,470.00	4,047.00			
AMBULATORY SURGERY	3,728.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	168,400.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	241,548.80	744.43			
			TOTAL ANCILLARY	8,936,754.40	545,595.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,936,754.40	545,595.83

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	176,426.25	ADJUSTMENTS	0.00
COVERED CHARGES	153,504.89	CONTRACTUAL ALLOW	66,248.79
NON-COVERD CHARGES	22,921.36	TOTAL MEDICAID LIAB	87,256.10
		LESS: COB	87,158.50
		LESS: COPAYMENT	97.60
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 101



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

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,631.00	1,190.00	OTHER LAB	2,131.00	0.00
MED/SURG SUPPLY	4,528.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,110.00	410.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,837.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,858.00	2,286.00	FEE SCHEDULE LAB	31,371.00	4,630.60
EKG/ECG	1,539.00	0.00	MRI SERVICES	7,607.00	0.00
IV THERAPY	6,755.00	1,176.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,442.00	11,180.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,434.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,677.00	1,040.00	FREE STANDING CLINIC	138.00	0.00
ANESTHESIA	6,240.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,833.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,716.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	204.00	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	426.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	355.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,284.00	405.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,045.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	738.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,605.89	240.76			
			TOTAL ANCILLARY	153,504.89	22,921.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	153,504.89	22,921.36

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

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

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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	563,341.56	ADJUSTMENTS	2,244.47
COVERED CHARGES	535,676.56	CONTRACTUAL ALLOW	497,223.60
NON-COVERD CHARGES	27,665.00	TOTAL MEDICAID LIAB	38,452.96
		LESS: COB	507.53
		LESS: COPAYMENT	1,134.01
		REIMBURSEMENT	36,811.42
		TOTAL NUMBER OF CLAIMS	679

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,980.00	61.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,982.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,804.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,542.00	2,673.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	357.00	FEE SCHEDULE LAB	100,614.00	16,640.00
EKG/ECG	3,078.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	39,146.00	5,349.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,350.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	248.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,803.00	758.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,768.00	390.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	259,737.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	572.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,651.00	83.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	78.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,134.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,518.00	1,354.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,671.56	0.00			
			TOTAL ANCILLARY	535,676.56	27,665.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	535,676.56	27,665.00

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

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

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,483.00	ADJUSTMENTS	0.00
COVERED CHARGES	16,288.00	CONTRACTUAL ALLOW	5,540.57
NON-COVERD CHARGES	1,195.00	TOTAL MEDICAID LIAB	10,747.43
		LESS: COB	10,732.43
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	17

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	375.00	0.00	OTHER LAB	0.00	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	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	0.00	FEE SCHEDULE LAB	6,195.00	1,195.00
EKG/ECG	513.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,840.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,598.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	544.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,288.00	1,195.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,288.00	1,195.00

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

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

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000448A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,827,443.40	ADJUSTMENTS	252,338.30
COVERED CHARGES	1,803,358.40	CONTRACTUAL ALLOW	1,473,585.60
NON-COVERD CHARGES	24,085.00	TOTAL MEDICAID LIAB	329,772.80
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	329,583.80
		TOTAL NUMBER OF CLAIMS	64

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,960.00	195.00	OTHER LAB	930.00	0.00
MED/SURG SUPPLY	27,573.00	61.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,015.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,767.00	1,533.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,383.00	1,279.00	FEE SCHEDULE LAB	20,819.00	3,451.00
EKG/ECG	2,907.00	1,026.00	MRI SERVICES	5,137.00	2,731.00
IV THERAPY	1,479.00	3,096.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,240,104.20	4,454.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,409.00	442.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	119,124.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,498.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,460.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,379.00	2,897.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	209,533.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,200.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,400.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	922.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,359.20	2,920.00			
			TOTAL ANCILLARY	1,803,358.40	24,085.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,803,358.40	24,085.00

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

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

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000448A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



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

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

Run Date: 07/23/2014  
 Run Time: 09:23:25  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000459A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,640,656.30	ADJUSTMENTS	1,643,439.68
COVERED CHARGES	35,483,752.75	CONTRACTUAL ALLOW	26,653,180.90
NON-COVERD CHARGES	1,156,903.55	TOTAL MEDICAID LIAB	8,830,571.85
		LESS: COB	74,486.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,756,084.91

TOTAL NUMBER OF ADMISSIONS 864

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,262		0	2,741,830.00		665,831.00
ROUTINE NURSERY	171		0	223,931.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,433		0	2,965,761.00		665,831.00
SPECIAL CARE SERVICES						
CCU	230		0	482,422.00		0.00
ICU	1,132		0	2,502,738.00		5,664.00
NICU	51		0	183,182.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,413		0	3,168,342.00		5,664.00
TOTAL ACCOMODATIONS	4,846		0	6,134,103.00		671,495.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,296,220.50	3,241.00	OTHER LAB	156,414.75	0.00
MED/SURG SUPPLY	1,351,798.00	10,629.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,080,541.00	10,626.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	968,615.00	6,607.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,010,564.25	260,141.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	552,381.50	343.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	344,310.50	944.25	MRI SERVICES	236,491.75	0.00
IV THERAPY	50,759.75	867.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,298,591.50	11,482.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	256,457.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,486,372.75	5,672.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	560,389.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	196,907.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	782,443.75	2,161.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	379,651.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	92,557.25
LABORATORY PATHOLOGIC	77,047.00	0.00	INJECTABLE DRUGS	5,839,439.30	9,704.25
RADIOLOGY THERAPEUTIC	16,320.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	506,032.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	178,932.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	169,189.00	17,230.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,464.00	45.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	888,703.75	0.00
LITHOTRIPSY	6,639.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	195,029.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	384,467.25	1,146.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	82,549.25	26,960.50			
AUDIOLOGY	1,204.00	0.00			
CARDIOLOGY	1,965,097.20	25,047.55			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,207.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,417.00	0.00			
			TOTAL ANCILLARY	29,349,649.75	485,408.55
			TOTAL ACCOMODATIONS	6,134,103.00	671,495.00
			TOTAL CHARGES	35,483,752.75	1,156,903.55

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000459A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	126,266.50	ADJUSTMENTS	0.00
COVERED CHARGES	122,127.25	CONTRACTUAL ALLOW	80,097.77
NON-COVERD CHARGES	4,139.25	TOTAL MEDICAID LIAB	42,029.48
		LESS: COB	42,029.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	16		0	13,488.00		2,095.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	16		0	13,488.00		2,095.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	16		0	13,488.00		2,095.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,075.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,685.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,278.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,294.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,593.25	2,044.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	346.25	0.00	MRI SERVICES	6,036.75	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,173.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,160.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	932.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,434.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,755.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,507.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,933.50	0.00	INJECTABLE DRUGS	11,390.00	0.00
RADIOLOGY THERAPEUTIC	5,132.25	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,954.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,956.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	108,639.25	2,044.25
			TOTAL ACCOMODATIONS	13,488.00	2,095.00
			TOTAL CHARGES	122,127.25	4,139.25

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

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

Run Date: 07/23/2014  
Run Time: 09:23:52  
Page: 5

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,038,686.35	ADJUSTMENTS	160,035.52
COVERED CHARGES	10,745,602.51	CONTRACTUAL ALLOW	8,731,763.98
NON-COVERD CHARGES	1,293,083.84	TOTAL MEDICAID LIAB	2,013,838.53
		LESS: COB	5,118.65
		LESS: COPAYMENT	1,826.01
		REIMBURSEMENT	2,006,893.87
		ALL OTHER	1,819,373.66
		FEE SCHEDULE-LAB	149,075.80
		INJECTABLE DRUGS	38,444.41

TOTAL NUMBER OF CLAIMS 3,685

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	303,421.25	791.50	OTHER LAB	86,050.75	1,078.00
MED/SURG SUPPLY	166,856.50	173.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	174.25	EDUCATION & TRAINING	523.00	0.00
RADIOLOGY-DIAGNOSTIC	787,643.75	6,300.50	OTHER THERAPEUTIC SVC	0.00	994.75
CT SCAN	1,691,574.75	56,649.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,283.25	FEE SCHEDULE LAB	2,214,988.99	349,912.25
EKG/ECG	201,324.75	15,455.25	MRI SERVICES	90,104.50	22,428.50
IV THERAPY	251,834.75	46,205.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	598,331.93	320,500.51	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,095.75	12,143.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,306.00	5,189.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	319,193.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	275,568.54	57,341.46	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,112,207.50	37,785.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	242,413.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	360,146.75	93,728.25
RADIOLOGY THERAPEUTIC	8,734.50	674.75	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	672.50	17,694.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,960.00	270.00	IMPL DEV CHARGE PATIENTS	32,811.00	0.00
LITHOTRIPSY	6,639.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	422,998.25	54,618.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	110,329.75	5,077.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	34,980.00	11,393.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	324,441.13	170,430.87			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,405.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,044.42	3,879.00			
			TOTAL ANCILLARY	10,745,602.51	1,292,172.34
			TOTAL ACCOMODATIONS	0.00	911.50
			TOTAL CHARGES	10,745,602.51	1,293,083.84

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

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

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	216,359.50	ADJUSTMENTS	0.00
COVERED CHARGES	197,613.75	CONTRACTUAL ALLOW	127,453.07
NON-COVERD CHARGES	18,745.75	TOTAL MEDICAID LIAB	70,160.68
		LESS: COB	70,119.69
		LESS: COPAYMENT	40.99
		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

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,740.50	0.00	OTHER LAB	2,156.00	0.00
MED/SURG SUPPLY	1,293.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,876.00	916.75	OTHER THERAPEUTIC SVC	0.00	1,010.25
CT SCAN	18,192.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,653.75	2,972.00
EKG/ECG	3,053.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,735.25	57.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,370.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	697.50	409.25	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	785.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,504.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	8,091.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,221.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,587.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,771.50	253.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,646.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,376.75	2,025.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,595.00	2,806.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,356.75	204.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	197,613.75	18,745.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	197,613.75	18,745.75



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

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

Run Date: 07/23/2014  
Run Time: 09:25:04  
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COLISEUM MEDICAL CENTER  
350 HOSPITAL DR  
MACON,GA 31217-3838

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	941,463.50	ADJUSTMENTS	1,282.56
COVERED CHARGES	896,781.00	CONTRACTUAL ALLOW	860,196.24
NON-COVERD CHARGES	44,682.50	TOTAL MEDICAID LIAB	36,584.76
		LESS: COB	0.00
		LESS: COPAYMENT	1,143.05
		REIMBURSEMENT	35,441.71

TOTAL NUMBER OF CLAIMS 654

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,700.00	0.00	OTHER LAB	4,774.00	539.00
MED/SURG SUPPLY	1,438.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,500.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,322.75	5,041.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	205,491.50	28,078.75
EKG/ECG	14,290.50	346.25	MRI SERVICES	0.00	0.00
IV THERAPY	25,616.50	2,196.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,924.50	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	449,427.50	1,424.25	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	21,717.50	4,160.25
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	93.50	43.50	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	33,484.75	2,407.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	896,781.00	44,682.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	896,781.00	44,682.50

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

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

Run Date: 07/23/2014  
Run Time: 09:25:14  
Page: 11

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,754.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,275.00	CONTRACTUAL ALLOW	7,911.34
NON-COVERD CHARGES	479.00	TOTAL MEDICAID LIAB	4,363.66
		LESS: COB	4,345.66
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	3,551.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,862.25	479.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,696.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,275.00	479.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,275.00	479.00

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

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

Run Date: 07/23/2014  
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Page: 13

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,795,402.50	ADJUSTMENTS	32,659.38
COVERED CHARGES	1,702,936.04	CONTRACTUAL ALLOW	1,512,761.99
NON-COVERD CHARGES	92,466.46	TOTAL MEDICAID LIAB	190,174.05
		LESS: COB	0.00
		LESS: COPAYMENT	87.40
		REIMBURSEMENT	190,086.65

TOTAL NUMBER OF CLAIMS 35

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

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

PROVIDER NUMBER  
 000000459A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,575.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	93,689.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,523.00	1,808.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,894.50	3,889.00
EKG/ECG	3,997.50	2,392.25	MRI SERVICES	0.00	0.00
IV THERAPY	1,626.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	819,465.92	31,603.83	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	272.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	137,142.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	68,022.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60,673.25	3,135.50
RADIOLOGY THERAPEUTIC	0.00	236.75	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	410,031.50	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.	304.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	189.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	19,718.62	49,211.38			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,702,936.04	92,466.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,702,936.04	92,466.46

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

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

Run Date: 07/23/2014  
Run Time: 09:25:17  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000459A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 11:10:46  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

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

PROVIDER NUMBER 000000492A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,169,058.99	ADJUSTMENTS	233,579.31
COVERED CHARGES	16,935,807.15	CONTRACTUAL ALLOW	12,381,507.86
NON-COVERD CHARGES	233,251.84	TOTAL MEDICAID LIAB	4,554,299.29
		LESS: COB	9,128.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,545,170.97

TOTAL NUMBER OF ADMISSIONS 650

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,728		0	1,034,170.00		34,570.00
ROUTINE NURSERY	344		0	286,400.00		98,935.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		1,216.00
TOTAL ROUTINE	2,072		0	1,320,570.00		134,721.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	700		0	1,022,595.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	700		0	1,022,595.00		0.00
TOTAL ACCOMODATIONS	2,772		0	2,343,165.00		134,721.00



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,965,568.43	120.00	OTHER LAB	134,318.00	0.00
MED/SURG SUPPLY	601,626.34	1,757.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,863,723.44	12,872.00	EDUCATION & TRAINING	389.00	0.00
RADIOLOGY-DIAGNOSTIC	471,817.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,071,813.00	8,960.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	123,339.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	133,814.00	0.00	MRI SERVICES	240,839.00	0.00
IV THERAPY	137,427.00	860.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,299,815.00	23,593.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	369,957.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	786,447.00	1,806.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	241,418.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	44,455.00	3,969.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	788,953.00	560.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	439,188.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	55,410.00	0.00	INJECTABLE DRUGS	2,228.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	44,103.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	43,904.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,384.58	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	737,882.56	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	20,951.00
OTHER IMAGING SERVICE	169,247.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	358,185.00	17,654.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	73,738.00	5,243.00			
AUDIOLOGY	11,781.00	185.00			
CARDIOLOGY	330,699.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	37,066.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,106.80	0.00			
			TOTAL ANCILLARY	14,592,642.15	98,530.84
			TOTAL ACCOMODATIONS	2,343,165.00	134,721.00
			TOTAL CHARGES	16,935,807.15	233,251.84

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

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

Run Date: 07/23/2014  
Run Time: 11:10:46  
Page: 3

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1112324005966	08/14/12 - 09/01/12	12/03/12	0.00	3,001.00	0.00	0.00	0.00
615	2012363074621	12/03/12 - 12/08/12	01/07/13	0.00	3,001.00	0.00	0.00	0.00
615	2013018073898	09/06/12 - 09/22/12	01/28/13	0.00	5,974.00	0.00	0.00	0.00
615	2213182006123	08/23/12 - 08/26/12	07/08/13	0.00	3,001.00	0.00	0.00	0.00
615	2213259005084	11/27/12 - 12/06/12	09/23/13	0.00	5,974.00	0.00	0.00	0.00
TOTAL				0.00	20,951.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
 Run Time: 11:11:01  
 Page: 4

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,043.09	ADJUSTMENTS	0.00
COVERED CHARGES	35,764.09	CONTRACTUAL ALLOW	21,238.91
NON-COVERD CHARGES	11,279.00	TOTAL MEDICAID LIAB	14,525.18
		LESS: COB	14,525.18
		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	9		0	4,880.00		610.00
ROUTINE NURSERY	0		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	4,880.00		610.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	9		0	4,880.00		610.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,315.09	2,006.00	OTHER LAB	1,108.00	0.00
MED/SURG SUPPLY	440.00	282.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,229.00	3,596.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	378.00	351.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	434.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	354.00	255.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,468.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,222.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	688.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,062.00	2,449.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,170.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	413.00	0.00	INJECTABLE DRUGS	291.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,042.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,884.09	10,669.00
			TOTAL ACCOMODATIONS	4,880.00	610.00
			TOTAL CHARGES	35,764.09	11,279.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,156,670.79	ADJUSTMENTS	450,037.55
COVERED CHARGES	13,543,123.69	CONTRACTUAL ALLOW	10,967,509.02
NON-COVERD CHARGES	1,613,547.10	TOTAL MEDICAID LIAB	2,575,614.67
		LESS: COB	22,660.75
		LESS: COPAYMENT	3,574.11
		REIMBURSEMENT	2,549,379.81
		ALL OTHER	2,348,510.33
		FEE SCHEDULE-LAB	164,900.13
		INJECTABLE DRUGS	35,969.35
		TOTAL NUMBER OF CLAIMS	4,523

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	744,520.04	69,061.04	OTHER LAB	210,225.00	1,142.00
MED/SURG SUPPLY	264,746.88	13,512.41	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	830,854.00	29,197.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,046,035.00	356,289.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,858.00	14,484.00	FEE SCHEDULE LAB	2,541,824.35	315,147.00
EKG/ECG	188,823.00	5,892.00	MRI SERVICES	183,221.00	19,326.00
IV THERAPY	21,999.00	2,978.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,056,729.00	171,566.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	108,271.00	1,366.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	86,795.00	19,970.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	232,769.00	966.00	AMBULANCE	0.00	0.00
GI SERVICES	89,973.00	32,335.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,773,865.00	263,660.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	303,147.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	366,233.38	93,002.68
RADIOLOGY THERAPEUTIC	27,082.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	3,184.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	32,745.00	5,999.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,585.45	5,461.97
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,975.00
OTHER IMAGING SERVICE	426,779.00	104,130.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	38,917.00	5,649.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	258,591.00	17,512.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	329,021.00	45,689.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	121,414.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	226,100.59	7,053.00			
			TOTAL ANCILLARY	13,543,123.69	1,613,547.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,543,123.69	1,613,547.10

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: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012265101432	08/13/12 - 08/13/12	10/01/12	0.00	3,001.00	0.00	0.00	0.00
615	2313326000156	01/09/13 - 01/09/13	12/30/13	0.00	3,001.00	0.00	0.00	0.00
615	2313326000156	01/09/13 - 01/09/13	12/30/13	0.00	2,973.00	0.00	0.00	0.00
TOTAL				0.00	8,975.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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

PROVIDER NUMBER  
000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	223,356.90	ADJUSTMENTS	0.00
COVERED CHARGES	161,333.34	CONTRACTUAL ALLOW	88,326.80
NON-COVERD CHARGES	62,023.56	TOTAL MEDICAID LIAB	73,006.54
		LESS: COB	72,982.54
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 81



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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,993.45	1,100.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,561.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	211.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,037.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,686.00	32,678.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	39,027.00	3,296.00
EKG/ECG	2,550.00	0.00	MRI SERVICES	3,830.00	0.00
IV THERAPY	296.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,097.00	14,109.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,919.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	735.00	812.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,351.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,263.00	2,196.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,771.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,496.08	1,796.56
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	489.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	560.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,483.00	5,127.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,878.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,799.00	209.00			
			TOTAL ANCILLARY	161,333.34	62,023.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	161,333.34	62,023.56

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

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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	677,495.49	ADJUSTMENTS	426.52
COVERED CHARGES	627,280.37	CONTRACTUAL ALLOW	595,114.87
NON-COVERD CHARGES	50,215.12	TOTAL MEDICAID LIAB	32,165.50
		LESS: COB	0.00
		LESS: COPAYMENT	888.03
		REIMBURSEMENT	31,277.47
		TOTAL NUMBER OF CLAIMS	575

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

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

PROVIDER NUMBER  
 000000492A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,977.45	756.07	OTHER LAB	3,566.00	0.00
MED/SURG SUPPLY	728.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,458.00	621.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,523.00	13,862.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	131,991.40	10,936.20
EKG/ECG	8,513.00	255.00	MRI SERVICES	4,047.00	0.00
IV THERAPY	958.00	209.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,011.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	349,844.00	13,673.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,145.52	2,369.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	128.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,504.00	7,405.00			
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	2,214.00	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	1,800.00	0.00			
			TOTAL ANCILLARY	627,280.37	50,215.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	627,280.37	50,215.12

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,332.53	ADJUSTMENTS	0.00
COVERED CHARGES	16,689.80	CONTRACTUAL ALLOW	8,190.35
NON-COVERD CHARGES	642.73	TOTAL MEDICAID LIAB	8,499.45
		LESS: COB	8,493.45
		LESS: COPAYMENT	6.00
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	181.50	10.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	30.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	942.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,388.00	363.00
EKG/ECG	337.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,723.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	144.30	239.73
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,974.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,689.80	642.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,689.80	642.73

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

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

Run Date: 07/23/2014  
Run Time: 11:12:14  
Page: 15

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,401,011.46	ADJUSTMENTS	40,696.33
COVERED CHARGES	1,354,220.10	CONTRACTUAL ALLOW	1,176,141.16
NON-COVERD CHARGES	46,791.36	TOTAL MEDICAID LIAB	178,078.94
		LESS: COB	4,764.95
		LESS: COPAYMENT	234.00
		REIMBURSEMENT	173,079.99
		TOTAL NUMBER OF CLAIMS	36

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	642,391.91	11,347.00	OTHER LAB	2,617.00	0.00
MED/SURG SUPPLY	64,525.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,356.00	1,035.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,472.00	6,219.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,258.00	1,010.00
EKG/ECG	1,317.00	765.00	MRI SERVICES	2,821.00	0.00
IV THERAPY	13,052.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	155,364.00	6,000.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,164.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,549.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,617.00	3,232.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,038.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	219,352.11	10,129.36
RADIOLOGY THERAPEUTIC	50,239.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	128.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,503.00	4,932.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,667.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,166.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,008.00	886.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,617.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,034.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,091.84	1,108.00			
			TOTAL ANCILLARY	1,354,220.10	46,791.36
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,354,220.10	46,791.36

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

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

Run Date: 07/23/2014  
Run Time: 11:12:16  
Page: 17

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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

PROVIDER NUMBER  
000000492A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



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

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

Run Date: 07/23/2014  
 Run Time: 09:54:25  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY UNIVERSITY HOSPITAL MIDTOWN  
 550 PEACHTREE ST NE  
 ATLANTA,GA 30308-2247

PROVIDER NUMBER 000000503A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	81,192,680.03	ADJUSTMENTS	4,576,583.44
COVERED CHARGES	77,600,008.81	CONTRACTUAL ALLOW	52,034,981.44
NON-COVERD CHARGES	3,592,671.22	TOTAL MEDICAID LIAB	25,565,027.37
		LESS: COB	370,059.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	25,194,967.73

TOTAL NUMBER OF ADMISSIONS 2,248

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11,366		2	12,810,179.00		1,098,990.00
ROUTINE NURSERY	1,169		22	1,262,725.00		19,635.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12,535		24	14,072,904.00		1,118,625.00
SPECIAL CARE SERVICES						
CCU	296		0	1,224,940.00		16,780.00
ICU	1,837		0	7,653,990.00		62,925.00
NICU	444		0	1,206,420.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,577		0	10,085,350.00		79,705.00
TOTAL ACCOMODATIONS	15,112		24	24,158,254.00		1,198,330.00

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,184,605.79	106,179.89	OTHER LAB	411,879.00	7,593.00
MED/SURG SUPPLY	4,500,853.86	187,787.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,089,662.00	263,502.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,035,712.00	41,611.00	OTHER THERAPEUTIC SVC	0.00	5,245.00
CT SCAN	2,566,919.00	35,720.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	678,095.02	17,179.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	311,856.00	2,276.00	MRI SERVICES	1,884,920.00	74,702.00
IV THERAPY	38,505.75	2,620.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,080,326.25	89,590.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,406,608.00	2,420.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,509,896.81	60,172.19	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,560,658.00	9,512.00	AMBULANCE	0.00	0.00
GI SERVICES	265,739.00	28,531.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,846,546.00	21,075.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	502,035.00	8,603.00	DRUG-SPECIFIC/HOME IV	0.00	48,803.85
LABORATORY PATHOLOGIC	508,914.00	12,886.00	INJECTABLE DRUGS	7,822,249.75	356,040.29
RADIOLOGY THERAPEUTIC	24,950.00	8,373.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	234,645.00	2,819.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	136,866.00	2,202.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,262,286.00	298,703.00	PATIENT CONVENIENCE	0.00	38.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	228.00	3,572.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,393,847.40	35,908.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	141,052.00
OTHER IMAGING SERVICE	317,437.00	291,367.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,257,513.50	55,470.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	144,496.00	107,372.00			
AUDIOLOGY	16,626.00	0.00			
CARDIOLOGY	2,236,885.00	58,262.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	177,009.00	1,815.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,984.68	5,340.00			
			TOTAL ANCILLARY	53,441,754.81	2,394,341.22
			TOTAL ACCOMODATIONS	24,158,254.00	1,198,330.00
			TOTAL CHARGES	77,600,008.81	3,592,671.22

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012271020707	09/18/12 - 09/21/12	10/01/12	0.00	5,982.00	0.00	0.00	0.00
614	2012279025961	09/10/12 - 09/27/12	10/08/12	0.00	5,982.00	0.00	0.00	0.00
614	2012312020084	10/29/12 - 10/31/12	11/26/12	0.00	5,982.00	0.00	0.00	0.00
614	2012333055344	11/15/12 - 11/20/12	12/03/12	0.00	5,982.00	0.00	0.00	0.00
614	2212342006246	11/01/12 - 11/21/12	12/10/12	0.00	5,982.00	0.00	0.00	0.00
614	2013010041263	12/10/12 - 12/25/12	01/14/13	0.00	5,982.00	0.00	0.00	0.00
614	2013045018235	11/20/12 - 02/08/13	02/18/13	0.00	5,982.00	0.00	0.00	0.00
614	2013052036601	02/07/13 - 02/15/13	02/25/13	0.00	5,982.00	0.00	0.00	0.00
614	2013144038025	05/01/13 - 05/16/13	05/27/13	0.00	5,982.00	0.00	0.00	0.00
614	2013148019993	05/04/13 - 05/11/13	06/03/13	0.00	5,982.00	0.00	0.00	0.00
614	2213158006117	04/12/13 - 04/15/13	06/10/13	0.00	2,705.00	0.00	0.00	0.00
614	5213206000105	02/08/13 - 05/02/13	07/29/13	0.00	5,982.00	0.00	0.00	0.00
614	2013207049133	02/01/13 - 02/04/13	07/29/13	0.00	5,982.00	0.00	0.00	0.00
614	2013210008027	07/14/13 - 07/22/13	08/05/13	0.00	5,982.00	0.00	0.00	0.00
614	2013234044995	08/09/13 - 08/15/13	08/26/13	0.00	5,982.00	0.00	0.00	0.00
614	2013256017705	08/27/13 - 09/07/13	09/16/13	0.00	5,982.00	0.00	0.00	0.00
614	2013261018523	08/18/13 - 08/25/13	09/23/13	0.00	5,982.00	0.00	0.00	0.00
614	2013270037724	08/16/13 - 08/27/13	09/30/13	0.00	5,982.00	0.00	0.00	0.00
614	5213284000118	06/06/13 - 06/27/13	10/21/13	0.00	5,982.00	0.00	0.00	0.00
614	2013296018244	08/19/13 - 08/23/13	10/28/13	0.00	5,982.00	0.00	0.00	0.00
614	2014021024108	05/19/13 - 05/22/13	01/27/14	0.00	5,982.00	0.00	0.00	0.00
614	5214099014656	07/10/13 - 08/08/13	04/14/14	0.00	5,982.00	0.00	0.00	0.00
614	2014169016864	10/16/12 - 10/26/12	06/23/14	0.00	2,033.00	0.00	0.00	0.00
615	2014169016864	10/16/12 - 10/26/12	06/23/14	0.00	10,692.00	0.00	0.00	0.00
TOTAL				0.00	141,052.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
 Run Time: 09:55:24  
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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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,202,295.27	ADJUSTMENTS	0.00
COVERED CHARGES	2,159,797.47	CONTRACTUAL ALLOW	1,080,451.47
NON-COVERD CHARGES	42,497.80	TOTAL MEDICAID LIAB	1,079,346.00
		LESS: COB	1,079,346.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	174		0	198,834.00		9,420.00
ROUTINE NURSERY	45		0	56,880.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	219		0	255,714.00		9,420.00
SPECIAL CARE SERVICES						
CCU	4		0	16,780.00		0.00
ICU	33		0	138,435.00		0.00
NICU	179		0	484,195.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	216		0	639,410.00		0.00
TOTAL ACCOMODATIONS	435		0	895,124.00		9,420.00

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	161,234.70	0.00	OTHER LAB	3,004.00	0.00
MED/SURG SUPPLY	88,148.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	214,337.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,119.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,084.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,628.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,984.00	0.00	MRI SERVICES	69,432.00	0.00
IV THERAPY	272.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,626.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	145,327.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	173,368.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,765.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,889.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,160.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,887.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	8,460.80
LABORATORY PATHOLOGIC	12,113.00	0.00	INJECTABLE DRUGS	113,643.26	0.00
RADIOLOGY THERAPEUTIC	2,620.00	612.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,552.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,073.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,877.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,410.00	21,639.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,924.51	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,941.00	2,366.00			
AUDIOLOGY	472.00	0.00			
CARDIOLOGY	13,937.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,609.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	237.00	0.00			
			TOTAL ANCILLARY	1,264,673.47	33,077.80
			TOTAL ACCOMODATIONS	895,124.00	9,420.00
			TOTAL CHARGES	2,159,797.47	42,497.80

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: 07/23/2014  
Run Time: 09:55:28  
Page: 6

EMORY UNIVERSITY HOSPITAL MIDTOWN  
550 PEACHTREE ST NE  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,647,397.58	ADJUSTMENTS	1,272,230.00
COVERED CHARGES	24,864,018.67	CONTRACTUAL ALLOW	18,637,304.45
NON-COVERD CHARGES	7,783,378.91	TOTAL MEDICAID LIAB	6,226,714.22
		LESS: COB	13,468.61
		LESS: COPAYMENT	16,427.57
		REIMBURSEMENT	6,196,818.04
		ALL OTHER	4,126,384.64
		FEE SCHEDULE-LAB	501,402.62
		INJECTABLE DRUGS	1,569,030.78

TOTAL NUMBER OF CLAIMS 9,496

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE III  
 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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	266,690.00	287,565.68	OTHER LAB	247,442.00	392.00
MED/SURG SUPPLY	639,052.75	141,965.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	180.00	0.00
RADIOLOGY-DIAGNOSTIC	764,703.00	32,900.00	OTHER THERAPEUTIC SVC	0.00	21,142.00
CT SCAN	1,493,051.00	995,329.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,114.00	31,456.02	FEE SCHEDULE LAB	4,216,502.88	671,487.82
EKG/ECG	250,540.00	7,298.00	MRI SERVICES	1,585,971.00	326,765.00
IV THERAPY	1,007,703.00	20,132.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,632,402.00	751,317.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	69,917.00	714.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	121,914.00	45,209.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	487,914.00	1,792.00	AMBULANCE	0.00	0.00
GI SERVICES	109,681.00	49,527.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,349,997.00	335,852.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	546,805.00	5,348.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,092,674.02	2,113,276.39
RADIOLOGY THERAPEUTIC	237,517.00	16,151.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	15,658.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	6,431.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	17,076.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	47,740.00	7,657.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	117,713.00	188,178.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	77,194.00
OTHER IMAGING SERVICE	993,843.00	779,052.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	366,324.50	38,753.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	285,288.00	324,629.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	586,884.00	409,091.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	605.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	336,850.52	64,041.00			
			TOTAL ANCILLARY	24,864,018.67	7,783,378.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,864,018.67	7,783,378.91

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

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

Run Date: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012270017363	09/16/12 - 09/16/12	10/01/12	0.00	2,705.00	0.00	0.00	0.00
614	2013007013466	12/27/12 - 12/27/12	01/14/13	0.00	5,982.00	0.00	0.00	0.00
614	2013049007330	02/06/13 - 02/06/13	02/25/13	0.00	5,982.00	0.00	0.00	0.00
614	2013056009938	02/18/13 - 02/18/13	03/04/13	0.00	5,982.00	0.00	0.00	0.00
614	2013070000813	02/18/13 - 02/18/13	03/18/13	0.00	5,982.00	0.00	1,117.43	0.00
614	2013086060621	03/18/13 - 03/18/13	04/01/13	0.00	5,982.00	0.00	0.00	0.00
614	2013101048080	09/13/12 - 09/13/12	04/15/13	0.00	5,982.00	0.00	0.00	0.00
614	2013113033987	04/01/13 - 04/01/13	04/29/13	0.00	5,982.00	0.00	1,846.40	0.00
614	2013114037235	10/25/12 - 10/25/12	04/29/13	0.00	5,982.00	0.00	0.00	0.00
614	2013140009151	05/10/13 - 05/10/13	05/27/13	0.00	2,705.00	0.00	0.00	0.00
614	2213211010458	02/28/13 - 03/01/13	08/05/13	0.00	5,982.00	0.00	0.00	0.00
614	2213211010458	02/28/13 - 03/01/13	08/05/13	0.00	5,982.00	0.00	0.00	0.00
614	2013252010684	04/11/13 - 04/11/13	09/16/13	0.00	5,982.00	0.00	0.00	0.00
614	2013331070240	08/01/13 - 08/01/13	12/02/13	0.00	5,982.00	0.00	0.00	0.00
TOTAL				0.00	77,194.00	0.00	2,963.83	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

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	807,483.12	ADJUSTMENTS	0.00
COVERED CHARGES	350,273.18	CONTRACTUAL ALLOW	95,988.25
NON-COVERD CHARGES	457,209.94	TOTAL MEDICAID LIAB	254,284.93
		LESS: COB	253,941.83
		LESS: COPAYMENT	343.10
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 169

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

EMORY UNIVERSITY HOSPITAL MIDTOWN PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 550 PEACHTREE ST NE 000000503A SERVICE DATES 09/01/12 THROUGH 08/31/13  
 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	5,250.49	5,111.09	OTHER LAB	3,046.00	0.00
MED/SURG SUPPLY	11,971.75	2,910.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,169.00	144.00	OTHER THERAPEUTIC SVC	0.00	492.00
CT SCAN	12,663.00	31,541.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	81,296.00	8,812.00
EKG/ECG	2,232.00	372.00	MRI SERVICES	0.00	29,244.00
IV THERAPY	8,934.00	158.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,514.00	56,265.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,505.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	238.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,328.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,271.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,607.00	2,551.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,826.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	66,132.94	291,175.85
RADIOLOGY THERAPEUTIC	12,700.00	1,054.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	784.00	38.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	224.00	1.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,982.00
OTHER IMAGING SERVICE	2,450.00	13,094.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,750.00	1,360.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	2,453.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,646.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,006.00	181.00			
			TOTAL ANCILLARY	350,273.18	457,209.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	350,273.18	457,209.94

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

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

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIVERSITY HOSPITAL MIDTOWN  
550 PEACHTREE ST NE  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013077000577	02/19/13 - 02/19/13	03/25/13	0.00	5,982.00	0.00	4,711.92	0.00
TOTAL				0.00	5,982.00	0.00	4,711.92	0.00

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

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

Run Date: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	692,949.84	ADJUSTMENTS	794.34
COVERED CHARGES	611,421.69	CONTRACTUAL ALLOW	564,645.65
NON-COVERD CHARGES	81,528.15	TOTAL MEDICAID LIAB	46,776.04
		LESS: COB	0.00
		LESS: COPAYMENT	2,188.16
		REIMBURSEMENT	44,587.88
		TOTAL NUMBER OF CLAIMS	839

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,888.83	3,655.79	OTHER LAB	10,051.00	0.00
MED/SURG SUPPLY	4,250.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,478.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,739.00	15,565.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	336.00	FEE SCHEDULE LAB	122,566.00	24,939.00
EKG/ECG	10,540.00	0.00	MRI SERVICES	5,848.00	8,774.00
IV THERAPY	0.00	50.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	5,307.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	357.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,160.00	220.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,392.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	351,714.50	4,786.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,232.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,136.11	5,311.11
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,316.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,982.00
OTHER IMAGING SERVICE	13,528.00	5,887.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,225.00	714.00			
			TOTAL ANCILLARY	611,421.69	81,528.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	611,421.69	81,528.15

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

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

Run Date: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2014014045002	03/06/13 - 03/06/13	01/20/14	0.00	5,982.00	0.00	0.00	0.00
TOTAL				0.00	5,982.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 09:58:09  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,612.35	ADJUSTMENTS	0.00
COVERED CHARGES	11,177.00	CONTRACTUAL ALLOW	5,263.10
NON-COVERD CHARGES	1,435.35	TOTAL MEDICAID LIAB	5,913.90
		LESS: COB	5,901.90
		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: 07/23/2014  
 Run Time: 09:58:09  
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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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23.28	0.00	OTHER LAB	602.00	0.00
MED/SURG SUPPLY	143.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	958.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,627.00	796.00
EKG/ECG	124.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	79.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	393.47	103.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	571.00	457.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51.00	0.00			
			TOTAL ANCILLARY	11,177.00	1,435.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,177.00	1,435.35



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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY UNIVERSITY HOSPITAL MIDTOWN  
550 PEACHTREE ST NE  
ATLANTA,GA 30308-2247

PROVIDER NUMBER  
000000503A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,045,412.73	ADJUSTMENTS	492,901.19
COVERED CHARGES	5,565,636.38	CONTRACTUAL ALLOW	4,261,014.93
NON-COVERD CHARGES	479,776.35	TOTAL MEDICAID LIAB	1,304,621.45
		LESS: COB	0.00
		LESS: COPAYMENT	1,508.08
		REIMBURSEMENT	1,303,113.37
		TOTAL NUMBER OF CLAIMS	248

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 09/01/12 THROUGH 08/31/13  
 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	32,994.96	6,011.12	OTHER LAB	2,243.00	100.00
MED/SURG SUPPLY	183,599.00	26,995.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,110.00	6,534.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,532.00	6,918.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,706.00	FEE SCHEDULE LAB	207,379.61	38,700.50
EKG/ECG	2,710.00	124.00	MRI SERVICES	62,580.00	16,540.00
IV THERAPY	232,719.00	4,956.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	455,704.75	77,242.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,489.00	5,966.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	97,728.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,205.00	9,724.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	58,489.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,498,023.06	214,241.73
RADIOLOGY THERAPEUTIC	88,888.00	9,434.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	551.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	564.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,829.00	84.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	220,575.00	28,736.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,982.00
OTHER IMAGING SERVICE	1,299.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,423.00	5,032.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	235,354.00	13,635.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	18,762.00	0.00			
			TOTAL ANCILLARY	5,565,636.38	479,776.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,565,636.38	479,776.35

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: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013042011532	12/12/12 - 12/12/12	02/18/13	0.00	5,982.00	0.00	0.00	0.00
TOTAL				0.00	5,982.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 09:58:18  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,363.91	ADJUSTMENTS	0.00
COVERED CHARGES	52,402.27	CONTRACTUAL ALLOW	12,118.23
NON-COVERD CHARGES	1,961.64	TOTAL MEDICAID LIAB	40,284.04
		LESS: COB	40,284.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

ZERO PAID 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	09/01/12	THROUGH	08/31/13
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	1,405.23	441.17	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,440.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	144.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,581.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	498.00	FEE SCHEDULE LAB	348.00	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	27,023.00	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	7,088.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,552.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	357.04	994.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,239.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,225.00	0.00			
			TOTAL ANCILLARY	52,402.27	1,961.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,402.27	1,961.64

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

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

Run Date: 07/23/2014  
 Run Time: 09:33:04  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,880,263.50	ADJUSTMENTS	171,625.60
COVERED CHARGES	5,756,355.00	CONTRACTUAL ALLOW	3,042,402.32
NON-COVERD CHARGES	123,908.50	TOTAL MEDICAID LIAB	2,713,952.68
		LESS: COB	28,969.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,684,983.59

TOTAL NUMBER OF ADMISSIONS 380

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,352		0	864,032.00		40,880.00
ROUTINE NURSERY	63		0	40,320.00		15,395.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		15.00
TOTAL ROUTINE	1,415		0	904,352.00		56,290.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	507		0	674,310.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	507		0	674,310.00		0.00
TOTAL ACCOMODATIONS	1,922		0	1,578,662.00		56,290.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CRISP REGIONAL HOSPITAL  
 902 N 7TH ST  
 CORDELE,GA 31015-3234

PROVIDER NUMBER  
 000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	432,850.66	69.00	OTHER LAB	23,007.00	0.00
MED/SURG SUPPLY	356,459.71	1,533.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	987,858.64	13.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	112,986.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	401,061.50	2,625.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,149.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	48,373.00	0.00	MRI SERVICES	68,260.00	0.00
IV THERAPY	40,440.50	327.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	236,167.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,116.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	146,227.00	154.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,793.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	182,000.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,015.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,516.50	0.00	INJECTABLE DRUGS	713,288.76	0.00
RADIOLOGY THERAPEUTIC	30.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,394.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,659.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	12,660.00	4,220.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	86.50	650.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	54,670.23	0.00
LITHOTRIPSY	0.00	10,447.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,301.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	62,732.00	43,920.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	17,732.00	3,660.00			
AUDIOLOGY	1,244.00	0.00			
CARDIOLOGY	103,696.50	0.00			
AMBULATORY SURGERY	592.50	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,038.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,285.50	0.00			
			TOTAL ANCILLARY	4,177,693.00	67,618.50
			TOTAL ACCOMODATIONS	1,578,662.00	56,290.00
			TOTAL CHARGES	5,756,355.00	123,908.50

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

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

Run Date: 07/23/2014  
 Run Time: 09:33:16  
 Page: 3

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,609.36	ADJUSTMENTS	0.00
COVERED CHARGES	11,609.36	CONTRACTUAL ALLOW	1,809.19
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	9,800.17
		LESS: COB	9,800.17
		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	1,280.00		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	1,280.00		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	1,280.00		0.00



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,191.86	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	267.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,206.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	251.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,611.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	129.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	163.50	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	686.50	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	516.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,306.50	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	10,329.36	0.00
			TOTAL ACCOMODATIONS	1,280.00	0.00
			TOTAL CHARGES	11,609.36	0.00

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

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

Run Date: 07/23/2014  
Run Time: 09:33:17  
Page: 5

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,197,591.05	ADJUSTMENTS	214,021.82
COVERED CHARGES	4,890,748.09	CONTRACTUAL ALLOW	3,699,258.36
NON-COVERD CHARGES	1,306,842.96	TOTAL MEDICAID LIAB	1,191,489.73
		LESS: COB	865.49
		LESS: COPAYMENT	4,418.13
		REIMBURSEMENT	1,186,206.11
		ALL OTHER	798,428.40
		FEE SCHEDULE-LAB	167,200.94
		INJECTABLE DRUGS	220,576.77

TOTAL NUMBER OF CLAIMS 4,778

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

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

Run Date: 07/23/2014  
 Run Time: 09:33:17  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,172.50	36,627.37	OTHER LAB	159,005.22	0.00
MED/SURG SUPPLY	159,790.95	5,601.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	322.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	270,342.00	5,994.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	503,309.00	425,138.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,385.00	1,570.50	FEE SCHEDULE LAB	1,391,156.00	462,032.20
EKG/ECG	51,201.00	1,161.00	MRI SERVICES	224,287.00	20,220.50
IV THERAPY	83,694.00	23,506.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	334,340.12	99,406.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	849.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,188.50	2,079.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	50,211.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	417,145.50	47,731.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	50,899.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	528,237.94	114,808.36
RADIOLOGY THERAPEUTIC	42,170.50	2,796.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,961.50	1,940.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	50,225.00	2,751.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,739.36	6,874.15
LITHOTRIPSY	41,788.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	168,826.50	17,530.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,008.50	2,928.00			
ONCOLOGY	177.00	88.50			
NUCLEAR MEDICINE	140,172.50	20,882.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	72,384.00	2,613.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,787.00	0.00			
ORGAN ACQUISITION	0.00	1,530.00			
TREATMENT/OBSERV. RM	75,294.00	711.00			
			TOTAL ANCILLARY	4,890,748.09	1,306,842.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,890,748.09	1,306,842.96

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

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

Run Date: 07/23/2014  
Run Time: 09:34:51  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	139,561.77	ADJUSTMENTS	0.00
COVERED CHARGES	106,892.94	CONTRACTUAL ALLOW	27,928.34
NON-COVERD CHARGES	32,668.83	TOTAL MEDICAID LIAB	78,964.60
		LESS: COB	78,913.60
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 108

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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	503.15	133.29	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,072.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,461.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,345.50	10,462.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,312.50	2,027.50	FEE SCHEDULE LAB	45,975.50	14,359.00
EKG/ECG	774.00	0.00	MRI SERVICES	2,189.50	0.00
IV THERAPY	490.50	163.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,283.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	121.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	612.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,392.50	622.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	808.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,064.90	980.54
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,880.50	340.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,380.00	136.50	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	225.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,744.00	3,119.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,132.50	325.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,123.00	0.00			
			TOTAL ANCILLARY	106,892.94	32,668.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	106,892.94	32,668.83

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: 07/23/2014  
Run Time: 09:34:54  
Page: 9

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	271,622.81	ADJUSTMENTS	1,114.73
COVERED CHARGES	209,532.49	CONTRACTUAL ALLOW	193,345.74
NON-COVERD CHARGES	62,090.32	TOTAL MEDICAID LIAB	16,186.75
		LESS: COB	7.60
		LESS: COPAYMENT	513.03
		REIMBURSEMENT	15,666.12
		TOTAL NUMBER OF CLAIMS	290

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

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

Run Date: 07/23/2014  
 Run Time: 09:34:54  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

CRISP REGIONAL HOSPITAL  
 902 N 7TH ST  
 CORDELE,GA 31015-3234

PROVIDER NUMBER  
 000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	270.84	297.38	OTHER LAB	562.50	0.00
MED/SURG SUPPLY	2,549.00	33.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,644.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,591.50	25,262.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	79,535.50	29,799.00
EKG/ECG	3,612.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,924.00	654.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	243.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	72,938.00	4,429.50	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	13,742.65	1,446.94
RADIOLOGY THERAPEUTIC	0.00	168.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	253.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,096.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	570.00	0.00			
			TOTAL ANCILLARY	209,532.49	62,090.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	209,532.49	62,090.32

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

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

Run Date: 07/23/2014  
Run Time: 09:34:59  
Page: 11

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,546.92	ADJUSTMENTS	0.00
COVERED CHARGES	5,021.12	CONTRACTUAL ALLOW	3,101.69
NON-COVERD CHARGES	525.80	TOTAL MEDICAID LIAB	1,919.43
		LESS: COB	1,919.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8



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

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

Run Date: 07/23/2014  
 Run Time: 09:34:59  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	53.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	796.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,099.00	440.00
EKG/ECG	129.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	163.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,167.50	57.50	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	78.48	28.30
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	517.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,021.12	525.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,021.12	525.80

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

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

Run Date: 07/23/2014  
Run Time: 09:35:01  
Page: 13

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	89,559.75	ADJUSTMENTS	9,575.48
COVERED CHARGES	85,733.06	CONTRACTUAL ALLOW	61,779.36
NON-COVERD CHARGES	3,826.69	TOTAL MEDICAID LIAB	23,953.70
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	23,941.70
		TOTAL NUMBER OF CLAIMS	5

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

CRISP REGIONAL HOSPITAL  
 902 N 7TH ST  
 CORDELE,GA 31015-3234

PROVIDER NUMBER  
 000000514A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156.56	986.51	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,427.41	13.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	181.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,421.50	39.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	225.50	306.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,919.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	651.50	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	536.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47,775.14	427.38
RADIOLOGY THERAPEUTIC	2,750.50	194.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,968.45	1,860.30
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	516.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,162.50	0.00			
			TOTAL ANCILLARY	85,733.06	3,826.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	85,733.06	3,826.69

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

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

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 09:29:23  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	547,251.18	ADJUSTMENTS	222,779.89
COVERED CHARGES	487,623.18	CONTRACTUAL ALLOW	180,255.57
NON-COVERD CHARGES	59,628.00	TOTAL MEDICAID LIAB	307,367.61
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	307,367.61

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	67		0	45,560.00		59,483.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	67		0	45,560.00		59,483.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	40		0	73,065.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	40		0	73,065.00		0.00
TOTAL ACCOMODATIONS	107		0	118,625.00		59,483.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,255.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26,930.48	145.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,495.02	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,859.44	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,778.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	614.10	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,756.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	152,730.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,083.43	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	270.01	0.00	INJECTABLE DRUGS	46,023.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,757.17	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,723.48	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	872.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	888.95	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,961.00	0.00			
			TOTAL ANCILLARY	368,998.18	145.00
			TOTAL ACCOMODATIONS	118,625.00	59,483.00
			TOTAL CHARGES	487,623.18	59,628.00

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

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

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

DECATUR HLTH RESOURCES INCHOSP  
450 N CANDLER ST  
DECATUR,GA 30030-2626

PROVIDER NUMBER  
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
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 07/01/12 THROUGH 06/30/13  
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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DECATUR HLTH RESOURCES INCHOSP  
450 N CANDLER ST  
DECATUR,GA 30030-2626

PROVIDER NUMBER  
000000525A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,222,097.13	ADJUSTMENTS	3,315,094.59
COVERED CHARGES	57,294,145.22	CONTRACTUAL ALLOW	35,885,638.36
NON-COVERD CHARGES	1,927,951.91	TOTAL MEDICAID LIAB	21,408,506.86
		LESS: COB	215,713.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	21,192,793.07

TOTAL NUMBER OF ADMISSIONS 3,466

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11,096		6	8,118,593.00		933,009.08
ROUTINE NURSERY	3,439		5	3,216,499.00		116,989.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	14,535		11	11,335,092.00		1,049,998.08
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2,122		0	3,763,783.00		18,387.00
NICU	451		0	984,214.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		109	0.00		95,818.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,573		109	4,747,997.00		114,205.00
TOTAL ACCOMODATIONS	17,108		120	16,083,089.00		1,164,203.08

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,989,028.86	67,190.00	OTHER LAB	623,549.87	2,245.00
MED/SURG SUPPLY	1,484,185.91	43,825.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,649,724.04	102,951.85	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,174,827.71	13,240.83	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,625,395.42	90,270.26	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	579,924.50	40,858.77	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	475,540.70	622.61	MRI SERVICES	422,793.00	5,906.00
IV THERAPY	525,824.86	15,612.69	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,129,212.60	34,926.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,956,615.43	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,906,844.86	42,510.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	577,534.30	3,375.78	AMBULANCE	0.00	0.00
GI SERVICES	249,951.09	1,208.48	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,643,958.96	4,822.72	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,107,269.38	4,514.58	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	294,101.26	678.15	INJECTABLE DRUGS	5,468,271.63	57,213.95
RADIOLOGY THERAPEUTIC	188,412.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	228,281.32	24,013.35	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	206,713.76	6,994.81	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	213,043.00	17,594.68	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	368.64	888.16	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	165,613.75	319.00	IMPL DEV CHARGE PATIENTS	1,040,490.28	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	520,389.39	2,009.00			
BLOOD	174.00	0.00			
BLOOD STORAGE & PRO.	663,799.00	54,968.47			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	372,605.48	89,815.82			
AUDIOLOGY	134,058.51	0.00			
CARDIOLOGY	1,361,984.95	1,242.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	79,383.57	1,911.24			
ORGAN ACQUISITION	0.00	4,664.00			
TREATMENT/OBSERV. RM	151,184.19	27,353.83			
			TOTAL ANCILLARY	41,211,056.22	763,748.83
			TOTAL ACCOMODATIONS	16,083,089.00	1,164,203.08
			TOTAL CHARGES	57,294,145.22	1,927,951.91

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,238,187.13	ADJUSTMENTS	0.00
COVERED CHARGES	1,235,307.06	CONTRACTUAL ALLOW	558,286.56
NON-COVERD CHARGES	2,880.07	TOTAL MEDICAID LIAB	677,020.50
		LESS: COB	677,020.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	130		0	97,500.00		1,766.00
ROUTINE NURSERY	28		0	39,234.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	158		0	136,734.00		1,766.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	46		0	83,827.00		0.00
NICU	53		0	114,056.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	99		0	197,883.00		0.00
TOTAL ACCOMODATIONS	257		0	334,617.00		1,766.00



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166,053.40	0.00	OTHER LAB	8,332.71	0.00
MED/SURG SUPPLY	20,316.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	106,520.95	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,093.03	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,376.78	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,700.64	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,727.15	0.00	MRI SERVICES	3,892.00	0.00
IV THERAPY	3,188.84	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,470.76	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,058.20	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	194,251.78	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,026.28	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,622.12	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,681.82	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,780.88	0.00	INJECTABLE DRUGS	193,703.36	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	218.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,790.79	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	5,500.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	51.58	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	319.00	0.00	IMPL DEV CHARGE PATIENTS	17,446.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,068.95	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,287.00	768.89			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,068.00	345.18			
AUDIOLOGY	1,247.87	0.00			
CARDIOLOGY	9,456.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,439.33	0.00			
			TOTAL ANCILLARY	900,690.06	1,114.07
			TOTAL ACCOMODATIONS	334,617.00	1,766.00
			TOTAL CHARGES	1,235,307.06	2,880.07

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

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

Run Date: 07/23/2014  
Run Time: 09:30:42  
Page: 5

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,171,860.04	ADJUSTMENTS	1,157,653.69
COVERED CHARGES	19,290,727.48	CONTRACTUAL ALLOW	15,313,830.34
NON-COVERD CHARGES	2,881,132.56	TOTAL MEDICAID LIAB	3,976,897.14
		LESS: COB	10,578.82
		LESS: COPAYMENT	9,270.59
		REIMBURSEMENT	3,957,047.73
		ALL OTHER	3,304,669.41
		FEE SCHEDULE-LAB	309,090.91
		INJECTABLE DRUGS	343,287.41

TOTAL NUMBER OF CLAIMS 7,912

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

DEKALB MEDICAL CENTER  
 2701 N DECATUR RD  
 DECATUR,GA 30033-5918

PROVIDER NUMBER  
 000000536A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	301,406.99	9,550.85	OTHER LAB	623,639.62	42,480.59
MED/SURG SUPPLY	438,016.71	47,285.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	29.42	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	967,240.74	50,250.14	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,361,796.86	87,256.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	47,756.42	24,947.97	FEE SCHEDULE LAB	3,335,640.58	635,337.73
EKG/ECG	327,478.70	20,179.51	MRI SERVICES	358,445.00	28,137.45
IV THERAPY	725,334.02	114,350.98	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,392,403.34	276,135.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	410,347.14	703.80	REHAB THERAPY	0.00	2,618.55
RESPIRATORY SERVICES	100,862.01	133,108.59	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	325,142.80	4,534.65	AMBULANCE	0.00	0.00
GI SERVICES	43,238.08	13,609.38	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,218,055.72	47,954.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	590,822.58	7,850.93	DRUG-SPECIFIC/HOME IV	2,268.00	10,304.60
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,182,568.70	423,527.66
RADIOLOGY THERAPEUTIC	244,338.04	620.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,093.57	7,705.77	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	298.95	3,752.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	40,502.10	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	40,492.45	1,791.79	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	31,935.20	0.00	IMPL DEV CHARGE PATIENTS	66,002.80	355,802.51
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,492,082.65	160,038.56			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	73,783.84	22,377.89			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	297,728.88	142,838.79			
AUDIOLOGY	7,663.58	1,163.69			
CARDIOLOGY	440,621.85	121,675.64			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,112.80	888.95			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	811,108.86	41,819.77			
			TOTAL ANCILLARY	19,290,727.48	2,881,132.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,290,727.48	2,881,132.56

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	282,595.29	ADJUSTMENTS	0.00
COVERED CHARGES	234,996.24	CONTRACTUAL ALLOW	128,900.62
NON-COVERD CHARGES	47,599.05	TOTAL MEDICAID LIAB	106,095.62
		LESS: COB	106,044.62
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 101

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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,297.30	0.00	OTHER LAB	4,489.65	1,093.54
MED/SURG SUPPLY	1,705.86	130.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,668.26	574.48	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,649.40	6,960.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	320.00	0.00	FEE SCHEDULE LAB	57,602.11	6,275.73
EKG/ECG	3,087.52	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,756.06	817.22	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,824.14	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,668.40	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	304.10	1,300.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,217.11	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,492.11	143.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,327.02	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,643.00	965.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	436.78	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	970.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,804.05	25,199.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	436.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,251.70	3,170.08			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,015.67	0.00			
			TOTAL ANCILLARY	234,996.24	47,599.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	234,996.24	47,599.05

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: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,266,916.56	ADJUSTMENTS	3,292.24
COVERED CHARGES	1,180,855.07	CONTRACTUAL ALLOW	1,127,824.00
NON-COVERD CHARGES	86,061.49	TOTAL MEDICAID LIAB	53,031.07
		LESS: COB	0.00
		LESS: COPAYMENT	1,950.18
		REIMBURSEMENT	51,080.89
		TOTAL NUMBER OF CLAIMS	948

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,186.60	380.60	OTHER LAB	14,907.32	577.62
MED/SURG SUPPLY	8,531.66	2,126.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,905.96	203.55	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,324.90	4,628.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,238.84	FEE SCHEDULE LAB	287,459.54	50,312.70
EKG/ECG	22,559.32	0.00	MRI SERVICES	1,497.00	0.00
IV THERAPY	41,948.15	4,043.22	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,820.76	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,038.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,019.30	327.12	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,105.35	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	557,632.88	474.87	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,738.23	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,807.00	3,029.70
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	2,266.54	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	134.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,871.00	319.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	58,879.40	14,368.95			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,744.00	1,629.73			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	19,878.70	0.00			
			TOTAL ANCILLARY	1,180,855.07	86,061.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,180,855.07	86,061.49

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,536.87	ADJUSTMENTS	0.00
COVERED CHARGES	22,170.72	CONTRACTUAL ALLOW	9,342.51
NON-COVERD CHARGES	5,366.15	TOTAL MEDICAID LIAB	12,828.21
		LESS: COB	12,819.21
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13



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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	202.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	140.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	696.38	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,320.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,279.92	1,077.99
EKG/ECG	315.56	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,173.47	260.86	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	111.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,329.50	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	450.20	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,471.05	1,707.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,170.72	5,366.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,170.72	5,366.15

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

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

Run Date: 07/23/2014  
Run Time: 09:32:51  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,059,258.72	ADJUSTMENTS	76,313.70
COVERED CHARGES	1,625,867.06	CONTRACTUAL ALLOW	1,340,458.58
NON-COVERD CHARGES	433,391.66	TOTAL MEDICAID LIAB	285,408.48
		LESS: COB	0.00
		LESS: COPAYMENT	669.00
		REIMBURSEMENT	284,739.48
		TOTAL NUMBER OF CLAIMS	56

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,926.16	232.60	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	48,512.92	5,277.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,520.24	18,035.54	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,050.00	921.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	320.00	FEE SCHEDULE LAB	35,800.55	2,162.83
EKG/ECG	3,138.58	2,183.39	MRI SERVICES	4,514.00	0.00
IV THERAPY	96,690.58	795.55	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	272,717.94	19,450.90	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,681.66	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,200.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,755.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	627,222.00	137,200.60
RADIOLOGY THERAPEUTIC	177,240.90	64,741.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,867.40	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	53,973.00	170,150.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,944.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,836.00	768.89			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,105.23	383.53			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	151,197.21	5,935.70			
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	21,973.66	4,832.63			
			TOTAL ANCILLARY	1,625,867.06	433,391.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,625,867.06	433,391.66

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

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

Run Date: 07/23/2014  
Run Time: 09:32:54  
Page: 15

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 09:40:35  
 Page: 1

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,249,702.93	ADJUSTMENTS	478,251.79
COVERED CHARGES	12,830,019.41	CONTRACTUAL ALLOW	7,826,413.10
NON-COVERD CHARGES	419,683.52	TOTAL MEDICAID LIAB	5,003,606.31
		LESS: COB	33,277.51
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,970,328.80
		TOTAL NUMBER OF ADMISSIONS	636

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,979		0	2,180,628.00		309,427.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,979		0	2,180,628.00		309,427.00
SPECIAL CARE SERVICES						
CCU	25		0	22,842.00		0.00
ICU	314		0	599,668.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	339		0	622,510.00		0.00
TOTAL ACCOMODATIONS	3,318		0	2,803,138.00		309,427.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE  
 2801 DEKALB MEDICAL PKWY  
 LITHONIA,GA 30058-4996

PROVIDER NUMBER  
 000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	832,014.51	307.30	OTHER LAB	136,113.88	0.00
MED/SURG SUPPLY	267,032.74	4,082.63	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,324,677.92	15,244.83	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	350,944.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	717,757.76	6,528.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	100,182.49	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	170,690.45	0.00	MRI SERVICES	123,816.00	0.00
IV THERAPY	407,599.23	6,610.81	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	417,648.37	5,743.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	797,674.74	8,633.02	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	105,770.11	0.00	AMBULANCE	0.00	0.00
GI SERVICES	51,943.83	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	663,919.57	586.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	75,575.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	45,392.96	0.00	INJECTABLE DRUGS	1,497,816.80	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	35,299.58	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,389.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	48,834.00	12,905.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	199.59	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	15,631.00	0.00	IMPL DEV CHARGE PATIENTS	28,984.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	138,715.29	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	176,875.00	9,686.43			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	140,643.34	34,104.42			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	245,745.37	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	30,092.54	0.00			
ORGAN ACQUISITION	0.00	1,497.00			
TREATMENT/OBSERV. RM	42,900.73	4,327.05			
			TOTAL ANCILLARY	10,026,881.41	110,256.52
			TOTAL ACCOMODATIONS	2,803,138.00	309,427.00
			TOTAL CHARGES	12,830,019.41	419,683.52

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

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

Run Date: 07/23/2014  
 Run Time: 09:40:49  
 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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,846.61	ADJUSTMENTS	0.00
COVERED CHARGES	7,810.61	CONTRACTUAL ALLOW	2,955.15
NON-COVERD CHARGES	36.00	TOTAL MEDICAID LIAB	4,855.46
		LESS: COB	4,855.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		0	1,464.00		36.00
ROUTINE NURSERY	0		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	1,464.00		36.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,464.00		36.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DEKALB MEDICAL CENTER AT HILLANDALE  
 2801 DEKALB MEDICAL PKWY  
 LITHONIA,GA 30058-4996

PROVIDER NUMBER  
 000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	498.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	101.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	697.65	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	573.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,320.00	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	788.86	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	925.75	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	441.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,346.61	0.00
			TOTAL ACCOMODATIONS	1,464.00	36.00
			TOTAL CHARGES	7,810.61	36.00



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

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

Run Date: 07/23/2014  
Run Time: 09:40:50  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,825,239.04	ADJUSTMENTS	397,750.11
COVERED CHARGES	9,757,267.14	CONTRACTUAL ALLOW	7,653,091.53
NON-COVERD CHARGES	1,067,971.90	TOTAL MEDICAID LIAB	2,104,175.61
		LESS: COB	1,831.53
		LESS: COPAYMENT	3,187.48
		REIMBURSEMENT	2,099,156.60
		ALL OTHER	1,899,564.51
		FEE SCHEDULE-LAB	171,120.97
		INJECTABLE DRUGS	28,471.12

TOTAL NUMBER OF CLAIMS 4,965

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	119,360.79	751.80	OTHER LAB	85,866.94	2,708.38
MED/SURG SUPPLY	135,157.43	6,616.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	26.45	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	657,066.49	7,888.39	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	980,512.50	53,342.03	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,890.78	4,338.21	FEE SCHEDULE LAB	1,932,500.48	378,107.18
EKG/ECG	181,137.65	10,891.42	MRI SERVICES	224,419.00	16,087.80
IV THERAPY	444,283.66	104,662.74	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	421,858.73	64,578.27	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,334.20	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,705.90	12,288.56	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	167,193.43	0.00	AMBULANCE	0.00	0.00
GI SERVICES	81,250.26	18,076.29	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,731,713.54	33,298.79	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	140,688.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	174,120.30	155,815.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	993.94	1,128.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	738.25	2,296.88	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,675.36	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,619.28	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	19,459.00	638.00	IMPL DEV CHARGE PATIENTS	36,489.00	64,086.64
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	544,082.79	68,330.05			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,202.00	1,629.73			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	162,473.01	38,082.06			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	108,330.85	12,905.70			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,815.53	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	335,622.55	2,102.51			
			TOTAL ANCILLARY	9,757,267.14	1,067,971.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,757,267.14	1,067,971.90

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

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

Run Date: 07/23/2014  
Run Time: 09:42:02  
Page: 7

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	145,251.78	ADJUSTMENTS	0.00
COVERED CHARGES	115,226.64	CONTRACTUAL ALLOW	53,677.41
NON-COVERD CHARGES	30,025.14	TOTAL MEDICAID LIAB	61,549.23
		LESS: COB	61,519.23
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 60

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,628.90	0.00	OTHER LAB	831.00	0.00
MED/SURG SUPPLY	1,592.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,214.48	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,200.00	12,171.89	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,302.07	3,152.14
EKG/ECG	938.17	0.00	MRI SERVICES	5,643.00	2,395.00
IV THERAPY	8,668.98	1,250.80	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,483.99	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,102.29	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,907.31	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,074.30	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,084.43	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,644.00	488.10
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	8,818.11	6,659.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	115,226.64	30,025.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	115,226.64	30,025.14

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

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

Run Date: 07/23/2014  
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DEKALB MEDICAL CENTER AT HILLANDALE  
2801 DEKALB MEDICAL PKWY  
LITHONIA,GA 30058-4996

PROVIDER NUMBER  
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,061,448.28	ADJUSTMENTS	2,877.80
COVERED CHARGES	1,000,666.97	CONTRACTUAL ALLOW	948,642.77
NON-COVERD CHARGES	60,781.31	TOTAL MEDICAID LIAB	52,024.20
		LESS: COB	0.00
		LESS: COPAYMENT	1,524.11
		REIMBURSEMENT	50,500.09
		TOTAL NUMBER OF CLAIMS	930

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,401.50	148.40	OTHER LAB	5,419.55	0.00
MED/SURG SUPPLY	3,770.10	653.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	75,419.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,660.81	2,481.64	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	214,770.38	38,396.76
EKG/ECG	17,015.40	0.00	MRI SERVICES	4,245.00	2,395.00
IV THERAPY	43,014.73	5,742.46	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,731.61	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,899.70	135.36	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	534,668.82	1,298.59	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,219.80	1,358.20
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	51.58	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,595.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	343.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	46,460.40	7,170.95			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,068.00	300.15			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	306.22	306.22			
			TOTAL ANCILLARY	1,000,666.97	60,781.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,000,666.97	60,781.31

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,577.81	ADJUSTMENTS	0.00
COVERED CHARGES	14,603.52	CONTRACTUAL ALLOW	5,361.44
NON-COVERD CHARGES	1,974.29	TOTAL MEDICAID LIAB	9,242.08
		LESS: COB	9,224.08
		LESS: COPAYMENT	18.00
		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: 07/23/2014  
 Run Time: 09:42:16  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89.00	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	501.73	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,563.59	372.56
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	513.95	130.43	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,310.00	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	88.20	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	537.05	1,471.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,603.52	1,974.29
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,603.52	1,974.29



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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DEKALB MEDICAL CENTER AT HILLANDALE  
2801 DEKALB MEDICAL PKWY  
LITHONIA,GA 30058-4996

PROVIDER NUMBER  
000000536U

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	126,217.56	ADJUSTMENTS	15,477.78
COVERED CHARGES	124,764.76	CONTRACTUAL ALLOW	109,274.98
NON-COVERD CHARGES	1,452.80	TOTAL MEDICAID LIAB	15,489.78
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	15,477.78

TOTAL NUMBER OF CLAIMS 3

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	596.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,292.88	131.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,699.58	272.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	628.00	26.45
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,479.80	727.95	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,616.12	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,383.38	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	161.50	60.80
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	85,719.00	234.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,188.00	0.00			
			TOTAL ANCILLARY	124,764.76	1,452.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	124,764.76	1,452.80

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

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

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
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 Page: 1

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,794,154.56	ADJUSTMENTS	5,979,468.84
COVERED CHARGES	56,510,080.24	CONTRACTUAL ALLOW	45,485,098.16
NON-COVERD CHARGES	1,284,074.32	TOTAL MEDICAID LIAB	11,024,982.08
		LESS: COB	55,177.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,969,804.27

TOTAL NUMBER OF ADMISSIONS 778

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,392		19	1,307,036.00		562,425.00
ROUTINE NURSERY	273		0	325,779.00		105,725.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,665		19	1,632,815.00		668,150.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,600		17	3,712,269.00		52,164.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	809		2	4,453,546.00		7,056.00
HOSPICE	0		0	0.00		0.00
REHAB	0		27	0.00		35,560.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,409		46	8,165,815.00		94,780.00
TOTAL ACCOMODATIONS	4,074		65	9,798,630.00		762,930.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,928,479.09	102,598.09	OTHER LAB	171,595.05	0.00
MED/SURG SUPPLY	5,864,118.80	53,616.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,395,052.44	6,197.22	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	505,192.17	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	778,340.02	190,730.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	203,371.14	538.98	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	179,690.01	0.00	MRI SERVICES	150,887.19	2,776.02
IV THERAPY	55,781.42	1,899.23	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,224,589.34	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	160,130.07	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,374,099.69	119.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	142,272.96	4,537.21	CAST ROOM	0.00	0.00
EMERGENCY ROOM	641,433.52	3,512.03	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,217,537.51	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	190,660.09	0.00	INJECTABLE DRUGS	12,075,097.72	65,858.20
RADIOLOGY THERAPEUTIC	20,522.38	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	189,975.48	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	21,848.96	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	175,394.60	0.00	PATIENT CONVENIENCE	0.00	2,596.45
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,533.15	36,984.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	608,664.43	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	159,684.45	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	501,159.17	3,859.58			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	179,536.10	34,667.35			
AUDIOLOGY	0.00	10,313.72			
CARDIOLOGY	538,404.08	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,930.28	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,468.93	339.82			
			TOTAL ANCILLARY	46,711,450.24	521,144.32
			TOTAL ACCOMODATIONS	9,798,630.00	762,930.00
			TOTAL CHARGES	56,510,080.24	1,284,074.32

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	187,345.83	ADJUSTMENTS	0.00
COVERED CHARGES	147,086.99	CONTRACTUAL ALLOW	82,791.39
NON-COVERD CHARGES	40,258.84	TOTAL MEDICAID LIAB	64,295.60
		LESS: COB	64,295.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	10

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	19		0	17,996.00		39,828.00
ROUTINE NURSERY	3		0	2,748.00		339.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	22		0	20,744.00		40,167.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	6,668.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	6,668.00		0.00
TOTAL ACCOMODATIONS	25		0	27,412.00		40,167.00

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,282.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	11,341.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	13,226.49	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	46,572.18	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,597.18	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	855.90	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	2,148.64	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,660.53	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,891.67	0.00	INJECTABLE DRUGS	25,684.39	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	93.23	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	617.75	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	91.84			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	703.67	0.00			
			TOTAL ANCILLARY	119,674.99	91.84
			TOTAL ACCOMODATIONS	27,412.00	40,167.00
			TOTAL CHARGES	147,086.99	40,258.84

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

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

Run Date: 07/23/2014  
Run Time: 09:38:07  
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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,609,015.26	ADJUSTMENTS	90,050.04
COVERED CHARGES	10,936,204.02	CONTRACTUAL ALLOW	8,613,550.42
NON-COVERD CHARGES	1,672,811.24	TOTAL MEDICAID LIAB	2,322,653.60
		LESS: COB	7,787.11
		LESS: COPAYMENT	5,811.00
		REIMBURSEMENT	2,309,055.49
		ALL OTHER	2,177,299.35
		FEE SCHEDULE-LAB	86,291.21
		INJECTABLE DRUGS	45,464.93
		TOTAL NUMBER OF CLAIMS	4,993



DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	203,145.53	0.00	OTHER LAB	63,806.18	0.00
MED/SURG SUPPLY	545,164.38	22,702.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	1,780.20	0.00
RADIOLOGY-DIAGNOSTIC	554,256.78	3,922.81	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	739,137.60	283,386.21	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	61,611.23	49,172.19	FEE SCHEDULE LAB	817,940.92	160,484.43
EKG/ECG	175,831.16	9,575.41	MRI SERVICES	106,349.19	15,698.37
IV THERAPY	404,259.72	69,899.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,356,763.19	701,894.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	152,502.48	100,305.80	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	98,095.50	2,609.66	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	253,501.38	48,152.73	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,835,381.23	4,158.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	711,138.53	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	328,151.44	51,463.87
RADIOLOGY THERAPEUTIC	217,508.95	5,508.85	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,699.77	15,234.43	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	52.92
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	179,449.95	7,504.89	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,653.00	31,884.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	323,684.20	12,113.23			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,975.96	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	301,608.16	49,317.89			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	180,124.82	11,147.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	61,286.36	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	240,396.21	16,620.54			
			TOTAL ANCILLARY	10,936,204.02	1,672,811.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,936,204.02	1,672,811.24

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

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

Run Date: 07/23/2014  
Run Time: 09:40:12  
Page: 7

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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	395,186.51	ADJUSTMENTS	0.00
COVERED CHARGES	204,481.54	CONTRACTUAL ALLOW	124,778.87
NON-COVERD CHARGES	190,704.97	TOTAL MEDICAID LIAB	79,702.67
		LESS: COB	79,669.67
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 81

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

DOCTORS HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 3651 WHEELER RD 000000558A SERVICE DATES 04/01/12 THROUGH 03/31/13  
 AUGUSTA,GA 30909-6521 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,072.01	0.00	OTHER LAB	1,207.05	0.00
MED/SURG SUPPLY	18,788.28	40.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,164.57	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,103.65	28,459.11	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,040.98	FEE SCHEDULE LAB	14,332.19	1,157.01
EKG/ECG	2,098.65	0.00	MRI SERVICES	4,847.87	4,847.87
IV THERAPY	8,192.38	853.66	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,273.81	134,676.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,277.52	3,798.59	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	356.48	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	5,381.35	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,594.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	40,934.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,619.01	1,900.82
RADIOLOGY THERAPEUTIC	0.00	1,275.52	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,056.29	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,730.58	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,243.65	5,253.91			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	962.70			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,644.78	0.00			
			TOTAL ANCILLARY	204,481.54	190,704.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	204,481.54	190,704.97

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

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

Run Date: 07/23/2014  
Run Time: 09:40:15  
Page: 9

DOCTORS HOSPITAL  
3651 WHEELER RD  
AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	515,560.32	ADJUSTMENTS	441.52
COVERED CHARGES	492,092.04	CONTRACTUAL ALLOW	465,184.91
NON-COVERD CHARGES	23,468.28	TOTAL MEDICAID LIAB	26,907.13
		LESS: COB	0.00
		LESS: COPAYMENT	828.02
		REIMBURSEMENT	26,079.11
		TOTAL NUMBER OF CLAIMS	481

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL  
 3651 WHEELER RD  
 AUGUSTA,GA 30909-6521

PROVIDER NUMBER  
 000000558A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,161.83	0.00	OTHER LAB	1,312.95	0.00
MED/SURG SUPPLY	2,240.00	92.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	26,630.29	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,371.20	5,986.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	27,235.24	9,149.20
EKG/ECG	8,735.82	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	34,225.82	3,843.16	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,960.94	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	332,539.80	1,585.08	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,931.90	2,811.74
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	502.60	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,243.65	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	492,092.04	23,468.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	492,092.04	23,468.28

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

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

Run Date: 07/23/2014  
Run Time: 09:40:22  
Page: 11

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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,327.41	ADJUSTMENTS	0.00
COVERED CHARGES	12,878.81	CONTRACTUAL ALLOW	7,723.39
NON-COVERD CHARGES	1,448.60	TOTAL MEDICAID LIAB	5,155.42
		LESS: COB	5,149.42
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	14

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73.96	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	375.05	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,055.33	222.11
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,403.70	473.12	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,579.01	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	391.76	34.88
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	718.49			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,878.81	1,448.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,878.81	1,448.60

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

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

Run Date: 07/23/2014  
Run Time: 09:40:24  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,512,405.38	ADJUSTMENTS	20,415.88
COVERED CHARGES	3,246,701.40	CONTRACTUAL ALLOW	2,721,431.24
NON-COVERD CHARGES	265,703.98	TOTAL MEDICAID LIAB	525,270.16
		LESS: COB	0.00
		LESS: COPAYMENT	750.00
		REIMBURSEMENT	524,520.16
		TOTAL NUMBER OF CLAIMS	103



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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,452.18	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	436,744.11	4,422.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,390.62	347.37	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,690.67	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,502.44	1,996.62
EKG/ECG	2,358.13	1,202.88	MRI SERVICES	0.00	0.00
IV THERAPY	2,217.79	1,792.33	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,503,172.19	211,935.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,452.19	2,609.66	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,148.74	207.05	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	432,417.31	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,527.17	5,282.26
RADIOLOGY THERAPEUTIC	497,880.40	3,807.93	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,501.05	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,542.08	217.77	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	90,549.00	5,127.50
LITHOTRIPSY	20,575.64	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,668.87	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,838.34	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,623.98	1,041.86			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	42,187.42	24,211.82			
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	24,762.13	0.00			
			TOTAL ANCILLARY	3,246,701.40	265,703.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,246,701.40	265,703.98

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

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

Run Date: 07/23/2014  
Run Time: 09:40:27  
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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 09:36:00  
 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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,921,660.05	ADJUSTMENTS	65,137.35
COVERED CHARGES	2,837,581.06	CONTRACTUAL ALLOW	1,551,436.96
NON-COVERD CHARGES	84,078.99	TOTAL MEDICAID LIAB	1,286,144.10
		LESS: COB	13,936.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,272,207.41

TOTAL NUMBER OF ADMISSIONS 223

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	636		0	448,600.00		41,325.00
ROUTINE NURSERY	72		0	30,375.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		6,500.00
TOTAL ROUTINE	708		0	478,975.00		47,825.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	138		0	194,290.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	138		0	194,290.00		0.00
TOTAL ACCOMODATIONS	846		0	673,265.00		47,825.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	274,322.04	0.00	OTHER LAB	6,943.96	0.00
MED/SURG SUPPLY	321,622.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	464,588.37	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	54,502.03	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	110,011.88	16,115.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,400.67	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	38,139.58	0.00	MRI SERVICES	7,685.37	0.00
IV THERAPY	50,983.77	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	117,761.48	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	34,374.77	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	166,255.83	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	66,090.98	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,608.83	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	133,642.07	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,941.45	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	105.36	0.00	INJECTABLE DRUGS	114,780.73	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	881.08	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	163.90	212.64	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	64,664.39	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,494.44	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	54,596.04	19,368.92			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,852.15	556.51			
AUDIOLOGY	2,720.11	0.00			
CARDIOLOGY	16,231.79	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	456.74	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,494.19	0.00			
			TOTAL ANCILLARY	2,164,316.06	36,253.99
			TOTAL ACCOMODATIONS	673,265.00	47,825.00
			TOTAL CHARGES	2,837,581.06	84,078.99

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

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

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

DODGE COUNTY HOSPITAL  
901 GRIFFIN AVE  
EASTMAN,GA 31023-6720

PROVIDER NUMBER  
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 09:36:08  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,098,363.81	ADJUSTMENTS	121,259.41
COVERED CHARGES	3,786,936.63	CONTRACTUAL ALLOW	2,995,048.84
NON-COVERD CHARGES	311,427.18	TOTAL MEDICAID LIAB	791,887.79
		LESS: COB	2,198.83
		LESS: COPAYMENT	2,598.00
		REIMBURSEMENT	787,090.96
		ALL OTHER	710,141.11
		FEE SCHEDULE-LAB	74,401.99
		INJECTABLE DRUGS	2,547.86
		TOTAL NUMBER OF CLAIMS	2,825

SUMMARY TYPE III  
 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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102,648.57	9,351.18	OTHER LAB	33,075.47	2,636.25
MED/SURG SUPPLY	360,683.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	320.07	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	196,926.83	2,457.37	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	318,981.67	10,079.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,050.77	0.00	FEE SCHEDULE LAB	670,884.38	208,553.16
EKG/ECG	66,404.13	8,406.97	MRI SERVICES	178,708.08	1,744.88
IV THERAPY	161,266.38	19,826.13	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	218,044.37	9,993.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	126,034.23	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,425.26	6,211.93	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	178,935.72	0.00	AMBULANCE	0.00	0.00
GI SERVICES	57,855.69	1,367.08	CAST ROOM	0.00	0.00
EMERGENCY ROOM	731,239.13	7,801.51	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,352.99	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	44,690.43	12,178.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	242.98	352.67	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,240.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,555.61	1,253.49			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,606.12	2,188.62			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,050.67	4,175.45			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,513.91	1,213.77			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	63,261.98	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	74,257.30	1,314.76			
			TOTAL ANCILLARY	3,786,936.63	311,427.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,786,936.63	311,427.18

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,339.61	ADJUSTMENTS	0.00
COVERED CHARGES	25,688.27	CONTRACTUAL ALLOW	15,039.19
NON-COVERD CHARGES	3,651.34	TOTAL MEDICAID LIAB	10,649.08
		LESS: COB	10,634.08
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27



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

DODGE COUNTY HOSPITAL  
 901 GRIFFIN AVE  
 EASTMAN,GA 31023-6720

PROVIDER NUMBER  
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	388.17	0.00	OTHER LAB	431.47	0.00
MED/SURG SUPPLY	1,417.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	99.07	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	801.93	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,609.34	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,784.02	0.00	FEE SCHEDULE LAB	7,059.63	3,303.37
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	796.57	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,044.22	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,406.67	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	848.72	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,297.91	72.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	236.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4.82	175.95
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	560.62	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	25,688.27	3,651.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,688.27	3,651.34

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	277,176.22	ADJUSTMENTS	585.34
COVERED CHARGES	262,217.35	CONTRACTUAL ALLOW	244,428.43
NON-COVERD CHARGES	14,958.87	TOTAL MEDICAID LIAB	17,788.92
		LESS: COB	0.00
		LESS: COPAYMENT	636.02
		REIMBURSEMENT	17,152.90
		TOTAL NUMBER OF CLAIMS	318

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,982.68	0.00	OTHER LAB	1,175.50	0.00
MED/SURG SUPPLY	6,575.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,208.27	126.28	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,435.44	1,755.12	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	46,948.37	9,375.93
EKG/ECG	3,418.04	285.53	MRI SERVICES	0.00	0.00
IV THERAPY	9,880.26	1,924.33	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	873.28	281.06	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	165,276.11	973.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,307.85	237.62
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	152.29	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	983.84	0.00			
			TOTAL ANCILLARY	262,217.35	14,958.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	262,217.35	14,958.87

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: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
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

DODGE COUNTY HOSPITAL  
901 GRIFFIN AVE  
EASTMAN,GA 31023-6720

PROVIDER NUMBER  
000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,620.53	ADJUSTMENTS	0.00
COVERED CHARGES	22,585.37	CONTRACTUAL ALLOW	17,737.74
NON-COVERD CHARGES	35.16	TOTAL MEDICAID LIAB	4,847.63
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	4,841.63

TOTAL NUMBER OF CLAIMS 1

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

DODGE COUNTY HOSPITAL  
 901 GRIFFIN AVE  
 EASTMAN,GA 31023-6720

PROVIDER NUMBER  
 000000591A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	509.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,342.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	264.90	0.00
EKG/ECG	261.30	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,730.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,210.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	229.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38.20	35.16
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,585.37	35.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,585.37	35.16

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

DODGE COUNTY HOSPITAL  
901 GRIFFIN AVE  
EASTMAN,GA 31023-6720

PROVIDER NUMBER  
000000591A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DORMINY MEDICAL CENTER  
 200 PERRY HOUSE RD  
 FITZGERALD,GA 31750-8857

PROVIDER NUMBER 000000613A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,174,195.28	ADJUSTMENTS	14,396.56
COVERED CHARGES	2,133,031.03	CONTRACTUAL ALLOW	1,000,430.53
NON-COVERD CHARGES	41,164.25	TOTAL MEDICAID LIAB	1,132,600.50
		LESS: COB	19,317.90
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,113,282.60

TOTAL NUMBER OF ADMISSIONS 185

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	309		0	126,270.00		11,195.00
ROUTINE NURSERY	22		0	5,720.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	331		0	131,990.00		11,195.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	261		11	264,350.00		9,075.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	261		11	264,350.00		9,075.00
TOTAL ACCOMODATIONS	592		11	396,340.00		20,270.00



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

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

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	415,368.94	4,100.50	OTHER LAB	8,567.00	0.00
MED/SURG SUPPLY	144,404.03	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	324,224.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,969.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	171,945.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,386.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	28,165.50	0.00	MRI SERVICES	22,492.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	1,050.75
OPERATING ROOM	68,808.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,712.75	5,157.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	132,512.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,566.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,476.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,269.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,807.75	0.00	INJECTABLE DRUGS	175,338.81	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	393.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,069.75	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	690.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,406.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,860.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	26,510.75	6,368.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,484.50	234.00			
AUDIOLOGY	425.00	0.00			
CARDIOLOGY	32,732.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,480.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,313.75	3,293.75			
			TOTAL ANCILLARY	1,736,691.03	20,894.25
			TOTAL ACCOMODATIONS	396,340.00	20,270.00
			TOTAL CHARGES	2,133,031.03	41,164.25

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

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

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

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	08/01/12	THROUGH	07/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 09:46:40  
Page: 4

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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,365,549.32	ADJUSTMENTS	73,176.16
COVERED CHARGES	2,050,073.61	CONTRACTUAL ALLOW	1,374,052.10
NON-COVERD CHARGES	315,475.71	TOTAL MEDICAID LIAB	676,021.51
		LESS: COB	867.12
		LESS: COPAYMENT	2,468.63
		REIMBURSEMENT	672,685.76
		ALL OTHER	590,177.84
		FEE SCHEDULE-LAB	71,717.57
		INJECTABLE DRUGS	10,790.35

TOTAL NUMBER OF CLAIMS 2,342

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	87,972.66	46,364.31	OTHER LAB	16,118.50	65.00
MED/SURG SUPPLY	130,762.19	51.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	422.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	102,064.25	3,044.25	OTHER THERAPEUTIC SVC	0.00	1,857.25
CT SCAN	243,136.00	13,358.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,555.25	8,443.75	FEE SCHEDULE LAB	429,708.85	103,521.90
EKG/ECG	30,582.25	3,921.00	MRI SERVICES	75,539.00	2,015.75
IV THERAPY	1,849.25	150.00	PROFESSIONAL FEES	0.00	1,401.00
OPERATING ROOM	162,193.50	36,122.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,537.00	1,007.25	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,112.50	9,241.75	FREE STANDING CLINIC	67.04	0.00
ANESTHESIA	23,350.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	218,318.75	850.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,994.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100,897.38	28,040.40
RADIOLOGY THERAPEUTIC	8,920.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,163.00	2,811.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,388.50	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	14,355.95	2,110.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	18,989.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	62,684.50	4,266.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,830.25	1,928.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	103,012.00	20,148.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	53,234.75	4,350.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	61,835.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	32,890.79	993.25			
			TOTAL ANCILLARY	2,050,073.61	315,475.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,050,073.61	315,475.71

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,990.60	ADJUSTMENTS	0.00
COVERED CHARGES	18,216.10	CONTRACTUAL ALLOW	622.31
NON-COVERD CHARGES	10,774.50	TOTAL MEDICAID LIAB	17,593.79
		LESS: COB	17,569.79
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

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

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225.00	301.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,414.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,337.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,611.00	5,644.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,008.25	965.00
EKG/ECG	503.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,448.25	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	583.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,227.75	53.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	803.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,165.50	362.50
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	74.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,262.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,216.10	10,774.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,216.10	10,774.50

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

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

Run Date: 07/23/2014  
Run Time: 09:47:10  
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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	224,562.94	ADJUSTMENTS	1,500.31
COVERED CHARGES	206,907.69	CONTRACTUAL ALLOW	184,875.38
NON-COVERD CHARGES	17,655.25	TOTAL MEDICAID LIAB	22,032.31
		LESS: COB	24.22
		LESS: COPAYMENT	681.06
		REIMBURSEMENT	21,327.03
		TOTAL NUMBER OF CLAIMS	394

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,433.50	3,332.00	OTHER LAB	955.00	0.00
MED/SURG SUPPLY	5,315.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,453.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,029.00	2,540.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	54,521.75	8,994.75
EKG/ECG	5,142.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	1,280.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	89,303.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,991.50	1,508.50
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	11.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,237.75	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	513.25	0.00			
			TOTAL ANCILLARY	206,907.69	17,655.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	206,907.69	17,655.25



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

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

Run Date: 07/23/2014  
Run Time: 09:47:15  
Page: 10

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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,523.43	ADJUSTMENTS	0.00
COVERED CHARGES	6,299.93	CONTRACTUAL ALLOW	5,134.80
NON-COVERD CHARGES	223.50	TOTAL MEDICAID LIAB	1,165.13
		LESS: COB	1,156.13
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 8

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24.00	207.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	66.43	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	308.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,110.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	824.75	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,765.75	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	201.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,299.93	223.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,299.93	223.50

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

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

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	605,019.76	ADJUSTMENTS	19,177.08
COVERED CHARGES	597,245.55	CONTRACTUAL ALLOW	496,219.38
NON-COVERD CHARGES	7,774.21	TOTAL MEDICAID LIAB	101,026.17
		LESS: COB	0.00
		LESS: COPAYMENT	258.00
		REIMBURSEMENT	100,768.17
		TOTAL NUMBER OF CLAIMS	21

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,934.52	1,359.21	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,320.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	170.00	0.00	OTHER THERAPEUTIC SVC	0.00	3,035.25
CT SCAN	3,522.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,513.25	1,760.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,592.25	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	64.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	522,935.77	711.00
RADIOLOGY THERAPEUTIC	27,150.00	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	3,209.00	446.25	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	898.75	398.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	597,245.55	7,774.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	597,245.55	7,774.21

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

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

Run Date: 07/23/2014  
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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	08/01/12	THROUGH	07/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 12:15:29  
 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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,344,376.91	ADJUSTMENTS	1,329,056.49
COVERED CHARGES	21,861,247.10	CONTRACTUAL ALLOW	15,804,697.65
NON-COVERD CHARGES	483,129.81	TOTAL MEDICAID LIAB	6,056,549.45
		LESS: COB	36,543.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,020,006.03

TOTAL NUMBER OF ADMISSIONS 723

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	978	71	990,679.00	72,398.00
ROUTINE NURSERY	181	0	63,678.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	1,159	71	1,054,357.00	72,398.00
SPECIAL CARE SERVICES				
CCU	1,389	24	1,929,292.00	51,874.00
ICU	354	0	918,004.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,743	24	2,847,296.00	51,874.00
TOTAL ACCOMODATIONS	2,902	95	3,901,653.00	124,272.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR DOUGLAS HOSPITAL  
 8954 HOSPITAL DR  
 DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,018,299.83	30,786.75	OTHER LAB	215,264.00	0.00
MED/SURG SUPPLY	724,434.77	14,798.06	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,286,225.00	13,161.00	EDUCATION & TRAINING	7,655.00	0.00
RADIOLOGY-DIAGNOSTIC	569,011.00	4,794.00	OTHER THERAPEUTIC SVC	0.00	320.00
CT SCAN	1,505,580.00	6,895.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	58,362.00	173.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	181,526.00	646.00	MRI SERVICES	386,929.00	0.00
IV THERAPY	461,613.00	73,571.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	968,625.00	3,467.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	577,263.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,191,272.00	14,844.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	275,203.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,115,682.00	3,821.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	147,069.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	83,260.64	348.00	INJECTABLE DRUGS	516.00	0.00
RADIOLOGY THERAPEUTIC	2,178.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	33,446.00	856.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	358,224.00	46,710.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,618.00	2,637.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	4,824.00	0.00	IMPL DEV CHARGE PATIENTS	106,563.84	1,725.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	63,187.00
OTHER IMAGING SERVICE	182,053.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	179,539.00	50,078.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	307,100.00	10,717.00			
AUDIOLOGY	32,760.00	0.00			
CARDIOLOGY	861,239.00	15,114.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	66,300.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,959.02	209.00			
			TOTAL ANCILLARY	17,959,594.10	358,857.81
			TOTAL ACCOMODATIONS	3,901,653.00	124,272.00
			TOTAL CHARGES	21,861,247.10	483,129.81

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: 07/23/2014  
Run Time: 12:15:29  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012234054595	08/09/12 - 08/11/12	08/27/12	0.00	6,533.00	0.00	0.00	0.00
615	2012242106473	08/21/12 - 08/22/12	09/03/12	0.00	6,533.00	0.00	0.00	0.00
615	2012264066731	09/09/12 - 09/11/12	09/24/12	0.00	2,947.00	0.00	0.00	0.00
615	2012265102171	09/14/12 - 09/15/12	10/01/12	0.00	6,533.00	0.00	0.00	0.00
615	2012271081653	09/19/12 - 09/21/12	10/01/12	0.00	2,947.00	0.00	0.00	0.00
615	2012299077340	07/25/12 - 07/30/12	10/29/12	0.00	6,533.00	0.00	0.00	0.00
615	2013003018586	12/13/12 - 12/19/12	01/07/13	0.00	2,947.00	0.00	0.00	0.00
615	2013056039426	02/13/13 - 02/15/13	03/04/13	0.00	6,533.00	0.00	0.00	0.00
615	2013119032512	04/19/13 - 04/20/13	05/06/13	0.00	6,533.00	0.00	0.00	0.00
615	2013213084367	04/16/13 - 04/23/13	08/05/13	0.00	2,834.00	0.00	0.00	0.00
615	2013263094582	02/17/13 - 02/19/13	09/30/13	0.00	5,781.00	0.00	0.00	0.00
615	2014058079014	02/13/13 - 02/17/13	03/03/14	0.00	6,533.00	0.00	0.00	0.00
TOTAL				0.00	63,187.00	0.00	0.00	0.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR DOUGLAS HOSPITAL  
 8954 HOSPITAL DR  
 DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER 000000624A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,705.25	ADJUSTMENTS	0.00
COVERED CHARGES	76,455.25	CONTRACTUAL ALLOW	22,348.38
NON-COVERD CHARGES	250.00	TOTAL MEDICAID LIAB	54,106.87
		LESS: COB	54,106.87
		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	12		0	12,168.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	12,168.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	12		0	12,168.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR DOUGLAS HOSPITAL  
 8954 HOSPITAL DR  
 DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,482.25	250.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,751.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,833.00	0.00	EDUCATION & TRAINING	218.00	0.00
RADIOLOGY-DIAGNOSTIC	1,898.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	323.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,101.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,478.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,217.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,408.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,679.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,848.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	672.00	0.00	INJECTABLE DRUGS	234.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	72.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	864.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	209.00	0.00			
			TOTAL ANCILLARY	64,287.25	250.00
			TOTAL ACCOMODATIONS	12,168.00	0.00
			TOTAL CHARGES	76,455.25	250.00

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

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

Run Date: 07/23/2014  
Run Time: 12:15:45  
Page: 6

WELLSTAR DOUGLAS HOSPITAL  
8954 HOSPITAL DR  
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,618,564.18	ADJUSTMENTS	413,327.59
COVERED CHARGES	12,837,763.74	CONTRACTUAL ALLOW	10,250,454.11
NON-COVERD CHARGES	780,800.44	TOTAL MEDICAID LIAB	2,587,309.63
		LESS: COB	5,156.12
		LESS: COPAYMENT	3,204.00
		REIMBURSEMENT	2,578,949.51
		ALL OTHER	2,404,667.86
		FEE SCHEDULE-LAB	148,989.20
		INJECTABLE DRUGS	25,292.45
		TOTAL NUMBER OF CLAIMS	5,679

WELLSTAR DOUGLAS HOSPITAL  
 8954 HOSPITAL DR  
 DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	337,930.75	32,959.50	OTHER LAB	120,360.00	3,016.00
MED/SURG SUPPLY	112,970.00	1,867.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	3,078.00	1,140.00
RADIOLOGY-DIAGNOSTIC	925,489.00	4,457.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,205,835.00	77,537.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,572.00	19,364.00	FEE SCHEDULE LAB	1,911,483.26	239,073.94
EKG/ECG	155,315.00	3,553.00	MRI SERVICES	412,592.00	40,954.00
IV THERAPY	469,128.00	3,808.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	511,970.00	43,664.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	102,600.00	0.00	REHAB THERAPY	1,255.00	0.00
RESPIRATORY SERVICES	107,066.00	51,438.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	177,481.00	3,054.00	AMBULANCE	0.00	0.00
GI SERVICES	7,928.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,676,519.00	44,901.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	143,892.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	687.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	145,057.00	79,136.00
RADIOLOGY THERAPEUTIC	18,726.00	1,848.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	23,355.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,772.00	3,654.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	16,884.00	0.00	IMPL DEV CHARGE PATIENTS	14,442.00	19,788.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	520,450.00	56,792.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,433.00	2,142.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	222,481.00	2,339.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	139,437.00	20,273.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	230,078.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	104,539.73	0.00			
			TOTAL ANCILLARY	12,837,763.74	780,800.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,837,763.74	780,800.44

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	231,192.71	ADJUSTMENTS	0.00
COVERED CHARGES	204,102.51	CONTRACTUAL ALLOW	46,029.70
NON-COVERD CHARGES	27,090.20	TOTAL MEDICAID LIAB	158,072.81
		LESS: COB	158,006.81
		LESS: COPAYMENT	66.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 88

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

WELLSTAR DOUGLAS HOSPITAL  
 8954 HOSPITAL DR  
 DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,596.75	615.00	OTHER LAB	0.00	1,084.00
MED/SURG SUPPLY	2,982.00	235.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	228.00	0.00
RADIOLOGY-DIAGNOSTIC	16,247.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,197.00	15,972.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	32,483.14	3,286.20
EKG/ECG	2,907.00	0.00	MRI SERVICES	6,533.00	0.00
IV THERAPY	9,250.00	80.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,107.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,288.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,528.00	611.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	2,645.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	54,062.00	315.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,344.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	195.00	750.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	5,798.00	1,497.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,634.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	303.62	0.00			
			TOTAL ANCILLARY	204,102.51	27,090.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	204,102.51	27,090.20

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,396,763.18	ADJUSTMENTS	1,064.79
COVERED CHARGES	1,364,299.18	CONTRACTUAL ALLOW	1,306,121.58
NON-COVERD CHARGES	32,464.00	TOTAL MEDICAID LIAB	58,177.60
		LESS: COB	0.00
		LESS: COPAYMENT	1,683.08
		REIMBURSEMENT	56,494.52
		TOTAL NUMBER OF CLAIMS	1,040

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,601.25	1,350.00	OTHER LAB	7,828.00	4,336.00
MED/SURG SUPPLY	4,639.00	235.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	73,164.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	105,245.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	238,355.80	18,672.50
EKG/ECG	15,827.00	0.00	MRI SERVICES	5,651.00	0.00
IV THERAPY	46,083.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,748.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,901.00	2,704.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	509.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	766,505.00	2,450.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,693.00	623.50
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	87.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,841.00	1,497.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,787.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,430.13	0.00			
			TOTAL ANCILLARY	1,364,299.18	32,464.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,364,299.18	32,464.00



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

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

Run Date: 07/23/2014  
Run Time: 12:16:39  
Page: 12

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,170.25	ADJUSTMENTS	0.00
COVERED CHARGES	32,477.25	CONTRACTUAL ALLOW	17,313.18
NON-COVERD CHARGES	693.00	TOTAL MEDICAID LIAB	15,164.07
		LESS: COB	15,140.07
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	13

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WELLSTAR DOUGLAS HOSPITAL  
 8954 HOSPITAL DR  
 DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	354.50	300.00	OTHER LAB	2,003.00	0.00
MED/SURG SUPPLY	179.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,210.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,044.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,381.00	208.00
EKG/ECG	323.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,455.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	218.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,200.00	140.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	109.75	45.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,477.25	693.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,477.25	693.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	658,082.25	ADJUSTMENTS	9,067.24
COVERED CHARGES	640,325.50	CONTRACTUAL ALLOW	554,016.66
NON-COVERD CHARGES	17,756.75	TOTAL MEDICAID LIAB	86,308.84
		LESS: COB	0.00
		LESS: COPAYMENT	283.80
		REIMBURSEMENT	86,025.04
		TOTAL NUMBER OF CLAIMS	17

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,815.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,938.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	829.00	818.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,755.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,333.00	5,182.00
EKG/ECG	323.00	323.00	MRI SERVICES	0.00	0.00
IV THERAPY	54,329.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,175.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,102.00	4,006.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,291.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,830.00	209.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,293.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	411,844.25	6,013.75
RADIOLOGY THERAPEUTIC	12,006.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,578.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	31,594.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,634.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	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	1,205.00			
			TOTAL ANCILLARY	640,325.50	17,756.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	640,325.50	17,756.75

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: 07/23/2014  
Run Time: 12:16:43  
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR DOUGLAS HOSPITAL  
8954 HOSPITAL DR  
DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,561.00	ADJUSTMENTS	0.00
COVERED CHARGES	21,471.00	CONTRACTUAL ALLOW	7,944.97
NON-COVERD CHARGES	90.00	TOTAL MEDICAID LIAB	13,526.03
		LESS: COB	13,523.03
		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

WELLSTAR DOUGLAS HOSPITAL  
 8954 HOSPITAL DR  
 DOUGLASVILLE,GA 30134-2224

PROVIDER NUMBER  
 000000624A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15.00	90.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	80.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	20,310.00	0.00
RADIOLOGY THERAPEUTIC	378.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	21,471.00	90.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	21,471.00	90.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	231,204.91	ADJUSTMENTS	0.00
COVERED CHARGES	222,556.91	CONTRACTUAL ALLOW	113,291.17
NON-COVERD CHARGES	8,648.00	TOTAL MEDICAID LIAB	109,265.74
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	109,265.74

TOTAL NUMBER OF ADMISSIONS 25

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	58		14	31,320.00		7,560.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	58		14	31,320.00		7,560.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	58		14	31,320.00		7,560.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,851.73	0.00	OTHER LAB	636.00	0.00
MED/SURG SUPPLY	17,675.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,615.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,370.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,791.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,606.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,160.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,071.00	0.00	PROFESSIONAL FEES	0.00	619.00
OPERATING ROOM	0.00	57.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,032.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,584.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	153.00	0.00	INJECTABLE DRUGS	3,551.18	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	447.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	880.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	412.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,814.00	0.00			
			TOTAL ANCILLARY	191,236.91	1,088.00
			TOTAL ACCOMODATIONS	31,320.00	7,560.00
			TOTAL CHARGES	222,556.91	8,648.00



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

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

Run Date: 07/23/2014  
Run Time: 09:46:20  
Page: 3

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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 09:46:20  
Page: 4

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	869,800.58	ADJUSTMENTS	20,056.35
COVERED CHARGES	763,783.58	CONTRACTUAL ALLOW	528,739.70
NON-COVERD CHARGES	106,017.00	TOTAL MEDICAID LIAB	235,043.88
		LESS: COB	0.00
		LESS: COPAYMENT	885.00
		REIMBURSEMENT	234,158.88
		ALL OTHER	210,249.76
		FEE SCHEDULE-LAB	20,814.71
		INJECTABLE DRUGS	3,094.41

TOTAL NUMBER OF CLAIMS 815

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,784.63	21.00	OTHER LAB	2,320.00	0.00
MED/SURG SUPPLY	14,851.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,396.00	716.00	OTHER THERAPEUTIC SVC	0.00	1,830.00
CT SCAN	105,537.00	16,454.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,084.00	4,999.00	FEE SCHEDULE LAB	249,486.00	54,296.00
EKG/ECG	4,272.00	0.00	MRI SERVICES	6,535.00	0.00
IV THERAPY	13,911.00	424.00	PROFESSIONAL FEES	0.00	491.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,883.00	15,064.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	227,678.00	9,364.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,269.95	400.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	165.00	338.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	534.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,323.00	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	1,769.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	25,985.00	1,620.00			
			TOTAL ANCILLARY	763,783.58	106,017.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	763,783.58	106,017.00

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

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

Run Date: 07/23/2014  
Run Time: 09:46:27  
Page: 6

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,537.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,537.00	CONTRACTUAL ALLOW	854.85
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	682.15
		LESS: COB	679.15
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

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

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
 11740 COLUMBIA ST  
 BLAKELY,GA 39823-2574

PROVIDER NUMBER  
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	358.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	509.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	670.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,537.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,537.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 09:46:27  
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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	89,582.02	ADJUSTMENTS	0.00
COVERED CHARGES	83,016.02	CONTRACTUAL ALLOW	77,316.02
NON-COVERD CHARGES	6,566.00	TOTAL MEDICAID LIAB	5,700.00
		LESS: COB	0.00
		LESS: COPAYMENT	186.00
		REIMBURSEMENT	5,514.00
		TOTAL NUMBER OF CLAIMS	114

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,938.03	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	3,524.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,978.00	4,765.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,229.00	1,413.00
EKG/ECG	420.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	296.00	0.00	PROFESSIONAL FEES	0.00	313.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,713.00	75.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	428.99	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	255.00	0.00			
			TOTAL ANCILLARY	83,016.02	6,566.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	83,016.02	6,566.00

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

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

Run Date: 07/23/2014  
Run Time: 09:46:28  
Page: 10

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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



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

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

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
11740 COLUMBIA ST  
BLAKELY,GA 39823-2574

PROVIDER NUMBER  
000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	72,611.64	ADJUSTMENTS	0.00
COVERED CHARGES	42,905.64	CONTRACTUAL ALLOW	34,189.22
NON-COVERD CHARGES	29,706.00	TOTAL MEDICAID LIAB	8,716.42
		LESS: COB	0.00
		LESS: COPAYMENT	180.00
		REIMBURSEMENT	8,536.42
		TOTAL NUMBER OF CLAIMS	2

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

PIONEER HEALTH SERVICES OF EARLY COUNTY, LLC  
 11740 COLUMBIA ST  
 BLAKELY,GA 39823-2574

PROVIDER NUMBER  
 000000635A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,353.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,580.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	895.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,085.00	1,093.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,711.00	28,613.00	FREE STANDING CLINIC	0.00	0.00
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	1,280.88	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,905.64	29,706.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,905.64	29,706.00

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

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

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	139,435.38	ADJUSTMENTS	5,090.17
COVERED CHARGES	100,206.38	CONTRACTUAL ALLOW	65,579.03
NON-COVERD CHARGES	39,229.00	TOTAL MEDICAID LIAB	34,627.35
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	34,627.35

TOTAL NUMBER OF ADMISSIONS 8

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	15		0	12,375.00		22,958.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	15		0	12,375.00		22,958.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	15		0	12,375.00		22,958.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,011.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,581.00	314.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,259.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,886.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,103.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,418.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.78	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	13,611.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,124.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,530.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,636.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,663.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,021.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	257.00	0.00	INJECTABLE DRUGS	72.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,153.00	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.	1,228.00	2,244.00			
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	50.00	0.00			
			TOTAL ANCILLARY	87,831.38	16,271.00
			TOTAL ACCOMODATIONS	12,375.00	22,958.00
			TOTAL CHARGES	100,206.38	39,229.00

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

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

Run Date: 07/23/2014  
Run Time: 09:42:55  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 09:42:56  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,976,410.40	ADJUSTMENTS	38,490.57
COVERED CHARGES	1,653,852.60	CONTRACTUAL ALLOW	1,173,595.67
NON-COVERD CHARGES	322,557.80	TOTAL MEDICAID LIAB	480,256.93
		LESS: COB	1,342.51
		LESS: COPAYMENT	885.00
		REIMBURSEMENT	478,029.42
		ALL OTHER	447,088.74
		FEE SCHEDULE-LAB	29,733.85
		INJECTABLE DRUGS	1,206.83

TOTAL NUMBER OF CLAIMS 1,360

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	64,036.00	0.00	OTHER LAB	19,452.00	2,890.00
MED/SURG SUPPLY	75,013.70	6.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	168,901.00	5,201.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	157,781.00	189,423.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,912.00	4,689.00	FEE SCHEDULE LAB	281,118.40	69,445.80
EKG/ECG	25,672.00	3,646.00	MRI SERVICES	80,857.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	68.00
OPERATING ROOM	48,149.00	18,326.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,446.00	1,969.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,908.00	4,565.00	AMBULANCE	0.00	0.00
GI SERVICES	28,210.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	559,053.00	950.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,736.00	1,620.00	DRUG-SPECIFIC/HOME IV	0.00	1,243.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,027.50	1,416.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,237.00	577.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	448.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,014.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	64,077.00	12,354.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,244.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,826.00	1,477.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,150.00	0.00			
AMBULATORY SURGERY	2,687.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,589.00	0.00			
			TOTAL ANCILLARY	1,653,852.60	322,557.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,653,852.60	322,557.80



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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,385.00	ADJUSTMENTS	0.00
COVERED CHARGES	33,375.00	CONTRACTUAL ALLOW	15,010.06
NON-COVERD CHARGES	7,010.00	TOTAL MEDICAID LIAB	18,364.94
		LESS: COB	18,355.94
		LESS: COPAYMENT	9.00
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	938.00	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	2,526.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,243.00	3,953.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,589.00	2,479.00
EKG/ECG	0.00	0.00	MRI SERVICES	3,043.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	257.00	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	13,385.00	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	149.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	956.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	942.00	321.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,375.00	7,010.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,375.00	7,010.00

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

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

Run Date: 07/23/2014  
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Page: 8

EFFINGHAM COUNTY HOSPITAL  
459 GA HIGHWAY 119 S  
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER  
000000657A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	169,748.00	ADJUSTMENTS	326.00
COVERED CHARGES	160,808.00	CONTRACTUAL ALLOW	152,658.00
NON-COVERD CHARGES	8,940.00	TOTAL MEDICAID LIAB	8,150.00
		LESS: COB	0.00
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	7,934.00
		TOTAL NUMBER OF CLAIMS	163

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,379.00	0.00	OTHER LAB	2,742.00	0.00
MED/SURG SUPPLY	1,110.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,275.00	409.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,243.00	2,243.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,620.00	2,524.00
EKG/ECG	1,242.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,078.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	115,693.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,064.00	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	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	2,010.00	3,610.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,352.00	0.00			
			TOTAL ANCILLARY	160,808.00	8,940.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	160,808.00	8,940.00



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	311.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	548.00	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	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,623.00	299.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,033.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,890.00	299.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,890.00	299.00

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

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

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL  
459 GA HIGHWAY 119 S  
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER  
000000657A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EFFINGHAM COUNTY HOSPITAL  
459 GA HIGHWAY 119 S  
SPRINGFIELD,GA 31329-3021

PROVIDER NUMBER  
000000657A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



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

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

Run Date: 07/23/2014  
 Run Time: 09:42:26  
 Page: 1

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

PROVIDER NUMBER 000000668A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	834,897.18	ADJUSTMENTS	5,847.41
COVERED CHARGES	769,183.18	CONTRACTUAL ALLOW	325,761.03
NON-COVERD CHARGES	65,714.00	TOTAL MEDICAID LIAB	443,422.15
		LESS: COB	7,418.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	436,003.75
		TOTAL NUMBER OF ADMISSIONS	75

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	277		0	140,716.00		62,354.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	277		0	140,716.00		62,354.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	5		0	6,025.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	6,025.00		0.00
TOTAL ACCOMODATIONS	282		0	146,741.00		62,354.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	137,327.34	0.00	OTHER LAB	7,065.17	0.00
MED/SURG SUPPLY	49,736.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	128,552.97	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,700.94	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	53,203.68	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,532.98	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,884.42	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,727.90	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,680.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56,773.73	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,938.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,400.96	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,555.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	50.00	0.00	INJECTABLE DRUGS	48,737.21	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,419.66	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,565.68	2,780.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,882.00	580.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,166.93	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	551.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	990.11	0.00			
			TOTAL ANCILLARY	622,442.18	3,360.00
			TOTAL ACCOMODATIONS	146,741.00	62,354.00
			TOTAL CHARGES	769,183.18	65,714.00

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

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

Run Date: 07/23/2014  
Run Time: 09:42:28  
Page: 3

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 09:42:28  
Page: 4

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

PROVIDER NUMBER  
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,485,124.88	ADJUSTMENTS	22,453.97
COVERED CHARGES	1,371,938.99	CONTRACTUAL ALLOW	1,038,267.72
NON-COVERD CHARGES	113,185.89	TOTAL MEDICAID LIAB	333,671.27
		LESS: COB	315.11
		LESS: COPAYMENT	1,467.00
		REIMBURSEMENT	331,889.16
		ALL OTHER	304,524.97
		FEE SCHEDULE-LAB	27,188.97
		INJECTABLE DRUGS	175.22
		TOTAL NUMBER OF CLAIMS	1,136

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

PROVIDER NUMBER  
 000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	72,917.23	5,858.02	OTHER LAB	18,752.93	0.00
MED/SURG SUPPLY	20,208.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	148.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	113,175.17	2,470.39	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	219,925.25	50,390.32	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,946.65	4,533.35	FEE SCHEDULE LAB	266,108.80	19,091.18
EKG/ECG	23,426.23	2,186.12	MRI SERVICES	24,811.72	0.00
IV THERAPY	52,285.54	14,467.08	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	107,220.00	4,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	17,818.52	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,537.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	296,249.12	1,858.44	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,825.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,174.12	2,050.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,100.00	1,407.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	320.00
OTHER IMAGING SERVICE	41,515.07	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,692.23	1,668.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,816.57	337.51			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,532.72	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,352.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,548.62	1,899.12			
			TOTAL ANCILLARY	1,371,938.99	113,185.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,371,938.99	113,185.89

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012201058010	07/14/12 - 07/14/12	07/23/12	0.00	160.00	0.00	0.00	0.00
392	2012201058010	07/15/12 - 07/15/12	07/23/12	0.00	160.00	0.00	0.00	0.00
TOTAL				0.00	320.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,925.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,885.00	CONTRACTUAL ALLOW	1,112.56
NON-COVERD CHARGES	40.50	TOTAL MEDICAID LIAB	772.44
		LESS: COB	772.44
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	21.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	683.00	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	410.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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	1,885.00	40.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,885.00	40.50



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

PROVIDER NUMBER  
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,769.79	ADJUSTMENTS	323.64
COVERED CHARGES	67,434.98	CONTRACTUAL ALLOW	61,617.22
NON-COVERD CHARGES	4,334.81	TOTAL MEDICAID LIAB	5,817.76
		LESS: COB	0.00
		LESS: COPAYMENT	201.00
		REIMBURSEMENT	5,616.76
		TOTAL NUMBER OF CLAIMS	104

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,326.21	252.15	OTHER LAB	1,852.66	0.00
MED/SURG SUPPLY	118.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,218.67	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,177.75	2,586.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,409.37	539.16
EKG/ECG	749.09	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,629.51	847.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	162.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,459.22	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	332.00	110.50
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	67,434.98	4,334.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,434.98	4,334.81

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

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

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

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

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

PROVIDER NUMBER  
000000668A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	95,283.22	ADJUSTMENTS	0.00
COVERED CHARGES	92,681.72	CONTRACTUAL ALLOW	82,735.46
NON-COVERD CHARGES	2,601.50	TOTAL MEDICAID LIAB	9,946.26
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	9,931.26

TOTAL NUMBER OF CLAIMS 2

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,168.22	15.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	72,145.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	278.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,586.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,398.00	0.00
EKG/ECG	137.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	253.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,760.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	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	575.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	395.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	69.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	280.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	92,681.72	2,601.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,681.72	2,601.50

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

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

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,998,578.54	ADJUSTMENTS	8,383.51
COVERED CHARGES	2,971,339.54	CONTRACTUAL ALLOW	1,870,011.15
NON-COVERD CHARGES	27,239.00	TOTAL MEDICAID LIAB	1,101,328.39
		LESS: COB	13,908.24
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,087,420.15

TOTAL NUMBER OF ADMISSIONS 208

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	570		0	282,857.30		8,080.00
ROUTINE NURSERY	44		0	21,868.00		3,678.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	614		0	304,725.30		11,758.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	125		0	137,750.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	125		0	137,750.00		0.00
TOTAL ACCOMODATIONS	739		0	442,475.30		11,758.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	996,746.90	2,576.00	OTHER LAB	6,323.00	0.00
MED/SURG SUPPLY	107,713.72	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	523,020.62	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	56,017.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	112,096.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,660.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	22,080.00	0.00	MRI SERVICES	30,466.00	0.00
IV THERAPY	48,928.00	0.00	PROFESSIONAL FEES	0.00	4,158.00
OPERATING ROOM	59,375.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,695.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	288,929.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,802.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	145,110.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,909.50	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	7,124.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,350.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,114.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	308.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,959.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	14,960.00	7,633.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,427.00	0.00			
AUDIOLOGY	6,980.00	0.00			
CARDIOLOGY	33,661.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,223.00	0.00			
			TOTAL ANCILLARY	2,528,864.24	15,481.00
			TOTAL ACCOMODATIONS	442,475.30	11,758.00
			TOTAL CHARGES	2,971,339.54	27,239.00



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

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

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Run Time: 09:49:31  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,808,903.10	ADJUSTMENTS	54,328.08
COVERED CHARGES	3,493,583.60	CONTRACTUAL ALLOW	2,736,350.47
NON-COVERD CHARGES	315,319.50	TOTAL MEDICAID LIAB	757,233.13
		LESS: COB	92.89
		LESS: COPAYMENT	1,869.00
		REIMBURSEMENT	755,271.24
		ALL OTHER	697,877.52
		FEE SCHEDULE-LAB	57,392.90
		INJECTABLE DRUGS	0.82
		TOTAL NUMBER OF CLAIMS	2,257

EMANUEL MEDICAL CENTER  
 117 KITE RD  
 SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
 000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	330,652.00	0.00	OTHER LAB	14,940.00	1,436.00
MED/SURG SUPPLY	145,958.60	1,497.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	16.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	210,184.00	4,970.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	353,342.00	30,976.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	828,449.00	203,656.50
EKG/ECG	49,620.00	2,880.00	MRI SERVICES	169,138.00	2,964.00
IV THERAPY	126,806.00	20,104.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	123,136.00	10,154.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	975.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,430.00	3,238.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,142.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	683,565.00	9,385.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,322.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	351.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	728.00	364.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,894.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	5,270.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	159,471.00	1,520.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,760.00	898.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	23,014.00	4,510.00			
AUDIOLOGY	0.00	349.00			
CARDIOLOGY	33,310.00	1,421.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	58,883.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	120,513.00	9,711.00			
			TOTAL ANCILLARY	3,493,583.60	315,319.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,493,583.60	315,319.50

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMANUEL MEDICAL CENTER  
117 KITE RD  
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,675.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,612.00	CONTRACTUAL ALLOW	12,590.68
NON-COVERD CHARGES	10,063.00	TOTAL MEDICAID LIAB	7,021.32
		LESS: COB	7,015.32
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

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

EMANUEL MEDICAL CENTER  
 117 KITE RD  
 SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
 000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,322.00	616.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	199.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	999.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,454.00	2,639.00
EKG/ECG	960.00	0.00	MRI SERVICES	6,449.00	6,708.00
IV THERAPY	371.00	100.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,132.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	601.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,612.00	10,063.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,612.00	10,063.00

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

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

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EMANUEL MEDICAL CENTER  
117 KITE RD  
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
000000701A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	327,186.00	ADJUSTMENTS	329.64
COVERED CHARGES	306,220.00	CONTRACTUAL ALLOW	288,542.96
NON-COVERD CHARGES	20,966.00	TOTAL MEDICAID LIAB	17,677.04
		LESS: COB	0.00
		LESS: COPAYMENT	525.00
		REIMBURSEMENT	17,152.04
		TOTAL NUMBER OF CLAIMS	316

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	42,158.00	0.00	OTHER LAB	0.00	718.00
MED/SURG SUPPLY	4,756.00	41.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,600.00	2,868.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,479.00	3,250.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	59,733.00	9,364.00
EKG/ECG	1,440.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,711.00	2,479.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,628.00	285.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	135,650.00	361.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	601.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,464.00	1,600.00			
			TOTAL ANCILLARY	306,220.00	20,966.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	306,220.00	20,966.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,279.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,279.00	CONTRACTUAL ALLOW	1,350.29
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,928.71
		LESS: COB	2,928.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5



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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	271.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	57.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,066.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	241.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,644.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,279.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,279.00	0.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,946.00	ADJUSTMENTS	0.00
COVERED CHARGES	42,013.00	CONTRACTUAL ALLOW	32,365.72
NON-COVERD CHARGES	1,933.00	TOTAL MEDICAID LIAB	9,647.28
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	9,644.28
		TOTAL NUMBER OF CLAIMS	2

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,371.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	562.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	231.00	231.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,443.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,969.00	1,446.00
EKG/ECG	960.00	0.00	MRI SERVICES	19,545.00	0.00
IV THERAPY	678.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	491.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,507.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,421.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,835.00	256.00			
			TOTAL ANCILLARY	42,013.00	1,933.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,013.00	1,933.00

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

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

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMANUEL MEDICAL CENTER  
117 KITE RD  
SWAINSBORO,GA 30401-3231

PROVIDER NUMBER  
000000701A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY UNIV HOSPPT FINANCIALSERV  
 1364 CLIFTON RD NE DEPT RM  
 ATLANTA,GA 30322-1059

PROVIDER NUMBER 000000712A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	121,648,980.10	ADJUSTMENTS	9,533,338.51
COVERED CHARGES	115,016,277.62	CONTRACTUAL ALLOW	76,634,996.06
NON-COVERD CHARGES	6,632,702.48	TOTAL MEDICAID LIAB	38,381,281.56
		LESS: COB	246,302.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	38,134,978.69

TOTAL NUMBER OF ADMISSIONS 1,923

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,179		23	9,380,709.70		679,485.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,179		23	9,380,709.70		679,485.00
SPECIAL CARE SERVICES						
CCU	542		0	2,277,885.00		0.00
ICU	6,748		0	19,318,477.70		157,435.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	542		0	1,054,490.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		1,976	0.00		3,258,020.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	7,832		1,976	22,650,852.70		3,415,455.00
TOTAL ACCOMODATIONS	16,011		1,999	32,031,562.40		4,094,940.00

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

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

Run Date: 07/23/2014  
 Run Time: 12:04:21  
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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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,063,754.18	87,999.65	OTHER LAB	759,768.00	4,372.00
MED/SURG SUPPLY	7,127,114.32	245,188.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,578,387.28	304,782.00	EDUCATION & TRAINING	0.00	100.00
RADIOLOGY-DIAGNOSTIC	1,625,369.00	5,692.00	OTHER THERAPEUTIC SVC	0.00	8,264.00
CT SCAN	3,513,896.00	41,193.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,678,013.08	32,730.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	316,881.00	1,123.00	MRI SERVICES	3,120,472.00	17,042.00
IV THERAPY	13,228.25	1,831.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,074,789.92	55,576.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,356,126.00	87,438.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,284,448.00	18,560.00	AMBULANCE	0.00	0.00
GI SERVICES	409,116.00	18,974.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,092,695.00	17,036.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	684,960.00	5,685.00	DRUG-SPECIFIC/HOME IV	0.00	372,671.87
LABORATORY PATHOLOGIC	995,436.00	4,312.00	INJECTABLE DRUGS	14,045,481.60	206,417.93
RADIOLOGY THERAPEUTIC	134,028.00	13,464.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,568,908.02	33,608.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	621,325.00	14,876.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	615,657.00	62,612.00	PATIENT CONVENIENCE	0.00	218.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	38.00	341.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,770.00	0.00	IMPL DEV CHARGE PATIENTS	2,738,988.82	1,570.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	364,400.00
OTHER IMAGING SERVICE	246,530.00	256,780.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,732,755.00	17,524.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	91,344.00	87,379.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,202,589.00	6,552.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,122,302.00	9,821.00			
ORGAN ACQUISITION	1,152,654.75	131,629.00			
TREATMENT/OBSERV. RM	8,890.00	0.00			
			TOTAL ANCILLARY	82,984,715.22	2,537,762.48
			TOTAL ACCOMODATIONS	32,031,562.40	4,094,940.00
			TOTAL CHARGES	115,016,277.62	6,632,702.48

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012262032803	09/01/12 - 09/10/12	09/24/12	0.00	5,982.00	0.00	0.00	0.00
614	2012270018054	09/04/12 - 09/19/12	10/01/12	0.00	5,982.00	0.00	0.00	0.00
614	2012276014024	09/15/12 - 09/25/12	10/08/12	0.00	5,982.00	0.00	0.00	0.00
614	2012289011511	09/23/12 - 10/03/12	10/22/12	0.00	5,982.00	0.00	0.00	0.00
614	2012296011899	10/08/12 - 10/12/12	11/05/12	0.00	5,982.00	0.00	0.00	0.00
614	2212307006319	09/24/12 - 10/12/12	11/05/12	0.00	204.00	0.00	0.00	0.00
614	2012310010673	10/23/12 - 10/27/12	11/12/12	0.00	5,982.00	0.00	0.00	0.00
614	2012313019668	10/27/12 - 11/02/12	11/12/12	0.00	5,982.00	0.00	0.00	0.00
614	2212319000416	10/15/12 - 10/23/12	11/19/12	0.00	5,982.00	0.00	0.00	0.00
614	2012319006840	11/02/12 - 11/07/12	11/19/12	0.00	5,982.00	0.00	0.00	0.00
614	2012328045019	11/05/12 - 11/09/12	11/26/12	0.00	5,982.00	0.00	0.00	0.00
614	2212341007674	10/18/12 - 10/30/12	12/10/12	0.00	5,982.00	0.00	0.00	0.00
614	2012347054465	11/04/12 - 11/25/12	12/17/12	0.00	5,982.00	0.00	0.00	0.00
614	2012355024486	10/07/12 - 10/20/12	12/24/12	0.00	5,982.00	0.00	0.00	0.00
614	2213043012794	01/12/13 - 01/17/13	02/18/13	0.00	5,982.00	0.00	0.00	0.00
614	2013050049864	02/08/13 - 02/13/13	02/25/13	0.00	5,982.00	0.00	0.00	0.00
614	2013052037564	09/20/12 - 09/29/12	02/25/13	0.00	5,982.00	0.00	0.00	0.00
614	2013056009738	02/13/13 - 02/18/13	03/04/13	0.00	11,964.00	0.00	0.00	0.00
614	5213056000102	11/07/12 - 11/30/12	03/04/13	0.00	5,982.00	0.00	0.00	0.00
614	2013057036469	02/12/13 - 02/20/13	03/04/13	0.00	5,982.00	0.00	0.00	0.00
614	2013105039953	12/01/12 - 12/11/12	04/22/13	0.00	5,982.00	0.00	0.00	0.00
614	2013109044063	03/31/13 - 04/04/13	04/22/13	0.00	5,982.00	0.00	0.00	0.00
614	5213109000134	01/17/13 - 02/08/13	04/29/13	0.00	5,982.00	0.00	0.00	0.00
614	2213127006555	03/28/13 - 04/05/13	05/13/13	0.00	5,982.00	0.00	0.00	0.00
614	5213137000122	02/08/13 - 03/01/13	05/27/13	0.00	2,705.00	0.00	0.00	0.00
614	2013141042772	03/30/13 - 04/15/13	05/27/13	0.00	5,982.00	0.00	0.00	0.00
614	2013154016018	12/27/12 - 01/07/13	06/10/13	0.00	5,982.00	0.00	0.00	0.00
614	2013154016187	04/04/13 - 04/09/13	06/10/13	0.00	5,982.00	0.00	0.00	0.00
614	5213161000183	01/09/13 - 03/20/13	06/17/13	0.00	5,982.00	0.00	0.00	0.00
614	2013177042873	01/22/13 - 02/05/13	07/01/13	0.00	5,982.00	0.00	0.00	0.00
614	2013191056803	12/04/12 - 12/18/12	07/15/13	0.00	5,982.00	0.00	0.00	0.00
614	2013196007860	06/25/13 - 07/01/13	07/22/13	0.00	5,982.00	0.00	0.00	0.00
614	2013198017001	06/13/13 - 07/08/13	07/22/13	0.00	5,982.00	0.00	0.00	0.00
614	2213211008261	12/06/12 - 12/28/12	08/05/13	0.00	5,982.00	0.00	0.00	0.00
614	5213212000157	01/10/13 - 04/04/13	08/05/13	0.00	14,669.00	0.00	0.00	0.00
614	2013217016948	07/22/13 - 07/26/13	08/12/13	0.00	5,982.00	0.00	0.00	0.00
614	5213226020619	05/16/13 - 05/24/13	08/19/13	0.00	5,982.00	0.00	0.00	0.00
614	2013249055593	08/21/13 - 08/31/13	09/09/13	0.00	5,982.00	0.00	0.00	0.00
614	5213256000128	03/14/13 - 04/29/13	09/23/13	0.00	5,982.00	0.00	0.00	0.00
614	2313259000073	02/02/13 - 02/12/13	10/21/13	0.00	5,982.00	0.00	0.00	0.00
614	2213260008759	05/10/13 - 05/15/13	09/23/13	0.00	5,982.00	0.00	0.00	0.00
618	5213262000125	10/06/12 - 10/24/12	09/23/13	0.00	5,848.00	0.00	0.00	0.00

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

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

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SUMMARY TYPE I  
INPATIENT PAID CLAIMS

EMORY 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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

614	2013263078181	12/01/12 - 12/17/12	09/23/13	0.00	5,982.00	0.00	0.00	0.00
614	2313268000105	02/24/13 - 03/04/13	11/04/13	0.00	5,982.00	0.00	0.00	0.00
614	2213289010793	07/04/13 - 07/19/13	10/21/13	0.00	5,982.00	0.00	0.00	0.00
614	5213296004416	04/11/13 - 05/10/13	10/28/13	0.00	5,982.00	0.00	0.00	0.00
614	1113284000752	08/20/13 - 08/25/13	11/04/13	0.00	5,982.00	0.00	0.00	0.00
614	5213302000023	08/18/13 - 09/06/13	11/04/13	0.00	5,982.00	0.00	0.00	0.00
614	5213310000021	03/13/13 - 04/12/13	11/11/13	0.00	5,982.00	0.00	0.00	0.00
614	2013319035575	08/18/13 - 08/30/13	11/18/13	0.00	5,982.00	0.00	0.00	0.00
614	5213326000144	06/26/13 - 08/02/13	12/02/13	0.00	5,982.00	0.00	0.00	0.00
614	9113287000053	02/12/13 - 02/20/13	12/16/13	0.00	5,982.00	0.00	3,832.42	0.00
614	1113337000104	05/06/13 - 05/11/13	12/23/13	0.00	5,982.00	0.00	2,500.00	0.00
614	2013353066725	08/15/13 - 08/20/13	12/23/13	0.00	5,982.00	0.00	0.00	0.00
614	2013354059347	11/12/12 - 11/18/12	12/23/13	0.00	5,982.00	0.00	0.00	0.00
614	5214017000006	06/02/13 - 07/03/13	01/20/14	0.00	5,982.00	0.00	0.00	0.00
614	2214048010599	05/15/13 - 05/28/13	02/24/14	0.00	5,982.00	0.00	0.00	0.00
614	2014141018327	05/01/13 - 05/02/13	05/26/14	0.00	11,964.00	0.00	0.00	0.00
614	9114162003582	05/30/13 - 06/01/13	07/07/14	0.00	5,982.00	0.00	1,296.04	0.00
TOTAL				0.00	364,400.00	0.00	7,628.46	0.00



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

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

Run Date: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,964,205.86	ADJUSTMENTS	0.00
COVERED CHARGES	2,949,377.84	CONTRACTUAL ALLOW	1,518,683.58
NON-COVERD CHARGES	14,828.02	TOTAL MEDICAID LIAB	1,430,694.26
		LESS: COB	1,430,694.26
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 36

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	226		0	263,960.00		12,890.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	226		0	263,960.00		12,890.00
SPECIAL CARE SERVICES						
CCU	70		0	293,650.00		0.00
ICU	99		0	361,830.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	10		0	19,450.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	179		0	674,930.00		0.00
TOTAL ACCOMODATIONS	405		0	938,890.00		12,890.00

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,802.17	0.00	OTHER LAB	7,706.00	0.00
MED/SURG SUPPLY	183,002.00	1,938.02	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	290,160.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,183.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	63,532.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,096.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,200.00	0.00	MRI SERVICES	23,518.00	0.00
IV THERAPY	5,944.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	321,802.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	77,708.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	67,271.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,526.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,967.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,106.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	14,254.00	0.00	INJECTABLE DRUGS	446,199.72	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,166.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,448.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	7,115.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	79,911.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,975.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	68,864.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,519.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,915.00	0.00			
ORGAN ACQUISITION	46,464.00	0.00			
TREATMENT/OBSERV. RM	1,133.00	0.00			
			TOTAL ANCILLARY	2,010,487.84	1,938.02
			TOTAL ACCOMODATIONS	938,890.00	12,890.00
			TOTAL CHARGES	2,949,377.84	14,828.02

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: 07/23/2014  
Run Time: 12:05:00  
Page: 7

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,745,184.29	ADJUSTMENTS	581,484.86
COVERED CHARGES	19,361,742.04	CONTRACTUAL ALLOW	15,026,776.48
NON-COVERD CHARGES	7,383,442.25	TOTAL MEDICAID LIAB	4,334,965.56
		LESS: COB	11,547.97
		LESS: COPAYMENT	15,340.85
		REIMBURSEMENT	4,308,076.74
		ALL OTHER	3,500,815.04
		FEE SCHEDULE-LAB	752,950.13
		INJECTABLE DRUGS	54,311.57
		TOTAL NUMBER OF CLAIMS	12,382

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	225,074.71	385,140.01	OTHER LAB	138,773.00	276.00
MED/SURG SUPPLY	773,951.00	154,580.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	996.00	EDUCATION & TRAINING	0.00	2,400.00
RADIOLOGY-DIAGNOSTIC	750,604.00	161,589.00	OTHER THERAPEUTIC SVC	56,342.00	279,318.00
CT SCAN	2,047,594.00	621,037.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	130,071.00	74,236.02	FEE SCHEDULE LAB	4,069,540.57	1,076,715.68
EKG/ECG	90,892.00	2,976.00	MRI SERVICES	4,716,957.00	778,232.00
IV THERAPY	3,317.50	172.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,973,597.00	461,932.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,500.00	5,643.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	295,331.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	79,922.00	16,431.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,045,099.00	74,857.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	195,677.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	626.00	INJECTABLE DRUGS	305,589.17	792,962.77
RADIOLOGY THERAPEUTIC	7,247.00	306.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	99,010.00	78,759.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	52,971.00	36,823.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	15,653.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,291.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	195,375.09	478,263.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	443,660.00
OTHER IMAGING SERVICE	838,804.00	517,585.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	34,647.00	4,433.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	280,858.00	247,035.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	607,596.00	647,979.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	51,531.00	2,490.00			
ORGAN ACQUISITION	0.00	7,375.00			
TREATMENT/OBSERV. RM	250,871.00	10,670.00			
			TOTAL ANCILLARY	19,361,742.04	7,383,442.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,361,742.04	7,383,442.25

EMORY UNIV HOSPPT FINANCIALSERV  
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 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012265022678	09/14/12 - 09/14/12	09/24/12	0.00	5,982.00	0.00	0.00	0.00
614	2012275011943	09/17/12 - 09/17/12	10/08/12	0.00	5,982.00	0.00	0.00	0.00
614	2012276015288	09/26/12 - 09/26/12	10/08/12	0.00	5,982.00	0.00	0.00	0.00
614	2012277016469	09/21/12 - 09/21/12	10/08/12	0.00	5,982.00	0.00	0.00	0.00
614	2012292043367	10/09/12 - 10/09/12	10/22/12	0.00	5,982.00	0.00	0.00	0.00
614	2012296011976	10/12/12 - 10/12/12	10/29/12	0.00	5,982.00	0.00	0.00	0.00
614	2012296011980	09/24/12 - 09/24/12	10/29/12	0.00	5,982.00	0.00	0.00	0.00
614	2012298016642	10/12/12 - 10/12/12	10/29/12	0.00	5,982.00	0.00	0.00	0.00
614	2012299042246	10/15/12 - 10/15/12	10/29/12	0.00	204.00	0.00	0.00	0.00
614	2012303009306	10/17/12 - 10/17/12	11/05/12	0.00	5,982.00	0.00	0.00	0.00
614	2012305014604	10/25/12 - 10/25/12	11/05/12	0.00	5,982.00	0.00	0.00	0.00
614	2012306032552	10/25/12 - 10/25/12	11/05/12	0.00	5,982.00	0.00	0.00	0.00
614	2012307029465	10/25/12 - 10/25/12	11/05/12	0.00	5,982.00	0.00	0.00	0.00
614	2012321002536	11/08/12 - 11/08/12	11/19/12	0.00	5,982.00	0.00	0.00	0.00
614	2212331002058	10/19/12 - 10/19/12	12/03/12	0.00	5,982.00	0.00	0.00	0.00
614	2012332029322	11/14/12 - 11/14/12	12/03/12	0.00	5,982.00	0.00	0.00	0.00
618	2012332029324	11/10/12 - 11/10/12	12/03/12	0.00	5,848.00	0.00	0.00	0.00
614	2012333055802	11/21/12 - 11/21/12	12/03/12	0.00	5,982.00	0.00	0.00	0.00
614	2012334054013	11/14/12 - 11/14/12	12/03/12	0.00	5,982.00	0.00	0.00	0.00
614	2012341021355	11/28/12 - 11/28/12	12/10/12	0.00	204.00	0.00	0.00	0.00
614	2212341013370	10/23/12 - 10/23/12	12/10/12	0.00	204.00	0.00	0.00	0.00
614	2012352011817	12/05/12 - 12/05/12	12/24/12	0.00	5,982.00	0.00	0.00	0.00
614	2012356031716	12/10/12 - 12/10/12	12/24/12	0.00	5,982.00	0.00	0.00	0.00
614	2012362019410	12/17/12 - 12/17/12	12/31/12	0.00	5,982.00	0.00	0.00	0.00
614	2012363052916	12/21/12 - 12/21/12	12/31/12	0.00	5,982.00	0.00	0.00	0.00
614	2012366017504	12/15/12 - 12/15/12	01/07/13	0.00	5,982.00	0.00	0.00	0.00
614	2013003021900	12/26/12 - 12/26/12	01/07/13	0.00	5,982.00	0.00	0.00	0.00
614	2013007013721	12/26/12 - 12/26/12	01/14/13	0.00	5,982.00	0.00	0.00	0.00
614	2013007013750	12/28/12 - 12/28/12	01/14/13	0.00	5,982.00	0.00	0.00	0.00
614	2213008008433	11/15/12 - 11/15/12	01/14/13	0.00	5,982.00	0.00	0.00	0.00
614	2213010003647	12/06/12 - 12/06/12	01/14/13	0.00	5,982.00	0.00	0.00	0.00
614	2213015002607	11/29/12 - 11/29/12	01/21/13	0.00	5,982.00	0.00	0.00	0.00
614	2013016023626	01/10/13 - 01/10/13	01/21/13	0.00	5,982.00	0.00	0.00	0.00
614	2013017042645	01/05/13 - 01/05/13	01/21/13	0.00	5,982.00	0.00	0.00	0.00
614	2013018046822	01/07/13 - 01/07/13	01/21/13	0.00	5,982.00	0.00	0.00	0.00
614	2013023012171	01/08/13 - 01/08/13	01/28/13	0.00	5,982.00	0.00	0.00	0.00
614	2013024035887	01/14/13 - 01/14/13	01/28/13	0.00	5,982.00	0.00	0.00	0.00
614	2013028012882	01/17/13 - 01/17/13	02/04/13	0.00	5,982.00	0.00	0.00	0.00
614	2013028012922	01/12/13 - 01/12/13	02/04/13	0.00	5,982.00	0.00	0.00	0.00
614	2013032056870	01/23/13 - 01/23/13	02/04/13	0.00	5,982.00	0.00	0.00	0.00
614	2013038017060	01/29/13 - 01/29/13	02/11/13	0.00	5,982.00	0.00	0.00	0.00
614	2013038017309	02/01/13 - 02/01/13	02/11/13	0.00	5,982.00	0.00	0.00	0.00

SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY UNIV HOSPPT FINANCIALSERV  
1364 CLIFTON RD NE DEPT RM  
ATLANTA,GA 30322-1059

PROVIDER NUMBER  
000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM
614	2013042012385	01/24/13 - 01/24/13	02/18/13	0.00	5,982.00	0.00	0.00	0.00	0.00
614	2013042012518	01/31/13 - 01/31/13	02/18/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013046063854	02/07/13 - 02/07/13	02/18/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013046063868	02/04/13 - 02/04/13	02/18/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013049009825	02/05/13 - 02/05/13	02/25/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013053033663	01/02/13 - 01/02/13	02/25/13	0.00	5,982.00	0.00	0.00	0.00	
614	2213056001867	01/17/13 - 01/17/13	03/04/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013056010368	02/12/13 - 02/12/13	03/04/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013060034132	02/22/13 - 02/22/13	03/04/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013066026921	02/27/13 - 02/27/13	03/11/13	0.00	204.00	0.00	0.00	0.00	
614	2013070001577	02/27/13 - 02/27/13	03/18/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013072039267	02/28/13 - 02/28/13	03/18/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013077001258	02/16/13 - 02/16/13	03/25/13	0.00	5,982.00	0.00	2,292.00	0.00	
614	2013077001282	03/07/13 - 03/07/13	03/25/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013077001395	03/06/13 - 03/06/13	03/25/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013080063412	03/11/13 - 03/11/13	03/25/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013084008262	01/28/13 - 01/28/13	04/01/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013084008314	03/15/13 - 03/15/13	04/01/13	0.00	5,982.00	0.00	0.00	0.00	
614	5913086000632	09/21/12 - 09/21/12	04/01/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013091009743	02/05/13 - 02/05/13	04/08/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013094035063	03/29/13 - 03/29/13	04/08/13	0.00	5,982.00	0.00	0.00	0.00	
614	5213105000439	01/03/13 - 01/03/13	11/11/13	0.00	5,982.00	0.00	0.00	0.00	
614	5213105005088	01/14/13 - 01/14/13	11/11/13	0.00	5,982.00	0.00	0.00	0.00	
614	5213105028664	02/27/13 - 02/27/13	08/19/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013109045064	12/28/12 - 12/28/12	04/22/13	0.00	5,982.00	0.00	0.00	0.00	
614	2213120002107	03/20/13 - 03/20/13	05/06/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013140010368	05/09/13 - 05/09/13	05/27/13	0.00	204.00	0.00	0.00	0.00	
614	2013143040092	05/16/13 - 05/16/13	05/27/13	0.00	204.00	0.00	0.00	0.00	
614	2013144038903	05/15/13 - 05/15/13	05/27/13	0.00	204.00	0.00	0.00	0.00	
614	2013149017576	03/30/13 - 03/30/13	06/03/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013171043346	04/25/13 - 04/25/13	06/24/13	0.00	5,982.00	0.00	0.00	0.00	
614	5913178000846	03/29/13 - 03/29/13	07/01/13	0.00	2,636.00	0.00	0.00	0.00	
616	5913178000846	03/29/13 - 03/29/13	07/01/13	0.00	2,636.00	0.00	0.00	0.00	
614	5913178000846	03/29/13 - 03/29/13	07/01/13	0.00	5,982.00	0.00	0.00	0.00	
614	2213260013730	03/28/13 - 03/28/13	09/23/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013261019206	08/22/13 - 08/22/13	09/23/13	0.00	204.00	0.00	0.00	0.00	
614	2213262017978	08/22/13 - 08/22/13	09/23/13	0.00	204.00	0.00	0.00	0.00	
614	2013296018538	06/28/13 - 06/28/13	10/28/13	0.00	5,982.00	0.00	0.00	0.00	
614	2013340057378	04/22/13 - 04/22/13	12/09/13	0.00	5,982.00	0.00	0.00	0.00	
614	2014022043911	08/13/13 - 08/13/13	01/27/14	0.00	5,982.00	0.00	0.00	0.00	
614	2014086030420	01/24/13 - 01/24/13	03/31/14	0.00	5,982.00	0.00	0.00	0.00	
614	2014157023016	05/02/13 - 05/02/13	06/09/14	0.00	5,982.00	0.00	0.00	0.00	

TOTAL 0.00 443,660.00 0.00 2,292.00 0.00

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

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

Run Date: 07/23/2014  
Run Time: 12:07:03  
Page: 11

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	927,817.44	ADJUSTMENTS	0.00
COVERED CHARGES	506,944.40	CONTRACTUAL ALLOW	154,272.15
NON-COVERD CHARGES	420,873.04	TOTAL MEDICAID LIAB	352,672.25
		LESS: COB	352,269.91
		LESS: COPAYMENT	402.34
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 180

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

EMORY UNIV HOSPPT FINANCIALSERV  
 1364 CLIFTON RD NE DEPT RM  
 ATLANTA,GA 30322-1059

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 000000712A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,700.37	12,850.30	OTHER LAB	4,964.00	0.00
MED/SURG SUPPLY	31,643.00	21,173.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,321.00	5,432.00	OTHER THERAPEUTIC SVC	0.00	12,370.00
CT SCAN	35,482.00	31,268.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	980.00	FEE SCHEDULE LAB	104,789.00	31,390.00
EKG/ECG	2,728.00	0.00	MRI SERVICES	85,239.00	71,277.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,428.00	47,876.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,406.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,183.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	8,457.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,444.00	3,941.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,084.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,052.03	15,506.99
RADIOLOGY THERAPEUTIC	266.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	551.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	413.00	564.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	33,784.00	360.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	32,526.00
OTHER IMAGING SERVICE	7,368.00	13,952.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,463.00	8,100.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,689.00	100,828.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	953.00	803.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,545.00	629.00			
			TOTAL ANCILLARY	506,944.40	420,873.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	506,944.40	420,873.04



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

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

Run Date: 07/23/2014  
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Page: 13

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013170037879	12/20/12 - 12/20/12	06/24/13	0.00	204.00	0.00	4,053.21	0.00
614	2013183045722	05/31/13 - 05/31/13	07/08/13	0.00	5,982.00	0.00	1,822.14	0.00
614	2013193039293	01/31/13 - 01/31/13	07/15/13	0.00	5,982.00	0.00	4,290.03	0.00
614	2013196007928	06/20/13 - 06/20/13	07/22/13	0.00	2,448.00	0.00	4,435.64	0.00
614	2014125002697	02/06/13 - 02/06/13	05/12/14	0.00	5,946.00	0.00	0.00	0.00
614	2014125002697	02/06/13 - 02/06/13	05/12/14	0.00	5,982.00	0.00	0.00	0.00
614	2014125002697	02/06/13 - 02/06/13	05/12/14	0.00	5,982.00	0.00	0.00	0.00
TOTAL				0.00	32,526.00	0.00	14,601.02	0.00

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

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

Run Date: 07/23/2014  
Run Time: 12:07:07  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	275,356.41	ADJUSTMENTS	470.53
COVERED CHARGES	215,716.36	CONTRACTUAL ALLOW	206,227.04
NON-COVERD CHARGES	59,640.05	TOTAL MEDICAID LIAB	9,489.32
		LESS: COB	0.00
		LESS: COPAYMENT	477.06
		REIMBURSEMENT	9,012.26
		TOTAL NUMBER OF CLAIMS	170

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,484.65	178.78	OTHER LAB	5,493.00	0.00
MED/SURG SUPPLY	3,342.00	428.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,202.00	3,612.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,740.00	21,284.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	642.00	FEE SCHEDULE LAB	41,806.00	5,149.00
EKG/ECG	2,604.00	0.00	MRI SERVICES	34,043.00	11,696.00
IV THERAPY	172.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	446.00	286.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	96,901.00	3,853.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,094.71	5,326.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	552.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,848.00
OTHER IMAGING SERVICE	359.00	785.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,029.00	0.00			
			TOTAL ANCILLARY	215,716.36	59,640.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	215,716.36	59,640.05

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: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013254042613	01/14/13 - 01/14/13	09/16/13	0.00	5,848.00	0.00	0.00	0.00
TOTAL				0.00	5,848.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 12:07:11  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,185.81	ADJUSTMENTS	0.00
COVERED CHARGES	7,231.63	CONTRACTUAL ALLOW	3,125.39
NON-COVERD CHARGES	1,954.18	TOTAL MEDICAID LIAB	4,106.24
		LESS: COB	4,088.24
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	53.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	35.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	144.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,485.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,163.00	0.00
EKG/ECG	124.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,625.00	412.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140.63	3.78
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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,231.63	1,954.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,231.63	1,954.18

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

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

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

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,201,013.90	ADJUSTMENTS	43,574.89
COVERED CHARGES	1,805,889.52	CONTRACTUAL ALLOW	1,482,123.48
NON-COVERD CHARGES	395,124.38	TOTAL MEDICAID LIAB	323,766.04
		LESS: COB	0.00
		LESS: COPAYMENT	213.00
		REIMBURSEMENT	323,553.04

TOTAL NUMBER OF CLAIMS 52

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,444.42	3,000.67	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	190,501.00	62,418.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	168,237.00	65,755.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,247.00	1,831.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	336.00	FEE SCHEDULE LAB	28,786.00	3,357.00
EKG/ECG	744.00	0.00	MRI SERVICES	46,717.00	2,475.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	446,691.00	178,496.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	458.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	61,728.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,986.00	624.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,030.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,112.10	39,520.71
RADIOLOGY THERAPEUTIC	532.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	759,571.00	32,279.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	820.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	630.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,980.00	160.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	4,872.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,675.00	0.00			
			TOTAL ANCILLARY	1,805,889.52	395,124.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,805,889.52	395,124.38



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: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	150,561.81	ADJUSTMENTS	0.00
COVERED CHARGES	129,147.35	CONTRACTUAL ALLOW	26,572.04
NON-COVERD CHARGES	21,414.46	TOTAL MEDICAID LIAB	102,575.31
		LESS: COB	102,554.31
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

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

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

Run Date: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	588.38	305.78	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	32,559.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,099.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	20,923.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,488.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,098.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	498.97	185.68
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	85,816.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	129,147.35	21,414.46
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	129,147.35	21,414.46

\*\* END OF REPORT \*\*

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	128,530,988.86	ADJUSTMENTS	10,643,624.78
COVERED CHARGES	123,152,186.43	CONTRACTUAL ALLOW	86,696,743.08
NON-COVERD CHARGES	5,378,802.43	TOTAL MEDICAID LIAB	36,455,443.35
		LESS: COB	254,474.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	36,200,968.61

TOTAL NUMBER OF ADMISSIONS 2,814

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,834		265	8,561,836.00		2,067,188.10
ROUTINE NURSERY	1,376		0	2,322,438.00		150,928.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		6.18
TOTAL ROUTINE	14,210		265	10,884,274.00		2,218,122.28
SPECIAL CARE SERVICES						
CCU	115		0	180,073.00		0.00
ICU	2,661		0	4,869,625.00		21,115.00
NICU	496		0	1,673,148.00		0.00
PED ICU	731		0	2,444,559.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	340		0	1,012,146.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4,343		0	10,179,551.00		21,115.00
TOTAL ACCOMODATIONS	18,553		265	21,063,825.00		2,239,237.28

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,183,492.48	297,961.03	OTHER LAB	272,102.00	15,911.00
MED/SURG SUPPLY	11,608,343.00	279,607.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	17,080,753.08	562,138.40	EDUCATION & TRAINING	4,850.00	0.00
RADIOLOGY-DIAGNOSTIC	2,532,705.00	15,371.00	OTHER THERAPEUTIC SVC	0.00	113,845.00
CT SCAN	1,862,871.00	867,248.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	621,438.00	13,121.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	160,159.00	256.00	MRI SERVICES	784,630.00	2,622.00
IV THERAPY	491,302.68	24,817.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,833,930.00	23,272.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	355,107.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,998,231.00	121,204.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,983,948.00	3,069.00	AMBULANCE	0.00	0.00
GI SERVICES	328,786.00	7,048.00	CAST ROOM	295.00	0.00
EMERGENCY ROOM	2,024,589.00	1,324.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	893,245.00	1,163.00	DRUG-SPECIFIC/HOME IV	0.00	33,687.44
LABORATORY PATHOLOGIC	1,201,772.00	21,641.00	INJECTABLE DRUGS	7,955,942.38	200,045.28
RADIOLOGY THERAPEUTIC	405,506.00	371.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	255,672.00	10,846.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	181,256.00	2,134.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	215,030.00	124,608.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	126.81	61,871.00	TRAUMA RESPONSE	0.00	136,223.00
PSYCHIATRIC SERVICES	33,229.00	0.00	IMPL DEV CHARGE PATIENTS	8,064,399.00	6,114.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	367,833.00	30,047.00			
BLOOD	253,205.00	1,138.00			
BLOOD STORAGE & PRO.	1,640,040.00	154,336.00			
ONCOLOGY	563.00	0.00			
NUCLEAR MEDICINE	129,697.00	4,994.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,475,499.00	1,532.00			
AMBULATORY SURGERY	10,060.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,675,004.00	0.00			
ORGAN ACQUISITION	62,307.00	0.00			
TREATMENT/OBSERV. RM	140,443.00	0.00			
			TOTAL ANCILLARY	102,088,361.43	3,139,565.15
			TOTAL ACCOMODATIONS	21,063,825.00	2,239,237.28
			TOTAL CHARGES	123,152,186.43	5,378,802.43

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

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

Run Date: 07/23/2014  
 Run Time: 10:17:48  
 Page: 3

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,385,630.26	ADJUSTMENTS	0.00
COVERED CHARGES	2,336,113.46	CONTRACTUAL ALLOW	1,105,812.37
NON-COVERD CHARGES	49,516.80	TOTAL MEDICAID LIAB	1,230,301.09
		LESS: COB	1,230,301.09
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 56

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	189		0	126,786.00		27,701.00
ROUTINE NURSERY	19		0	45,258.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	208		0	172,044.00		27,701.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	22		0	36,352.00		0.00
NICU	30		0	104,100.00		0.00
PED ICU	67		0	229,274.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	119		0	369,726.00		0.00
TOTAL ACCOMODATIONS	327		0	541,770.00		27,701.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	323,893.61	783.50	OTHER LAB	8,457.00	0.00
MED/SURG SUPPLY	236,507.00	965.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	279,985.06	4,542.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,471.00	275.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,989.00	7,122.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,222.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,468.00	0.00	MRI SERVICES	9,683.00	0.00
IV THERAPY	10,823.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	96,180.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,516.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	240,217.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	57,076.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,150.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,338.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,423.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	885.30
LABORATORY PATHOLOGIC	15,528.00	0.00	INJECTABLE DRUGS	116,673.79	0.00
RADIOLOGY THERAPEUTIC	228.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,243.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,367.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	7,908.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,007.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	93,585.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,384.00
OTHER IMAGING SERVICE	6,925.00	0.00			
BLOOD	3,414.00	0.00			
BLOOD STORAGE & PRO.	12,446.00	1,028.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,923.00	824.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	113,704.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,794,343.46	21,815.80
			TOTAL ACCOMODATIONS	541,770.00	27,701.00
			TOTAL CHARGES	2,336,113.46	49,516.80

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

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

Run Date: 07/23/2014  
Run Time: 10:17:48  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013178047636	05/24/13 - 05/27/13	07/01/13	0.00	2,192.00	0.00	5,592.77	0.00
614	2013193048116	06/10/13 - 06/16/13	07/15/13	0.00	2,192.00	0.00	5,724.60	0.00
TOTAL				0.00	4,384.00	0.00	11,317.37	0.00

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

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

Run Date: 07/23/2014  
Run Time: 10:18:00  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,395,927.15	ADJUSTMENTS	2,376,575.49
COVERED CHARGES	47,843,802.34	CONTRACTUAL ALLOW	34,997,675.31
NON-COVERD CHARGES	6,552,124.81	TOTAL MEDICAID LIAB	12,846,127.03
		LESS: COB	88,235.10
		LESS: COPAYMENT	57,369.00
		REIMBURSEMENT	12,700,522.93
		ALL OTHER	10,907,266.90
		FEE SCHEDULE-LAB	895,098.44
		INJECTABLE DRUGS	898,157.59

TOTAL NUMBER OF CLAIMS 39,006



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,555,057.28	128,671.33	OTHER LAB	794,393.32	42,547.00
MED/SURG SUPPLY	1,325,552.83	105,027.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	2,381.00	EDUCATION & TRAINING	8,502.00	1,458.00
RADIOLOGY-DIAGNOSTIC	1,635,718.83	16,977.00	OTHER THERAPEUTIC SVC	0.00	90,986.00
CT SCAN	2,596,239.00	167,931.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	62,830.00	32,643.00	FEE SCHEDULE LAB	8,685,759.92	1,454,542.10
EKG/ECG	208,388.00	4,048.00	MRI SERVICES	1,400,530.00	115,388.00
IV THERAPY	722,873.00	46,069.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,865,272.50	646,079.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	69,001.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	982,552.00	39,329.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,577,370.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	431,606.83	71,339.16	CAST ROOM	31,863.00	317.00
EMERGENCY ROOM	3,563,056.91	3,629.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,072,944.00	891.00	DRUG-SPECIFIC/HOME IV	0.00	1,456.89
LABORATORY PATHOLOGIC	0.00	542.00	INJECTABLE DRUGS	5,684,571.66	1,559,181.26
RADIOLOGY THERAPEUTIC	1,692,179.00	154,395.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,363.00	14,623.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	25,940.00	14,864.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,500.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,092,614.21	75,061.44	TRAUMA RESPONSE	0.00	50,074.00
PSYCHIATRIC SERVICES	137,538.00	18,824.00	IMPL DEV CHARGE PATIENTS	218,842.00	770,874.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	311.00
OTHER IMAGING SERVICE	1,206,065.00	123,636.00			
BLOOD	63,159.00	0.00			
BLOOD STORAGE & PRO.	402,193.00	772.00			
ONCOLOGY	37,327.00	725.00			
NUCLEAR MEDICINE	466,880.00	27,496.00			
AUDIOLOGY	12,319.00	5,387.00			
CARDIOLOGY	946,235.80	704,578.50			
AMBULATORY SURGERY	5,935.00	0.00			
OSTEOPATHIC SERVICES	0.00	96.00			
E E G	592,096.00	2,088.00			
ORGAN ACQUISITION	0.00	7,321.00			
TREATMENT/OBSERV. RM	660,033.75	40,066.00			
			TOTAL ANCILLARY	47,843,802.34	6,552,124.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	47,843,802.34	6,552,124.81

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

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

Run Date: 07/23/2014  
Run Time: 10:18:00  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5913210001229	02/17/13 - 02/17/13	08/05/13	0.00	166.00	0.00	0.00	0.00
30	5913210001229	02/17/13 - 02/17/13	08/05/13	0.00	145.00	0.00	0.00	0.00
TOTAL				0.00	311.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 10:22:18  
Page: 9

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,352,640.46	ADJUSTMENTS	0.00
COVERED CHARGES	1,034,726.78	CONTRACTUAL ALLOW	548,928.39
NON-COVERD CHARGES	317,913.68	TOTAL MEDICAID LIAB	485,798.39
		LESS: COB	485,199.78
		LESS: COPAYMENT	598.61
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 790

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90,624.85	2,646.16	OTHER LAB	18,087.00	7,729.00
MED/SURG SUPPLY	20,495.00	23,441.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	128.00	670.00
RADIOLOGY-DIAGNOSTIC	23,469.00	859.00	OTHER THERAPEUTIC SVC	0.00	682.00
CT SCAN	32,228.00	2,480.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,513.00	FEE SCHEDULE LAB	179,381.93	30,351.00
EKG/ECG	2,367.00	0.00	MRI SERVICES	33,733.00	4,190.00
IV THERAPY	13,858.00	4,047.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	125,707.59	69,046.41	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,225.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,913.00	1,102.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,122.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,612.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,342.00	779.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,887.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	340.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	165,323.41	141,028.80
RADIOLOGY THERAPEUTIC	10,596.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,207.00	1,610.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	438.00	403.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,340.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	47,033.00	3,745.81	TRAUMA RESPONSE	0.00	3,677.00
PSYCHIATRIC SERVICES	1,389.00	936.00	IMPL DEV CHARGE PATIENTS	1,858.00	6,864.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	222.00
OTHER IMAGING SERVICE	16,737.00	6,599.00			
BLOOD	1,707.00	0.00			
BLOOD STORAGE & PRO.	3,434.00	0.00			
ONCOLOGY	2,444.00	0.00			
NUCLEAR MEDICINE	5,188.00	0.00			
AUDIOLOGY	401.00	0.00			
CARDIOLOGY	11,363.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	30,588.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,452.00	0.00			
			TOTAL ANCILLARY	1,034,726.78	317,913.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,034,726.78	317,913.68

Report : 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

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
9332	5213107008113	01/10/13 - 01/10/13	08/19/13	0.00	222.00	0.00	1,413.68	0.00
TOTAL				0.00	222.00	0.00	1,413.68	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: 07/23/2014  
Run Time: 10:22:32  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,647,450.83	ADJUSTMENTS	2,353.99
COVERED CHARGES	1,572,387.01	CONTRACTUAL ALLOW	1,457,987.01
NON-COVERD CHARGES	75,063.82	TOTAL MEDICAID LIAB	114,400.00
		LESS: COB	50.58
		LESS: COPAYMENT	3,813.03
		REIMBURSEMENT	110,536.39
		TOTAL NUMBER OF CLAIMS	2,288

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85,075.37	733.02	OTHER LAB	9,117.00	0.00
MED/SURG SUPPLY	15,122.00	4,125.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	271.00	EDUCATION & TRAINING	128.00	0.00
RADIOLOGY-DIAGNOSTIC	92,109.00	192.00	OTHER THERAPEUTIC SVC	0.00	74.00
CT SCAN	76,754.00	1,208.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,113.00	FEE SCHEDULE LAB	240,913.75	34,138.00
EKG/ECG	11,348.00	0.00	MRI SERVICES	31,418.00	9,148.00
IV THERAPY	54,650.00	2,804.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,150.00	7,857.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,400.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,019.00	238.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,405.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,500.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	875,111.00	1,422.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,036.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,607.89	4,792.80
RADIOLOGY THERAPEUTIC	1,849.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,580.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,925.00	61.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,868.00	2,807.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,399.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,178.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,804.00	0.00			
			TOTAL ANCILLARY	1,572,387.01	75,063.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,572,387.01	75,063.82

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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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,293.35	ADJUSTMENTS	0.00
COVERED CHARGES	48,956.35	CONTRACTUAL ALLOW	34,649.01
NON-COVERD CHARGES	337.00	TOTAL MEDICAID LIAB	14,307.34
		LESS: COB	14,265.34
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	45



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,135.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	780.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,671.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,688.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,390.00	209.00
EKG/ECG	128.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,105.00	128.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	238.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,750.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,098.00	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	511.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	48,956.35	337.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,956.35	337.00

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

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

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

MEDICAL COLLEGE OF GA HOSPITALS AND  
1120 15TH ST  
AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,086,383.42	ADJUSTMENTS	854,042.98
COVERED CHARGES	11,761,735.28	CONTRACTUAL ALLOW	9,887,193.95
NON-COVERD CHARGES	2,324,648.14	TOTAL MEDICAID LIAB	1,874,541.33
		LESS: COB	20,609.57
		LESS: COPAYMENT	1,700.35
		REIMBURSEMENT	1,852,231.41

TOTAL NUMBER OF CLAIMS 343

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,362,989.40	7,462.72	OTHER LAB	7,271.00	0.00
MED/SURG SUPPLY	973,358.00	206,118.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	169,255.00	5,292.00	OTHER THERAPEUTIC SVC	0.00	7,572.00
CT SCAN	60,223.00	10,218.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	294.00	6,766.00	FEE SCHEDULE LAB	271,326.05	59,868.50
EKG/ECG	6,738.00	1,566.00	MRI SERVICES	25,666.00	12,821.00
IV THERAPY	26,723.00	3,121.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,348,464.10	161,139.89	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,358.00	1,609.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	421,481.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,625.00	5,240.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,031.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	159,933.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,160,305.19	87,260.54
RADIOLOGY THERAPEUTIC	1,048,731.00	25,806.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,355.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,434.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,246.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,614.00	10.00	TRAUMA RESPONSE	0.00	3,422.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,053,601.00	1,150,605.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	126.00
OTHER IMAGING SERVICE	16,423.00	832.00			
BLOOD	3,414.00	0.00			
BLOOD STORAGE & PRO.	12,738.00	0.00			
ONCOLOGY	3,759.00	0.00			
NUCLEAR MEDICINE	19,125.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,452,132.54	562,592.49			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,314.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,843.00	165.00			
			TOTAL ANCILLARY	11,761,735.28	2,324,648.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,761,735.28	2,324,648.14

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

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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3018	5913235000286	04/11/13 - 04/11/13	08/26/13	0.00	126.00	0.00	0.00	0.00
TOTAL				0.00	126.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
Run Time: 10:23:12  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	127,103.95	ADJUSTMENTS	0.00
COVERED CHARGES	125,558.15	CONTRACTUAL ALLOW	70,844.90
NON-COVERD CHARGES	1,545.80	TOTAL MEDICAID LIAB	54,713.25
		LESS: COB	54,713.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL COLLEGE OF GA HOSPITALS AND  
 1120 15TH ST  
 AUGUSTA,GA 30912-0004

PROVIDER NUMBER  
 000000723A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,160.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,111.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,521.00	929.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,135.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	757.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,620.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	891.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	85,352.56	616.80
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	23,010.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	125,558.15	1,545.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	125,558.15	1,545.80

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	778,633.75	ADJUSTMENTS	3,530.91
COVERED CHARGES	705,887.75	CONTRACTUAL ALLOW	424,622.79
NON-COVERD CHARGES	72,746.00	TOTAL MEDICAID LIAB	281,264.96
		LESS: COB	3,105.23
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	278,159.73

TOTAL NUMBER OF ADMISSIONS 43

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	108		0	94,107.00		42,981.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	108		0	94,107.00		42,981.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	36		0	56,700.00		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	36		0	56,700.00		0.00
TOTAL ACCOMODATIONS	144		0	150,807.00		42,981.00

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

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

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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EVANS MEMORIAL HOSPITAL  
 200 N RIVER ST  
 CLAXTON,GA 30417-1659

PROVIDER NUMBER  
 000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	93,936.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	60,531.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	177,109.00	0.00	EDUCATION & TRAINING	869.00	0.00
RADIOLOGY-DIAGNOSTIC	20,306.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	53,840.00	9,556.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	237.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,237.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,412.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	9,986.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,687.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	56,578.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	962.00
OTHER IMAGING SERVICE	3,849.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,540.00	9,261.00			
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	0.00	0.00			
			TOTAL ANCILLARY	555,080.75	29,765.00
			TOTAL ACCOMODATIONS	150,807.00	42,981.00
			TOTAL CHARGES	705,887.75	72,746.00



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

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

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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
455	2213193021069	06/27/13 - 07/02/13	07/15/13	0.00	962.00	0.00	0.00	0.00
TOTAL				0.00	962.00	0.00	0.00	0.00

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,353.00	ADJUSTMENTS	0.00
COVERED CHARGES	8,104.00	CONTRACTUAL ALLOW	2,089.84
NON-COVERD CHARGES	249.00	TOTAL MEDICAID LIAB	6,014.16
		LESS: COB	6,014.16
		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	864.00	249.00
ROUTINE NURSERY	0	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	864.00	249.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	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	864.00	249.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	610.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	342.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,362.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,896.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,030.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,240.00	0.00
			TOTAL ACCOMODATIONS	864.00	249.00
			TOTAL CHARGES	8,104.00	249.00

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,545,708.65	ADJUSTMENTS	35,127.88
COVERED CHARGES	1,420,295.25	CONTRACTUAL ALLOW	1,122,349.13
NON-COVERD CHARGES	125,413.40	TOTAL MEDICAID LIAB	297,946.12
		LESS: COB	1,518.29
		LESS: COPAYMENT	1,215.00
		REIMBURSEMENT	295,212.83
		ALL OTHER	270,502.43
		FEE SCHEDULE-LAB	22,597.43
		INJECTABLE DRUGS	2,112.97
		TOTAL NUMBER OF CLAIMS	1,228

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,660.25	279.00	OTHER LAB	7,147.00	0.00
MED/SURG SUPPLY	40,556.00	561.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	158.00
RADIOLOGY-DIAGNOSTIC	103,166.00	1,116.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	226,109.00	12,036.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,159.00	210.00	FEE SCHEDULE LAB	302,765.00	51,167.40
EKG/ECG	20,979.00	945.00	MRI SERVICES	77,975.00	6,154.00
IV THERAPY	15,390.00	5,178.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,641.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	179.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,682.00	1,598.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	40,450.00	6,670.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	374,046.00	12,721.00	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	24,942.00	7,874.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	284.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	660.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,077.00
OTHER IMAGING SERVICE	38,480.00	594.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,997.00	4,225.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,235.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,813.00	10,566.00			
			TOTAL ANCILLARY	1,420,295.25	125,413.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,420,295.25	125,413.40

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: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5914091001180	07/11/13 - 07/11/13	04/07/14	0.00	3,077.00	0.00	0.00	0.00
TOTAL				0.00	3,077.00	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

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,503.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,863.00	CONTRACTUAL ALLOW	3,042.98
NON-COVERD CHARGES	2,640.00	TOTAL MEDICAID LIAB	1,820.02
		LESS: COB	1,808.02
		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

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	337.00	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	0.00	1,938.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,568.00	108.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,444.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	64.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	185.00	594.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,863.00	2,640.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,863.00	2,640.00



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

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

Run Date: 07/23/2014  
Run Time: 09:53:20  
Page: 11

EVANS MEMORIAL HOSPITAL  
200 N RIVER ST  
CLAXTON,GA 30417-1659

PROVIDER NUMBER  
000000734A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	104,160.00	ADJUSTMENTS	432.52
COVERED CHARGES	97,270.00	CONTRACTUAL ALLOW	89,829.98
NON-COVERD CHARGES	6,890.00	TOTAL MEDICAID LIAB	7,440.02
		LESS: COB	0.00
		LESS: COPAYMENT	216.00
		REIMBURSEMENT	7,224.02
		TOTAL NUMBER OF CLAIMS	133

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,910.00	0.00	OTHER LAB	531.00	0.00
MED/SURG SUPPLY	1,335.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,865.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,752.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,954.00	4,295.00
EKG/ECG	189.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,721.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	404.00	58.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,277.00	1,646.00	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	2,580.00	432.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,224.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	528.00	459.00			
			TOTAL ANCILLARY	97,270.00	6,890.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	97,270.00	6,890.00

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

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

Run Date: 07/23/2014  
Run Time: 09:53:22  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	626.00	ADJUSTMENTS	0.00
COVERED CHARGES	626.00	CONTRACTUAL ALLOW	497.74
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	128.26
		LESS: COB	125.26
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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

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

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	216.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	410.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	626.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	626.00	0.00

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

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

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

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

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

Run Date: 07/23/2014  
Run Time: 09:53:23  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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

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

Run Date: 07/23/2014  
 Run Time: 12:37:18  
 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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,056,572.54	ADJUSTMENTS	3,518,598.80
COVERED CHARGES	44,065,966.17	CONTRACTUAL ALLOW	31,617,525.83
NON-COVERD CHARGES	1,990,606.37	TOTAL MEDICAID LIAB	12,448,440.34
		LESS: COB	172,467.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,275,972.59

TOTAL NUMBER OF ADMISSIONS 1,789

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,545		8	3,048,650.00		897,400.00
ROUTINE NURSERY	974		0	760,000.00		2,860.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6,519		8	3,808,650.00		900,260.00
SPECIAL CARE SERVICES						
CCU	1,285		0	1,108,140.00		0.00
ICU	1,290		0	1,631,431.00		0.00
NICU	403		0	747,941.00		0.00
PED ICU	29		0	35,090.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,007		0	3,522,602.00		0.00
TOTAL ACCOMODATIONS	9,526		8	7,331,252.00		900,260.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

FLOYD MEDICAL CENTER  
 304 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER  
 000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,114,345.50	4,950.62	OTHER LAB	228,825.00	0.00
MED/SURG SUPPLY	3,742,385.79	150,011.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,493,261.85	1,024.00	EDUCATION & TRAINING	4,332.00	108.00
RADIOLOGY-DIAGNOSTIC	589,293.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	803,787.00	311,449.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	115,605.50	630.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	604,171.00	609.00	MRI SERVICES	344,365.00	0.00
IV THERAPY	216,207.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,813,763.50	35,620.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	983,171.00	3,450.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,457,038.00	17,993.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	570,224.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,269,422.00	16,234.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	404,524.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	74,480.00
LABORATORY PATHOLOGIC	114,273.00	510.00	INJECTABLE DRUGS	1,083,014.18	3,205.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	34,265.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	54,156.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	180,911.00	36,836.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	49.00	3,194.00	TRAUMA RESPONSE	0.00	42,192.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,644,616.35	107,941.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	188,550.50	11,700.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	224,007.00	138,750.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	182,202.00	25,205.00			
AUDIOLOGY	84,674.00	0.00			
CARDIOLOGY	1,025,716.00	96,373.00			
AMBULATORY SURGERY	1,865.00	456.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	29,806.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	131,888.00	7,425.00			
			TOTAL ANCILLARY	36,734,714.17	1,090,346.37
			TOTAL ACCOMODATIONS	7,331,252.00	900,260.00
			TOTAL CHARGES	44,065,966.17	1,990,606.37



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,061,933.31	ADJUSTMENTS	0.00
COVERED CHARGES	1,021,488.31	CONTRACTUAL ALLOW	585,589.56
NON-COVERD CHARGES	40,445.00	TOTAL MEDICAID LIAB	435,898.75
		LESS: COB	435,898.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	93		0	51,150.00		8,965.00
ROUTINE NURSERY	14		0	16,940.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	107		0	68,090.00		8,965.00
SPECIAL CARE SERVICES						
CCU	6		0	4,950.00		0.00
ICU	3		0	4,848.00		0.00
NICU	97		0	179,256.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	106		0	189,054.00		0.00
TOTAL ACCOMODATIONS	213		0	257,144.00		8,965.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	137,401.00	0.00	OTHER LAB	7,252.00	0.00
MED/SURG SUPPLY	106,926.31	232.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	102,156.00	0.00	EDUCATION & TRAINING	36.00	0.00
RADIOLOGY-DIAGNOSTIC	8,673.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,656.00	9,360.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,374.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,577.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	22,456.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	85,553.00	833.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	65,851.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	63,498.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,106.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,987.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,605.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,600.00
LABORATORY PATHOLOGIC	1,347.00	0.00	INJECTABLE DRUGS	15,741.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	454.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,702.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	16,572.00	6,905.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	49.00	0.00	TRAUMA RESPONSE	0.00	3,600.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	45,167.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,675.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,193.00	4,950.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	840.00	0.00			
CARDIOLOGY	12,346.00	0.00			
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	7,524.00	0.00			
			TOTAL ANCILLARY	764,344.31	31,480.00
			TOTAL ACCOMODATIONS	257,144.00	8,965.00
			TOTAL CHARGES	1,021,488.31	40,445.00

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

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

Run Date: 07/23/2014  
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Page: 5

FLOYD MEDICAL CENTER  
304 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,834,369.17	ADJUSTMENTS	914,208.15
COVERED CHARGES	29,331,411.01	CONTRACTUAL ALLOW	23,657,737.96
NON-COVERD CHARGES	4,502,958.16	TOTAL MEDICAID LIAB	5,673,673.05
		LESS: COB	27,959.26
		LESS: COPAYMENT	12,720.00
		REIMBURSEMENT	5,632,993.79
		ALL OTHER	4,973,599.09
		FEE SCHEDULE-LAB	528,040.35
		INJECTABLE DRUGS	131,354.35

TOTAL NUMBER OF CLAIMS 14,353

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	699,615.25	14,424.00	OTHER LAB	168,672.00	4,021.00
MED/SURG SUPPLY	2,017,714.32	5,057.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	4,415.00	EDUCATION & TRAINING	2,090.00	516.00
RADIOLOGY-DIAGNOSTIC	1,053,574.00	25,210.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,006,915.00	226,455.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	146,784.00	37,430.04	FEE SCHEDULE LAB	5,391,672.17	1,170,608.30
EKG/ECG	301,507.00	80,688.00	MRI SERVICES	531,420.00	98,064.00
IV THERAPY	1,109,545.00	315,577.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,806,934.53	1,009,765.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	179,635.00	1,170.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	157,141.00	47,603.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	526,158.85	754.00	AMBULANCE	0.00	0.00
GI SERVICES	3,036.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,104,365.03	400,866.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	556,960.24	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,525,396.62	784,026.85
RADIOLOGY THERAPEUTIC	280.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	326.00	840.00	HOSPICE SERVICES	0.00	36.00
SPEECH PATHOLOGY	3,344.00	3,119.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,369.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	266,625.00	11,629.00	TRAUMA RESPONSE	0.00	50,544.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	230,801.00	0.00
LITHOTRIPSY	97,664.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	422,144.00	31,860.00			
BLOOD	7,201.00	0.00			
BLOOD STORAGE & PRO.	38,775.00	21,701.00			
ONCOLOGY	38.00	0.00			
NUCLEAR MEDICINE	450,054.00	47,302.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	411,136.00	77,260.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	124,895.00	1,126.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	988,992.00	23,221.00			
			TOTAL ANCILLARY	29,331,411.01	4,499,658.16
			TOTAL ACCOMODATIONS	0.00	3,300.00
			TOTAL CHARGES	29,331,411.01	4,502,958.16

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

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

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	829,394.75	ADJUSTMENTS	0.00
COVERED CHARGES	589,455.00	CONTRACTUAL ALLOW	201,432.11
NON-COVERD CHARGES	239,939.75	TOTAL MEDICAID LIAB	388,022.89
		LESS: COB	387,939.65
		LESS: COPAYMENT	83.24
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 243

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,056.25	0.00	OTHER LAB	7,125.00	375.00
MED/SURG SUPPLY	40,030.00	286.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	474.00	EDUCATION & TRAINING	980.00	0.00
RADIOLOGY-DIAGNOSTIC	19,261.00	578.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,992.00	61,043.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	318.00	1,772.00	FEE SCHEDULE LAB	106,234.00	15,660.00
EKG/ECG	3,711.00	786.00	MRI SERVICES	11,406.00	9,122.00
IV THERAPY	18,651.00	6,472.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,536.00	104,277.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	20,631.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,360.00	1,730.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	23,815.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	166,894.00	12,665.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,002.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	40,083.75	17,831.75
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	4,320.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,832.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	199.00
OTHER IMAGING SERVICE	7,208.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,737.00	1,435.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,846.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,746.00	914.00			
			TOTAL ANCILLARY	589,455.00	239,939.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	589,455.00	239,939.75

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

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

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1113119004309	03/18/13 - 03/18/13	05/13/13	0.00	199.00	0.00	4,749.10	0.00
TOTAL				0.00	199.00	0.00	4,749.10	0.00

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,221,570.75	ADJUSTMENTS	3,462.10
COVERED CHARGES	2,107,641.25	CONTRACTUAL ALLOW	2,014,924.52
NON-COVERD CHARGES	113,929.50	TOTAL MEDICAID LIAB	92,716.73
		LESS: COB	16.96
		LESS: COPAYMENT	3,534.15
		REIMBURSEMENT	89,165.62
		TOTAL NUMBER OF CLAIMS	1,659



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,947.50	0.00	OTHER LAB	3,831.00	479.00
MED/SURG SUPPLY	54,872.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	114,644.00	597.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	29,874.00	5,901.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	288,482.00	27,953.00
EKG/ECG	9,561.00	585.00	MRI SERVICES	8,957.00	0.00
IV THERAPY	42,901.00	6,469.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,201.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,975.00	450.00	FREE STANDING CLINIC	0.00	56.00
ANESTHESIA	1,524.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,445,921.00	45,992.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,324.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	82,047.75	24,632.50
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	201.00	145.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	708.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	154.00
OTHER IMAGING SERVICE	4,468.00	516.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,202.00	0.00			
			TOTAL ANCILLARY	2,107,641.25	113,929.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,107,641.25	113,929.50

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

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

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

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

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
9637	5912293000808	09/21/12 - 09/22/12	10/22/12	0.00	154.00	0.00	0.00	0.00
TOTAL				0.00	154.00	0.00	0.00	0.00

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	81,463.25	ADJUSTMENTS	0.00
COVERED CHARGES	73,781.25	CONTRACTUAL ALLOW	36,230.09
NON-COVERD CHARGES	7,682.00	TOTAL MEDICAID LIAB	37,551.16
		LESS: COB	37,509.16
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	42

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	963.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,638.00	48.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,663.00	195.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,191.00	4,264.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,607.00	832.00
EKG/ECG	390.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	337.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	64.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,314.00	1,311.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,759.50	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	234.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	620.00	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	73,781.25	7,682.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	73,781.25	7,682.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FLOYD MEDICAL CENTER  
304 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000000756A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,531,475.50	ADJUSTMENTS	101,490.93
COVERED CHARGES	4,260,230.75	CONTRACTUAL ALLOW	3,720,431.84
NON-COVERD CHARGES	271,244.75	TOTAL MEDICAID LIAB	539,798.91
		LESS: COB	828.00
		LESS: COPAYMENT	444.00
		REIMBURSEMENT	538,526.91

TOTAL NUMBER OF CLAIMS 107

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,144.25	134.00	OTHER LAB	37,517.00	0.00
MED/SURG SUPPLY	338,319.00	77.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	432.00	108.00
RADIOLOGY-DIAGNOSTIC	18,908.00	6,180.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,185.00	19,941.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	228.00	FEE SCHEDULE LAB	65,101.00	7,695.00
EKG/ECG	4,545.00	2,571.00	MRI SERVICES	0.00	0.00
IV THERAPY	78,450.00	19,256.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,047,949.00	73,997.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40,214.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	135,302.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,465.00	332.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	104,039.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	435.00	INJECTABLE DRUGS	1,016,246.50	117,324.75
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	545.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,126,772.00	0.00
LITHOTRIPSY	13,952.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,921.00	1,576.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,751.00	19,410.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	77,473.00	1,980.00			
			TOTAL ANCILLARY	4,260,230.75	271,244.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,260,230.75	271,244.75

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: 07/23/2014  
Run Time: 12:40:22  
Page: 17

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,131.00	ADJUSTMENTS	0.00
COVERED CHARGES	28,999.00	CONTRACTUAL ALLOW	4,938.20
NON-COVERD CHARGES	1,132.00	TOTAL MEDICAID LIAB	24,060.80
		LESS: COB	24,054.80
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	790.50	0.00	OTHER LAB	2,385.00	0.00
MED/SURG SUPPLY	2,539.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	390.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	229.00	0.00
EKG/ECG	195.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,150.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,885.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,633.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	620.50	742.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	572.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,999.00	1,132.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,999.00	1,132.00



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:38:05  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL FORSYTH  
 1200 NORTHSIDE FORSYTH DR  
 CUMMING,GA 30041-7659

PROVIDER NUMBER 000000767A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,485,741.95	ADJUSTMENTS	1,619,194.93
COVERED CHARGES	28,411,654.95	CONTRACTUAL ALLOW	22,224,082.76
NON-COVERD CHARGES	1,074,087.00	TOTAL MEDICAID LIAB	6,187,572.19
		LESS: COB	49,621.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,137,950.48

TOTAL NUMBER OF ADMISSIONS 1,033

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,296		5	3,186,053.00		425,960.00
ROUTINE NURSERY	1,116		47	1,097,809.00		348,768.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,412		52	4,283,862.00		774,728.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	396		0	1,306,769.00		0.00
NICU	21		0	110,733.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	417		0	1,417,502.00		0.00
TOTAL ACCOMODATIONS	4,829		52	5,701,364.00		774,728.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,368,999.00	17,502.50	OTHER LAB	68,725.00	1,023.00
MED/SURG SUPPLY	1,603,172.00	9,188.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,277,885.95	32,675.00	EDUCATION & TRAINING	1,642.00	0.00
RADIOLOGY-DIAGNOSTIC	591,675.00	0.00	OTHER THERAPEUTIC SVC	0.00	7,458.00
CT SCAN	756,623.00	2,780.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	194,258.00	4,783.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	130,231.00	0.00	MRI SERVICES	268,195.00	0.00
IV THERAPY	30,980.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,288,329.00	33,601.00	DURABLE MED. EQUIP.	0.00	691.00
LABOR/DELIVERY ROOM	1,003,533.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	965,832.00	282.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	301,156.00	822.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	654,442.00	7,325.00	SPECIAL SERVICES	0.00	34,696.00
RECOVERY ROOM	252,529.00	224.00	DRUG-SPECIFIC/HOME IV	0.00	17,473.50
LABORATORY PATHOLOGIC	240,401.00	0.00	INJECTABLE DRUGS	5,427,257.00	20,332.00
RADIOLOGY THERAPEUTIC	83,798.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	59,066.00	375.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	45,202.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	116,471.00	18,180.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	132.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	605,636.00	0.00
LITHOTRIPSY	18,296.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	186,274.00	70,356.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	448,989.00	11,018.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	101,646.00	8,574.00			
AUDIOLOGY	109,402.00	0.00			
CARDIOLOGY	479,786.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,660.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,068.00	0.00			
			TOTAL ANCILLARY	22,710,290.95	299,359.00
			TOTAL ACCOMODATIONS	5,701,364.00	774,728.00
			TOTAL CHARGES	28,411,654.95	1,074,087.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	638,894.95	ADJUSTMENTS	0.00
COVERED CHARGES	583,531.95	CONTRACTUAL ALLOW	261,217.21
NON-COVERD CHARGES	55,363.00	TOTAL MEDICAID LIAB	322,314.74
		LESS: COB	322,314.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	23		0	22,008.00		2,955.00
ROUTINE NURSERY	87		0	296,238.00		47,905.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	110		0	318,246.00		50,860.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	110		0	318,246.00		50,860.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,674.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	30,231.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	45,483.95	0.00	EDUCATION & TRAINING	282.00	0.00
RADIOLOGY-DIAGNOSTIC	9,960.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,251.00
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	271.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	834.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,134.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,613.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,361.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,821.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,746.00	0.00	SPECIAL SERVICES	0.00	3,252.00
RECOVERY ROOM	1,191.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	959.00	0.00	INJECTABLE DRUGS	87,440.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,775.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	2,224.00	0.00			
CARDIOLOGY	9,286.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	265,285.95	4,503.00
			TOTAL ACCOMODATIONS	318,246.00	50,860.00
			TOTAL CHARGES	583,531.95	55,363.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:38:29  
Page: 5

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,516,779.08	ADJUSTMENTS	658,978.59
COVERED CHARGES	12,175,068.42	CONTRACTUAL ALLOW	9,833,237.71
NON-COVERD CHARGES	1,341,710.66	TOTAL MEDICAID LIAB	2,341,830.71
		LESS: COB	5,060.40
		LESS: COPAYMENT	5,456.18
		REIMBURSEMENT	2,331,314.13
		ALL OTHER	2,033,456.62
		FEE SCHEDULE-LAB	103,722.31
		INJECTABLE DRUGS	194,135.20

TOTAL NUMBER OF CLAIMS 3,519

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	498,915.42	6,247.00	OTHER LAB	156,165.00	1,972.00
MED/SURG SUPPLY	339,992.50	23,631.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	1,047.00	248.00
RADIOLOGY-DIAGNOSTIC	446,156.00	12,768.00	OTHER THERAPEUTIC SVC	0.00	12,610.00
CT SCAN	1,276,374.00	79,141.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	42,940.00	10,657.00	FEE SCHEDULE LAB	1,614,496.65	321,654.00
EKG/ECG	92,212.00	7,074.00	MRI SERVICES	366,917.00	26,369.00
IV THERAPY	445,740.00	109,653.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	972,334.00	119,340.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	63,629.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	74,481.00	4,775.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	147,643.00	19,203.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,275,188.00	89,840.00	SPECIAL SERVICES	0.00	146.00
RECOVERY ROOM	154,878.00	880.00	DRUG-SPECIFIC/HOME IV	0.00	246.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,359,012.97	317,306.66
RADIOLOGY THERAPEUTIC	468,632.00	2,296.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	870.00	750.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	273.00	2,185.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,015.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	856.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	96,194.00	8,647.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	646,344.00	90,679.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	61,928.00	3,148.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	151,362.00	11,125.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	185,853.00	55,957.00			
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	232,890.88	292.00			
			TOTAL ANCILLARY	12,175,068.42	1,341,710.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,175,068.42	1,341,710.66

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	331,841.40	ADJUSTMENTS	0.00
COVERED CHARGES	268,498.80	CONTRACTUAL ALLOW	141,281.56
NON-COVERD CHARGES	63,342.60	TOTAL MEDICAID LIAB	127,217.24
		LESS: COB	127,167.64
		LESS: COPAYMENT	49.60
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 135

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,544.00	67.00	OTHER LAB	9,588.00	0.00
MED/SURG SUPPLY	9,155.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,174.00	0.00	OTHER THERAPEUTIC SVC	0.00	153.00
CT SCAN	6,640.00	14,273.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	49,838.80	10,665.60
EKG/ECG	1,355.00	0.00	MRI SERVICES	3,596.00	0.00
IV THERAPY	3,153.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,779.00	17,702.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,859.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,109.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,336.00	1,134.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	100,654.00	2,459.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,841.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,386.50	8,663.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,042.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,145.00	8,226.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,303.00	0.00			
			TOTAL ANCILLARY	268,498.80	63,342.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	268,498.80	63,342.60



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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NORTHSIDE HOSPITAL FORSYTH  
1200 NORTHSIDE FORSYTH DR  
CUMMING,GA 30041-7659

PROVIDER NUMBER  
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	490,447.00	ADJUSTMENTS	1,126.71
COVERED CHARGES	453,655.50	CONTRACTUAL ALLOW	435,419.09
NON-COVERD CHARGES	36,791.50	TOTAL MEDICAID LIAB	18,236.41
		LESS: COB	0.00
		LESS: COPAYMENT	462.00
		REIMBURSEMENT	17,774.41
		TOTAL NUMBER OF CLAIMS	326

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,882.00	677.00	OTHER LAB	2,515.00	0.00
MED/SURG SUPPLY	9,857.00	68.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,308.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,734.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	355.00	FEE SCHEDULE LAB	62,800.00	9,817.00
EKG/ECG	4,163.00	271.00	MRI SERVICES	10,788.00	0.00
IV THERAPY	7,521.00	2,726.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,169.00	4,595.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	807.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,353.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	245,017.00	3,624.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	725.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,243.50	8,681.50
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	32.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,920.00	2,211.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,853.00	3,734.00			
			TOTAL ANCILLARY	453,655.50	36,791.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	453,655.50	36,791.50

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH  
1200 NORTHSIDE FORSYTH DR  
CUMMING,GA 30041-7659

PROVIDER NUMBER  
000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,360.00	ADJUSTMENTS	0.00
COVERED CHARGES	10,853.50	CONTRACTUAL ALLOW	6,459.52
NON-COVERD CHARGES	506.50	TOTAL MEDICAID LIAB	4,393.98
		LESS: COB	4,381.98
		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: 07/23/2014  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE HOSPITAL FORSYTH  
 1200 NORTHSIDE FORSYTH DR  
 CUMMING,GA 30041-7659

PROVIDER NUMBER  
 000000767A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	219.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	101.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	722.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,540.00	92.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	465.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,524.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	282.50	414.50
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	10,853.50	506.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,853.50	506.50

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,247,981.63	ADJUSTMENTS	140,970.20
COVERED CHARGES	1,874,510.33	CONTRACTUAL ALLOW	1,582,928.65
NON-COVERD CHARGES	373,471.30	TOTAL MEDICAID LIAB	291,581.68
		LESS: COB	0.00
		LESS: COPAYMENT	393.00
		REIMBURSEMENT	291,188.68

TOTAL NUMBER OF CLAIMS 52

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 1200 NORTHSIDE FORSYTH DR 000000767A SERVICE DATES 01/01/13 THROUGH 12/31/13  
 CUMMING,GA 30041-7659 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	130,087.00	201.00	OTHER LAB	2,480.00	0.00
MED/SURG SUPPLY	151,113.50	10,882.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	27,938.00	6,064.00	OTHER THERAPEUTIC SVC	0.00	3,060.00
CT SCAN	40,325.00	11,384.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	709.00	1,332.00	FEE SCHEDULE LAB	119,424.17	22,273.80
EKG/ECG	4,462.00	2,196.00	MRI SERVICES	19,166.00	8,198.00
IV THERAPY	82,922.00	6,653.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	271,486.00	141,945.00	DURABLE MED. EQUIP.	0.00	452.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,209.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	60,757.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,897.00	3,701.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	26,587.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	562.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	349,008.50	42,812.00
RADIOLOGY THERAPEUTIC	165,582.00	1,217.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	677.00	500.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,948.00	1,125.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,015.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	78.00	32.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	231,023.00	70,528.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,781.00	375.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,338.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,107.00	1,694.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	78,599.00	34,269.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,806.16	0.00			
			TOTAL ANCILLARY	1,874,510.33	373,471.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,874,510.33	373,471.30

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: 07/23/2014  
Run Time: 10:39:30  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL FORSYTH  
1200 NORTHSIDE FORSYTH DR  
CUMMING,GA 30041-7659

PROVIDER NUMBER  
000000767A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS HOSPITAL  
 6135 ROOSEVELT HWY  
 WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER 000000778A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,620,360.07	ADJUSTMENTS	1,005,736.69
COVERED CHARGES	2,357,054.12	CONTRACTUAL ALLOW	-71,714.01
NON-COVERD CHARGES	263,305.95	TOTAL MEDICAID LIAB	2,428,768.13
		LESS: COB	496.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,428,271.41

TOTAL NUMBER OF ADMISSIONS 111

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,825		0	1,314,835.00		255,900.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,825		0	1,314,835.00		255,900.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,825		0	1,314,835.00		255,900.00



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:06:26  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS HOSPITAL  
 6135 ROOSEVELT HWY  
 WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
 000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	246,251.28	0.00	OTHER LAB	3,471.00	0.00
MED/SURG SUPPLY	91,785.96	3,101.25	RECREATIONAL THERAPY	53.00	0.00
LABORATORY-GENERAL	61,635.30	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,758.15	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,596.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	194,212.30	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,269.40	0.00	MRI SERVICES	3,756.48	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	52,197.50	444.10	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,184.00	0.00	INJECTABLE DRUGS	515.05	20.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	252,961.40	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	106,321.90	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,016.00	0.00			
BLOOD	3,246.60	0.00			
BLOOD STORAGE & PRO.	0.00	3,340.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	500.00			
AUDIOLOGY	921.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	66.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,042,219.12	7,405.95
			TOTAL ACCOMODATIONS	1,314,835.00	255,900.00
			TOTAL CHARGES	2,357,054.12	263,305.95

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,074.20	ADJUSTMENTS	4,470.52
COVERED CHARGES	9,753.20	CONTRACTUAL ALLOW	1,404.41
NON-COVERD CHARGES	321.00	TOTAL MEDICAID LIAB	8,348.79
		LESS: COB	92.27
		LESS: COPAYMENT	111.00
		REIMBURSEMENT	8,145.52
		ALL OTHER	8,145.52
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 71

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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ROOSEVELT WARM SPRINGS HOSPITAL  
 6135 ROOSEVELT HWY  
 WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
 000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	329.00	0.00
MED/SURG SUPPLY	0.00	25.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	415.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,465.20	296.00	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	1,544.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,753.20	321.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,753.20	321.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
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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ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROOSEVELT WARM SPRINGS HOSPITAL  
6135 ROOSEVELT HWY  
WARM SPRINGS,GA 31830-2757

PROVIDER NUMBER  
000000778A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER 000000789A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	230,342,025.74	ADJUSTMENTS	15,228,825.53
COVERED CHARGES	222,605,789.55	CONTRACTUAL ALLOW	182,988,870.90
NON-COVERD CHARGES	7,736,236.19	TOTAL MEDICAID LIAB	39,616,918.65
		LESS: COB	284,972.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	39,331,946.20

TOTAL NUMBER OF ADMISSIONS 5,291

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	17,150	246	22,636,430.46	1,951,039.54
ROUTINE NURSERY	3,435	50	4,209,713.08	97,441.92
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	20,585	296	26,846,143.54	2,048,481.46
SPECIAL CARE SERVICES				
CCU	695	1	2,530,613.00	3,612.00
ICU	5,506	0	15,906,726.00	228,652.00
NICU	209	0	712,458.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6,410	1	19,149,797.00	232,264.00
TOTAL ACCOMODATIONS	26,995	297	45,995,940.54	2,280,745.46

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,535,904.55	674,862.56	OTHER LAB	570,796.34	2,661.89
MED/SURG SUPPLY	16,053,431.02	1,000,570.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	20,551,575.39	377,477.95	EDUCATION & TRAINING	31,446.00	1,618.00
RADIOLOGY-DIAGNOSTIC	3,890,805.57	19,076.37	OTHER THERAPEUTIC SVC	168,159.30	129,129.04
CT SCAN	7,538,713.48	96,331.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	879,762.99	35,254.90	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	897,647.35	3,158.85	MRI SERVICES	2,097,250.29	32,262.48
IV THERAPY	9,029.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,066,185.92	133,797.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,767,583.87	23,715.30	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,193,042.17	28,581.58	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,346,730.92	34,247.84	AMBULANCE	0.00	0.00
GI SERVICES	585,084.19	4,017.33	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,649,230.00	123,212.47	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,166,936.68	19,506.05	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	797,842.07	7,775.82	INJECTABLE DRUGS	12,773.17	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	511,714.51	22,154.32	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	497,371.70	38,525.08	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	736,489.54	36,310.14	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,932.70	106.00	TRAUMA RESPONSE	0.00	884,091.40
PSYCHIATRIC SERVICES	1,237,796.49	861.00	IMPL DEV CHARGE PATIENTS	6,391,303.60	0.00
LITHOTRIPSY	110,557.72	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,109,706.71	43,562.57			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	273,919.49	1,666,753.85			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,735,824.69	7,771.05			
AUDIOLOGY	171,431.35	0.00			
CARDIOLOGY	3,474,695.64	6,650.62			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	167,070.32	1,446.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	372,103.46	0.00			
			TOTAL ANCILLARY	176,609,849.01	5,455,490.73
			TOTAL ACCOMODATIONS	45,995,940.54	2,280,745.46
			TOTAL CHARGES	222,605,789.55	7,736,236.19

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	260,516.58	ADJUSTMENTS	0.00
COVERED CHARGES	259,468.50	CONTRACTUAL ALLOW	233,501.96
NON-COVERD CHARGES	1,048.08	TOTAL MEDICAID LIAB	25,966.54
		LESS: COB	25,966.54
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14		0	18,791.92		1,048.08
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	14		0	18,791.92		1,048.08
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	17		0	51,223.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	17		0	51,223.00		0.00
TOTAL ACCOMODATIONS	31		0	70,014.92		1,048.08

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	50,219.34	0.00	OTHER LAB	1,490.00	0.00
MED/SURG SUPPLY	13,220.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,192.02	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,325.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,071.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,067.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	680.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,330.41	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	20,286.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,284.85	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,617.74	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,027.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,001.47	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	432.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,233.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,893.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,083.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	189,453.58	0.00
			TOTAL ACCOMODATIONS	70,014.92	1,048.08
			TOTAL CHARGES	259,468.50	1,048.08

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:30:51  
Page: 5

ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,111,030.74	ADJUSTMENTS	1,716,828.67
COVERED CHARGES	46,177,994.86	CONTRACTUAL ALLOW	37,561,599.91
NON-COVERD CHARGES	6,933,035.88	TOTAL MEDICAID LIAB	8,616,394.95
		LESS: COB	5,162.71
		LESS: COPAYMENT	9,451.32
		REIMBURSEMENT	8,601,780.92
		ALL OTHER	8,219,103.06
		FEE SCHEDULE-LAB	323,202.36
		INJECTABLE DRUGS	59,475.50

TOTAL NUMBER OF CLAIMS 14,823

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,881,619.07	43,395.28	OTHER LAB	260,672.06	8,259.38
MED/SURG SUPPLY	2,016,910.91	81,312.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	836.00
RADIOLOGY-DIAGNOSTIC	3,130,642.35	66,354.67	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,106,117.80	1,267,867.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	67,871.80	22,395.03	FEE SCHEDULE LAB	6,733,929.03	1,528,745.77
EKG/ECG	704,194.18	28,065.64	MRI SERVICES	1,001,958.28	122,340.44
IV THERAPY	1,884,662.24	228,972.52	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,150,759.92	1,367,754.64	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,723.49	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	189,799.29	85,029.81	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,928,689.92	0.00	AMBULANCE	0.00	0.00
GI SERVICES	291,861.85	73,500.09	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,255,456.30	56,351.97	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	563,284.32	0.00	DRUG-SPECIFIC/HOME IV	0.00	25,431.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,547,063.71	884,626.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,551.41	5,525.66	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,078.08	3,668.98	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	21,856.63	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	223,040.03	21,906.55	TRAUMA RESPONSE	0.00	154,176.10
PSYCHIATRIC SERVICES	285,674.35	0.00	IMPL DEV CHARGE PATIENTS	60,824.06	41,747.46
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,742,894.31	286,147.21			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,782.88	57,233.77			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	871,319.60	0.00			
AUDIOLOGY	3,370.27	259.01			
CARDIOLOGY	284,372.96	275,970.32			
AMBULATORY SURGERY	1,521.01	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	601,363.94	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	355,985.44	173,305.10			
			TOTAL ANCILLARY	46,177,994.86	6,933,035.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	46,177,994.86	6,933,035.88

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: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	163,841.37	ADJUSTMENTS	0.00
COVERED CHARGES	133,444.23	CONTRACTUAL ALLOW	70,191.41
NON-COVERD CHARGES	30,397.14	TOTAL MEDICAID LIAB	63,252.82
		LESS: COB	63,243.89
		LESS: COPAYMENT	8.93
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 50



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,488.26	1,238.00	OTHER LAB	3,170.98	0.00
MED/SURG SUPPLY	3,766.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,262.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	20,025.21	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	30,679.70	2,207.31
EKG/ECG	4,625.70	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,922.38	3,158.48	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	408.75	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	46,089.56	141.20	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	12,924.25	2,098.43
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	181.91	44.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,429.03	1,199.02			
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	2,494.87	284.90			
			TOTAL ANCILLARY	133,444.23	30,397.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	133,444.23	30,397.14

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:32:50  
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ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,427,826.96	ADJUSTMENTS	4,638.74
COVERED CHARGES	3,200,980.80	CONTRACTUAL ALLOW	3,067,563.99
NON-COVERD CHARGES	226,846.16	TOTAL MEDICAID LIAB	133,416.81
		LESS: COB	0.00
		LESS: COPAYMENT	4,899.15
		REIMBURSEMENT	128,517.66
		TOTAL NUMBER OF CLAIMS	2,385

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	69,774.89	614.71	OTHER LAB	12,364.10	0.00
MED/SURG SUPPLY	88,712.74	247.73	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	130,468.80	737.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	76,392.95	39,079.74	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	502,938.89	114,871.39
EKG/ECG	31,508.48	857.14	MRI SERVICES	31,857.24	6,899.32
IV THERAPY	140,661.40	7,682.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,610.06	11,488.53	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,851.45	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	18,332.08	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,330.31	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,856,801.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,317.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	94,221.62	20,611.32
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	520.23	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	186.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	29,406.83	0.00	IMPL DEV CHARGE PATIENTS	34,608.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	47,518.96	15,698.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,722.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,633.41	3,300.00			
			TOTAL ANCILLARY	3,200,980.80	226,846.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,200,980.80	226,846.16



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:33:05  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,774.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,715.95	2,612.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	604.46	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,817.33	9.91
EKG/ECG	340.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,997.56	148.64	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	7,122.27	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,963.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,468.04	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,796.04	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,282.45	557.50
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	39,760.24	10,450.66
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	39,760.24	10,450.66

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 11:33:10  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,898,462.58	ADJUSTMENTS	382,657.12
COVERED CHARGES	6,607,718.82	CONTRACTUAL ALLOW	5,627,557.91
NON-COVERD CHARGES	1,290,743.76	TOTAL MEDICAID LIAB	980,160.91
		LESS: COB	0.00
		LESS: COPAYMENT	704.58
		REIMBURSEMENT	979,456.33

TOTAL NUMBER OF CLAIMS 179

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	363,560.11	11,233.08	OTHER LAB	4,428.21	0.00
MED/SURG SUPPLY	1,051,678.18	47,876.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	75,387.19	15,858.89	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	173,441.66	16,819.77	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	5,796.56	FEE SCHEDULE LAB	242,079.31	53,867.54
EKG/ECG	21,399.94	7,019.98	MRI SERVICES	3,449.66	0.00
IV THERAPY	11,443.60	7,038.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,726,203.16	273,527.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,391.43	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,822.83	1,741.51	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	779,499.04	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,366.68	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	51,029.62	7,173.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	274,711.11	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,386.40
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	335,944.96	170,544.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,608.09	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,050.39	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	235.94	390.79	TRAUMA RESPONSE	0.00	49,930.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	448,369.80	394,747.55
LITHOTRIpsy	661,681.08	77,228.23	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,804.73	2,495.53			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	4,522.36			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	179,311.46	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	116,051.75	88,899.31			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	69,427.37	47,987.14			
			TOTAL ANCILLARY	6,607,718.82	1,290,743.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,607,718.82	1,290,743.76

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:33:17  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER  
303 PARKWAY DR NE  
ATLANTA,GA 30312-1212

PROVIDER NUMBER  
000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	59,422.25	ADJUSTMENTS	0.00
COVERED CHARGES	52,322.42	CONTRACTUAL ALLOW	16,371.87
NON-COVERD CHARGES	7,099.83	TOTAL MEDICAID LIAB	35,950.55
		LESS: COB	35,944.55
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1



Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:33:17  
 Page: 16

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER  
 303 PARKWAY DR NE  
 ATLANTA,GA 30312-1212

PROVIDER NUMBER  
 000000789A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	203.07	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,244.40	868.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	504.14	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	580.91	0.00
EKG/ECG	0.00	1,285.71	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,415.86	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	374.04	2,062.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	2,883.60			
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	0.00	0.00			
			TOTAL ANCILLARY	52,322.42	7,099.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,322.42	7,099.83

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER 000000811A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,035,774.31	ADJUSTMENTS	313,293.26
COVERED CHARGES	1,912,340.93	CONTRACTUAL ALLOW	1,057,297.33
NON-COVERD CHARGES	123,433.38	TOTAL MEDICAID LIAB	855,043.60
		LESS: COB	8,576.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	846,467.38

TOTAL NUMBER OF ADMISSIONS 137

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	333		0	287,911.00		49,220.00
ROUTINE NURSERY	115		0	100,050.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	448		0	387,961.00		49,220.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	65		0	125,645.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	125,645.00		0.00
TOTAL ACCOMODATIONS	513		0	513,606.00		49,220.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	378,203.15	26,642.78	OTHER LAB	2,988.00	0.00
MED/SURG SUPPLY	141,328.17	5,939.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	179,625.01	12,510.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,808.00	426.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,843.00	734.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,966.45	2,606.10	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,118.00	0.00	MRI SERVICES	25,465.00	0.00
IV THERAPY	17,420.00	6,695.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	164,682.00	2,078.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	36,220.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	99,932.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	54,092.00	945.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,483.00	87.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,197.00	567.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,053.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	927.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,236.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	475.65	331.80	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,392.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	43,460.00	12,826.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,879.00	0.00			
AUDIOLOGY	2,848.00	0.00			
CARDIOLOGY	18,351.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,916.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,826.00	1,825.00			
			TOTAL ANCILLARY	1,398,734.93	74,213.38
			TOTAL ACCOMODATIONS	513,606.00	49,220.00
			TOTAL CHARGES	1,912,340.93	123,433.38

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	94,404.39	ADJUSTMENTS	0.00
COVERED CHARGES	90,848.39	CONTRACTUAL ALLOW	26,158.05
NON-COVERD CHARGES	3,556.00	TOTAL MEDICAID LIAB	64,690.34
		LESS: COB	64,690.34
		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	28		0	25,940.00		3,556.00
ROUTINE NURSERY	0		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	25,940.00		3,556.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	25,940.00		3,556.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,121.10	0.00	OTHER LAB	420.00	0.00
MED/SURG SUPPLY	4,319.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,976.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	619.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,780.00	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	930.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,029.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	9,871.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,116.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,263.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,349.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,402.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	363.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,350.00	0.00			
			TOTAL ANCILLARY	64,908.39	0.00
			TOTAL ACCOMODATIONS	25,940.00	3,556.00
			TOTAL CHARGES	90,848.39	3,556.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:13:32  
Page: 5

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,053,464.85	ADJUSTMENTS	190,990.31
COVERED CHARGES	2,869,484.68	CONTRACTUAL ALLOW	2,094,777.52
NON-COVERD CHARGES	183,980.17	TOTAL MEDICAID LIAB	774,707.16
		LESS: COB	1,266.98
		LESS: COPAYMENT	2,907.00
		REIMBURSEMENT	770,533.18
		ALL OTHER	622,642.93
		FEE SCHEDULE-LAB	86,320.16
		INJECTABLE DRUGS	61,570.09

TOTAL NUMBER OF CLAIMS 2,725

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	141,164.69	1,846.82	OTHER LAB	32,115.00	0.00
MED/SURG SUPPLY	61,901.15	42.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	530.00	306.00
RADIOLOGY-DIAGNOSTIC	144,578.00	1,634.00	OTHER THERAPEUTIC SVC	0.00	3,890.00
CT SCAN	293,588.00	8,954.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,213.80	361.20	FEE SCHEDULE LAB	443,854.30	79,607.60
EKG/ECG	37,260.00	990.00	MRI SERVICES	92,488.00	1,690.00
IV THERAPY	132,681.00	9,474.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	83,170.50	6,219.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,726.00	3,600.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,598.00	3,504.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,300.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	648,842.00	7,538.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,279.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	213,578.24	38,542.76
RADIOLOGY THERAPEUTIC	163,975.00	10,328.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	196.35	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	1,259.00	230.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	656.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	91.00
OTHER IMAGING SERVICE	77,550.00	2,320.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	46,353.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,940.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	37,925.00	0.00			
AMBULATORY SURGERY	2,864.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,706.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	56,389.00	2,614.60			
			TOTAL ANCILLARY	2,869,484.68	183,980.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,869,484.68	183,980.17

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:13:32  
Page: 7

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3600	5912264002130	08/01/12 - 08/01/12	09/24/12	0.00	91.00	0.00	0.00	0.00
TOTAL				0.00	91.00	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 11:14:34  
Page: 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	97,257.03	ADJUSTMENTS	0.00
COVERED CHARGES	76,392.44	CONTRACTUAL ALLOW	25,791.06
NON-COVERD CHARGES	20,864.59	TOTAL MEDICAID LIAB	50,601.38
		LESS: COB	50,580.38
		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

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,331.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,367.85	890.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	116.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,980.00	213.00	OTHER THERAPEUTIC SVC	0.00	174.00
CT SCAN	2,028.00	9,439.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,363.00	2,987.00
EKG/ECG	1,188.00	0.00	MRI SERVICES	1,690.00	0.00
IV THERAPY	3,831.00	281.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,432.00	2,078.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	962.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,371.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,125.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,310.00	87.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	585.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,719.04	2,214.05
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	1,021.00	1,341.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,170.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	958.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	960.00	1,044.00			
			TOTAL ANCILLARY	76,392.44	20,864.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	76,392.44	20,864.59

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:14:37  
Page: 10

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	197,020.37	ADJUSTMENTS	1,200.66
COVERED CHARGES	189,654.27	CONTRACTUAL ALLOW	170,802.49
NON-COVERD CHARGES	7,366.10	TOTAL MEDICAID LIAB	18,851.78
		LESS: COB	45.55
		LESS: COPAYMENT	447.05
		REIMBURSEMENT	18,359.18
		TOTAL NUMBER OF CLAIMS	337

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,643.12	0.00	OTHER LAB	924.00	0.00
MED/SURG SUPPLY	590.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,462.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,494.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,293.00	5,450.00
EKG/ECG	792.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,585.00	370.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	153.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,409.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	120,909.00	1,024.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,453.15	522.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,947.00	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	189,654.27	7,366.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	189,654.27	7,366.10

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,087.15	ADJUSTMENTS	0.00
COVERED CHARGES	10,503.90	CONTRACTUAL ALLOW	3,923.26
NON-COVERD CHARGES	2,583.25	TOTAL MEDICAID LIAB	6,580.64
		LESS: COB	6,562.64
		LESS: COPAYMENT	18.00
		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: 07/23/2014  
 Run Time: 11:14:44  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	441.20	0.00	OTHER LAB	462.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	1,921.00	164.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	1,860.00
IV THERAPY	384.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	90.00	45.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,353.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	426.70	221.25
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	293.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,503.90	2,583.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,503.90	2,583.25

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 11:14:45  
Page: 14

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	130,960.66	ADJUSTMENTS	14,811.39
COVERED CHARGES	129,935.26	CONTRACTUAL ALLOW	105,134.61
NON-COVERD CHARGES	1,025.40	TOTAL MEDICAID LIAB	24,800.65
		LESS: COB	0.00
		LESS: COPAYMENT	132.00
		REIMBURSEMENT	24,668.65

TOTAL NUMBER OF CLAIMS 5

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINGS BAY COMMUNITY HOSPITAL INC  
 2000 DAN PROCTOR DR  
 SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
 000000811A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	895.10	6.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	159.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	254.00
CT SCAN	10,997.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,260.00	35.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,252.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	37,082.38	372.30
RADIOLOGY THERAPEUTIC	68,129.00	358.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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.	6,045.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	129,935.26	1,025.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	129,935.26	1,025.40



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:14:45  
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINGS BAY COMMUNITY HOSPITAL INC  
2000 DAN PROCTOR DR  
SAINT MARYS,GA 31558-3810

PROVIDER NUMBER  
000000811A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/12	THROUGH	04/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:14:53  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER 000000822A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,051,732.37	ADJUSTMENTS	1,099,494.52
COVERED CHARGES	25,086,952.88	CONTRACTUAL ALLOW	16,408,691.63
NON-COVERD CHARGES	964,779.49	TOTAL MEDICAID LIAB	8,678,261.25
		LESS: COB	60,216.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,618,044.45

TOTAL NUMBER OF ADMISSIONS 948

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,915		0	2,623,164.00		275,999.00
ROUTINE NURSERY	301		0	261,870.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,216		0	2,885,034.00		275,999.00
SPECIAL CARE SERVICES						
CCU	505		0	920,444.00		56,057.00
ICU	1,904		0	3,018,903.00		7,275.00
NICU	44		0	69,388.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,453		0	4,008,735.00		63,332.00
TOTAL ACCOMODATIONS	5,669		0	6,893,769.00		339,331.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,672,951.82	113,613.07	OTHER LAB	91,529.00	462.00
MED/SURG SUPPLY	2,023,650.80	33,800.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,134,511.18	53,484.00	EDUCATION & TRAINING	49.00	0.00
RADIOLOGY-DIAGNOSTIC	451,350.00	5,581.00	OTHER THERAPEUTIC SVC	0.00	504.00
CT SCAN	401,125.00	144,488.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	174,857.00	2,780.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	97,127.00	583.00	MRI SERVICES	157,577.00	0.00
IV THERAPY	261,891.00	6,958.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,948,188.00	42,401.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	158,189.00	0.00	REHAB THERAPY	1,239.00	0.00
RESPIRATORY SERVICES	1,473,013.58	36,451.42	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	437,808.00	1,408.00	AMBULANCE	0.00	0.00
GI SERVICES	903.00	903.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	330,149.00	174.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	163,843.00	581.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	52,735.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	140,870.00	1,157.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	27,595.00	366.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	254,364.00	46,939.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	260.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,636.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,444.00
OTHER IMAGING SERVICE	87,255.00	11,536.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	558,272.00	93,892.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	75,275.00	18,144.00			
AUDIOLOGY	11,125.00	0.00			
CARDIOLOGY	849,830.00	539.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	41,343.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	111,932.00	0.00			
			TOTAL ANCILLARY	18,193,183.88	625,448.49
			TOTAL ACCOMODATIONS	6,893,769.00	339,331.00
			TOTAL CHARGES	25,086,952.88	964,779.49

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 11:14:53  
Page: 3

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012257011810	09/04/12 - 09/06/12	09/17/12	0.00	2,700.00	0.00	0.00	0.00
466	2212347007019	10/24/12 - 12/06/12	12/17/12	0.00	344.00	0.00	0.00	0.00
615	2213337006929	04/23/13 - 05/30/13	12/09/13	0.00	2,700.00	0.00	0.00	0.00
615	5214015000009	01/22/13 - 03/21/13	01/20/14	0.00	2,700.00	0.00	0.00	0.00
TOTAL				0.00	8,444.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:15:18  
 Page: 4

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	279,511.26	ADJUSTMENTS	0.00
COVERED CHARGES	272,180.26	CONTRACTUAL ALLOW	53,159.12
NON-COVERD CHARGES	7,331.00	TOTAL MEDICAID LIAB	219,021.14
		LESS: COB	219,021.14
		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	56		0	51,916.00		6,201.00
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	56		0	51,916.00		6,201.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	11		0	21,263.00		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	11		0	21,263.00		0.00
TOTAL ACCOMODATIONS	67		0	73,179.00		6,201.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53,224.19	0.00	OTHER LAB	2,403.00	0.00
MED/SURG SUPPLY	20,294.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,606.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,686.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,785.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,515.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	798.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,225.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,401.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	10,420.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,617.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,009.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,693.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,835.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,944.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	392.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,217.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,725.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,395.00	1,130.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,817.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	199,001.26	1,130.00
			TOTAL ACCOMODATIONS	73,179.00	6,201.00
			TOTAL CHARGES	272,180.26	7,331.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:15:20  
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GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,488,760.31	ADJUSTMENTS	822,976.88
COVERED CHARGES	11,560,650.58	CONTRACTUAL ALLOW	8,625,394.78
NON-COVERD CHARGES	928,109.73	TOTAL MEDICAID LIAB	2,935,255.80
		LESS: COB	2,302.39
		LESS: COPAYMENT	12,509.60
		REIMBURSEMENT	2,920,443.81
		ALL OTHER	2,338,282.71
		FEE SCHEDULE-LAB	280,372.66
		INJECTABLE DRUGS	301,788.44
		TOTAL NUMBER OF CLAIMS	8,117

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	745,975.96	7,057.71	OTHER LAB	189,402.00	0.00
MED/SURG SUPPLY	584,006.47	2,768.98	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	199.42	EDUCATION & TRAINING	212.00	0.00
RADIOLOGY-DIAGNOSTIC	502,499.00	22,710.00	OTHER THERAPEUTIC SVC	0.00	9,572.00
CT SCAN	799,945.00	16,656.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	105,747.00	33,993.00	FEE SCHEDULE LAB	1,378,781.06	271,771.20
EKG/ECG	95,678.00	3,828.00	MRI SERVICES	365,819.00	21,694.00
IV THERAPY	486,439.00	40,143.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	877,623.18	168,199.84	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,561.00	13,574.00	REHAB THERAPY	118.00	1,576.00
RESPIRATORY SERVICES	123,462.00	8,627.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	173,657.00	326.00	AMBULANCE	0.00	0.00
GI SERVICES	903.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,439,107.50	15,874.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	127,444.00	283.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	912,905.41	166,168.08
RADIOLOGY THERAPEUTIC	1,313,473.00	19,883.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	21,883.00	12,095.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,179.00	1,063.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,347.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	101,424.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	468,115.00	20,772.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	138,515.00	1,971.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	71,831.00	5,476.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	195,580.00	56,540.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,325.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	281,693.00	5,288.00			
			TOTAL ANCILLARY	11,560,650.58	928,109.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,560,650.58	928,109.73



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	260,190.26	ADJUSTMENTS	0.00
COVERED CHARGES	229,872.21	CONTRACTUAL ALLOW	141,119.74
NON-COVERD CHARGES	30,318.05	TOTAL MEDICAID LIAB	88,752.47
		LESS: COB	88,599.66
		LESS: COPAYMENT	152.81
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 139

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,705.29	10.20	OTHER LAB	5,939.00	0.00
MED/SURG SUPPLY	10,541.31	3,122.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,583.00	968.00	OTHER THERAPEUTIC SVC	0.00	258.00
CT SCAN	5,800.00	3,155.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	636.00	181.00	FEE SCHEDULE LAB	24,316.36	4,162.00
EKG/ECG	1,717.00	133.00	MRI SERVICES	14,668.00	1,690.00
IV THERAPY	16,484.00	651.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,612.00	4,226.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	786.00	310.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,086.00	186.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,794.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,218.00	709.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,842.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	44,431.25	6,047.85
RADIOLOGY THERAPEUTIC	498.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	279.00	279.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	12,678.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,644.00	1,848.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,019.00	2,382.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	539.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	769.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,287.00	0.00			
			TOTAL ANCILLARY	229,872.21	30,318.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	229,872.21	30,318.05

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: 07/23/2014  
Run Time: 11:17:21  
Page: 10

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	613,961.36	ADJUSTMENTS	4,435.98
COVERED CHARGES	588,334.51	CONTRACTUAL ALLOW	542,463.74
NON-COVERD CHARGES	25,626.85	TOTAL MEDICAID LIAB	45,870.77
		LESS: COB	38.90
		LESS: COPAYMENT	1,566.10
		REIMBURSEMENT	44,265.77
		TOTAL NUMBER OF CLAIMS	820

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,127.11	330.90	OTHER LAB	2,310.00	0.00
MED/SURG SUPPLY	6,948.60	68.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,404.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,171.00	1,459.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,774.00	925.00	FEE SCHEDULE LAB	77,822.00	8,468.00
EKG/ECG	4,921.00	0.00	MRI SERVICES	7,270.00	0.00
IV THERAPY	21,558.00	1,213.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,432.00	2,078.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,476.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	799.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	308,014.00	3,611.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	566.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,557.80	4,679.95
RADIOLOGY THERAPEUTIC	8,929.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,655.00	2,719.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,600.00	75.00			
			TOTAL ANCILLARY	588,334.51	25,626.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	588,334.51	25,626.85

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:17:32  
Page: 12

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,991.49	ADJUSTMENTS	0.00
COVERED CHARGES	13,476.04	CONTRACTUAL ALLOW	5,308.73
NON-COVERD CHARGES	2,515.45	TOTAL MEDICAID LIAB	8,167.31
		LESS: COB	8,158.31
		LESS: COPAYMENT	9.00
		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: 07/23/2014  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	578.24	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	410.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	16.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	852.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	975.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,964.00	296.00
EKG/ECG	133.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	754.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	382.80	304.45
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,341.00	924.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	13,476.04	2,515.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,476.04	2,515.45

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,063,405.56	ADJUSTMENTS	120,461.13
COVERED CHARGES	1,012,687.06	CONTRACTUAL ALLOW	797,827.82
NON-COVERD CHARGES	50,718.50	TOTAL MEDICAID LIAB	214,859.24
		LESS: COB	0.00
		LESS: COPAYMENT	480.76
		REIMBURSEMENT	214,378.48
		TOTAL NUMBER OF CLAIMS	41

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
 2415 PARKWOOD DR  
 BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
 000000822A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,558.36	605.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	112,889.88	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,077.00	2,308.00	OTHER THERAPEUTIC SVC	0.00	2,580.00
CT SCAN	8,202.00	734.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,304.00	768.00
EKG/ECG	665.00	532.00	MRI SERVICES	0.00	0.00
IV THERAPY	46,978.00	208.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,453.00	2,317.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	59.00	0.00
RESPIRATORY SERVICES	59,797.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,426.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,084.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,874.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	281,055.82	32,187.50
RADIOLOGY THERAPEUTIC	302,180.00	4,751.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	145.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	54.00	3,728.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,154.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	37,467.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,264.00	0.00			
			TOTAL ANCILLARY	1,012,687.06	50,718.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,012,687.06	50,718.50



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GLYNN-BRUNSWICK MEMORIAL HOSPITAL  
2415 PARKWOOD DR  
BRUNSWICK,GA 31520-4722

PROVIDER NUMBER  
000000822A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/12	THROUGH	04/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:35:21  
 Page: 1

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,580,372.52	ADJUSTMENTS	412,681.36
COVERED CHARGES	12,985,740.67	CONTRACTUAL ALLOW	9,650,400.06
NON-COVERD CHARGES	594,631.85	TOTAL MEDICAID LIAB	3,335,340.61
		LESS: COB	3,315.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,332,025.31

TOTAL NUMBER OF ADMISSIONS 491

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	994		0	545,803.56		20,040.64
ROUTINE NURSERY	167		0	81,360.90		120.27
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,161		0	627,164.46		20,160.91
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	684		1	1,203,070.65		2,742.89
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	684		1	1,203,070.65		2,742.89
TOTAL ACCOMODATIONS	1,845		1	1,830,235.11		22,903.80

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	566,349.88	0.00	OTHER LAB	46,836.92	0.00
MED/SURG SUPPLY	360,213.64	1,615.42	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,837,020.14	14,099.16	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	312,970.06	0.00	OTHER THERAPEUTIC SVC	0.00	2,122.92
CT SCAN	365,968.14	522,892.77	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	132,755.43	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	213,827.05	0.00	MRI SERVICES	152,904.90	0.00
IV THERAPY	89,576.16	485.05	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	911,527.71	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	141,117.18	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,031,842.26	575.86	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	186,455.63	0.00	AMBULANCE	0.00	0.00
GI SERVICES	42,427.44	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	505,979.18	194.13	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	44,896.64	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	45,626.81	0.00	INJECTABLE DRUGS	2,689,108.73	0.00
RADIOLOGY THERAPEUTIC	80,146.89	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,379.42	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,923.72	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	57.21	217.56	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	771,163.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	60,673.59	13,476.62			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	50,244.89	2,439.36			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	116,465.40	13,609.20			
AUDIOLOGY	9,375.84	0.00			
CARDIOLOGY	360,808.95	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,464.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,397.85	0.00			
			TOTAL ANCILLARY	11,155,505.56	571,728.05
			TOTAL ACCOMODATIONS	1,830,235.11	22,903.80
			TOTAL CHARGES	12,985,740.67	594,631.85

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 12:35:34  
 Page: 3

GORDON HOSPITAL  
 1035 RED BUD RD NE  
 CALHOUN,GA 30701-2082

PROVIDER NUMBER  
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,873.95	ADJUSTMENTS	0.00
COVERED CHARGES	14,873.95	CONTRACTUAL ALLOW	8,079.55
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	6,794.40
		LESS: COB	6,794.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3		0	1,714.59		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3		0	1,714.59		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	3		0	1,714.59		0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:35:34  
 Page: 4

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	778.21	0.00	OTHER LAB	319.67	0.00
MED/SURG SUPPLY	1,649.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	645.45	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	6,564.06	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,498.82	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	439.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,263.96	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	13,159.36	0.00
			TOTAL ACCOMODATIONS	1,714.59	0.00
			TOTAL CHARGES	14,873.95	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:35:36  
Page: 5

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,592,606.55	ADJUSTMENTS	361,249.04
COVERED CHARGES	13,149,687.73	CONTRACTUAL ALLOW	10,578,705.70
NON-COVERD CHARGES	1,442,918.82	TOTAL MEDICAID LIAB	2,570,982.03
		LESS: COB	7,290.46
		LESS: COPAYMENT	4,790.94
		REIMBURSEMENT	2,558,900.63
		ALL OTHER	2,321,847.11
		FEE SCHEDULE-LAB	165,836.88
		INJECTABLE DRUGS	71,216.64

TOTAL NUMBER OF CLAIMS 5,309

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	164,768.65	30,055.28	OTHER LAB	48,829.70	0.00
MED/SURG SUPPLY	341,875.54	95.31	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	298.35	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	721,646.69	20,036.24	OTHER THERAPEUTIC SVC	0.00	37,415.06
CT SCAN	2,398,546.19	228,352.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	110,418.96	54,568.84	FEE SCHEDULE LAB	2,088,874.01	378,804.75
EKG/ECG	149,657.55	8,947.84	MRI SERVICES	702,806.03	39,748.72
IV THERAPY	262,190.40	61,540.18	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	883,051.79	96,319.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,164.81	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,846.60	4,410.61	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	196,927.64	3,024.01	AMBULANCE	0.00	0.00
GI SERVICES	153,224.85	17,350.51	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,759,961.81	24,141.54	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	70,286.74	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	564,381.56	141,185.41
RADIOLOGY THERAPEUTIC	143,129.86	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,489.45	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	171.96	944.26	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	25,841.80	2,722.08	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	17,329.85	84,262.24
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	391,211.74	66,978.72			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,459.45	29,418.68			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	354,151.89	45,547.93			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	243,888.83	58,276.16			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	186,477.19	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	112,076.19	8,474.89			
			TOTAL ANCILLARY	13,149,687.73	1,442,918.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,149,687.73	1,442,918.82

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: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	178,628.83	ADJUSTMENTS	0.00
COVERED CHARGES	136,777.62	CONTRACTUAL ALLOW	65,410.52
NON-COVERD CHARGES	41,851.21	TOTAL MEDICAID LIAB	71,367.10
		LESS: COB	71,334.10
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 60



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,747.57	663.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,984.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,766.09	354.23	OTHER THERAPEUTIC SVC	0.00	815.04
CT SCAN	0.00	18,840.83	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,627.10	3,090.88	FEE SCHEDULE LAB	29,161.51	5,339.05
EKG/ECG	1,443.20	0.00	MRI SERVICES	3,686.59	0.00
IV THERAPY	3,072.30	2,348.83	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,965.95	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	598.63	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,932.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,470.78	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,563.36	494.51	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,770.67	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,930.15	2,119.18
RADIOLOGY THERAPEUTIC	2,121.22	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	135.80	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,161.09	3,314.68			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,720.05	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,708.80	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,681.10	0.00			
			TOTAL ANCILLARY	136,777.62	41,851.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	136,777.62	41,851.21

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:36:59  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	643,014.47	ADJUSTMENTS	1,279.56
COVERED CHARGES	622,123.56	CONTRACTUAL ALLOW	587,552.66
NON-COVERD CHARGES	20,890.91	TOTAL MEDICAID LIAB	34,570.90
		LESS: COB	0.00
		LESS: COPAYMENT	1,188.00
		REIMBURSEMENT	33,382.90
		TOTAL NUMBER OF CLAIMS	618

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,393.35	484.14	OTHER LAB	1,066.96	0.00
MED/SURG SUPPLY	2,627.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,651.58	824.03	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,259.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	75,292.74	11,260.30
EKG/ECG	2,886.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	29,230.12	982.38	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,045.94	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,281.76	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,216.69	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	408,823.20	417.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	439.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,169.22	2,486.12
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	217.56	57.21	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	975.22	3,634.96			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	546.15	744.75			
			TOTAL ANCILLARY	622,123.56	20,890.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	622,123.56	20,890.91

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GORDON HOSPITAL  
1035 RED BUD RD NE  
CALHOUN,GA 30701-2082

PROVIDER NUMBER 000000833A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,238.97	ADJUSTMENTS	0.00
COVERED CHARGES	9,271.17	CONTRACTUAL ALLOW	4,642.72
NON-COVERD CHARGES	967.80	TOTAL MEDICAID LIAB	4,628.45
		LESS: COB	4,619.45
		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: 07/23/2014  
 Run Time: 12:37:07  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GORDON HOSPITAL  
 1035 RED BUD RD NE  
 CALHOUN,GA 30701-2082

PROVIDER NUMBER  
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	884.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	580.37	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,204.96	139.74
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	550.06	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,015.06	210.02	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	618.04
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	9,271.17	967.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,271.17	967.80

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 12:37:08  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GORDON HOSPITAL  
1035 RED BUD RD NE  
CALHOUN,GA 30701-2082

PROVIDER NUMBER  
000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,715,275.63	ADJUSTMENTS	67,131.00
COVERED CHARGES	1,612,382.90	CONTRACTUAL ALLOW	1,385,613.11
NON-COVERD CHARGES	102,892.73	TOTAL MEDICAID LIAB	226,769.79
		LESS: COB	0.00
		LESS: COPAYMENT	573.00
		REIMBURSEMENT	226,196.79
		TOTAL NUMBER OF CLAIMS	44

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GORDON HOSPITAL  
 1035 RED BUD RD NE  
 CALHOUN,GA 30701-2082

PROVIDER NUMBER  
 000000833A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,961.95	1,871.58	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	51,879.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,117.55	1,531.55	OTHER THERAPEUTIC SVC	0.00	4,189.48
CT SCAN	222,340.03	10,259.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,060.71	FEE SCHEDULE LAB	31,507.29	4,972.28
EKG/ECG	3,175.04	0.00	MRI SERVICES	4,190.28	0.00
IV THERAPY	8,885.16	860.45	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	157,641.83	44,274.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,358.74	230.12	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	41,843.48	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,528.11	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,039.58	1,679.41	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,901.73	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	175,525.16	4,357.97
RADIOLOGY THERAPEUTIC	773,412.63	6,555.76	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	79.97	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	60,815.44	20,968.74
LITHOTRIPSY	23,197.38	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,908.24	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,508.18	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	7,646.10	0.00			
			TOTAL ANCILLARY	1,612,382.90	102,892.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,612,382.90	102,892.73

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 12:37:10  
Page: 15

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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:34:22  
 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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,526,577.06	ADJUSTMENTS	169,306.48
COVERED CHARGES	1,507,768.06	CONTRACTUAL ALLOW	735,791.52
NON-COVERD CHARGES	18,809.00	TOTAL MEDICAID LIAB	771,976.54
		LESS: COB	479.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	771,496.77

TOTAL NUMBER OF ADMISSIONS 223

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	347		0	189,240.00		16,549.00
ROUTINE NURSERY	123		2	55,983.00		910.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	470		2	245,223.00		17,459.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	21		0	28,056.00		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	21		0	28,056.00		0.00
TOTAL ACCOMODATIONS	491		2	273,279.00		17,459.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GRADY GENERAL HOSPITAL  
 1155 5TH ST SE  
 CAIRO,GA 39828-3142

PROVIDER NUMBER  
 000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	260,139.68	0.00	OTHER LAB	2,691.00	0.00
MED/SURG SUPPLY	109,864.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	275,480.90	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,936.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	78,847.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,916.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,929.00	0.00	MRI SERVICES	3,706.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	141,868.00	205.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	152,676.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	32,239.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,614.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,986.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	68,867.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,936.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,459.48	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	438.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	120.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	87.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	885.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,913.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,379.00	1,058.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	564.00	0.00			
AUDIOLOGY	10,375.00	0.00			
CARDIOLOGY	7,466.00	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	6,194.00	0.00			
			TOTAL ANCILLARY	1,234,489.06	1,350.00
			TOTAL ACCOMODATIONS	273,279.00	17,459.00
			TOTAL CHARGES	1,507,768.06	18,809.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:34:27  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

GRADY GENERAL HOSPITAL  
1155 5TH ST SE  
CAIRO,GA 39828-3142

PROVIDER NUMBER  
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:34:28  
Page: 4

GRADY GENERAL HOSPITAL  
1155 5TH ST SE  
CAIRO,GA 39828-3142

PROVIDER NUMBER  
000000844A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,259,964.97	ADJUSTMENTS	89,877.43
COVERED CHARGES	2,028,384.23	CONTRACTUAL ALLOW	1,530,523.53
NON-COVERD CHARGES	231,580.74	TOTAL MEDICAID LIAB	497,860.70
		LESS: COB	282.64
		LESS: COPAYMENT	2,673.00
		REIMBURSEMENT	494,905.06
		ALL OTHER	427,304.37
		FEE SCHEDULE-LAB	62,451.20
		INJECTABLE DRUGS	5,149.49

TOTAL NUMBER OF CLAIMS 2,125

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,840.20	2,945.00	OTHER LAB	4,617.00	0.00
MED/SURG SUPPLY	93,656.00	68.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	104,994.00	1,192.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	228,163.00	8,026.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	58,358.00	30,975.00	FEE SCHEDULE LAB	471,143.14	89,915.00
EKG/ECG	10,511.00	1,518.00	MRI SERVICES	51,072.00	1,625.00
IV THERAPY	92,762.00	17,226.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	212,900.09	18,473.24	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,869.00	0.00	REHAB THERAPY	0.00	924.00
RESPIRATORY SERVICES	11,427.00	3,090.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,672.00	786.00	AMBULANCE	0.00	0.00
GI SERVICES	75,022.00	2,040.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	304,754.00	2,065.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,106.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55,324.80	34,212.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,694.00	10,966.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,176.00	2,030.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	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	6,022.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	61,126.00	2,220.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,480.00	814.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,186.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,509.00	404.00			
			TOTAL ANCILLARY	2,028,384.23	231,580.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,028,384.23	231,580.74

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: 07/23/2014  
Run Time: 12:35:08  
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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,434.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,774.00	CONTRACTUAL ALLOW	2,080.46
NON-COVERD CHARGES	3,660.00	TOTAL MEDICAID LIAB	693.54
		LESS: COB	693.35
		LESS: COPAYMENT	0.19
		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

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,318.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,077.00	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	411.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	336.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	722.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	175.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	326.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,774.00	3,660.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,774.00	3,660.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:35:08  
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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	95,605.57	ADJUSTMENTS	815.10
COVERED CHARGES	92,007.57	CONTRACTUAL ALLOW	82,497.77
NON-COVERD CHARGES	3,598.00	TOTAL MEDICAID LIAB	9,509.80
		LESS: COB	0.00
		LESS: COPAYMENT	225.00
		REIMBURSEMENT	9,284.80
		TOTAL NUMBER OF CLAIMS	170



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	641.00	10.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	610.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,969.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,377.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,031.57	2,199.00
EKG/ECG	113.00	34.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,658.00	894.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	132.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,867.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,145.00	135.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,464.00	326.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	92,007.57	3,598.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,007.57	3,598.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	266.00	ADJUSTMENTS	0.00
COVERED CHARGES	266.00	CONTRACTUAL ALLOW	188.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	78.00
		LESS: COB	75.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	87.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	129.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	50.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	266.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	266.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GENERAL HOSPITAL  
1155 5TH ST SE  
CAIRO,GA 39828-3142

PROVIDER NUMBER  
000000844A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY GENERAL HOSPITAL  
1155 5TH ST SE  
CAIRO,GA 39828-3142

PROVIDER NUMBER  
000000844A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GRADY MEMORIAL HOSPITAL  
 80 JESSE HILL JR DR SE  
 ATLANTA,GA 30303-3031

PROVIDER NUMBER 000000855A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	377,798,135.10	ADJUSTMENTS	56,843,226.04
COVERED CHARGES	356,991,119.89	CONTRACTUAL ALLOW	236,616,490.84
NON-COVERD CHARGES	20,807,015.21	TOTAL MEDICAID LIAB	120,374,629.05
		LESS: COB	309,384.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	120,065,244.83

TOTAL NUMBER OF ADMISSIONS 8,167

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	29,375	18	40,984,023.00	4,340,117.00
ROUTINE NURSERY	6,591	6	13,293,437.00	1,401,877.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	35,966	24	54,277,460.00	5,741,994.00
SPECIAL CARE SERVICES				
CCU	3,147	0	10,674,056.00	221,026.00
ICU	12,263	0	46,104,766.00	908,688.00
NICU	1,442	0	6,756,296.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	8	0	22,448.00	0.00
BURN UNIT	629	0	4,368,860.00	63,162.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	17,489	0	67,926,426.00	1,192,876.00
TOTAL ACCOMODATIONS	53,455	24	122,203,886.00	6,934,870.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,130,213.26	429,550.14	OTHER LAB	878,825.00	21,787.00
MED/SURG SUPPLY	14,246,685.88	2,313,643.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	35,167,346.06	951,588.00	EDUCATION & TRAINING	165.00	0.00
RADIOLOGY-DIAGNOSTIC	6,540,346.00	79,709.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,574,185.00	3,444,156.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,259,003.21	181,180.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,262,934.00	10,617.00	MRI SERVICES	3,408,973.00	78,095.00
IV THERAPY	574,429.00	23,949.00	PROFESSIONAL FEES	0.00	692.00
OPERATING ROOM	57,497,660.00	1,726,748.00	DURABLE MED. EQUIP.	0.00	287.50
LABOR/DELIVERY ROOM	2,738,900.00	4,314.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	28,562,090.60	1,077,712.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	11,209,391.00	178,143.00	AMBULANCE	0.00	0.00
GI SERVICES	667,007.00	17,954.00	CAST ROOM	1,068.00	534.00
EMERGENCY ROOM	10,230,882.36	201,886.64	SPECIAL SERVICES	0.00	265.00
RECOVERY ROOM	1,798,799.00	23,811.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	725,346.00	17,249.00	INJECTABLE DRUGS	13,941,782.89	349,146.96
RADIOLOGY THERAPEUTIC	936,236.00	89,436.00	HOME HEALTH SERVICES	0.00	198.00
OCCUPATIONAL THERAPY	1,324,261.09	46,978.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,589,167.21	52,676.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	735,508.00	48,435.20	PATIENT CONVENIENCE	0.00	2,954.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,878.00	256,831.00	TRAUMA RESPONSE	0.00	752,420.00
PSYCHIATRIC SERVICES	38,967.00	0.00	IMPL DEV CHARGE PATIENTS	4,396,855.93	251,504.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,533.00
OTHER IMAGING SERVICE	1,294,967.00	336,603.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,296,770.68	275,997.68			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	622,682.00	472,827.16			
AUDIOLOGY	775,373.00	1,858.00			
CARDIOLOGY	2,753,746.00	36,308.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	988,840.00	50,786.00			
ORGAN ACQUISITION	4,590.00	0.00			
TREATMENT/OBSERV. RM	609,359.72	58,782.00			
			TOTAL ANCILLARY	234,787,233.89	13,872,145.21
			TOTAL ACCOMODATIONS	122,203,886.00	6,934,870.00
			TOTAL CHARGES	356,991,119.89	20,807,015.21

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 12:22:15  
Page: 3

GRADY MEMORIAL HOSPITAL  
80 JESSE HILL JR DR SE  
ATLANTA, GA 30303-3031

PROVIDER NUMBER  
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013219033774	07/25/13 - 07/27/13	08/12/13	0.00	1,058.00	0.00	0.00	0.00
478	2213256017107	05/30/13 - 06/01/13	09/16/13	0.00	545.00	0.00	0.00	0.00
618	2013290084114	08/06/13 - 08/09/13	10/21/13	0.00	1,058.00	0.00	0.00	0.00
3240	5213301000161	01/07/13 - 01/17/13	11/04/13	0.00	795.00	0.00	0.00	0.00
4400	2213319016509	08/01/13 - 08/13/13	11/18/13	0.00	1,077.00	0.00	0.00	0.00
TOTAL				0.00	4,533.00	0.00	0.00	0.00



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 12:25:20  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	960,865.59	ADJUSTMENTS	0.00
COVERED CHARGES	934,979.59	CONTRACTUAL ALLOW	454,038.63
NON-COVERD CHARGES	25,886.00	TOTAL MEDICAID LIAB	480,940.96
		LESS: COB	480,940.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 9

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	38		0	55,024.00		2,760.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	38		0	55,024.00		2,760.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	55		0	203,002.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	55		0	203,002.00		0.00
TOTAL ACCOMODATIONS	93		0	258,026.00		2,760.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,145.38	0.00	OTHER LAB	498.00	0.00
MED/SURG SUPPLY	30,120.61	755.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	82,467.34	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,298.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	26,970.00	11,594.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,502.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,916.00	0.00	MRI SERVICES	7,146.00	0.00
IV THERAPY	7,344.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	203,137.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,101.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	61,935.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,267.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,846.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,945.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,538.00	0.00	INJECTABLE DRUGS	46,928.41	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,027.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,212.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	396.00	TRAUMA RESPONSE	0.00	9,738.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	20,635.85	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.	22,242.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	831.00	643.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,400.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,497.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	676,953.59	23,126.00
			TOTAL ACCOMODATIONS	258,026.00	2,760.00
			TOTAL CHARGES	934,979.59	25,886.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:25:34  
Page: 6

GRADY MEMORIAL HOSPITAL  
80 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3031

PROVIDER NUMBER  
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	84,721,310.07	ADJUSTMENTS	1,588,489.92
COVERED CHARGES	72,613,494.69	CONTRACTUAL ALLOW	51,703,059.87
NON-COVERD CHARGES	12,107,815.38	TOTAL MEDICAID LIAB	20,910,434.82
		LESS: COB	25,217.28
		LESS: COPAYMENT	144,348.08
		REIMBURSEMENT	20,740,869.46
		ALL OTHER	17,368,884.08
		FEE SCHEDULE-LAB	1,952,990.90
		INJECTABLE DRUGS	1,418,994.48

TOTAL NUMBER OF CLAIMS 70,671

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	389,356.07	9,543.06	OTHER LAB	769,978.00	35,444.00
MED/SURG SUPPLY	594,627.55	131,483.74	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	116.00	EDUCATION & TRAINING	0.00	35,505.00
RADIOLOGY-DIAGNOSTIC	2,451,825.00	177,186.00	OTHER THERAPEUTIC SVC	0.00	12,103.00
CT SCAN	3,896,032.00	230,319.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	267,870.00	33,124.00	FEE SCHEDULE LAB	16,525,286.45	5,583,607.58
EKG/ECG	711,095.00	65,619.00	MRI SERVICES	2,158,983.00	109,656.00
IV THERAPY	1,221,732.50	251,951.00	PROFESSIONAL FEES	0.00	594.00
OPERATING ROOM	4,497,838.75	682,893.09	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	317,484.00	7,900.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	741,147.00	107,039.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	458,045.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	826,940.00	82,876.00	CAST ROOM	2,304.00	344.00
EMERGENCY ROOM	14,775,210.00	174,495.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	133,395.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,262,516.99	1,722,025.66
RADIOLOGY THERAPEUTIC	2,681,543.00	153,877.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	59,539.00	16,888.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	49,674.00	14,284.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,432.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,661,938.00	315,376.00	TRAUMA RESPONSE	0.00	232,412.00
PSYCHIATRIC SERVICES	422,678.00	321,400.00	IMPL DEV CHARGE PATIENTS	51,729.58	145,193.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,629,151.00	219,525.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	443,176.00	2,276.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	979,447.00	873,449.00			
AUDIOLOGY	57,638.00	14,327.00			
CARDIOLOGY	990,627.00	332,345.00			
AMBULATORY SURGERY	0.00	3,880.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,934.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	547,753.80	3,327.00			
			TOTAL ANCILLARY	72,613,494.69	12,107,815.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	72,613,494.69	12,107,815.38

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 12:32:35  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GRADY MEMORIAL HOSPITAL  
80 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3031

PROVIDER NUMBER  
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	177,453.97	ADJUSTMENTS	0.00
COVERED CHARGES	130,806.50	CONTRACTUAL ALLOW	55,738.06
NON-COVERD CHARGES	46,647.47	TOTAL MEDICAID LIAB	75,068.44
		LESS: COB	74,902.81
		LESS: COPAYMENT	165.63
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 145

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	172.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,656.00	9.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,509.00	463.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	13,464.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	713.00	FEE SCHEDULE LAB	44,540.00	15,723.00
EKG/ECG	648.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,618.00	2,318.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	290.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,981.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	233.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	6,775.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,550.00	122.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,604.00	648.47
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,742.00	2,526.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	1,229.00	IMPL DEV CHARGE PATIENTS	0.00	927.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,792.00	1,730.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,071.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,400.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	130,806.50	46,647.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	130,806.50	46,647.47

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: 07/23/2014  
Run Time: 12:32:53  
Page: 10

GRADY MEMORIAL HOSPITAL  
80 JESSE HILL JR DR SE  
ATLANTA, GA 30303-3031

PROVIDER NUMBER  
000000855A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,059,882.64	ADJUSTMENTS	2,084.59
COVERED CHARGES	1,915,200.37	CONTRACTUAL ALLOW	1,849,191.20
NON-COVERD CHARGES	144,682.27	TOTAL MEDICAID LIAB	66,009.17
		LESS: COB	0.01
		LESS: COPAYMENT	3,894.21
		REIMBURSEMENT	62,114.95
		TOTAL NUMBER OF CLAIMS	1,180

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,171.20	107.88	OTHER LAB	13,648.00	0.00
MED/SURG SUPPLY	3,477.00	3,424.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	934.00	EDUCATION & TRAINING	0.00	1,145.00
RADIOLOGY-DIAGNOSTIC	105,141.00	2,226.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	70,081.00	4,872.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	508.00	FEE SCHEDULE LAB	251,857.00	92,537.00
EKG/ECG	29,778.00	1,584.00	MRI SERVICES	24,609.00	2,753.00
IV THERAPY	29,126.00	8,052.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,312.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,500.00	291.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,640.00	466.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,306,498.00	7,144.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,884.17	5,636.39
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	508.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,792.00	162.00	TRAUMA RESPONSE	0.00	9,738.00
PSYCHIATRIC SERVICES	1,399.00	1,339.00	IMPL DEV CHARGE PATIENTS	291.00	266.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,912.00	346.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	831.00	643.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,400.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	381.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,472.00	0.00			
			TOTAL ANCILLARY	1,915,200.37	144,682.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,915,200.37	144,682.27



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: 07/23/2014  
Run Time: 12:33:16  
Page: 12

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,644.90	ADJUSTMENTS	0.00
COVERED CHARGES	7,535.04	CONTRACTUAL ALLOW	5,090.13
NON-COVERD CHARGES	1,109.86	TOTAL MEDICAID LIAB	2,444.91
		LESS: COB	2,441.91
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	133.04	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	1,073.00	1,050.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,314.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15.00	59.86
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,535.04	1,109.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,535.04	1,109.86

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,626,600.05	ADJUSTMENTS	717,018.48
COVERED CHARGES	16,274,550.86	CONTRACTUAL ALLOW	12,946,409.74
NON-COVERD CHARGES	1,352,049.19	TOTAL MEDICAID LIAB	3,328,141.12
		LESS: COB	2,280.00
		LESS: COPAYMENT	5,616.00
		REIMBURSEMENT	3,320,245.12

TOTAL NUMBER OF CLAIMS 509

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,760.15	4,392.52	OTHER LAB	4,686.00	88.00
MED/SURG SUPPLY	287,003.35	89,496.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	130,440.40	80,619.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,821.00	1,866.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	978.00	FEE SCHEDULE LAB	165,893.20	16,597.80
EKG/ECG	1,824.00	324.00	MRI SERVICES	5,601.00	0.00
IV THERAPY	92,649.00	4,295.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,192,008.91	353,891.19	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,356.00	1,951.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,535,892.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	34,420.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,741.00	3,898.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	405,144.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,500,086.95	115,083.27
RADIOLOGY THERAPEUTIC	4,170,579.00	130,899.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	9,298.00	1,596.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	371,709.90	448,906.03
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,068.00	1,485.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,153.00	1,387.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	28,577.00	18,888.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	189,111.00	75,407.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,728.00	0.00			
			TOTAL ANCILLARY	16,274,550.86	1,352,049.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,274,550.86	1,352,049.19

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GRADY MEMORIAL HOSPITAL  
80 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3031

PROVIDER NUMBER  
000000855A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:01:11  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SPALDING REGIONAL HOSPITAL  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER 000000866A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	37,192,039.53	ADJUSTMENTS	1,609,436.90
COVERED CHARGES	36,036,047.69	CONTRACTUAL ALLOW	29,190,207.88
NON-COVERD CHARGES	1,155,991.84	TOTAL MEDICAID LIAB	6,845,839.81
		LESS: COB	49,667.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,796,172.66

TOTAL NUMBER OF ADMISSIONS 826

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,099		170	3,071,683.75		485,132.75
ROUTINE NURSERY	125		0	96,623.40		957.80
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,224		170	3,168,307.15		486,090.55
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	666		3	1,276,377.23		9,475.00
NICU	1		0	1,805.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	667		3	1,278,182.23		9,475.00
TOTAL ACCOMODATIONS	3,891		173	4,446,489.38		495,565.55

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SPALDING REGIONAL HOSPITAL  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,217,233.27	123,698.94	OTHER LAB	142,888.70	0.00
MED/SURG SUPPLY	4,172,391.52	71,720.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,868,696.30	55,360.80	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	830,627.65	833.00	OTHER THERAPEUTIC SVC	0.00	308.00
CT SCAN	1,753,116.60	2,532.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	125,234.38	36,662.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	266,178.70	0.00	MRI SERVICES	387,325.00	0.00
IV THERAPY	6,189.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,355,769.93	2,666.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	197,409.05	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,681,175.56	10,029.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	595,900.25	0.00	AMBULANCE	0.00	13,954.00
GI SERVICES	176,134.15	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,530,585.20	5,990.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	177,696.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	129,773.18	0.00	INJECTABLE DRUGS	1,279.28	0.00
RADIOLOGY THERAPEUTIC	17,413.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,781.15	13,934.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	42,292.62	7,847.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	251,238.00	21,840.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,805.50	110.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	604,600.69	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	135,159.30	8,288.15			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	124,948.53	281,638.06			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	208,236.09	0.00			
AUDIOLOGY	10,177.50	0.00			
CARDIOLOGY	1,283,610.41	2,553.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	31,321.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	221,369.15	462.00			
			TOTAL ANCILLARY	31,589,558.31	660,426.29
			TOTAL ACCOMODATIONS	4,446,489.38	495,565.55
			TOTAL CHARGES	36,036,047.69	1,155,991.84

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SPALDING REGIONAL HOSPITAL  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	93,551.21	ADJUSTMENTS	0.00
COVERED CHARGES	93,131.71	CONTRACTUAL ALLOW	64,446.80
NON-COVERD CHARGES	419.50	TOTAL MEDICAID LIAB	28,684.91
		LESS: COB	28,684.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	8,288.00		419.50
ROUTINE NURSERY	7		0	4,615.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	15		0	12,903.00		419.50
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	15		0	12,903.00		419.50



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SPALDING REGIONAL HOSPITAL  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,126.54	0.00	OTHER LAB	718.20	0.00
MED/SURG SUPPLY	21,217.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,096.17	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	9,107.65	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,076.55	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,058.91	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,087.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,090.05	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	110.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	539.85	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	80,228.71	0.00
			TOTAL ACCOMODATIONS	12,903.00	419.50
			TOTAL CHARGES	93,131.71	419.50

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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SPALDING REGIONAL HOSPITAL  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,915,020.68	ADJUSTMENTS	1,157,297.07
COVERED CHARGES	22,074,511.92	CONTRACTUAL ALLOW	17,951,952.47
NON-COVERD CHARGES	2,840,508.76	TOTAL MEDICAID LIAB	4,122,559.45
		LESS: COB	9,283.42
		LESS: COPAYMENT	5,736.00
		REIMBURSEMENT	4,107,540.03
		ALL OTHER	3,761,798.93
		FEE SCHEDULE-LAB	229,622.36
		INJECTABLE DRUGS	116,118.74
		TOTAL NUMBER OF CLAIMS	6,998

SPALDING REGIONAL HOSPITAL  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	735,235.85	18,585.80	OTHER LAB	151,498.85	626.00
MED/SURG SUPPLY	1,247,396.46	44,264.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,305,437.80	20,397.55	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,108,231.55	485,689.30	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	26,142.35	16,217.10	FEE SCHEDULE LAB	3,690,269.28	752,205.43
EKG/ECG	389,058.90	46,624.10	MRI SERVICES	251,197.94	55,811.75
IV THERAPY	515,732.20	94,385.89	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	674,739.26	109,975.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,283.75	3,867.15	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	126,486.93	66,316.83	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	371,521.15	13,460.50	AMBULANCE	0.00	0.00
GI SERVICES	194,773.17	41,473.53	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,550,800.65	24,027.35	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	96,939.80	3,598.60	DRUG-SPECIFIC/HOME IV	0.00	1,728.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,468,827.82	434,464.61
RADIOLOGY THERAPEUTIC	60,524.01	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,619.75	4,630.20	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	332.85	7,010.92	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	275,480.24	85,221.66	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	61,613.68	13,896.95
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	467,194.45	105,068.65			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,955.03	35,313.45			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	283,208.25	1,207.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	189,531.95	228,711.60			
AMBULATORY SURGERY	8,494.25	1,251.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	610,777.65	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	188,206.10	124,477.75			
			TOTAL ANCILLARY	22,074,511.92	2,840,508.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,074,511.92	2,840,508.76

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SPALDING REGIONAL HOSPITAL  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	218,334.15	ADJUSTMENTS	0.00
COVERED CHARGES	163,840.09	CONTRACTUAL ALLOW	93,673.61
NON-COVERD CHARGES	54,494.06	TOTAL MEDICAID LIAB	70,166.48
		LESS: COB	70,124.48
		LESS: COPAYMENT	42.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 65

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SPALDING REGIONAL HOSPITAL  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,337.42	630.44	OTHER LAB	1,707.00	0.00
MED/SURG SUPPLY	13,302.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,689.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	21,014.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,252.24	4,174.75
EKG/ECG	2,338.15	463.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,814.60	735.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,415.25	13,671.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	338.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,727.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,492.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	910.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,038.91	3,090.02
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	866.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,534.40	1,125.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,096.00	8,839.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	980.00	751.00			
			TOTAL ANCILLARY	163,840.09	54,494.06
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	163,840.09	54,494.06

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:03:55  
Page: 9

SPALDING REGIONAL HOSPITAL  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,600,648.23	ADJUSTMENTS	3,415.13
COVERED CHARGES	1,469,424.23	CONTRACTUAL ALLOW	1,414,379.31
NON-COVERD CHARGES	131,224.00	TOTAL MEDICAID LIAB	55,044.92
		LESS: COB	0.00
		LESS: COPAYMENT	1,854.11
		REIMBURSEMENT	53,190.81
		TOTAL NUMBER OF CLAIMS	984

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

SPALDING REGIONAL HOSPITAL  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,494.19	441.24	OTHER LAB	4,234.60	0.00
MED/SURG SUPPLY	26,830.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	108,758.75	1,879.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	61,315.50	52,984.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	449.00	FEE SCHEDULE LAB	230,314.67	40,142.45
EKG/ECG	19,561.75	2,315.00	MRI SERVICES	6,855.95	3,791.00
IV THERAPY	53,841.40	5,034.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,269.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	835,720.05	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	66,889.65	14,832.46
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	21,109.35	8,230.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	229.00	1,125.00			
			TOTAL ANCILLARY	1,469,424.23	131,224.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,469,424.23	131,224.00

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SPALDING REGIONAL HOSPITAL  
 601 S 8TH ST  
 GRIFFIN, GA 30224-4213

PROVIDER NUMBER                                 000000866A  
 PAYMENT DATES   00/00/00   THROUGH   00/00/00  
 SERVICE DATES   01/01/13   THROUGH   12/31/13  
 ADMISSION DATES   00/00/00   THROUGH   00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,543.77	ADJUSTMENTS	0.00
COVERED CHARGES	24,778.47	CONTRACTUAL ALLOW	20,602.38
NON-COVERD CHARGES	7,765.30	TOTAL MEDICAID LIAB	4,176.09
		LESS: COB	4,158.08
		LESS: COPAYMENT	18.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9



SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SPALDING REGIONAL HOSPITAL  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,111.44	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	332.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,738.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,004.00	4,951.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,185.00	1,039.00
EKG/ECG	463.00	463.00	MRI SERVICES	0.00	0.00
IV THERAPY	418.00	315.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,233.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,272.11	164.30
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	833.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,778.47	7,765.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,778.47	7,765.30

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 09:04:15  
Page: 13

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SPALDING REGIONAL HOSPITAL  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,706,107.03	ADJUSTMENTS	83,159.96
COVERED CHARGES	1,513,954.29	CONTRACTUAL ALLOW	1,267,846.57
NON-COVERD CHARGES	192,152.74	TOTAL MEDICAID LIAB	246,107.72
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	245,834.72
		TOTAL NUMBER OF CLAIMS	48

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SPALDING REGIONAL HOSPITAL  
 601 S 8TH ST  
 GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
 000000866A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102,720.03	3,827.57	OTHER LAB	1,106.00	810.00
MED/SURG SUPPLY	348,276.17	16,181.38	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,575.70	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,251.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	680.60	FEE SCHEDULE LAB	66,739.35	1,884.10
EKG/ECG	7,037.60	463.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,989.00	494.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	374,908.00	17,440.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,356.15	3,628.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	213,211.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,018.00	2,018.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,999.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	380.16
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	192,778.91	41,039.92
RADIOLOGY THERAPEUTIC	11,112.00	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	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	0.00	220.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	28,532.03	21,242.76
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	861.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	100,754.00	61,510.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	8,521.50			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,980.00	0.00			
			TOTAL ANCILLARY	1,513,954.29	192,152.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,513,954.29	192,152.74

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 09:04:19  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SPALDING REGIONAL HOSPITAL  
601 S 8TH ST  
GRIFFIN,GA 30224-4213

PROVIDER NUMBER  
000000866A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
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 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER 000000877A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,252,483.39	ADJUSTMENTS	135,726.75
COVERED CHARGES	2,241,689.60	CONTRACTUAL ALLOW	1,014,362.68
NON-COVERD CHARGES	10,793.79	TOTAL MEDICAID LIAB	1,227,326.92
		LESS: COB	8,826.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,218,500.45

TOTAL NUMBER OF ADMISSIONS 259

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	438		4	191,844.00		1,752.00
ROUTINE NURSERY	153		0	42,270.00		318.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	591		4	234,114.00		2,070.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	80		0	81,600.00		0.00
NICU	1		0	1,308.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	81		0	82,908.00		0.00
TOTAL ACCOMODATIONS	672		4	317,022.00		2,070.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	137,683.40	0.00	OTHER LAB	7,766.75	0.00
MED/SURG SUPPLY	154,111.11	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	253,871.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	25,517.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	84,533.25	1,011.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,516.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,307.00	0.00	MRI SERVICES	14,883.50	0.00
IV THERAPY	235,342.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	98,712.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	231,444.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	34,545.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	43,732.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	116,848.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	64,651.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,960.00	0.00	INJECTABLE DRUGS	68,354.11	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,084.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,623.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	378.54
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,554.00	740.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	238,055.73	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,390.00
OTHER IMAGING SERVICE	6,153.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,849.00	5,204.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,620.00	0.00			
AUDIOLOGY	15,580.50	0.00			
CARDIOLOGY	20,263.25	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	23,102.75	0.00			
			TOTAL ANCILLARY	1,924,667.60	8,723.79
			TOTAL ACCOMODATIONS	317,022.00	2,070.00
			TOTAL CHARGES	2,241,689.60	10,793.79

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 10:02:19  
Page: 3

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213170002424	05/30/13 - 06/04/13	06/24/13	0.00	1,390.00	0.00	0.00	0.00
TOTAL				0.00	1,390.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 10:02:26  
 Page: 4

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,937.92	ADJUSTMENTS	0.00
COVERED CHARGES	10,869.38	CONTRACTUAL ALLOW	3,932.35
NON-COVERD CHARGES	68.54	TOTAL MEDICAID LIAB	6,937.03
		LESS: COB	6,937.03
		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	5		0	2,190.00		0.00
ROUTINE NURSERY	2		0	546.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	7		0	2,736.00		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	7		0	2,736.00		0.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	348.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,188.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,852.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,159.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	994.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	110.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	747.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	556.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	358.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	433.28	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	68.54
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	28.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	157.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	199.75	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,133.38	68.54
			TOTAL ACCOMODATIONS	2,736.00	0.00
			TOTAL CHARGES	10,869.38	68.54

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: 07/23/2014  
Run Time: 10:02:26  
Page: 6

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,112,813.35	ADJUSTMENTS	86,004.41
COVERED CHARGES	2,689,410.28	CONTRACTUAL ALLOW	1,972,666.28
NON-COVERD CHARGES	423,403.07	TOTAL MEDICAID LIAB	716,744.00
		LESS: COB	4,324.10
		LESS: COPAYMENT	1,134.00
		REIMBURSEMENT	711,285.90
		ALL OTHER	634,622.69
		FEE SCHEDULE-LAB	63,869.51
		INJECTABLE DRUGS	12,793.70

TOTAL NUMBER OF CLAIMS 2,549

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	68,982.46	1,241.21	OTHER LAB	66,956.00	0.00
MED/SURG SUPPLY	138,679.39	1,690.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	126,360.50	3,052.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	263,436.50	182,940.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,092.25	1,483.25	FEE SCHEDULE LAB	495,007.75	110,226.70
EKG/ECG	30,089.75	2,923.50	MRI SERVICES	28,956.50	4,789.25
IV THERAPY	21,509.00	16,807.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	92,135.40	37,174.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,060.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	14,301.50	330.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,152.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	987,552.64	22,173.36	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,958.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	39,007.74	7,364.18
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,162.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	696.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	33.45
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	14,680.25	4,738.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,048.65	7,920.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	37,046.00	5,208.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,481.25	1,050.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	49,792.25	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	26,459.00	5,041.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	40,664.25	5,358.50			
			TOTAL ANCILLARY	2,689,410.28	423,403.07
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,689,410.28	423,403.07

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: 07/23/2014  
Run Time: 10:03:07  
Page: 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,865.28	ADJUSTMENTS	0.00
COVERED CHARGES	27,140.31	CONTRACTUAL ALLOW	12,361.78
NON-COVERD CHARGES	7,724.97	TOTAL MEDICAID LIAB	14,778.53
		LESS: COB	14,769.53
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 33

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	625.26	125.70	OTHER LAB	632.75	0.00
MED/SURG SUPPLY	255.32	25.59	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	95.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,097.50	244.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,395.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,972.75	759.00
EKG/ECG	206.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	768.50	79.75	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	77.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,512.75	916.75	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	153.23	1,295.64
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	2.04
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	191.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	786.25			
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	647.50	0.00			
			TOTAL ANCILLARY	27,140.31	7,724.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,140.31	7,724.97

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:03:08  
Page: 10

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	144,477.36	ADJUSTMENTS	273.70
COVERED CHARGES	137,635.85	CONTRACTUAL ALLOW	124,601.83
NON-COVERD CHARGES	6,841.51	TOTAL MEDICAID LIAB	13,034.02
		LESS: COB	0.00
		LESS: COPAYMENT	399.00
		REIMBURSEMENT	12,635.02
		TOTAL NUMBER OF CLAIMS	233

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,152.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	381.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,651.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,540.00	4,317.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,424.25	1,094.00
EKG/ECG	721.00	103.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	994.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	99,272.00	1,035.25	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	1,694.25	134.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	805.00	157.25			
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	137,635.85	6,841.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	137,635.85	6,841.51

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:03:12  
Page: 12

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,781.12	ADJUSTMENTS	0.00
COVERED CHARGES	1,351.87	CONTRACTUAL ALLOW	718.70
NON-COVERD CHARGES	429.25	TOTAL MEDICAID LIAB	633.17
		LESS: COB	633.17
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:03:12  
 Page: 13

SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HABERSHAM COUNTY MEDICAL CTR  
 541 CENTRAL AVE  
 DEMOREST,GA 30535-5531

PROVIDER NUMBER  
 000000877A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	136.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	364.00	136.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	947.75	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	40.12	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	157.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,351.87	429.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,351.87	429.25

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 10:03:12  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:03:13  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HABERSHAM COUNTY MEDICAL CTR  
541 CENTRAL AVE  
DEMOREST,GA 30535-5531

PROVIDER NUMBER  
000000877A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:30:24  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHEAST GEORGIA MEDICAL CENTER IN  
 743 SPRING ST NE  
 GAINESVILLE,GA 30501-3715

PROVIDER NUMBER 000000888A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	95,565,516.66	ADJUSTMENTS	8,352,692.59
COVERED CHARGES	91,070,963.16	CONTRACTUAL ALLOW	63,842,782.59
NON-COVERD CHARGES	4,494,553.50	TOTAL MEDICAID LIAB	27,228,180.57
		LESS: COB	186,231.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	27,041,949.43

TOTAL NUMBER OF ADMISSIONS 3,259

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10,829		7	8,147,142.10		3,058,314.00
ROUTINE NURSERY	2,876		0	1,988,433.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13,705		7	10,135,575.10		3,058,314.00
SPECIAL CARE SERVICES						
CCU	694		0	1,279,126.00		1,852.00
ICU	1,190		0	2,198,546.00		5,556.00
NICU	352		0	750,038.50		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		198	0.00		171,758.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,236		198	4,227,710.50		179,166.00
TOTAL ACCOMODATIONS	15,941		205	14,363,285.60		3,237,480.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,379,616.25	253,491.00	OTHER LAB	381,581.00	4,259.00
MED/SURG SUPPLY	6,789,684.75	236,016.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,855,809.05	117,794.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,105,966.00	4,923.00	OTHER THERAPEUTIC SVC	28,132.00	341.00
CT SCAN	3,021,798.00	22,438.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	369,317.00	22,601.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	530,707.00	2,590.00	MRI SERVICES	930,703.00	11,813.00
IV THERAPY	331,386.00	16,080.00	PROFESSIONAL FEES	0.00	987.00
OPERATING ROOM	7,185,362.00	50,415.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,414,374.00	1,536.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,432,409.01	83,109.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,467,165.00	2,971.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,692,090.00	3,609.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,054,931.00	3,990.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	475,558.00	1,675.00	INJECTABLE DRUGS	8,423,723.00	125,410.00
RADIOLOGY THERAPEUTIC	494,329.00	9,763.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	163,628.50	15,993.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	123,823.50	11,747.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	592,956.00	115,342.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36,350.00	328.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	7,406.00	IMPL DEV CHARGE PATIENTS	3,820,329.00	1,610.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,116.00
OTHER IMAGING SERVICE	600,136.00	5,329.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	588,682.00	35,515.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	358,071.00	79,440.00			
AUDIOLOGY	94,868.00	0.00			
CARDIOLOGY	2,590,200.50	4,416.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	132,684.00	1,222.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	241,308.00	798.00			
			TOTAL ANCILLARY	76,707,677.56	1,257,073.50
			TOTAL ACCOMODATIONS	14,363,285.60	3,237,480.00
			TOTAL CHARGES	91,070,963.16	4,494,553.50

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
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
905	2013109043475	02/14/13 - 02/24/13	04/22/13	0.00	2,116.00	0.00	0.00	0.00
TOTAL				0.00	2,116.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:31:34  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,792,162.20	ADJUSTMENTS	0.00
COVERED CHARGES	1,721,476.20	CONTRACTUAL ALLOW	692,690.43
NON-COVERD CHARGES	70,686.00	TOTAL MEDICAID LIAB	1,028,785.77
		LESS: COB	1,028,785.77
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 73

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	238		0	179,293.00		64,430.00
ROUTINE NURSERY	136		0	114,766.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	374		0	294,059.00		64,430.00
SPECIAL CARE SERVICES						
CCU	2		0	3,704.00		0.00
ICU	2		0	3,704.00		0.00
NICU	31		0	44,330.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK 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		3,452.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	35		4	51,738.00		3,452.00
TOTAL ACCOMODATIONS	409		4	345,797.00		67,882.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	219,892.00	0.00	OTHER LAB	2,239.00	0.00
MED/SURG SUPPLY	139,406.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	170,396.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,789.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,963.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,631.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,144.00	0.00	MRI SERVICES	2,196.00	0.00
IV THERAPY	2,251.00	0.00	PROFESSIONAL FEES	0.00	470.00
OPERATING ROOM	109,639.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	121,361.20	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	107,564.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	87,522.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,557.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	76,694.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,041.00	0.00	INJECTABLE DRUGS	159,626.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	897.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,134.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	574.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,275.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,298.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	20,204.00	1,419.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,719.00	915.00			
AUDIOLOGY	867.00	0.00			
CARDIOLOGY	56,437.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,363.00	0.00			
			TOTAL ANCILLARY	1,375,679.20	2,804.00
			TOTAL ACCOMODATIONS	345,797.00	67,882.00
			TOTAL CHARGES	1,721,476.20	70,686.00



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,005,332.82	ADJUSTMENTS	1,085,761.83
COVERED CHARGES	36,844,398.68	CONTRACTUAL ALLOW	29,630,472.72
NON-COVERD CHARGES	4,160,934.14	TOTAL MEDICAID LIAB	7,213,925.96
		LESS: COB	7,631.65
		LESS: COPAYMENT	14,818.02
		REIMBURSEMENT	7,191,476.29
		ALL OTHER	6,221,708.73
		FEE SCHEDULE-LAB	559,940.98
		INJECTABLE DRUGS	409,826.58

TOTAL NUMBER OF CLAIMS 13,881

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,067,266.63	53,835.00	OTHER LAB	349,497.00	5,516.00
MED/SURG SUPPLY	1,347,941.00	6,454.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	259.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,475,238.00	35,758.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,930,359.00	350,161.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	103,669.00	55,078.00	FEE SCHEDULE LAB	6,367,128.86	1,323,670.52
EKG/ECG	360,598.00	48,166.00	MRI SERVICES	1,093,558.00	120,371.00
IV THERAPY	1,617,091.38	230,296.00	PROFESSIONAL FEES	0.00	893.00
OPERATING ROOM	2,506,837.38	664,423.62	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	54,150.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	356,063.00	65,520.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	756,416.00	6,209.00	AMBULANCE	0.00	0.00
GI SERVICES	8,022.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,796,167.00	124,663.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	941,377.00	12,591.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,421,735.00	337,519.00
RADIOLOGY THERAPEUTIC	1,726,783.00	35,616.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	16,873.00	16,408.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,609.00	1,373.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,638.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	9,758.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	49,962.00	7,560.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,707.00
OTHER IMAGING SERVICE	1,153,047.00	116,074.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	72,322.00	65,096.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	649,039.00	175,480.00			
AUDIOLOGY	10,650.00	0.00			
CARDIOLOGY	1,015,489.00	211,191.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	682,351.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	911,159.43	73,650.00			
			TOTAL ANCILLARY	36,844,398.68	4,160,934.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,844,398.68	4,160,934.14

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
33	2213100005684	03/06/13 - 03/06/13	04/15/13	0.00	1,475.00	0.00	0.00	0.00
905	2013134033079	04/12/13 - 04/12/13	05/20/13	0.00	529.00	0.00	0.00	0.00
905	2013134033079	04/15/13 - 04/15/13	05/20/13	0.00	529.00	0.00	0.00	0.00
905	2013134033079	04/16/13 - 04/16/13	05/20/13	0.00	529.00	0.00	0.00	0.00
905	2013134033079	04/17/13 - 04/17/13	05/20/13	0.00	529.00	0.00	0.00	0.00
905	2013134033079	04/18/13 - 04/18/13	05/20/13	0.00	529.00	0.00	0.00	0.00
905	2013134033079	04/19/13 - 04/19/13	05/20/13	0.00	529.00	0.00	0.00	0.00
905	2013134033079	04/23/13 - 04/23/13	05/20/13	0.00	529.00	0.00	0.00	0.00
905	2013134033079	04/25/13 - 04/25/13	05/20/13	0.00	529.00	0.00	0.00	0.00
TOTAL				0.00	5,707.00	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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,194,513.63	ADJUSTMENTS	0.00
COVERED CHARGES	1,065,085.00	CONTRACTUAL ALLOW	594,255.45
NON-COVERD CHARGES	129,428.63	TOTAL MEDICAID LIAB	470,829.55
		LESS: COB	470,574.55
		LESS: COPAYMENT	255.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 390

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71,872.00	980.00	OTHER LAB	8,472.00	0.00
MED/SURG SUPPLY	44,136.00	1,412.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,482.00	1,008.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	110,318.00	13,867.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	210,164.00	36,615.00
EKG/ECG	9,583.00	1,813.00	MRI SERVICES	21,972.00	4,702.00
IV THERAPY	46,464.00	4,355.00	PROFESSIONAL FEES	0.00	1,833.00
OPERATING ROOM	59,479.00	23,239.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,409.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,935.00	3,073.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,524.00	1,618.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	172,932.00	6,896.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,344.00	1,950.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	42,498.00	3,234.63
RADIOLOGY THERAPEUTIC	19,319.00	732.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	328.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,174.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	158.00
OTHER IMAGING SERVICE	44,218.00	5,050.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,992.00	2,838.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	6,272.00	0.00			
CARDIOLOGY	10,975.00	12,422.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	30,795.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,756.00	1,305.00			
			TOTAL ANCILLARY	1,065,085.00	129,428.63
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,065,085.00	129,428.63

Report : 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

NORTHEAST GEORGIA MEDICAL CENTER IN	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
743 SPRING ST NE	000000888A	SERVICE DATES	10/01/12	THROUGH	09/30/13
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
9637	5913105000136	10/29/12 - 10/29/12	04/22/13	0.00	158.00	0.00	990.88	0.00
TOTAL				0.00	158.00	0.00	990.88	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:34:32  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,240,397.00	ADJUSTMENTS	1,700.08
COVERED CHARGES	2,106,023.00	CONTRACTUAL ALLOW	2,032,965.36
NON-COVERD CHARGES	134,374.00	TOTAL MEDICAID LIAB	73,057.64
		LESS: COB	0.00
		LESS: COPAYMENT	2,298.04
		REIMBURSEMENT	70,759.60
		TOTAL NUMBER OF CLAIMS	1,306

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92,326.00	0.00	OTHER LAB	10,993.00	0.00
MED/SURG SUPPLY	18,261.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	178,236.00	4,733.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	128,314.00	10,606.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	638.00	FEE SCHEDULE LAB	413,110.00	75,136.00
EKG/ECG	27,195.00	0.00	MRI SERVICES	26,170.00	6,769.00
IV THERAPY	114,867.00	9,607.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,440.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,424.00	248.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,420.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	976,490.00	10,117.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,919.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	48,377.00	8,117.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	164.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,950.00	6,703.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,162.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,369.00	1,536.00			
			TOTAL ANCILLARY	2,106,023.00	134,374.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,106,023.00	134,374.00



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,221.00	ADJUSTMENTS	0.00
COVERED CHARGES	67,292.00	CONTRACTUAL ALLOW	41,458.54
NON-COVERD CHARGES	3,929.00	TOTAL MEDICAID LIAB	25,833.46
		LESS: COB	25,806.46
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	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: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,400.00	725.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	199.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,870.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,854.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,178.00	1,975.00
EKG/ECG	518.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,415.00	794.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,165.00	234.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	637.00	201.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,304.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	752.00	0.00			
			TOTAL ANCILLARY	67,292.00	3,929.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,292.00	3,929.00

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,117,200.80	ADJUSTMENTS	326,681.07
COVERED CHARGES	7,448,208.00	CONTRACTUAL ALLOW	6,310,195.31
NON-COVERD CHARGES	668,992.80	TOTAL MEDICAID LIAB	1,138,012.69
		LESS: COB	1,200.00
		LESS: COPAYMENT	2,040.00
		REIMBURSEMENT	1,134,772.69

TOTAL NUMBER OF CLAIMS 220

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	368,158.00	8,663.00	OTHER LAB	2,285.00	0.00
MED/SURG SUPPLY	2,015,221.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,070.00	13,375.00	OTHER THERAPEUTIC SVC	14,696.00	0.00
CT SCAN	56,389.00	21,774.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	385.00	1,528.00	FEE SCHEDULE LAB	160,558.00	40,417.80
EKG/ECG	21,497.00	11,396.00	MRI SERVICES	2,996.00	8,475.00
IV THERAPY	126,171.00	11,234.00	PROFESSIONAL FEES	0.00	94.00
OPERATING ROOM	1,207,657.00	302,881.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,229.00	6,198.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	398,597.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,303.00	1,872.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	370,140.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,109,057.00	110,910.00
RADIOLOGY THERAPEUTIC	1,219,264.00	15,590.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	482.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,638.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	328.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,635.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,366.00	2,838.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,680.00	8,471.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	179,565.00	93,490.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,512.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	79,777.00	7,338.00			
			TOTAL ANCILLARY	7,448,208.00	668,992.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,448,208.00	668,992.80

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	160,100.00	ADJUSTMENTS	0.00
COVERED CHARGES	121,941.00	CONTRACTUAL ALLOW	32,426.33
NON-COVERD CHARGES	38,159.00	TOTAL MEDICAID LIAB	89,514.67
		LESS: COB	89,457.67
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,625.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	35,529.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,607.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	398.00	70.00
EKG/ECG	259.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	47.00
OPERATING ROOM	9,555.00	37,442.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,565.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,072.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	227.00	0.00
RADIOLOGY THERAPEUTIC	62,104.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	600.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	121,941.00	38,159.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	121,941.00	38,159.00

\*\* 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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,423,716.12	ADJUSTMENTS	1,526,405.57
COVERED CHARGES	22,775,563.43	CONTRACTUAL ALLOW	15,073,660.36
NON-COVERD CHARGES	648,152.69	TOTAL MEDICAID LIAB	7,701,903.07
		LESS: COB	91,008.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,610,894.92

TOTAL NUMBER OF ADMISSIONS 1,363

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,387	24	3,321,381.00	139,859.00
ROUTINE NURSERY	1,161	15	1,271,040.00	9,690.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,548	39	4,592,421.00	149,549.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	330	0	754,850.00	0.00
NICU	105	0	289,083.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	435	0	1,043,933.00	0.00
TOTAL ACCOMODATIONS	4,983	39	5,636,354.00	149,549.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HAMILTON MEDICAL CENTER  
 1200 MEMORIAL DR  
 DALTON,GA 30720-2529

PROVIDER NUMBER 000000899A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,939,410.10	202.05	OTHER LAB	65,522.00	0.00
MED/SURG SUPPLY	1,074,422.66	16,321.58	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,147,627.62	22,339.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	394,271.04	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	605,955.00	26,757.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	103,471.11	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	189,899.00	0.00	MRI SERVICES	276,361.00	0.00
IV THERAPY	298,703.00	15,998.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,035,239.59	41,100.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,321,893.78	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,128,058.35	4,783.96	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	95,143.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	526,529.19	362.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	206,636.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	113,211.55	23.46	INJECTABLE DRUGS	465,656.60	0.00
RADIOLOGY THERAPEUTIC	214,954.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	28,082.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	45,390.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	189,162.00	16,518.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	515.00	3,428.00	TRAUMA RESPONSE	0.00	5,100.00
PSYCHIATRIC SERVICES	312,593.21	217,184.64	IMPL DEV CHARGE PATIENTS	295,031.41	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	43,427.00
OTHER IMAGING SERVICE	141,182.50	5,462.00			
BLOOD	85,520.00	332.00			
BLOOD STORAGE & PRO.	142,381.00	73,331.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	65,850.00	5,934.00			
AUDIOLOGY	42,971.22	0.00			
CARDIOLOGY	509,859.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,376.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,331.00	0.00			
			TOTAL ANCILLARY	17,139,209.43	498,603.69
			TOTAL ACCOMODATIONS	5,636,354.00	149,549.00
			TOTAL CHARGES	22,775,563.43	648,152.69



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012310033586	10/22/12 - 10/29/12	11/12/12	0.00	1,446.00	0.00	0.00	0.00
615	2013015050782	01/05/13 - 01/06/13	01/21/13	0.00	2,892.00	0.00	0.00	0.00
615	2013038067419	12/31/12 - 01/02/13	02/11/13	0.00	2,892.00	0.00	0.00	0.00
615	2013053075261	02/06/13 - 02/06/13	03/04/13	0.00	2,892.00	0.00	0.00	0.00
615	2013112029231	01/05/13 - 01/16/13	04/29/13	0.00	2,892.00	0.00	0.00	0.00
615	2013122087920	11/26/12 - 11/29/12	05/20/13	0.00	2,892.00	0.00	0.00	0.00
615	2013128081221	04/16/13 - 04/17/13	05/13/13	0.00	1,446.00	0.00	0.00	0.00
615	2013130044416	04/11/13 - 04/14/13	05/20/13	0.00	1,446.00	0.00	0.00	0.00
615	2313136000055	02/13/13 - 02/15/13	06/24/13	0.00	2,892.00	0.00	0.00	0.00
615	2013137081118	03/16/13 - 03/25/13	05/27/13	0.00	2,892.00	0.00	0.00	0.00
615	2013141068677	04/30/13 - 05/07/13	05/27/13	0.00	3,470.00	0.00	0.00	0.00
615	2213165008324	03/26/13 - 04/02/13	06/17/13	0.00	2,892.00	0.00	0.00	0.00
615	2213230000108	03/20/13 - 03/24/13	08/26/13	0.00	2,892.00	0.00	4,671.98	0.00
614	2013240031416	08/16/13 - 08/20/13	09/02/13	0.00	2,390.00	0.00	0.00	0.00
614	2013284063060	08/26/13 - 09/06/13	10/21/13	0.00	2,390.00	0.00	0.00	0.00
614	2013289048428	09/12/13 - 09/17/13	10/21/13	0.00	4,811.00	0.00	0.00	0.00
TOTAL				0.00	43,427.00	0.00	4,671.98	0.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	111,642.30	ADJUSTMENTS	0.00
COVERED CHARGES	109,422.30	CONTRACTUAL ALLOW	39,151.73
NON-COVERD CHARGES	2,220.00	TOTAL MEDICAID LIAB	70,270.57
		LESS: COB	70,270.57
		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	12,780.00		2,220.00
ROUTINE NURSERY	12		0	18,740.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	25		2	31,520.00		2,220.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	1		0	2,186.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	2,186.00		0.00
TOTAL ACCOMODATIONS	26		2	33,706.00		2,220.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:00:39  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,838.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,302.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,871.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	223.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	546.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,533.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	30,321.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,910.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	343.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,250.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	872.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,609.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	98.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	75,716.30	0.00
			TOTAL ACCOMODATIONS	33,706.00	2,220.00
			TOTAL CHARGES	109,422.30	2,220.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:00:42  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,183,615.59	ADJUSTMENTS	369,198.39
COVERED CHARGES	19,285,657.41	CONTRACTUAL ALLOW	15,760,403.23
NON-COVERD CHARGES	1,897,958.18	TOTAL MEDICAID LIAB	3,525,254.18
		LESS: COB	2,362.62
		LESS: COPAYMENT	6,937.11
		REIMBURSEMENT	3,515,954.45
		ALL OTHER	3,091,136.08
		FEE SCHEDULE-LAB	315,776.10
		INJECTABLE DRUGS	109,042.27

TOTAL NUMBER OF CLAIMS 8,768

HAMILTON MEDICAL CENTER  
 1200 MEMORIAL DR  
 DALTON,GA 30720-2529

PROVIDER NUMBER  
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	564,555.70	12,267.86	OTHER LAB	211,046.22	6,100.00
MED/SURG SUPPLY	551,025.99	12,230.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	656.00	EDUCATION & TRAINING	5,645.00	0.00
RADIOLOGY-DIAGNOSTIC	1,128,506.00	28,915.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,465,977.44	70,964.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	21,780.00	4,745.00	FEE SCHEDULE LAB	5,073,903.86	892,640.90
EKG/ECG	341,919.76	40,702.00	MRI SERVICES	932,043.00	73,896.00
IV THERAPY	993,558.25	325,615.96	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,285,357.54	172,897.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	40,680.00	2,977.13	REHAB THERAPY	2,730.00	0.00
RESPIRATORY SERVICES	189,254.92	29,856.22	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	88,705.28	1,059.00	AMBULANCE	0.00	0.00
GI SERVICES	1,217.00	0.00	CAST ROOM	454.00	0.00
EMERGENCY ROOM	2,464,636.40	4,360.01	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	180,735.00	1,185.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	348,822.90	82,036.45
RADIOLOGY THERAPEUTIC	466,725.59	28,515.87	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	31,911.00	8,929.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,319.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,380.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	72,597.66	2,481.00	TRAUMA RESPONSE	0.00	15,021.00
PSYCHIATRIC SERVICES	1,456.00	2,190.00	IMPL DEV CHARGE PATIENTS	52,384.87	10,463.06
LITHOTRIPSY	18,139.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	993,090.55	24,226.00			
BLOOD	49,846.00	1,106.00			
BLOOD STORAGE & PRO.	29,858.00	3,419.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	275,347.73	4,133.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	588,572.08	25,519.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	433,304.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	379,870.67	2,152.00			
			TOTAL ANCILLARY	19,285,657.41	1,897,958.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,285,657.41	1,897,958.18

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 10:01:53  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	433,993.51	ADJUSTMENTS	0.00
COVERED CHARGES	266,502.24	CONTRACTUAL ALLOW	29,648.05
NON-COVERD CHARGES	167,491.27	TOTAL MEDICAID LIAB	236,854.19
		LESS: COB	236,752.19
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 129

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HAMILTON MEDICAL CENTER  
 1200 MEMORIAL DR  
 DALTON,GA 30720-2529

PROVIDER NUMBER  
 000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,325.13	1,296.68	OTHER LAB	1,307.00	0.00
MED/SURG SUPPLY	8,928.66	7,581.11	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	546.00	0.00
RADIOLOGY-DIAGNOSTIC	20,061.00	998.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,916.00	3,713.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	440.00	490.00	FEE SCHEDULE LAB	90,754.44	14,115.00
EKG/ECG	5,843.00	256.00	MRI SERVICES	7,148.00	4,091.00
IV THERAPY	7,435.00	4,349.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,802.00	118,540.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	662.00	268.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,323.24	507.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,615.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,662.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,110.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	453.25	4,019.30
RADIOLOGY THERAPEUTIC	180.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	128.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,401.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11.52	6,544.66
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,654.00	77.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,238.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,686.00	517.00			
			TOTAL ANCILLARY	266,502.24	167,491.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	266,502.24	167,491.27

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:01:57  
Page: 10

HAMILTON MEDICAL CENTER  
1200 MEMORIAL DR  
DALTON,GA 30720-2529

PROVIDER NUMBER  
000000899A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	984,519.87	ADJUSTMENTS	1,023.10
COVERED CHARGES	951,972.75	CONTRACTUAL ALLOW	902,108.37
NON-COVERD CHARGES	32,547.12	TOTAL MEDICAID LIAB	49,864.38
		LESS: COB	43.94
		LESS: COPAYMENT	2,037.00
		REIMBURSEMENT	47,783.44
		TOTAL NUMBER OF CLAIMS	894



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,412.15	1,021.05	OTHER LAB	5,202.00	0.00
MED/SURG SUPPLY	7,303.13	130.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	79,171.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,525.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	266,687.00	19,356.00
EKG/ECG	11,861.00	272.00	MRI SERVICES	0.00	0.00
IV THERAPY	73,155.00	6,608.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	358.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,910.76	1,582.17	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	381,581.01	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,800.70	3,032.40
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	679.00	228.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	300.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,681.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,646.00	17.00			
			TOTAL ANCILLARY	951,972.75	32,547.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	951,972.75	32,547.12



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	189.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	714.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,495.00	1,116.00
EKG/ECG	567.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	522.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,556.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,088.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,152.42	1,116.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,152.42	1,116.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 10:02:07  
Page: 14

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,791,511.88	ADJUSTMENTS	71,740.22
COVERED CHARGES	1,656,805.78	CONTRACTUAL ALLOW	1,412,835.59
NON-COVERD CHARGES	134,706.10	TOTAL MEDICAID LIAB	243,970.19
		LESS: COB	0.00
		LESS: COPAYMENT	510.00
		REIMBURSEMENT	243,460.19
		TOTAL NUMBER OF CLAIMS	48

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,611.22	672.92	OTHER LAB	1,083.00	0.00
MED/SURG SUPPLY	104,231.93	591.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,976.00	6,397.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,066.00	3,116.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	955.02	FEE SCHEDULE LAB	89,299.30	16,200.41
EKG/ECG	8,103.38	4,824.00	MRI SERVICES	3,747.00	0.00
IV THERAPY	8,550.00	9,860.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	302,214.00	4,545.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,553.16	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,351.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,560.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,465.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	478,991.35	10,628.65
RADIOLOGY THERAPEUTIC	210,352.00	9,553.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	480.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	126,716.84	12,779.50
LITHOTRIpsy	21,767.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	11,902.60	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	176,552.00	54,583.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,233.00	0.00			
			TOTAL ANCILLARY	1,656,805.78	134,706.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,656,805.78	134,706.10

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:02:10  
Page: 16

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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:52:35  
 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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	205,154,110.92	ADJUSTMENTS	38,066,874.51
COVERED CHARGES	199,229,204.20	CONTRACTUAL ALLOW	123,520,955.05
NON-COVERD CHARGES	5,924,906.72	TOTAL MEDICAID LIAB	75,708,249.15
		LESS: COB	195,531.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	75,512,717.82

TOTAL NUMBER OF ADMISSIONS 3,194

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	14,018		1	13,403,464.00		4,255,692.50
ROUTINE NURSERY	1,449		0	2,792,255.00		29,933.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	15,467		1	16,195,719.00		4,285,626.00
SPECIAL CARE SERVICES						
CCU	1,424		0	5,003,054.00		0.00
ICU	0		0	0.00		0.00
NICU	1,341		0	6,285,771.00		0.00
PED ICU	3,682		0	12,976,267.50		62,424.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	6,447		0	24,265,092.50		62,424.00
TOTAL ACCOMODATIONS	21,914		1	40,460,811.50		4,348,050.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,681,430.50	296,404.90	OTHER LAB	530,401.50	0.00
MED/SURG SUPPLY	13,202,150.97	154,863.21	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,098,449.38	345,199.60	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,368,561.00	2,896.00	OTHER THERAPEUTIC SVC	47,166.50	118,611.50
CT SCAN	1,596,507.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	833,481.50	9,545.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	169,479.00	0.00	MRI SERVICES	1,203,354.50	0.00
IV THERAPY	72,684.00	12,592.50	PROFESSIONAL FEES	0.00	32,230.50
OPERATING ROOM	19,856,258.53	7,114.04	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,620,815.31	192,666.59	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,635,624.50	3,248.00	AMBULANCE	0.00	0.00
GI SERVICES	17,120.50	3,227.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,748,560.01	42,879.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,440,666.00	1,969.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,085,893.00	6,099.50	INJECTABLE DRUGS	14,896.00	0.00
RADIOLOGY THERAPEUTIC	118,358.00	3,724.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	341,644.00	1,326.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	461,183.50	1,782.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	76,475.00	49,899.00	PATIENT CONVENIENCE	0.00	108.88
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	360.00	59,525.00	TRAUMA RESPONSE	0.00	77,062.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	11,587,405.50	3,147.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	500,281.00	80,189.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,451,772.00	28,951.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	161,604.00	17,886.00			
AUDIOLOGY	36,698.00	0.00			
CARDIOLOGY	4,121,408.50	11,297.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,265,209.00	4,025.00			
ORGAN ACQUISITION	2,273,977.00	7,816.50			
TREATMENT/OBSERV. RM	148,517.50	570.50			
			TOTAL ANCILLARY	158,768,392.70	1,576,856.72
			TOTAL ACCOMODATIONS	40,460,811.50	4,348,050.00
			TOTAL CHARGES	199,229,204.20	5,924,906.72



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:53:13  
 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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,189,330.78	ADJUSTMENTS	0.00
COVERED CHARGES	12,023,325.28	CONTRACTUAL ALLOW	4,551,354.93
NON-COVERD CHARGES	166,005.50	TOTAL MEDICAID LIAB	7,471,970.35
		LESS: COB	7,471,970.35
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 140

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	485		0	463,614.00		99,744.00
ROUTINE NURSERY	80		0	142,282.50		1,879.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	565		0	605,896.50		101,623.50
SPECIAL CARE SERVICES						
CCU	322		0	1,138,438.00		0.00
ICU	3		0	7,833.00		0.00
NICU	51		0	238,629.00		0.00
PED ICU	55		0	193,944.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	431		0	1,578,844.00		0.00
TOTAL ACCOMODATIONS	996		0	2,184,740.50		101,623.50

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER  
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,574,562.25	0.00	OTHER LAB	61,114.00	0.00
MED/SURG SUPPLY	690,835.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,844,520.86	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	236,772.50	0.00	OTHER THERAPEUTIC SVC	512.00	4,929.50
CT SCAN	52,476.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,543.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,081.00	0.00	MRI SERVICES	54,319.00	0.00
IV THERAPY	823.00	0.00	PROFESSIONAL FEES	0.00	57,009.00
OPERATING ROOM	1,141,229.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,057,784.95	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	442,861.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	154,919.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	71,198.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	50,916.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,971.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,264.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,449.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	841,297.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,250.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	131,261.00	929.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,194.50	65.50			
AUDIOLOGY	489.00	0.00			
CARDIOLOGY	270,380.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,109.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,899.00	0.00			
			TOTAL ANCILLARY	9,838,584.78	64,382.00
			TOTAL ACCOMODATIONS	2,184,740.50	101,623.50
			TOTAL CHARGES	12,023,325.28	166,005.50

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:53:18  
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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	52,893,033.06	ADJUSTMENTS	4,619,466.24
COVERED CHARGES	49,325,254.94	CONTRACTUAL ALLOW	36,048,872.06
NON-COVERD CHARGES	3,567,778.12	TOTAL MEDICAID LIAB	13,276,382.88
		LESS: COB	52,867.81
		LESS: COPAYMENT	270.00
		REIMBURSEMENT	13,223,245.07
		ALL OTHER	11,624,231.40
		FEE SCHEDULE-LAB	695,165.55
		INJECTABLE DRUGS	903,848.12

TOTAL NUMBER OF CLAIMS 19,653

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,511,332.50	727.00	OTHER LAB	360,980.00	3,778.00
MED/SURG SUPPLY	2,618,872.27	1,309.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	481.00	0.00
RADIOLOGY-DIAGNOSTIC	1,500,460.00	21,842.50	OTHER THERAPEUTIC SVC	583.00	2,162.00
CT SCAN	1,305,666.50	31,410.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	109,117.00	15,276.00	FEE SCHEDULE LAB	8,726,704.83	1,960,234.21
EKG/ECG	106,087.50	6,003.50	MRI SERVICES	2,947,593.00	218,226.50
IV THERAPY	1,111,268.50	33,855.50	PROFESSIONAL FEES	0.00	46,804.00
OPERATING ROOM	5,256,678.22	290,016.28	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,922.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	865,361.80	6,075.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,448,302.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	154,007.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,492,829.50	82,447.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,557,236.50	0.00	DRUG-SPECIFIC/HOME IV	310.75	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,995,882.57	279,023.00
RADIOLOGY THERAPEUTIC	394,940.00	1,484.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	33,837.00	1,070.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	371,795.50	5,328.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	3,277.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,298,781.00	125,752.50	TRAUMA RESPONSE	0.00	30,037.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	437,546.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	705,970.50	15,000.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	779,034.00	1,265.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	296,034.50	16,497.50			
AUDIOLOGY	191,679.00	409.00			
CARDIOLOGY	1,588,602.00	228,973.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,274,353.50	5,416.00			
ORGAN ACQUISITION	0.00	117,273.00			
TREATMENT/OBSERV. RM	881,005.00	16,803.50			
			TOTAL ANCILLARY	49,325,254.94	3,567,778.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	49,325,254.94	3,567,778.12

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,443,758.10	ADJUSTMENTS	0.00
COVERED CHARGES	1,913,557.85	CONTRACTUAL ALLOW	7,286.11
NON-COVERD CHARGES	530,200.25	TOTAL MEDICAID LIAB	1,906,271.74
		LESS: COB	1,906,259.74
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 313

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128,062.50	582.00	OTHER LAB	7,765.50	2,259.00
MED/SURG SUPPLY	149,591.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,779.00	2,206.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,451.50	7,604.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,993.00	985.00	FEE SCHEDULE LAB	225,377.50	55,356.00
EKG/ECG	1,392.00	232.00	MRI SERVICES	171,835.50	15,761.50
IV THERAPY	4,966.00	1,632.00	PROFESSIONAL FEES	0.00	28,835.00
OPERATING ROOM	346,381.50	129,699.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,082.50	5,310.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	282,506.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	83,700.50	803.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	105,311.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	141,971.25	115,294.75
RADIOLOGY THERAPEUTIC	23,162.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	919.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,759.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,248.50	1,581.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	39,501.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,411.50	40,839.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,360.50	15,633.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,834.00	457.50			
AUDIOLOGY	7,946.00	0.00			
CARDIOLOGY	28,258.50	64,315.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,657.00	0.00			
ORGAN ACQUISITION	0.00	13,699.00			
TREATMENT/OBSERV. RM	32,333.00	27,115.00			
			TOTAL ANCILLARY	1,913,557.85	530,200.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,913,557.85	530,200.25

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:55:21  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,394,842.02	ADJUSTMENTS	2,629.18
COVERED CHARGES	1,315,198.02	CONTRACTUAL ALLOW	1,238,336.48
NON-COVERD CHARGES	79,644.00	TOTAL MEDICAID LIAB	76,861.54
		LESS: COB	36.35
		LESS: COPAYMENT	24.01
		REIMBURSEMENT	76,801.18
		TOTAL NUMBER OF CLAIMS	1,374

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,357.75	0.00	OTHER LAB	7,094.50	0.00
MED/SURG SUPPLY	15,960.77	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	93,493.50	660.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,098.50	4,873.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	211,930.00	56,373.50
EKG/ECG	3,248.00	464.00	MRI SERVICES	10,266.00	4,261.50
IV THERAPY	4,373.00	272.00	PROFESSIONAL FEES	0.00	7,149.00
OPERATING ROOM	15,297.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,508.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,165.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	854,406.00	2,433.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,044.00	808.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	879.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	577.00	132.00	TRAUMA RESPONSE	0.00	1,621.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	826.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,276.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	408.00	0.00			
CARDIOLOGY	1,711.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	838.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,440.00	595.00			
			TOTAL ANCILLARY	1,315,198.02	79,644.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,315,198.02	79,644.00



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:55:30  
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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,562.03	ADJUSTMENTS	0.00
COVERED CHARGES	43,948.78	CONTRACTUAL ALLOW	22,902.14
NON-COVERD CHARGES	9,613.25	TOTAL MEDICAID LIAB	21,046.64
		LESS: COB	21,046.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHILDREN'S HEALTHCARE OF ATLANTA AT  
 1405 CLIFTON RD NE  
 ATLANTA,GA 30322-1062

PROVIDER NUMBER  
 000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,645.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,984.53	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,154.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,624.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	409.50	FEE SCHEDULE LAB	6,986.00	940.50
EKG/ECG	0.00	0.00	MRI SERVICES	8,420.50	1,947.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	3,866.50
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	1,353.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,389.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,130.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	376.50	63.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	409.50	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	1,621.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	797.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,677.50	765.00			
			TOTAL ANCILLARY	43,948.78	9,613.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	43,948.78	9,613.25

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA AT  
1405 CLIFTON RD NE  
ATLANTA,GA 30322-1062

PROVIDER NUMBER  
000000943A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,063,438.83	ADJUSTMENTS	1,445,378.94
COVERED CHARGES	16,550,845.98	CONTRACTUAL ALLOW	13,962,560.98
NON-COVERD CHARGES	1,512,592.85	TOTAL MEDICAID LIAB	2,588,285.00
		LESS: COB	35,837.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,552,447.57

TOTAL NUMBER OF CLAIMS 357

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	586,949.50	0.00	OTHER LAB	12,225.00	2,259.00
MED/SURG SUPPLY	2,422,983.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	282.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	587,234.50	269,909.50	OTHER THERAPEUTIC SVC	146.00	540.50
CT SCAN	13,064.50	1,624.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,643.50	11,976.50	FEE SCHEDULE LAB	522,614.00	301,140.25
EKG/ECG	2,784.00	6,960.00	MRI SERVICES	45,017.00	4,261.50
IV THERAPY	66,977.50	36,992.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,572,898.90	175,050.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,391.00	1,626.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,570,798.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	43,874.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,427.50	800.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	333,226.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,041,419.25	34,287.00
RADIOLOGY THERAPEUTIC	14,896.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,557.00	1,079.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,129.00	3,875.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,254.50	1,003.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,105,468.12	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,596.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,528.00	1,353.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,426.00	1,694.00			
AUDIOLOGY	408.00	0.00			
CARDIOLOGY	2,309,864.50	625,534.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	54,448.00	1,824.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	163,596.50	28,519.00			
			TOTAL ANCILLARY	16,550,845.98	1,512,592.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,550,845.98	1,512,592.85

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: 07/23/2014  
Run Time: 11:55:46  
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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	946,138.21	ADJUSTMENTS	0.00
COVERED CHARGES	847,175.31	CONTRACTUAL ALLOW	192.06
NON-COVERD CHARGES	98,962.90	TOTAL MEDICAID LIAB	846,983.25
		LESS: COB	846,983.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	20

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,034.50	0.00	OTHER LAB	1,831.50	0.00
MED/SURG SUPPLY	160,478.56	1,134.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,120.50	4,592.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	904.50	FEE SCHEDULE LAB	23,264.00	8,702.15
EKG/ECG	0.00	232.00	MRI SERVICES	1,947.00	0.00
IV THERAPY	2,085.50	1,632.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	131,505.50	31,875.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	105.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	99,357.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,308.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,376.75	4,641.75
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	243,132.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,806.50	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	106,509.00	42,868.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,312.50	2,380.00			
			TOTAL ANCILLARY	847,175.31	98,962.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	847,175.31	98,962.90

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,336,881.68	ADJUSTMENTS	13,132.93
COVERED CHARGES	1,327,208.68	CONTRACTUAL ALLOW	804,892.37
NON-COVERD CHARGES	9,673.00	TOTAL MEDICAID LIAB	522,316.31
		LESS: COB	8,105.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	514,210.85

TOTAL NUMBER OF ADMISSIONS 77

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	102		0	90,576.00		6,794.00
ROUTINE NURSERY	0		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	90,576.00		6,794.00
SPECIAL CARE SERVICES						
CCU	66		0	98,076.00		0.00
ICU	32		0	72,576.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	170,652.00		0.00
TOTAL ACCOMODATIONS	200		0	261,228.00		6,794.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	144,433.44	0.00	OTHER LAB	4,276.00	0.00
MED/SURG SUPPLY	75,328.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	279,639.00	0.00	EDUCATION & TRAINING	404.00	0.00
RADIOLOGY-DIAGNOSTIC	27,118.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	126,767.00	2,071.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,458.80	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,100.00	0.00	MRI SERVICES	3,096.00	0.00
IV THERAPY	37,907.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	25,042.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	88,116.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,992.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	85,696.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,104.00	0.00	INJECTABLE DRUGS	33,538.58	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,050.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,569.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,628.00	610.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,838.00	198.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	39,903.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,976.00	0.00			
			TOTAL ANCILLARY	1,065,980.68	2,879.00
			TOTAL ACCOMODATIONS	261,228.00	6,794.00
			TOTAL CHARGES	1,327,208.68	9,673.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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Page: 4

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,089,559.89	ADJUSTMENTS	150,220.30
COVERED CHARGES	4,775,512.90	CONTRACTUAL ALLOW	3,706,617.56
NON-COVERD CHARGES	314,046.99	TOTAL MEDICAID LIAB	1,068,895.34
		LESS: COB	623.66
		LESS: COPAYMENT	3,582.00
		REIMBURSEMENT	1,064,689.68
		ALL OTHER	992,570.86
		FEE SCHEDULE-LAB	66,362.14
		INJECTABLE DRUGS	5,756.68

TOTAL NUMBER OF CLAIMS 2,759

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	235,964.04	545.10	OTHER LAB	24,438.00	0.00
MED/SURG SUPPLY	155,661.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	160.00
RADIOLOGY-DIAGNOSTIC	274,929.00	3,751.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	911,785.00	32,482.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	112,144.04	3,703.38	FEE SCHEDULE LAB	866,972.60	136,987.20
EKG/ECG	49,611.00	8,050.00	MRI SERVICES	219,414.00	10,508.00
IV THERAPY	201,716.00	54,224.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	237,569.00	21,920.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,152.00	10,149.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,603.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	116,064.00	9,864.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	896,253.67	6,151.33	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,777.49	8,494.98
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	166.00	2,576.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	13,608.00	0.00	IMPL DEV CHARGE PATIENTS	13,442.50	395.00
LITHOTRIPSY	58,750.00	0.00	NO CC/INVALID REV CODE	0.00	52.00
OTHER IMAGING SERVICE	84,960.00	2,030.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,846.00	610.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	116,113.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	55,260.00	1,296.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,313.00	98.00			
			TOTAL ANCILLARY	4,775,512.90	314,046.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,775,512.90	314,046.99

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:53:32  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5912348001124	10/12/12 - 10/12/12	12/17/12	0.00	52.00	0.00	0.00	0.00
TOTAL				0.00	52.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 09:54:12  
Page: 7

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,194.58	ADJUSTMENTS	0.00
COVERED CHARGES	9,154.58	CONTRACTUAL ALLOW	7,537.57
NON-COVERD CHARGES	40.00	TOTAL MEDICAID LIAB	1,617.01
		LESS: COB	1,605.18
		LESS: COPAYMENT	11.83
		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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	218.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	116.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,924.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,006.08	0.00	FEE SCHEDULE LAB	1,491.00	40.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	730.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,669.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,154.58	40.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,154.58	40.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	257,317.08	ADJUSTMENTS	470.00
COVERED CHARGES	250,812.08	CONTRACTUAL ALLOW	233,612.08
NON-COVERD CHARGES	6,505.00	TOTAL MEDICAID LIAB	17,200.00
		LESS: COB	0.00
		LESS: COPAYMENT	702.01
		REIMBURSEMENT	16,497.99
		TOTAL NUMBER OF CLAIMS	344

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,118.48	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,322.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,075.00	535.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,170.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	52,700.00	3,906.00
EKG/ECG	1,840.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	15,840.00	2,064.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,310.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	125,168.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,567.60	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	4,701.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	250,812.08	6,505.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	250,812.08	6,505.00



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSPITAL  
200 ALLEN MEMORIAL DR  
BREMEN,GA 30110-2012

PROVIDER NUMBER  
000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	419.50	ADJUSTMENTS	0.00
COVERED CHARGES	419.50	CONTRACTUAL ALLOW	354.74
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	64.76
		LESS: COB	61.76
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HIGGINS GENERAL HOSPITAL  
 200 ALLEN MEMORIAL DR  
 BREMEN,GA 30110-2012

PROVIDER NUMBER  
 000000954A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	38.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	376.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	419.50	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	419.50	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	92,482.97	ADJUSTMENTS	4,651.20
COVERED CHARGES	90,554.97	CONTRACTUAL ALLOW	76,601.37
NON-COVERD CHARGES	1,928.00	TOTAL MEDICAID LIAB	13,953.60
		LESS: COB	0.00
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	13,863.60

TOTAL NUMBER OF CLAIMS 3

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,878.39	0.00	OTHER LAB	1,069.00	0.00
MED/SURG SUPPLY	4,641.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	213.00	213.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,398.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,764.00	749.00
EKG/ECG	230.00	230.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,193.00	736.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	23,152.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	241.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	740.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,288.58	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,165.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,578.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	780.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,224.00	0.00			
			TOTAL ANCILLARY	90,554.97	1,928.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	90,554.97	1,928.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,881,255.71	ADJUSTMENTS	1,400,685.06
COVERED CHARGES	26,338,084.48	CONTRACTUAL ALLOW	17,045,413.71
NON-COVERD CHARGES	1,543,171.23	TOTAL MEDICAID LIAB	9,292,670.77
		LESS: COB	108,726.45
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	9,183,944.32

TOTAL NUMBER OF ADMISSIONS 1,424

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,780		13	3,662,748.00		1,056,249.00
ROUTINE NURSERY	465		12	261,262.00		7,130.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6,245		25	3,924,010.00		1,063,379.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	956		0	1,330,674.00		102,546.00
NICU	7		0	13,272.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	963		0	1,343,946.00		102,546.00
TOTAL ACCOMODATIONS	7,208		25	5,267,956.00		1,165,925.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,814,091.79	67,619.02	OTHER LAB	197,939.00	0.00
MED/SURG SUPPLY	321,338.98	13,222.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,683,604.62	57,879.95	EDUCATION & TRAINING	254.00	0.00
RADIOLOGY-DIAGNOSTIC	625,471.00	10,914.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,029,610.81	26,001.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	282,377.02	11,603.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	447,515.73	2,682.00	MRI SERVICES	492,155.00	0.00
IV THERAPY	20,086.00	824.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,382,608.55	32,762.27	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	816,836.00	11,919.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	973,713.14	65,368.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	197,769.00	1,078.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,099,451.95	4,075.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	215,109.00	3,318.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	90,174.66	340.40	INJECTABLE DRUGS	114.66	0.00
RADIOLOGY THERAPEUTIC	8,664.00	341.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	60,964.03	978.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	92,775.00	3,882.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,716.00	1,872.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	9,900.00	0.00	IMPL DEV CHARGE PATIENTS	255,021.41	637.92
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	23,429.00
OTHER IMAGING SERVICE	225,649.86	8,871.00			
BLOOD	3,331.00	0.00			
BLOOD STORAGE & PRO.	254,238.78	9,570.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	117,073.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,089,536.13	5,271.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	153,206.00	10,027.00			
ORGAN ACQUISITION	3,395.00	0.00			
TREATMENT/OBSERV. RM	102,437.36	2,760.93			
			TOTAL ANCILLARY	21,070,128.48	377,246.23
			TOTAL ACCOMODATIONS	5,267,956.00	1,165,925.00
			TOTAL CHARGES	26,338,084.48	1,543,171.23

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 10:05:38  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9113198001926	03/01/13 - 03/07/13	09/23/13	0.00	3,395.00	0.00	1,092.06	0.00
615	9114006007361	06/22/13 - 06/25/13	02/24/14	0.00	3,395.00	0.00	1,691.43	0.00
615	9114017005578	10/14/13 - 10/20/13	03/10/14	0.00	3,059.00	0.00	6,456.10	0.00
615	2014091057328	12/31/13 - 01/03/14	04/07/14	0.00	3,395.00	0.00	180.00	0.00
615	9114052004076	06/07/13 - 06/11/13	04/07/14	0.00	3,395.00	0.00	1,605.25	0.00
615	9114092001358	05/28/13 - 05/31/13	05/12/14	0.00	3,395.00	0.00	1,043.78	0.00
615	2014136045291	12/15/13 - 12/20/13	05/19/14	0.00	3,395.00	0.00	300.00	0.00
TOTAL				0.00	23,429.00	0.00	12,368.62	0.00



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,269.94	ADJUSTMENTS	0.00
COVERED CHARGES	66,269.94	CONTRACTUAL ALLOW	29,354.60
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	36,915.34
		LESS: COB	36,915.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	7

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	26		0	16,614.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	26		0	16,614.00		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	26		0	16,614.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HOUSTON MEDICAL CENTER  
 1601 WATSON BLVD  
 WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER  
 000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,960.05	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	523.49	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,889.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,246.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,522.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	298.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,508.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,402.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,731.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,155.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	421.00	0.00			
			TOTAL ANCILLARY	49,655.94	0.00
			TOTAL ACCOMODATIONS	16,614.00	0.00
			TOTAL CHARGES	66,269.94	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,405,681.12	ADJUSTMENTS	784,289.07
COVERED CHARGES	14,831,113.39	CONTRACTUAL ALLOW	11,718,624.92
NON-COVERD CHARGES	1,574,567.73	TOTAL MEDICAID LIAB	3,112,488.47
		LESS: COB	17,334.10
		LESS: COPAYMENT	10,066.52
		REIMBURSEMENT	3,085,087.85
		ALL OTHER	2,463,856.60
		FEE SCHEDULE-LAB	279,068.35
		INJECTABLE DRUGS	342,162.90

TOTAL NUMBER OF CLAIMS 7,254

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	217,510.77	5,293.20	OTHER LAB	227,179.00	4,960.00
MED/SURG SUPPLY	160,863.61	8,123.38	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	80.00	EDUCATION & TRAINING	2,116.00	254.00
RADIOLOGY-DIAGNOSTIC	814,823.76	21,420.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,099,308.54	158,444.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,219.00	39,319.15	FEE SCHEDULE LAB	2,972,604.60	697,050.02
EKG/ECG	294,478.00	17,880.00	MRI SERVICES	381,160.00	12,953.00
IV THERAPY	256,815.00	22,230.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,855,729.40	162,186.10	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,263.00	13,216.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	226,317.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,260,402.86	31,666.18	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	409,343.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	961,220.89	178,001.90
RADIOLOGY THERAPEUTIC	38,838.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,407.00	7,860.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,071.00	3,259.20	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,941.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	22,939.92	4,194.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,200.00	0.00	IMPL DEV CHARGE PATIENTS	64,958.19	18,633.51
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	536,396.03	103,538.43			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	56,646.62	4,805.93			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	191,670.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	349,383.20	53,521.15			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	34,619.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	278,630.00	3,737.58			
			TOTAL ANCILLARY	14,831,113.39	1,574,567.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,831,113.39	1,574,567.73

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5014003961003	09/10/13 - 01/01/00	01/13/14	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOUSTON MEDICAL CENTER  
1601 WATSON BLVD  
WARNER ROBINS,GA 31093-3431

PROVIDER NUMBER  
000000976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	464,993.74	ADJUSTMENTS	0.00
COVERED CHARGES	371,782.87	CONTRACTUAL ALLOW	147,863.56
NON-COVERD CHARGES	93,210.87	TOTAL MEDICAID LIAB	223,919.31
		LESS: COB	223,647.30
		LESS: COPAYMENT	272.01
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 270

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,436.79	402.40	OTHER LAB	11,667.00	0.00
MED/SURG SUPPLY	2,311.27	271.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	254.00	0.00
RADIOLOGY-DIAGNOSTIC	24,034.92	1,013.00	OTHER THERAPEUTIC SVC	0.00	83.00
CT SCAN	35,528.00	23,619.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	435.00	0.00	FEE SCHEDULE LAB	114,701.57	33,272.27
EKG/ECG	6,854.00	0.00	MRI SERVICES	7,973.00	0.00
IV THERAPY	6,096.00	246.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,654.08	18,280.05	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	916.00	237.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,448.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	59,732.00	1,964.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,377.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,413.70	8,772.97
RADIOLOGY THERAPEUTIC	914.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	499.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,068.85	124.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	300.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	300.84
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,846.36	4,126.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,997.62	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,175.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,173.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,496.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,979.71	0.00			

TOTAL ANCILLARY	371,782.87	93,210.87
TOTAL ACCOMODATIONS	0.00	0.00
TOTAL CHARGES	371,782.87	93,210.87

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: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	448,817.43	ADJUSTMENTS	2,135.60
COVERED CHARGES	423,223.73	CONTRACTUAL ALLOW	393,407.72
NON-COVERD CHARGES	25,593.70	TOTAL MEDICAID LIAB	29,816.01
		LESS: COB	0.00
		LESS: COPAYMENT	939.07
		REIMBURSEMENT	28,876.94
		TOTAL NUMBER OF CLAIMS	533



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,326.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	248.04	95.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	33,956.00	408.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,965.00	4,579.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	77,849.86	16,177.50
EKG/ECG	13,112.00	0.00	MRI SERVICES	6,183.00	0.00
IV THERAPY	4,348.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	228.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	439.00	172.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	247,305.00	887.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,451.90	1,307.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	151.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,181.00	1,816.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,630.08	0.00			
			TOTAL ANCILLARY	423,223.73	25,593.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	423,223.73	25,593.70

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	46,800.99	ADJUSTMENTS	0.00
COVERED CHARGES	36,885.15	CONTRACTUAL ALLOW	16,744.93
NON-COVERD CHARGES	9,915.84	TOTAL MEDICAID LIAB	20,140.22
		LESS: COB	20,122.22
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 23

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	141.86	0.00	OTHER LAB	860.00	0.00
MED/SURG SUPPLY	12.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,236.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,879.00	2,410.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,651.73	2,706.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	2,788.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,596.00	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	446.46	199.84
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	455.00	1,812.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	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	1,189.10	0.00			
			TOTAL ANCILLARY	36,885.15	9,915.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,885.15	9,915.84

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	348,217.76	ADJUSTMENTS	34,795.34
COVERED CHARGES	331,106.81	CONTRACTUAL ALLOW	220,969.68
NON-COVERD CHARGES	17,110.95	TOTAL MEDICAID LIAB	110,137.13
		LESS: COB	0.00
		LESS: COPAYMENT	174.00
		REIMBURSEMENT	109,963.13
		TOTAL NUMBER OF CLAIMS	22

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,507.35	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	358.52	79.18	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	512.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,139.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,054.70	2,863.00
EKG/ECG	1,490.00	596.00	MRI SERVICES	11,370.00	0.00
IV THERAPY	3,552.00	1,107.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,254.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,974.00	231.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,116.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	241,762.75	12,160.77
RADIOLOGY THERAPEUTIC	17,060.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	480.47	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	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	16,999.14	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	3,192.08	74.00			
			TOTAL ANCILLARY	331,106.81	17,110.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	331,106.81	17,110.95

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

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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,303.70	ADJUSTMENTS	0.00
COVERED CHARGES	25,268.11	CONTRACTUAL ALLOW	6,092.31
NON-COVERD CHARGES	35.59	TOTAL MEDICAID LIAB	19,175.80
		LESS: COB	19,175.80
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	409.97	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	354.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	114.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,518.90	35.59
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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	74.00	0.00			
			TOTAL ANCILLARY	25,268.11	35.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,268.11	35.59

\*\* END OF REPORT \*\*

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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,004,907.57	ADJUSTMENTS	203,589.44
COVERED CHARGES	1,881,605.17	CONTRACTUAL ALLOW	863,440.59
NON-COVERD CHARGES	123,302.40	TOTAL MEDICAID LIAB	1,018,164.58
		LESS: COB	2,340.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,015,824.27

TOTAL NUMBER OF ADMISSIONS 313

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	609		0	303,400.00		79,900.00
ROUTINE NURSERY	240		0	120,000.00		20,845.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	849		0	423,400.00		100,745.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	849		0	423,400.00		100,745.00



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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	269,412.36	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	142,668.56	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	169,171.92	0.00	EDUCATION & TRAINING	1,344.75	0.00
RADIOLOGY-DIAGNOSTIC	13,235.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,000.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,239.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,668.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	458,543.48	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	167,780.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,962.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	20,686.81	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,675.00	0.00	SPECIAL SERVICES	0.00	300.00
RECOVERY ROOM	25,744.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	8,493.86	0.00	INJECTABLE DRUGS	33,476.76	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,722.92	0.00			
BLOOD	0.00	12,272.40			
BLOOD STORAGE & PRO.	0.00	5,350.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	4,635.00			
CARDIOLOGY	7,978.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,100.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	300.00	0.00			
			TOTAL ANCILLARY	1,458,205.17	22,557.40
			TOTAL ACCOMODATIONS	423,400.00	100,745.00
			TOTAL CHARGES	1,881,605.17	123,302.40

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

IRWIN COUNTY HOSPITAL  
710 N IRWIN AVE  
OCILLA,GA 31774-5011

PROVIDER NUMBER  
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,341,375.74	ADJUSTMENTS	70,537.56
COVERED CHARGES	2,169,785.07	CONTRACTUAL ALLOW	1,668,894.94
NON-COVERD CHARGES	171,590.67	TOTAL MEDICAID LIAB	500,890.13
		LESS: COB	0.00
		LESS: COPAYMENT	1,464.00
		REIMBURSEMENT	499,426.13
		ALL OTHER	446,252.66
		FEE SCHEDULE-LAB	51,302.54
		INJECTABLE DRUGS	1,870.93
		TOTAL NUMBER OF CLAIMS	1,020

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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	147,685.37	0.00	OTHER LAB	3,593.20	0.00
MED/SURG SUPPLY	80,276.69	1,507.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	53.79	1,721.28
RADIOLOGY-DIAGNOSTIC	51,262.51	779.78	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,621.00	7,748.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	287,766.20	83,538.59
EKG/ECG	33,449.00	4,134.00	MRI SERVICES	17,706.78	0.00
IV THERAPY	168,200.00	10,834.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	863,996.98	36,485.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	27,067.73	1,066.51	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,759.71	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	133,550.00	725.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	44,192.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,003.40	300.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	950.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,104.00	5,390.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	84.90
OTHER IMAGING SERVICE	88,193.71	6,771.00			
BLOOD	0.00	3,374.91			
BLOOD STORAGE & PRO.	0.00	1,100.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,782.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	32,600.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	103,921.00	4,580.00			
			TOTAL ANCILLARY	2,169,785.07	171,090.67
			TOTAL ACCOMODATIONS	0.00	500.00
			TOTAL CHARGES	2,169,785.07	171,590.67

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:03:49  
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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 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8830	2213172009804	05/15/13 - 05/15/13	06/24/13	0.00	84.90	0.00	0.00	0.00
TOTAL				0.00	84.90	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 10:04:03  
Page: 7

SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

IRWIN COUNTY HOSPITAL  
710 N IRWIN AVE  
OCILLA,GA 31774-5011

PROVIDER NUMBER  
000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	983.31	ADJUSTMENTS	0.00
COVERED CHARGES	660.06	CONTRACTUAL ALLOW	476.37
NON-COVERD CHARGES	323.25	TOTAL MEDICAID LIAB	183.69
		LESS: COB	183.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 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	660.06	323.25
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	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	660.06	323.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	660.06	323.25

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:04:04  
Page: 9

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 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,651.81	ADJUSTMENTS	0.00
COVERED CHARGES	74,109.01	CONTRACTUAL ALLOW	67,340.27
NON-COVERD CHARGES	3,542.80	TOTAL MEDICAID LIAB	6,768.74
		LESS: COB	0.00
		LESS: COPAYMENT	189.00
		REIMBURSEMENT	6,579.74
		TOTAL NUMBER OF CLAIMS	121



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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,223.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	151.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	107.58
RADIOLOGY-DIAGNOSTIC	4,731.76	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,604.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,989.38	1,631.22
EKG/ECG	477.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,730.00	200.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,800.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,800.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	511.87	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	1,167.90	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,526.00	0.00			
			TOTAL ANCILLARY	74,109.01	3,542.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	74,109.01	3,542.80

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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Page: 11

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 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	872.27	ADJUSTMENTS	0.00
COVERED CHARGES	787.32	CONTRACTUAL ALLOW	320.33
NON-COVERD CHARGES	84.95	TOTAL MEDICAID LIAB	466.99
		LESS: COB	466.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 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	29.89	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	267.43	84.95
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	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	450.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	787.32	84.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	787.32	84.95

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,374.09	ADJUSTMENTS	0.00
COVERED CHARGES	49,749.82	CONTRACTUAL ALLOW	39,777.78
NON-COVERD CHARGES	624.27	TOTAL MEDICAID LIAB	9,972.04
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	9,960.04
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL  
 710 N IRWIN AVE  
 OCILLA,GA 31774-5011

PROVIDER NUMBER  
 000000987A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,022.29	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,715.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	53.79
RADIOLOGY-DIAGNOSTIC	368.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,292.37	411.48
EKG/ECG	1,063.00	159.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,015.94	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	480.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	812.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	345.21	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,635.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	49,749.82	624.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	49,749.82	624.27

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

IRWIN COUNTY HOSPITAL  
710 N IRWIN AVE  
OCILLA,GA 31774-5011

PROVIDER NUMBER  
000000987A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	12/01/12	THROUGH	11/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 10:03:23  
 Page: 1

JASPER MEMORIAL HOSP  
 898 COLLEGE ST  
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER 000000998A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,685.82	ADJUSTMENTS	0.00
COVERED CHARGES	8,455.82	CONTRACTUAL ALLOW	-40.72
NON-COVERD CHARGES	230.00	TOTAL MEDICAID LIAB	8,496.54
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,496.54

TOTAL NUMBER OF ADMISSIONS 2

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	1,828.75		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	1,828.75		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	1,828.75		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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,183.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,319.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	899.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	208.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	458.22	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	498.69	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	58.84	230.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,627.07	230.00
			TOTAL ACCOMODATIONS	1,828.75	0.00
			TOTAL CHARGES	8,455.82	230.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:03:24  
Page: 4

JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	308,942.72	ADJUSTMENTS	7,827.76
COVERED CHARGES	256,519.41	CONTRACTUAL ALLOW	127,417.78
NON-COVERD CHARGES	52,423.31	TOTAL MEDICAID LIAB	129,101.63
		LESS: COB	36.06
		LESS: COPAYMENT	741.00
		REIMBURSEMENT	128,324.57
		ALL OTHER	113,850.16
		FEE SCHEDULE-LAB	12,316.07
		INJECTABLE DRUGS	2,158.34

TOTAL NUMBER OF CLAIMS 625

JASPER MEMORIAL HOSP  
 898 COLLEGE ST  
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
 000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,606.86	0.00	OTHER LAB	1,578.20	0.00
MED/SURG SUPPLY	4,139.41	26.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,778.72	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	22,892.03	14,779.39	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	94,776.38	32,012.25
EKG/ECG	3,410.27	100.97	MRI SERVICES	9,223.85	0.00
IV THERAPY	6,430.98	729.52	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,046.32	170.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	70,999.83	827.84	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	6,717.67	2,771.18
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	7,406.72	526.94	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	1,681.41	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	978.14	478.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,461.05	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	391.57	0.00			
			TOTAL ANCILLARY	256,519.41	52,423.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	256,519.41	52,423.31

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

JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50.00	ADJUSTMENTS	0.00
COVERED CHARGES	50.00	CONTRACTUAL ALLOW	48.84
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1.16
		LESS: COB	0.00
		LESS: COPAYMENT	1.16
		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

JASPER MEMORIAL HOSP  
 898 COLLEGE ST  
 MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
 000000998A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	50.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	50.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	50.00	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,723.30	ADJUSTMENTS	144.00
COVERED CHARGES	28,183.53	CONTRACTUAL ALLOW	24,083.53
NON-COVERD CHARGES	1,539.77	TOTAL MEDICAID LIAB	4,100.00
		LESS: COB	0.00
		LESS: COPAYMENT	129.00
		REIMBURSEMENT	3,971.00
		TOTAL NUMBER OF CLAIMS	82

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	151.69	11.44	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	284.92	7.23	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,060.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,734.21	988.95
EKG/ECG	504.85	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	680.48	161.81	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	202.32	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	17,762.43	120.62	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,024.15	249.72
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	777.67	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,183.53	1,539.77
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,183.53	1,539.77

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:03:33  
Page: 10

JASPER MEMORIAL HOSP  
898 COLLEGE ST  
MONTICELLO,GA 31064-1258

PROVIDER NUMBER  
000000998A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:03:33  
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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	10/01/12	THROUGH	09/30/13
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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	995,112.80	ADJUSTMENTS	11,655.19
COVERED CHARGES	979,963.80	CONTRACTUAL ALLOW	613,763.12
NON-COVERD CHARGES	15,149.00	TOTAL MEDICAID LIAB	366,200.68
		LESS: COB	5,491.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	360,708.86

TOTAL NUMBER OF ADMISSIONS 63

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	207		0	93,150.00		10,125.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	207		0	93,150.00		10,125.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	53		0	53,000.00		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	53		0	53,000.00		0.00
TOTAL ACCOMODATIONS	260		0	146,150.00		10,125.00

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

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	340,167.30	0.00	OTHER LAB	5,050.00	0.00
MED/SURG SUPPLY	125,507.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	123,886.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,981.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,460.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,504.00	0.00	MRI SERVICES	5,600.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,983.00	1,678.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	67,464.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,573.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,476.00	1,430.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,266.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,267.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,235.50	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	2,400.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,605.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,800.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,311.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,278.00	1,916.00			
			TOTAL ANCILLARY	833,813.80	5,024.00
			TOTAL ACCOMODATIONS	146,150.00	10,125.00
			TOTAL CHARGES	979,963.80	15,149.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:44:44  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:44:45  
Page: 4

JEFF DAVIS HOSPITAL  
163 S TALLAHASSEE ST  
HAZLEHURST,GA 31539-6465

PROVIDER NUMBER  
000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,253,168.95	ADJUSTMENTS	9,993.66
COVERED CHARGES	1,111,288.60	CONTRACTUAL ALLOW	775,361.18
NON-COVERD CHARGES	141,880.35	TOTAL MEDICAID LIAB	335,927.42
		LESS: COB	0.00
		LESS: COPAYMENT	1,038.00
		REIMBURSEMENT	334,889.42
		ALL OTHER	300,533.71
		FEE SCHEDULE-LAB	32,161.00
		INJECTABLE DRUGS	2,194.71

TOTAL NUMBER OF CLAIMS 1,226

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	55,034.60	693.40	OTHER LAB	27,282.00	0.00
MED/SURG SUPPLY	99,563.00	10.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	210.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	85,527.00	6,818.00	OTHER THERAPEUTIC SVC	0.00	68.00
CT SCAN	202,644.00	13,446.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	259,049.00	63,155.00
EKG/ECG	13,888.00	1,344.00	MRI SERVICES	32,600.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,186.00	2,256.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,779.00	8,958.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,975.00	2,476.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	188,686.00	2,215.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,455.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,750.00	30,994.95
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	4,200.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,800.00
OTHER IMAGING SERVICE	21,762.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,875.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,800.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,187.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,046.00	7,436.00			
			TOTAL ANCILLARY	1,111,288.60	141,880.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,111,288.60	141,880.35

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: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012306074946	10/28/12 - 10/28/12	11/05/12	0.00	1,800.00	0.00	0.00	0.00
TOTAL				0.00	1,800.00	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 12:45:06  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,227.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,829.00	CONTRACTUAL ALLOW	2,968.57
NON-COVERD CHARGES	1,398.00	TOTAL MEDICAID LIAB	6,860.43
		LESS: COB	6,860.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFF DAVIS HOSPITAL  
 163 S TALLAHASSEE ST  
 HAZLEHURST,GA 31539-6465

PROVIDER NUMBER  
 000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	388.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	389.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,776.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,676.00	923.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	1,445.00	95.00	SPECIAL SERVICES	0.00	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	50.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	330.00			
			TOTAL ANCILLARY	9,829.00	1,398.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,829.00	1,398.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	107,106.25	ADJUSTMENTS	97.00
COVERED CHARGES	105,301.25	CONTRACTUAL ALLOW	94,771.25
NON-COVERD CHARGES	1,805.00	TOTAL MEDICAID LIAB	10,530.00
		LESS: COB	0.00
		LESS: COPAYMENT	393.03
		REIMBURSEMENT	10,136.97
		TOTAL NUMBER OF CLAIMS	211

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

JEFF DAVIS HOSPITAL  
 163 S TALLAHASSEE ST  
 HAZLEHURST,GA 31539-6465

PROVIDER NUMBER  
 000001009A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,652.00	30.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,898.00	165.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,131.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,974.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,795.00	799.00
EKG/ECG	560.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	981.00	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	60,199.00	229.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,692.25	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	419.00	32.00			
			TOTAL ANCILLARY	105,301.25	1,805.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	105,301.25	1,805.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,285.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,285.00	CONTRACTUAL ALLOW	569.53
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	715.47
		LESS: COB	715.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:45:10  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	118.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	165.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	481.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	493.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,285.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,285.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 12:45:10  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:44:05  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

JEFFERSON HOSPITAL  
 1067 PEACHTREE ST  
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER 000001031A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	354,121.90	ADJUSTMENTS	11,436.23
COVERED CHARGES	349,941.90	CONTRACTUAL ALLOW	90,855.34
NON-COVERD CHARGES	4,180.00	TOTAL MEDICAID LIAB	259,086.56
		LESS: COB	622.31
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	258,464.25

TOTAL NUMBER OF ADMISSIONS 46

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	160		0	63,600.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	160		0	63,600.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	160		0	63,600.00		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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,621.50	0.00	OTHER LAB	464.00	0.00
MED/SURG SUPPLY	35,340.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	68,354.00	0.00	EDUCATION & TRAINING	125.90	0.00
RADIOLOGY-DIAGNOSTIC	9,430.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,000.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	996.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	10,412.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,609.00	791.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	26,941.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	374.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,584.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	34,804.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	739.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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	2,801.00	0.00			
BLOOD STORAGE & PRO.	1,809.00	3,389.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,618.75	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	20.00	0.00			
			TOTAL ANCILLARY	286,341.90	4,180.00
			TOTAL ACCOMODATIONS	63,600.00	0.00
			TOTAL CHARGES	349,941.90	4,180.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:44:07  
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JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	778,679.95	ADJUSTMENTS	19,285.48
COVERED CHARGES	672,885.00	CONTRACTUAL ALLOW	432,529.54
NON-COVERD CHARGES	105,794.95	TOTAL MEDICAID LIAB	240,355.46
		LESS: COB	330.14
		LESS: COPAYMENT	1,767.63
		REIMBURSEMENT	238,257.69
		ALL OTHER	195,759.79
		FEE SCHEDULE-LAB	40,458.40
		INJECTABLE DRUGS	2,039.50
		TOTAL NUMBER OF CLAIMS	1,490

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 12:44:07  
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JEFFERSON HOSPITAL  
 1067 PEACHTREE ST  
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,619.00	2,531.00	OTHER LAB	15,679.50	0.00
MED/SURG SUPPLY	19,496.50	162.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	62.95
RADIOLOGY-DIAGNOSTIC	46,737.00	2,439.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	40,964.00	16,339.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	633.00	1,126.00	FEE SCHEDULE LAB	204,141.00	50,488.00
EKG/ECG	14,087.50	3,699.00	MRI SERVICES	0.00	0.00
IV THERAPY	835.00	1,727.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	35,638.50	4,601.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,717.00	3,407.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,344.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	175,912.00	9,744.00	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	9,952.00	4,852.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,954.00	82.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	29,745.00	1,453.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,956.00	317.00			
BLOOD	4,232.00	0.00			
BLOOD STORAGE & PRO.	1,206.00	1,827.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,900.00	937.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,136.00	0.00			
			TOTAL ANCILLARY	672,885.00	105,794.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	672,885.00	105,794.95

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	928.00	ADJUSTMENTS	0.00
COVERED CHARGES	824.00	CONTRACTUAL ALLOW	579.00
NON-COVERD CHARGES	104.00	TOTAL MEDICAID LIAB	245.00
		LESS: COB	245.00
		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

JEFFERSON HOSPITAL  
 1067 PEACHTREE ST  
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	60.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	225.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	267.00	44.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	170.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	162.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	824.00	104.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	824.00	104.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:44:32  
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JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,292.25	ADJUSTMENTS	329.64
COVERED CHARGES	69,646.50	CONTRACTUAL ALLOW	60,696.10
NON-COVERD CHARGES	6,645.75	TOTAL MEDICAID LIAB	8,950.40
		LESS: COB	0.00
		LESS: COPAYMENT	195.00
		REIMBURSEMENT	8,755.40
		TOTAL NUMBER OF CLAIMS	160



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,380.00	74.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	858.50	26.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,867.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,224.00	1,930.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,149.00	1,294.00
EKG/ECG	566.50	244.50	MRI SERVICES	0.00	0.00
IV THERAPY	1,069.00	330.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	814.50	41.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,922.00	783.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,919.00	1,923.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	877.00	0.00			
			TOTAL ANCILLARY	69,646.50	6,645.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	69,646.50	6,645.75

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSPITAL  
1067 PEACHTREE ST  
LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,891.25	ADJUSTMENTS	0.00
COVERED CHARGES	11,675.25	CONTRACTUAL ALLOW	6,840.60
NON-COVERD CHARGES	216.00	TOTAL MEDICAID LIAB	4,834.65
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,831.65

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

JEFFERSON HOSPITAL  
 1067 PEACHTREE ST  
 LOUISVILLE,GA 30434-1558

PROVIDER NUMBER  
 000001031A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	267.00	117.00	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	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,461.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	632.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23.00	99.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,675.25	216.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,675.25	216.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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Page: 13

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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:43:27  
 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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	147,311.68	ADJUSTMENTS	0.00
COVERED CHARGES	125,326.26	CONTRACTUAL ALLOW	28,886.08
NON-COVERD CHARGES	21,985.42	TOTAL MEDICAID LIAB	96,440.18
		LESS: COB	3,048.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	93,391.19

TOTAL NUMBER OF ADMISSIONS 21

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	49		0	36,701.00		19,021.92
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	49		0	36,701.00		19,021.92
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	49		0	36,701.00		19,021.92

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,441.60	0.00	OTHER LAB	2,520.10	0.00
MED/SURG SUPPLY	8,160.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,889.56	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,510.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,372.20	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	2,126.55	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,362.80	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,663.30	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	5,589.10	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	1,231.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,660.80	2,963.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	979.55	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,392.60	0.00			
			TOTAL ANCILLARY	88,625.26	2,963.50
			TOTAL ACCOMODATIONS	36,701.00	19,021.92
			TOTAL CHARGES	125,326.26	21,985.42

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:43:29  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,606,390.37	ADJUSTMENTS	8,685.40
COVERED CHARGES	1,521,977.90	CONTRACTUAL ALLOW	1,037,184.70
NON-COVERD CHARGES	84,412.47	TOTAL MEDICAID LIAB	484,793.20
		LESS: COB	70.46
		LESS: COPAYMENT	1,467.00
		REIMBURSEMENT	483,255.74
		ALL OTHER	325,895.53
		FEE SCHEDULE-LAB	157,360.21
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	1,978

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	70,394.48	3,214.65	OTHER LAB	34,877.77	1,000.00
MED/SURG SUPPLY	12,654.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,345.64	330.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,635.75	9,163.40	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,079.15	7,734.44	FEE SCHEDULE LAB	531,510.39	49,854.10
EKG/ECG	17,643.15	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	13,420.29	1,259.88	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	549,486.63	6,042.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,718.30	2,356.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	142,729.45	126.25	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,435.30	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,029.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,660.80	2,178.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,329.75	979.55			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,026.80	0.00			
			TOTAL ANCILLARY	1,521,977.90	84,412.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,521,977.90	84,412.47

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

JENKINS COUNTY HOSPITAL  
931 E WINTHROPE AVE  
MILLEN,GA 30442-1839

PROVIDER NUMBER  
000001042A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,148.72	ADJUSTMENTS	0.00
COVERED CHARGES	25,136.72	CONTRACTUAL ALLOW	22,296.96
NON-COVERD CHARGES	12.00	TOTAL MEDICAID LIAB	2,839.76
		LESS: COB	2,821.76
		LESS: COPAYMENT	18.00
		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

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	405.45	0.00	OTHER LAB	1,167.88	0.00
MED/SURG SUPPLY	45.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,596.04	12.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	197.58	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,463.32	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	639.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	504.10	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,136.72	12.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,136.72	12.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	79,908.74	ADJUSTMENTS	0.00
COVERED CHARGES	77,036.75	CONTRACTUAL ALLOW	69,186.75
NON-COVERD CHARGES	2,871.99	TOTAL MEDICAID LIAB	7,850.00
		LESS: COB	0.00
		LESS: COPAYMENT	327.00
		REIMBURSEMENT	7,523.00
		TOTAL NUMBER OF CLAIMS	157

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,338.30	373.15	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	721.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,924.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,686.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	348.96	0.00	FEE SCHEDULE LAB	9,591.60	1,921.37
EKG/ECG	862.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,463.19	184.77	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	709.50	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	47,811.35	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	504.10	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	2,074.80	0.00			
			TOTAL ANCILLARY	77,036.75	2,871.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	77,036.75	2,871.99

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:43:57  
Page: 10

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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:43:57  
Page: 11

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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 12:43:58  
Page: 12

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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HUTCHESON MEDICAL CENTER  
 100 GROSS CRESCENT CIR  
 FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER 000001075A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,150,414.07	ADJUSTMENTS	322,008.79
COVERED CHARGES	6,933,020.29	CONTRACTUAL ALLOW	4,511,005.65
NON-COVERD CHARGES	217,393.78	TOTAL MEDICAID LIAB	2,422,014.64
		LESS: COB	19,051.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,402,962.71

TOTAL NUMBER OF ADMISSIONS 330

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	992		10	701,938.45		77,186.95
ROUTINE NURSERY	145		2	83,641.00		12,674.85
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,137		12	785,579.45		89,861.80
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	274		0	393,435.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	274		0	393,435.00		0.00
TOTAL ACCOMODATIONS	1,411		12	1,179,014.45		89,861.80

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,511,942.38	0.00	OTHER LAB	20,936.26	0.00
MED/SURG SUPPLY	394,727.68	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,176,606.21	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	123,487.69	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	91,268.19	101,091.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	34,713.52	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	66,741.76	0.00	MRI SERVICES	43,540.62	0.00
IV THERAPY	168,782.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	343,564.48	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	76,234.10	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	904,127.66	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	28,011.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	19,283.36	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	297,212.79	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	54,175.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	11,355.43	0.00	INJECTABLE DRUGS	12,653.09	0.00
RADIOLOGY THERAPEUTIC	7,380.88	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,050.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,572.00	11,811.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	348.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,769.78	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,098.89	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	59,116.20	501.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	33,296.58	14,128.00			
AUDIOLOGY	2,330.00	0.00			
CARDIOLOGY	112,469.18	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,553.30	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	89,655.65	0.00			
			TOTAL ANCILLARY	5,754,005.84	127,531.98
			TOTAL ACCOMODATIONS	1,179,014.45	89,861.80
			TOTAL CHARGES	6,933,020.29	217,393.78

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:04:19  
 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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,003.60	ADJUSTMENTS	0.00
COVERED CHARGES	40,125.47	CONTRACTUAL ALLOW	15,993.15
NON-COVERD CHARGES	1,878.13	TOTAL MEDICAID LIAB	24,132.32
		LESS: COB	24,132.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	6,830.00		614.70
ROUTINE NURSERY	2		0	954.50		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	7,784.50		614.70
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	12		0	7,784.50		614.70

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,599.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,570.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,666.18	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	224.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,263.43	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	357.04	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,679.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,599.43	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,589.60	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	465.59	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,769.72	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,766.75	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	54.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,340.97	1,263.43
			TOTAL ACCOMODATIONS	7,784.50	614.70
			TOTAL CHARGES	40,125.47	1,878.13

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:04:20  
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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,665,979.15	ADJUSTMENTS	686,307.69
COVERED CHARGES	9,949,806.40	CONTRACTUAL ALLOW	7,878,508.33
NON-COVERD CHARGES	716,172.75	TOTAL MEDICAID LIAB	2,071,298.07
		LESS: COB	1,931.81
		LESS: COPAYMENT	8,867.13
		REIMBURSEMENT	2,060,499.13
		ALL OTHER	1,589,451.29
		FEE SCHEDULE-LAB	132,625.52
		INJECTABLE DRUGS	338,422.32

TOTAL NUMBER OF CLAIMS 5,533

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	617,913.01	4,421.21	OTHER LAB	77,818.78	5,397.42
MED/SURG SUPPLY	237,856.42	1,712.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	289.72	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	304,316.22	5,758.79	OTHER THERAPEUTIC SVC	0.00	942.00
CT SCAN	568,758.40	21,812.62	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	69,027.15	16,387.02	FEE SCHEDULE LAB	1,237,206.33	286,063.14
EKG/ECG	143,958.04	9,150.08	MRI SERVICES	71,055.80	3,767.68
IV THERAPY	531,120.68	87,123.90	PROFESSIONAL FEES	0.00	51.00
OPERATING ROOM	393,433.92	82,546.26	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	70,164.85	12,554.46	FREE STANDING CLINIC	0.00	628.00
ANESTHESIA	68,825.84	237.00	AMBULANCE	0.00	0.00
GI SERVICES	34,612.92	9,721.08	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,566,034.81	15,454.92	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	155,214.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,252,646.36	47,644.38
RADIOLOGY THERAPEUTIC	728,719.66	11,856.08	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,393.00	156.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	437.00	1,134.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	132,259.95	5,761.38	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,883.82	5,279.45
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	80,382.50	13,574.32			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	95,702.96	22,644.32			
ONCOLOGY	86.60	0.00			
NUCLEAR MEDICINE	146,473.46	29,650.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	177,984.47	6,169.70			
AMBULATORY SURGERY	55,860.35	3,409.29			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,069.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	91,588.56	4,875.53			
			TOTAL ANCILLARY	9,949,806.40	716,172.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,949,806.40	716,172.75

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 10:05:10  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HUTCHESON MEDICAL CENTER  
100 GROSS CRESCENT CIR  
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	159,096.34	ADJUSTMENTS	0.00
COVERED CHARGES	143,301.56	CONTRACTUAL ALLOW	119,531.70
NON-COVERD CHARGES	15,794.78	TOTAL MEDICAID LIAB	23,769.86
		LESS: COB	23,652.86
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 84



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,949.93	884.00	OTHER LAB	2,799.36	0.00
MED/SURG SUPPLY	5,022.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,238.36	264.48	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,804.52	1,144.92	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	267.00	1,068.00	FEE SCHEDULE LAB	23,073.65	7,644.59
EKG/ECG	1,345.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,116.39	1,320.28	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,742.32	936.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,325.85	50.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,451.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,436.40	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,493.91	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,245.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,373.66	1,417.75
RADIOLOGY THERAPEUTIC	1,039.75	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	602.28	298.40	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,876.80	379.32			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,619.20	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,478.22	386.68			
			TOTAL ANCILLARY	143,301.56	15,794.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	143,301.56	15,794.78

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

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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	510,422.03	ADJUSTMENTS	2,894.74
COVERED CHARGES	483,887.04	CONTRACTUAL ALLOW	451,497.78
NON-COVERD CHARGES	26,534.99	TOTAL MEDICAID LIAB	32,389.26
		LESS: COB	31.53
		LESS: COPAYMENT	1,041.08
		REIMBURSEMENT	31,316.65
		TOTAL NUMBER OF CLAIMS	579

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,581.43	62.50	OTHER LAB	3,227.12	0.00
MED/SURG SUPPLY	542.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,904.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	20,479.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	78,069.95	18,270.63
EKG/ECG	5,651.52	0.00	MRI SERVICES	4,521.68	0.00
IV THERAPY	36,461.42	3,461.91	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,414.90	277.81	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	284,685.93	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	17,784.80	2,736.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	60.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,178.24	1,726.08			
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	324.81	0.00			
			TOTAL ANCILLARY	483,887.04	26,534.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	483,887.04	26,534.99

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,630.17	ADJUSTMENTS	0.00
COVERED CHARGES	11,125.68	CONTRACTUAL ALLOW	10,714.22
NON-COVERD CHARGES	2,504.49	TOTAL MEDICAID LIAB	411.46
		LESS: COB	399.45
		LESS: COPAYMENT	12.01
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 6

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	246.70	125.00	OTHER LAB	0.00	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	264.48	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,905.30	1,113.29	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,555.51	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,983.79	1,074.60	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,236.15	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	706.75	191.60
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,125.68	2,504.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,125.68	2,504.49

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER  
100 GROSS CRESCENT CIR  
FORT OGLETHORPE, GA 30742-3643

PROVIDER NUMBER  
000001075A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,784,996.47	ADJUSTMENTS	98,289.60
COVERED CHARGES	1,757,005.66	CONTRACTUAL ALLOW	1,483,290.26
NON-COVERD CHARGES	27,990.81	TOTAL MEDICAID LIAB	273,715.40
		LESS: COB	0.00
		LESS: COPAYMENT	447.00
		REIMBURSEMENT	273,268.40

TOTAL NUMBER OF CLAIMS 55

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUTCHESON MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
100 GROSS CRESCENT CIR	000001075A	SERVICE DATES	10/01/12	THROUGH	09/30/13
FORT OGLETHORPE,GA 30742-3643		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	180,533.99	98.60	OTHER LAB	14,968.93	697.00
MED/SURG SUPPLY	3,663.00	154.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	924.52	576.45	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,144.92	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,540.49	3,325.23
EKG/ECG	0.00	0.00	MRI SERVICES	3,767.68	0.00
IV THERAPY	13,559.75	3,449.40	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,318.46	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	50.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,217,135.69	17,979.83
RADIOLOGY THERAPEUTIC	276,013.42	1,710.30	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	384.81	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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,757,005.66	27,990.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,757,005.66	27,990.81

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:48:19  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,558,868.72	ADJUSTMENTS	72,284.45
COVERED CHARGES	15,369,084.51	CONTRACTUAL ALLOW	10,983,518.27
NON-COVERD CHARGES	189,784.21	TOTAL MEDICAID LIAB	4,385,566.24
		LESS: COB	26,114.30
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,359,451.94

TOTAL NUMBER OF ADMISSIONS 747

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,397		0	1,150,490.00		6,535.00
ROUTINE NURSERY	340		0	268,313.50		6,779.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,737		0	1,418,803.50		13,314.50
SPECIAL CARE SERVICES						
CCU	322		0	443,125.00		0.00
ICU	291		0	582,002.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	613		0	1,025,127.00		0.00
TOTAL ACCOMODATIONS	2,350		0	2,443,930.50		13,314.50

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	825,600.18	0.00	OTHER LAB	106,290.50	0.00
MED/SURG SUPPLY	646,212.19	61.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,139,180.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	275,123.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	946,277.07	1,054.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	72,331.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	291,390.75	0.00	MRI SERVICES	182,942.25	0.00
IV THERAPY	17,460.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,050,483.25	34,402.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	521,973.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	678,021.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	298,824.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	813,935.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	169,977.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	37,709.00	0.00	INJECTABLE DRUGS	1,452,167.74	0.00
RADIOLOGY THERAPEUTIC	1,925.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,801.25	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,014.25	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	23,335.00	3,590.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,972.00	10,376.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	227,083.49	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	22,990.00
OTHER IMAGING SERVICE	97,624.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	125,317.01	90,372.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	111,666.25	13,623.00			
AUDIOLOGY	115,729.25	0.00			
CARDIOLOGY	656,857.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,927.68	0.00			
			TOTAL ANCILLARY	12,925,154.01	176,469.71
			TOTAL ACCOMODATIONS	2,443,930.50	13,314.50
			TOTAL CHARGES	15,369,084.51	189,784.21

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012248060644	08/09/12 - 08/14/12	09/10/12	0.00	2,299.00	0.00	0.00	0.00
615	2013059072010	01/28/13 - 02/04/13	03/04/13	0.00	2,299.00	0.00	0.00	0.00
615	2013106059957	03/20/13 - 03/23/13	04/22/13	0.00	2,299.00	0.00	0.00	0.00
615	2213122004756	03/27/13 - 03/28/13	05/06/13	0.00	2,299.00	0.00	0.00	0.00
615	2013161026653	02/20/13 - 02/22/13	06/17/13	0.00	2,299.00	0.00	0.00	0.00
615	2013171073723	05/21/13 - 05/23/13	06/24/13	0.00	2,299.00	0.00	0.00	0.00
615	2013191079486	06/14/13 - 06/17/13	07/15/13	0.00	2,299.00	0.00	0.00	0.00
615	2013204043100	06/23/13 - 06/25/13	07/29/13	0.00	2,299.00	0.00	0.00	0.00
615	2013205067793	06/23/13 - 07/01/13	07/29/13	0.00	2,299.00	0.00	0.00	0.00
615	2013247076480	05/08/13 - 05/10/13	09/09/13	0.00	2,299.00	0.00	0.00	0.00
TOTAL				0.00	22,990.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 12:48:34  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,111.95	ADJUSTMENTS	0.00
COVERED CHARGES	55,111.95	CONTRACTUAL ALLOW	27,309.12
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	27,802.83
		LESS: COB	27,802.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4		0	3,070.00		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	3,070.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	4,000.00		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	2		0	4,000.00		0.00
TOTAL ACCOMODATIONS	6		0	7,070.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEADOWS REGIONAL MEDICAL CENTER  
 1 MEADOWS PKWY  
 VIDALIA,GA 30474-8759

PROVIDER NUMBER  
 000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,318.15	0.00	OTHER LAB	359.50	0.00
MED/SURG SUPPLY	2,623.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,275.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,089.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	919.50	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	9,615.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	100.75	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	2,013.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,489.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,239.53	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,998.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	48,041.95	0.00
			TOTAL ACCOMODATIONS	7,070.00	0.00
			TOTAL CHARGES	55,111.95	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:48:35  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,989,975.37	ADJUSTMENTS	232,364.29
COVERED CHARGES	13,253,600.96	CONTRACTUAL ALLOW	10,597,528.22
NON-COVERD CHARGES	1,736,374.41	TOTAL MEDICAID LIAB	2,656,072.74
		LESS: COB	759.53
		LESS: COPAYMENT	10,488.06
		REIMBURSEMENT	2,644,825.15
		ALL OTHER	2,247,312.21
		FEE SCHEDULE-LAB	224,625.14
		INJECTABLE DRUGS	172,887.80

TOTAL NUMBER OF CLAIMS 6,418

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	106,030.81	11,965.86	OTHER LAB	104,408.00	7,284.00
MED/SURG SUPPLY	279,058.48	21,621.77	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	445.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	614,782.00	13,661.75	OTHER THERAPEUTIC SVC	0.00	603.00
CT SCAN	1,686,040.39	104,957.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,271.50	12,976.50	FEE SCHEDULE LAB	2,398,546.05	492,086.15
EKG/ECG	161,596.00	1,417.50	MRI SERVICES	714,810.95	11,527.25
IV THERAPY	250,932.50	9,311.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,721,351.75	293,140.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	77,964.75	80,093.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	258,230.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,010,491.00	46,932.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	153,253.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	753,397.33	131,390.25
RADIOLOGY THERAPEUTIC	59,600.09	723.75	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,021.75	5,830.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,244.75	1,995.50	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	372,408.56	24,288.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,641.62	101,621.92
LITHOTRIPSY	206,185.00	0.00	NO CC/INVALID REV CODE	0.00	9,606.50
OTHER IMAGING SERVICE	514,529.45	24,851.21			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	32,013.86	450.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	239,623.75	83,694.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	130,495.50	234,593.00			
AMBULATORY SURGERY	5,520.25	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	239,107.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	99,044.37	9,304.25			
			TOTAL ANCILLARY	13,253,600.96	1,736,374.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,253,600.96	1,736,374.41

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012276037134	09/18/12 - 09/18/12	10/08/12	0.00	2,299.00	0.00	0.00	0.00
615	2013100077284	01/29/13 - 01/29/13	04/15/13	0.00	2,299.00	0.00	0.00	0.00
615	5213105010045	01/18/13 - 01/18/13	11/11/13	0.00	2,299.00	0.00	0.00	0.00
615	2013176049188	06/05/13 - 06/05/13	07/01/13	0.00	2,299.00	0.00	0.00	0.00
2510	2213183011621	05/09/13 - 05/09/13	07/08/13	0.00	410.50	0.00	0.00	0.00
TOTAL				0.00	9,606.50	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 12:49:45  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	134,255.56	ADJUSTMENTS	0.00
COVERED CHARGES	97,807.07	CONTRACTUAL ALLOW	31,524.80
NON-COVERD CHARGES	36,448.49	TOTAL MEDICAID LIAB	66,282.27
		LESS: COB	66,228.27
		LESS: COPAYMENT	54.00
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,474.28	0.00	OTHER LAB	344.25	0.00
MED/SURG SUPPLY	3,728.71	526.53	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,130.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,452.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,970.50	1,951.00
EKG/ECG	306.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,196.75	0.00	PROFESSIONAL FEES	0.00	175.00
OPERATING ROOM	9,384.75	29,657.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	954.00	251.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,473.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,596.25	245.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,226.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,166.74	2,069.21
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	354.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,783.00	137.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,801.55	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,905.00	569.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,759.86	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,000.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	11,973.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,179.18	512.00			
			TOTAL ANCILLARY	97,807.07	36,448.49
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	97,807.07	36,448.49

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	772,702.29	ADJUSTMENTS	1,123.73
COVERED CHARGES	744,084.64	CONTRACTUAL ALLOW	710,968.17
NON-COVERD CHARGES	28,617.65	TOTAL MEDICAID LIAB	33,116.47
		LESS: COB	0.01
		LESS: COPAYMENT	1,029.04
		REIMBURSEMENT	32,087.42
		TOTAL NUMBER OF CLAIMS	592

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,290.57	0.00	OTHER LAB	2,480.50	940.75
MED/SURG SUPPLY	8,257.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,114.25	583.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	61,789.00	7,111.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	730.50	230.25	FEE SCHEDULE LAB	133,588.00	8,723.00
EKG/ECG	10,919.00	306.50	MRI SERVICES	7,371.50	0.00
IV THERAPY	877.00	438.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	20,416.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,582.50	391.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,316.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	414,524.75	3,973.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,095.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,687.82	2,797.15
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	354.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,002.75	400.25	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	16,765.75	2,367.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	127.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	149.00	0.00			
			TOTAL ANCILLARY	744,084.64	28,617.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	744,084.64	28,617.65

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEADOWS REGIONAL MEDICAL CENTER  
1 MEADOWS PKWY  
VIDALIA,GA 30474-8759

PROVIDER NUMBER  
000001086A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,620.50	ADJUSTMENTS	0.00
COVERED CHARGES	9,831.25	CONTRACTUAL ALLOW	4,607.33
NON-COVERD CHARGES	789.25	TOTAL MEDICAID LIAB	5,223.92
		LESS: COB	5,217.92
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	667.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,419.00	150.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,059.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	47.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	639.25	639.25			
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	9,831.25	789.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,831.25	789.25

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 12:49:54  
Page: 15

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,590,699.14	ADJUSTMENTS	51,361.70
COVERED CHARGES	1,423,354.25	CONTRACTUAL ALLOW	1,137,155.53
NON-COVERD CHARGES	167,344.89	TOTAL MEDICAID LIAB	286,198.72
		LESS: COB	0.00
		LESS: COPAYMENT	438.95
		REIMBURSEMENT	285,759.77
		TOTAL NUMBER OF CLAIMS	56

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,409.63	285.54	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	79,058.51	366.13	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	37.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,487.00	536.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,370.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	403.75	FEE SCHEDULE LAB	56,202.91	10,014.00
EKG/ECG	306.50	919.50	MRI SERVICES	3,932.50	0.00
IV THERAPY	69,000.75	5,470.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	434,892.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	503.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,265.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,968.25	1,300.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,725.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	526,061.90	118,745.56
RADIOLOGY THERAPEUTIC	12,270.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,379.00	3,472.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	34,533.66	20,966.66
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,089.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,567.16	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	40,365.25	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	11,963.98	4,826.75			
			TOTAL ANCILLARY	1,423,354.25	167,344.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,423,354.25	167,344.89



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 12:49:56  
Page: 17

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEADOWS REGIONAL MEDICAL CENTER  
1 MEADOWS PKWY  
VIDALIA,GA 30474-8759

PROVIDER NUMBER  
000001086A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:48:21  
 Page: 1

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,414,447.20	ADJUSTMENTS	1,923,017.06
COVERED CHARGES	14,811,240.30	CONTRACTUAL ALLOW	10,654,583.54
NON-COVERD CHARGES	603,206.90	TOTAL MEDICAID LIAB	4,156,656.76
		LESS: COB	28,513.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,128,143.38

TOTAL NUMBER OF ADMISSIONS 693

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,706		0	1,570,053.00		253,865.00
ROUTINE NURSERY	587		32	685,048.00		174,495.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,293		32	2,255,101.00		428,360.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	201		0	667,521.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	201		0	667,521.00		0.00
TOTAL ACCOMODATIONS	2,494		32	2,922,622.00		428,360.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,034,884.40	6,264.50	OTHER LAB	30,716.00	0.00
MED/SURG SUPPLY	636,707.50	15,536.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,052,509.40	42,470.40	EDUCATION & TRAINING	490.00	0.00
RADIOLOGY-DIAGNOSTIC	198,216.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,670.00
CT SCAN	475,111.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	132,272.00	1,440.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	68,021.00	0.00	MRI SERVICES	273,845.00	0.00
IV THERAPY	25,722.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,083,114.00	37,896.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	813,632.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	425,965.00	255.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	144,389.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	376,203.00	5,090.00	SPECIAL SERVICES	0.00	10,185.00
RECOVERY ROOM	119,196.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	10,682.00
LABORATORY PATHOLOGIC	93,933.00	0.00	INJECTABLE DRUGS	2,792,239.00	16,757.00
RADIOLOGY THERAPEUTIC	51,648.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	34,600.00	375.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	33,281.00	819.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	84,630.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	92,623.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	271.00
OTHER IMAGING SERVICE	119,261.00	5,767.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	174,714.00	15,740.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	51,426.00	325.00			
AUDIOLOGY	75,881.00	0.00			
CARDIOLOGY	385,446.00	1,774.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,943.00	530.00			
			TOTAL ANCILLARY	11,888,618.30	174,846.90
			TOTAL ACCOMODATIONS	2,922,622.00	428,360.00
			TOTAL CHARGES	14,811,240.30	603,206.90

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 10:48:21  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5913333000316	09/22/13 - 09/24/13	12/02/13	0.00	271.00	0.00	0.00	0.00
TOTAL				0.00	271.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:48:33  
 Page: 4

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	101,330.00	ADJUSTMENTS	0.00
COVERED CHARGES	96,831.00	CONTRACTUAL ALLOW	58,429.82
NON-COVERD CHARGES	4,499.00	TOTAL MEDICAID LIAB	38,401.18
		LESS: COB	38,401.18
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	18		0	16,776.00		2,889.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	18		0	16,776.00		2,889.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	18		0	16,776.00		2,889.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:48:33  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,328.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,233.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,481.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	447.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	8,212.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,074.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,058.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	1,610.00
RECOVERY ROOM	1,544.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	437.00	0.00	INJECTABLE DRUGS	18,694.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	702.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	845.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	80,055.00	1,610.00
			TOTAL ACCOMODATIONS	16,776.00	2,889.00
			TOTAL CHARGES	96,831.00	4,499.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:48:34  
Page: 6

NORTHSIDE HOSPITAL, INC  
201 HOSPITAL RD  
CANTON,GA 30114-2408

PROVIDER NUMBER  
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,905,979.33	ADJUSTMENTS	548,122.66
COVERED CHARGES	10,342,353.43	CONTRACTUAL ALLOW	8,381,129.74
NON-COVERD CHARGES	1,563,625.90	TOTAL MEDICAID LIAB	1,961,223.69
		LESS: COB	1,572.97
		LESS: COPAYMENT	2,878.96
		REIMBURSEMENT	1,956,771.76
		ALL OTHER	1,710,000.80
		FEE SCHEDULE-LAB	93,505.74
		INJECTABLE DRUGS	153,265.22

TOTAL NUMBER OF CLAIMS 2,798

NORTHSIDE HOSPITAL, INC  
 201 HOSPITAL RD  
 CANTON,GA 30114-2408

PROVIDER NUMBER  
 000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	410,203.79	13,899.50	OTHER LAB	110,945.00	0.00
MED/SURG SUPPLY	340,673.00	18,538.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	168.00	EDUCATION & TRAINING	531.00	0.00
RADIOLOGY-DIAGNOSTIC	367,141.00	10,741.00	OTHER THERAPEUTIC SVC	0.00	10,098.00
CT SCAN	1,188,437.00	89,142.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,231.00	15,660.00	FEE SCHEDULE LAB	1,513,250.85	326,772.90
EKG/ECG	121,575.00	8,672.00	MRI SERVICES	251,037.00	27,650.00
IV THERAPY	330,875.00	97,029.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	569,679.00	84,796.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,591.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	36,743.00	1,176.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	149,434.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,958.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,158,844.00	112,464.00	SPECIAL SERVICES	0.00	406.00
RECOVERY ROOM	160,984.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	535.50
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,128,330.67	570,822.00
RADIOLOGY THERAPEUTIC	301,037.00	586.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,251.00	2,943.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	6,366.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,015.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	138.00	1,312.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	33,627.00	0.00
LITHOTRIPSY	18,296.00	0.00	NO CC/INVALID REV CODE	0.00	153.00
OTHER IMAGING SERVICE	408,869.00	66,752.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	80,752.00	6,296.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	184,400.00	5,263.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	182,467.00	82,053.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,536.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	202,517.12	1,317.00			
			TOTAL ANCILLARY	10,342,353.43	1,563,625.90
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,342,353.43	1,563,625.90



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

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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
60	5912363000968	12/07/12 - 12/07/12	12/31/12	0.00	153.00	0.00	0.00	0.00
TOTAL				0.00	153.00	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

NORTHSIDE HOSPITAL, INC  
201 HOSPITAL RD  
CANTON,GA 30114-2408

PROVIDER NUMBER  
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	234,532.31	ADJUSTMENTS	0.00
COVERED CHARGES	210,232.81	CONTRACTUAL ALLOW	124,515.52
NON-COVERD CHARGES	24,299.50	TOTAL MEDICAID LIAB	85,717.29
		LESS: COB	85,714.29
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 65

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,089.50	1,085.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,394.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,585.00	332.00	OTHER THERAPEUTIC SVC	153.00	0.00
CT SCAN	8,517.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	53,870.75	6,616.00
EKG/ECG	1,626.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,409.00	2,758.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	6,051.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	465.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,328.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,287.00	470.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	10,332.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,412.00	6,625.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	32.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,115.00	6,191.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,598.56	190.00			
			TOTAL ANCILLARY	210,232.81	24,299.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	210,232.81	24,299.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	559,409.50	ADJUSTMENTS	694.20
COVERED CHARGES	528,095.50	CONTRACTUAL ALLOW	505,831.41
NON-COVERD CHARGES	31,314.00	TOTAL MEDICAID LIAB	22,264.09
		LESS: COB	30.79
		LESS: COPAYMENT	579.07
		REIMBURSEMENT	21,654.23
		TOTAL NUMBER OF CLAIMS	398

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,586.50	350.50	OTHER LAB	6,455.00	0.00
MED/SURG SUPPLY	7,084.00	203.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,399.00	274.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,783.00	2,177.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	608.00	FEE SCHEDULE LAB	93,603.00	11,452.00
EKG/ECG	6,233.00	0.00	MRI SERVICES	4,422.00	0.00
IV THERAPY	7,787.00	1,520.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,834.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	467.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,085.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,563.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	269,662.00	5,007.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,035.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23,587.00	8,373.50
RADIOLOGY THERAPEUTIC	881.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	96.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,146.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,390.00	1,253.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,093.00	0.00			
			TOTAL ANCILLARY	528,095.50	31,314.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	528,095.50	31,314.00



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	436.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	135.00	101.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	634.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,177.00	2,177.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,438.00	849.00
EKG/ECG	271.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,136.00	155.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	148.50	349.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,290.00	737.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,666.00	4,368.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,666.00	4,368.50

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTHSIDE HOSPITAL, INC  
201 HOSPITAL RD  
CANTON,GA 30114-2408

PROVIDER NUMBER  
000001108A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,954,028.37	ADJUSTMENTS	201,346.71
COVERED CHARGES	2,652,910.97	CONTRACTUAL ALLOW	2,226,273.90
NON-COVERD CHARGES	301,117.40	TOTAL MEDICAID LIAB	426,637.07
		LESS: COB	3,995.56
		LESS: COPAYMENT	600.97
		REIMBURSEMENT	422,040.54

TOTAL NUMBER OF CLAIMS 85



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,261.50	493.00	OTHER LAB	4,927.00	0.00
MED/SURG SUPPLY	132,245.00	1,705.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,942.00	1,988.00	OTHER THERAPEUTIC SVC	0.00	612.00
CT SCAN	225,450.00	4,354.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	355.00	FEE SCHEDULE LAB	89,592.60	26,765.40
EKG/ECG	4,878.00	2,710.00	MRI SERVICES	16,862.00	0.00
IV THERAPY	90,075.00	15,526.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	231,052.00	14,908.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,847.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,311.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,743.00	4,980.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,965.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,208,326.87	195,449.00
RADIOLOGY THERAPEUTIC	141,064.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,254.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	191,441.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,474.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,832.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	35,238.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	78,431.00	29,578.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,953.00	440.00			
			TOTAL ANCILLARY	2,652,910.97	301,117.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,652,910.97	301,117.40

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER 000001119A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	92,993,205.48	ADJUSTMENTS	8,565,010.43
COVERED CHARGES	90,385,624.20	CONTRACTUAL ALLOW	64,708,411.30
NON-COVERD CHARGES	2,607,581.28	TOTAL MEDICAID LIAB	25,677,212.90
		LESS: COB	134,547.36
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	25,542,665.54

TOTAL NUMBER OF ADMISSIONS 2,654

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	5,699	259	5,707,806.00	345,023.00
ROUTINE NURSERY	1,669	17	711,309.00	83,475.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	7,368	276	6,419,115.00	428,498.00
SPECIAL CARE SERVICES				
CCU	3,169	60	5,042,229.00	115,195.00
ICU	1,483	10	3,621,904.00	26,000.00
NICU	1,389	0	3,487,968.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	223	0.00	301,320.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	6,041	293	12,152,101.00	442,515.00
TOTAL ACCOMODATIONS	13,409	569	18,571,216.00	871,013.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,820,680.56	620,709.15	OTHER LAB	553,287.00	4,456.00
MED/SURG SUPPLY	3,592,488.80	100,396.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,910,560.16	47,566.00	EDUCATION & TRAINING	68,021.00	2,211.00
RADIOLOGY-DIAGNOSTIC	2,202,420.00	3,965.00	OTHER THERAPEUTIC SVC	0.00	9,259.00
CT SCAN	4,782,629.00	41,413.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	507,289.00	34,511.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	525,273.00	646.00	MRI SERVICES	1,587,143.00	4,934.00
IV THERAPY	1,018,794.75	118,533.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,154,360.50	18,755.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,572,106.00	8,828.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,914,649.00	21,163.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,585,069.00	29,101.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,728,517.00	11,308.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,468,832.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	407,938.00	1,098.00	INJECTABLE DRUGS	3,042.00	0.00
RADIOLOGY THERAPEUTIC	545,033.00	46,149.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	197,696.00	22,800.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	189,180.00	9,313.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	884,657.00	84,078.00	PATIENT CONVENIENCE	0.00	558.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,737.00	19,678.00	TRAUMA RESPONSE	0.00	37,200.00
PSYCHIATRIC SERVICES	1,206.00	8,841.00	IMPL DEV CHARGE PATIENTS	2,945,014.03	21,768.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	130,694.00
OTHER IMAGING SERVICE	521,210.00	8,416.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,098,241.00	244,539.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	613,147.00	22,732.00			
AUDIOLOGY	336,568.00	0.00			
CARDIOLOGY	2,635,314.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	157,070.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	267,235.40	949.00			
			TOTAL ANCILLARY	71,814,408.20	1,736,568.28
			TOTAL ACCOMODATIONS	18,571,216.00	871,013.00
			TOTAL CHARGES	90,385,624.20	2,607,581.28

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212240007103	08/08/12 - 08/10/12	09/03/12	0.00	5,781.00	0.00	0.00	0.00
615	5212272056517	07/25/12 - 08/16/12	10/08/12	0.00	2,947.00	0.00	0.00	0.00
615	2012279059734	07/15/12 - 08/10/12	10/15/12	0.00	5,781.00	0.00	0.00	0.00
615	2012283038697	09/04/12 - 10/01/12	10/15/12	0.00	2,947.00	0.00	0.00	0.00
615	2013004081204	12/26/12 - 12/29/12	01/14/13	0.00	5,781.00	0.00	0.00	0.00
615	2013024080437	11/04/12 - 11/08/12	01/28/13	0.00	5,781.00	0.00	0.00	0.00
615	2013024080449	01/08/13 - 01/10/13	01/28/13	0.00	5,781.00	0.00	0.00	0.00
615	2013053076847	02/07/13 - 02/12/13	03/04/13	0.00	2,947.00	0.00	0.00	0.00
615	2013063043813	02/23/13 - 02/26/13	03/11/13	0.00	5,781.00	0.00	0.00	0.00
615	2013066068774	02/24/13 - 02/26/13	03/11/13	0.00	5,781.00	0.00	0.00	0.00
615	2313070000041	11/23/12 - 11/28/12	06/17/13	0.00	2,947.00	0.00	0.00	0.00
615	2013101084219	04/03/13 - 04/06/13	04/15/13	0.00	5,781.00	0.00	0.00	0.00
615	2013119032710	04/16/13 - 04/18/13	05/20/13	0.00	5,781.00	0.00	0.00	0.00
615	2013128081277	04/25/13 - 05/03/13	05/13/13	0.00	2,947.00	0.00	0.00	0.00
615	5913136000176	04/12/13 - 04/14/13	05/20/13	0.00	2,947.00	0.00	0.00	0.00
615	2013141041037	05/08/13 - 05/13/13	05/27/13	0.00	5,781.00	0.00	0.00	0.00
615	2013151076890	05/19/13 - 05/23/13	06/10/13	0.00	2,947.00	0.00	0.00	0.00
615	2013165066879	04/09/13 - 04/12/13	06/24/13	0.00	5,781.00	0.00	0.00	0.00
615	2013172064324	06/07/13 - 06/09/13	07/01/13	0.00	2,947.00	0.00	0.00	0.00
615	2013176053659	06/17/13 - 06/20/13	07/01/13	0.00	8,728.00	0.00	0.00	0.00
615	2013178076368	06/13/13 - 06/22/13	07/01/13	0.00	2,947.00	0.00	0.00	0.00
615	2013197046137	06/21/13 - 06/22/13	07/22/13	0.00	5,781.00	0.00	0.00	0.00
615	5213200000138	04/23/13 - 05/06/13	07/29/13	0.00	5,781.00	0.00	0.00	0.00
615	2013240066495	05/13/13 - 05/24/13	09/23/13	0.00	5,781.00	0.00	0.00	0.00
615	2313287000015	05/16/13 - 06/05/13	11/25/13	0.00	5,781.00	0.00	0.00	0.00
615	5214107000108	04/24/13 - 05/03/13	04/21/14	0.00	2,947.00	0.00	0.00	0.00
615	2214177003970	05/01/13 - 05/13/13	06/30/14	0.00	5,781.00	0.00	0.00	0.00
TOTAL				0.00	130,694.00	0.00	0.00	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER 000001119A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	218,671.25	ADJUSTMENTS	0.00
COVERED CHARGES	147,827.00	CONTRACTUAL ALLOW	11,172.77
NON-COVERD CHARGES	70,844.25	TOTAL MEDICAID LIAB	136,654.23
		LESS: COB	136,654.23
		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	40		2	39,547.00		2,028.00
ROUTINE NURSERY	9		3	3,678.00		3,042.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	49		5	43,225.00		5,070.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	9,202.00		0.00
NICU	1		0	2,576.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		10	0.00		13,440.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		10	11,778.00		13,440.00
TOTAL ACCOMODATIONS	54		15	55,003.00		18,510.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR KENNESTONE HOSPITAL  
 677 CHURCH ST NE  
 MARIETTA,GA 30060-1101

PROVIDER NUMBER  
 000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,396.00	6,025.25	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,587.00	1,874.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,430.00	0.00	EDUCATION & TRAINING	2,700.00	0.00
RADIOLOGY-DIAGNOSTIC	422.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	440.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,612.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,331.00	42,804.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,222.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,888.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,241.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	468.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	159.00	72.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	514.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	1,092.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	836.00	1,045.00			
			TOTAL ANCILLARY	92,824.00	52,334.25
			TOTAL ACCOMODATIONS	55,003.00	18,510.00
			TOTAL CHARGES	147,827.00	70,844.25

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:12:41  
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WELLSTAR KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,620,978.02	ADJUSTMENTS	1,520,447.56
COVERED CHARGES	30,534,774.31	CONTRACTUAL ALLOW	24,189,196.57
NON-COVERD CHARGES	4,086,203.71	TOTAL MEDICAID LIAB	6,345,577.74
		LESS: COB	12,872.13
		LESS: COPAYMENT	10,506.68
		REIMBURSEMENT	6,322,198.93
		ALL OTHER	5,456,905.53
		FEE SCHEDULE-LAB	510,550.84
		INJECTABLE DRUGS	354,742.56

TOTAL NUMBER OF CLAIMS 12,489



WELLSTAR KENNESTONE HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 677 CHURCH ST NE 000001119A SERVICE DATES 07/01/12 THROUGH 06/30/13  
 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	771,394.14	99,338.50	OTHER LAB	402,601.00	11,786.00
MED/SURG SUPPLY	447,456.04	43,539.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	786.60	EDUCATION & TRAINING	6,291.00	1,653.00
RADIOLOGY-DIAGNOSTIC	1,529,074.00	17,393.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,262,039.00	251,211.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,578.00	37,607.00	FEE SCHEDULE LAB	4,338,196.41	869,992.08
EKG/ECG	315,773.00	26,551.00	MRI SERVICES	1,263,822.00	106,700.00
IV THERAPY	1,234,374.00	1,765.00	PROFESSIONAL FEES	0.00	588.00
OPERATING ROOM	1,584,662.00	233,835.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	257,283.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	217,705.00	64,499.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	686,721.00	3,054.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,655,918.00	160,363.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	552,312.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	339.33	INJECTABLE DRUGS	1,671,874.75	485,780.50
RADIOLOGY THERAPEUTIC	840,312.00	688,928.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	9,181.00	25,368.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	9,062.00	18,278.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	243,455.00	14,564.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	30,150.00	402.00	IMPL DEV CHARGE PATIENTS	81,077.00	486,328.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	204.70
OTHER IMAGING SERVICE	1,658,667.00	252,595.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	61,354.00	7,348.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	808,110.00	37,217.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	993,417.00	122,858.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	93,532.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	489,382.97	15,332.00			
			TOTAL ANCILLARY	30,534,774.31	4,086,203.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,534,774.31	4,086,203.71

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:12:41  
Page: 8

WELLSTAR KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3069	5912213000042	07/12/12 - 07/12/12	08/06/12	0.00	42.00	0.00	0.00	0.00
3066	5912242001435	08/06/12 - 08/06/12	09/03/12	0.00	82.00	0.00	0.00	0.00
3021	5913059000014	01/16/13 - 01/16/13	03/04/13	0.00	80.70	0.00	0.00	0.00
TOTAL				0.00	204.70	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 12:14:53  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR KENNESTONE HOSPITAL  
677 CHURCH ST NE  
MARIETTA,GA 30060-1101

PROVIDER NUMBER  
000001119A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	609,536.77	ADJUSTMENTS	0.00
COVERED CHARGES	541,806.02	CONTRACTUAL ALLOW	161,861.30
NON-COVERD CHARGES	67,730.75	TOTAL MEDICAID LIAB	379,944.72
		LESS: COB	379,789.03
		LESS: COPAYMENT	155.69
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 217

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,361.50	550.00	OTHER LAB	7,124.00	0.00
MED/SURG SUPPLY	9,407.00	101.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,883.00	1,072.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,842.00	9,139.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	780.00	155.00	FEE SCHEDULE LAB	74,988.02	7,250.50
EKG/ECG	3,322.00	0.00	MRI SERVICES	23,268.00	4,934.00
IV THERAPY	19,887.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	44,046.00	13,738.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	47,212.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,072.00	1,131.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,791.00	3,526.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	96,294.00	1,518.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	32,504.00	0.00	DRUG-SPECIFIC/HOME IV	15.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	48,489.50	8,017.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	173.00	481.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	714.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,060.00	261.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	402.00	0.00	IMPL DEV CHARGE PATIENTS	1,438.00	4,356.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,503.00	9,945.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,255.00	842.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,355.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,334.00	0.00			
			TOTAL ANCILLARY	541,806.02	67,730.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	541,806.02	67,730.75

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:14:59  
Page: 11

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,594,527.10	ADJUSTMENTS	2,315.42
COVERED CHARGES	1,529,406.85	CONTRACTUAL ALLOW	1,478,111.81
NON-COVERD CHARGES	65,120.25	TOTAL MEDICAID LIAB	51,295.04
		LESS: COB	0.00
		LESS: COPAYMENT	1,416.04
		REIMBURSEMENT	49,879.00
		TOTAL NUMBER OF CLAIMS	917

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,973.25	3,453.00	OTHER LAB	35,478.00	7,116.00
MED/SURG SUPPLY	5,285.00	59.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	118,460.00	370.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	96,427.00	12,621.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	249,499.00	20,795.00
EKG/ECG	22,417.00	0.00	MRI SERVICES	13,365.00	0.00
IV THERAPY	81,985.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,391.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	592.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,508.00	1,781.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,763.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	792,730.00	1,040.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,848.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,729.75	875.25
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	4,671.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	584.00	87.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,206.00	280.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	54,271.00	11,972.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,894.85	0.00			
			TOTAL ANCILLARY	1,529,406.85	65,120.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,529,406.85	65,120.25

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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Page: 13

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,152.75	ADJUSTMENTS	0.00
COVERED CHARGES	24,996.00	CONTRACTUAL ALLOW	12,571.70
NON-COVERD CHARGES	1,156.75	TOTAL MEDICAID LIAB	12,424.30
		LESS: COB	12,406.30
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	378.00	90.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	32.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,561.00	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	2,983.00	0.00
EKG/ECG	323.00	0.00	MRI SERVICES	4,934.00	0.00
IV THERAPY	960.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,036.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,238.00	35.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	108.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	551.00	923.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,996.00	1,156.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,996.00	1,156.75



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 12:15:12  
Page: 15

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,463,261.86	ADJUSTMENTS	300,974.38
COVERED CHARGES	6,684,222.56	CONTRACTUAL ALLOW	5,728,209.22
NON-COVERD CHARGES	779,039.30	TOTAL MEDICAID LIAB	956,013.34
		LESS: COB	0.00
		LESS: COPAYMENT	2,503.01
		REIMBURSEMENT	953,510.33

TOTAL NUMBER OF CLAIMS 187

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR KENNESTONE HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 677 CHURCH ST NE 000001119A SERVICE DATES 07/01/12 THROUGH 06/30/13  
 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	141,580.75	4,049.00	OTHER LAB	10,465.00	0.00
MED/SURG SUPPLY	136,432.40	12,910.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,570.00	19,601.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	394,772.00	7,229.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	618.00	299.00	FEE SCHEDULE LAB	106,568.70	19,558.80
EKG/ECG	11,305.00	4,199.00	MRI SERVICES	8,401.00	0.00
IV THERAPY	168,138.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	244,161.00	9,093.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,158.00	3,437.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	72,003.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	38,178.00	559.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,721.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,788,970.75	100,159.50
RADIOLOGY THERAPEUTIC	1,801,058.00	514,617.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	308.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	15,147.00	2,458.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	288,626.00	71,940.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,678.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,266.00	2,000.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	112,005.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	199,562.00	6,930.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,194.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	44,335.96	0.00			
			TOTAL ANCILLARY	6,684,222.56	779,039.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,684,222.56	779,039.30

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: 07/23/2014  
Run Time: 12:15:19  
Page: 17

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:51:32  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

FAIRVIEW PARK HOSPITAL  
 200 INDUSTRIAL BLVD  
 DUBLIN,GA 31021-2981

PROVIDER NUMBER 000001141A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,177,176.30	ADJUSTMENTS	649,106.26
COVERED CHARGES	25,608,545.12	CONTRACTUAL ALLOW	19,827,697.82
NON-COVERD CHARGES	568,631.18	TOTAL MEDICAID LIAB	5,780,847.30
		LESS: COB	64,751.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,716,095.84

TOTAL NUMBER OF ADMISSIONS 875

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,178		18	1,952,817.00		84,139.00
ROUTINE NURSERY	154		0	90,500.00		669.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,332		18	2,043,317.00		84,808.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	722		3	1,430,620.00		14,045.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	722		3	1,430,620.00		14,045.00
TOTAL ACCOMODATIONS	3,054		21	3,473,937.00		98,853.00

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,708,986.07	4,823.53	OTHER LAB	128,057.30	0.00
MED/SURG SUPPLY	1,404,133.30	2,124.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,206,295.19	10,773.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	546,807.25	0.00	OTHER THERAPEUTIC SVC	0.00	8,562.00
CT SCAN	759,506.00	194,195.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	110,172.00	313.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	250,702.00	394.00	MRI SERVICES	209,410.25	0.00
IV THERAPY	31,867.00	1,745.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,379,271.75	2,093.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	434,554.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,004,988.75	9,856.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	311,347.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	94,853.00	2,368.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	903,399.00	2,233.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	308,459.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	35,562.50
LABORATORY PATHOLOGIC	93,807.71	0.00	INJECTABLE DRUGS	5,383,216.52	37,085.80
RADIOLOGY THERAPEUTIC	2,032.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	56,638.00	622.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	24,865.50	622.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	77,081.00	7,752.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,541.00	166.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	517,746.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	176,015.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	89,782.01	93,255.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	273,480.00	54,837.00			
AUDIOLOGY	1,480.00	0.00			
CARDIOLOGY	1,531,889.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	36,866.00	394.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	69,357.82	0.00			
			TOTAL ANCILLARY	22,134,608.12	469,778.18
			TOTAL ACCOMODATIONS	3,473,937.00	98,853.00
			TOTAL CHARGES	25,608,545.12	568,631.18

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	187,944.10	ADJUSTMENTS	0.00
COVERED CHARGES	187,225.10	CONTRACTUAL ALLOW	93,689.71
NON-COVERD CHARGES	719.00	TOTAL MEDICAID LIAB	93,535.39
		LESS: COB	93,535.39
		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	26		0	23,460.00		514.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	26		0	23,460.00		514.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	2,170.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	2,170.00		0.00
TOTAL ACCOMODATIONS	27		0	25,630.00		514.00

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,947.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,139.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,273.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,967.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,846.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	758.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	158.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	12,945.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,130.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,441.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	550.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,697.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	20,179.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,361.25	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	232.90	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,287.00	205.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,271.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,280.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	130.00	0.00			
			TOTAL ANCILLARY	161,595.10	205.00
			TOTAL ACCOMODATIONS	25,630.00	514.00
			TOTAL CHARGES	187,225.10	719.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:51:48  
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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,755,258.67	ADJUSTMENTS	209,785.44
COVERED CHARGES	14,277,939.91	CONTRACTUAL ALLOW	11,771,561.04
NON-COVERD CHARGES	1,477,318.76	TOTAL MEDICAID LIAB	2,506,378.87
		LESS: COB	4,447.38
		LESS: COPAYMENT	4,569.00
		REIMBURSEMENT	2,497,362.49
		ALL OTHER	2,279,991.38
		FEE SCHEDULE-LAB	175,614.24
		INJECTABLE DRUGS	41,756.87

TOTAL NUMBER OF CLAIMS 4,937



FAIRVIEW PARK HOSPITAL  
 200 INDUSTRIAL BLVD  
 DUBLIN,GA 31021-2981

PROVIDER NUMBER  
 000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	364,798.60	610.00	OTHER LAB	104,964.80	0.00
MED/SURG SUPPLY	478,698.58	3,367.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,084,619.25	7,642.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,884,694.00	149,184.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,625.00	1,120.25	FEE SCHEDULE LAB	3,445,033.12	626,233.50
EKG/ECG	200,833.00	5,880.00	MRI SERVICES	281,581.00	14,820.00
IV THERAPY	255,415.00	65,452.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,206,954.68	152,390.07	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	24,757.00	16,900.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	98,554.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	314,502.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	278,562.01	40,912.99	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,082,776.00	4,723.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	164,884.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	601,878.84	263,420.50
RADIOLOGY THERAPEUTIC	1,270.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	25,237.50	453.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,570.25	2,532.25	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	18,113.00	4,639.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	101,114.50	22,489.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	384,885.50	13,773.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	26,857.60	2,729.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	190,011.00	42,686.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	425,282.75	29,411.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	65,090.00	1,280.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	108,376.68	4,669.00			
			TOTAL ANCILLARY	14,277,939.91	1,477,318.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,277,939.91	1,477,318.76

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

FAIRVIEW PARK HOSPITAL  
200 INDUSTRIAL BLVD  
DUBLIN,GA 31021-2981

PROVIDER NUMBER  
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	271,869.84	ADJUSTMENTS	0.00
COVERED CHARGES	225,815.01	CONTRACTUAL ALLOW	114,102.78
NON-COVERD CHARGES	46,054.83	TOTAL MEDICAID LIAB	111,712.23
		LESS: COB	111,688.23
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 76

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,058.25	0.00	OTHER LAB	1,007.25	0.00
MED/SURG SUPPLY	4,725.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	14,306.25	0.00	OTHER THERAPEUTIC SVC	0.00	266.00
CT SCAN	18,333.00	8,018.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	70,889.75	12,049.00
EKG/ECG	2,274.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,749.00	742.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	17,662.66	9,450.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	760.00	1,348.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,242.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,274.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,699.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,049.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,210.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,421.25	1,849.75
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	141.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	437.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,706.25	10,779.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,832.00	1,351.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,859.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,088.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,230.00	60.00			
			TOTAL ANCILLARY	225,815.01	46,054.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	225,815.01	46,054.83

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: 07/23/2014  
Run Time: 09:52:39  
Page: 9

FAIRVIEW PARK HOSPITAL  
200 INDUSTRIAL BLVD  
DUBLIN,GA 31021-2981

PROVIDER NUMBER  
000001141A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	951,019.65	ADJUSTMENTS	1,609.19
COVERED CHARGES	915,884.30	CONTRACTUAL ALLOW	884,110.40
NON-COVERD CHARGES	35,135.35	TOTAL MEDICAID LIAB	31,773.90
		LESS: COB	0.00
		LESS: COPAYMENT	999.11
		REIMBURSEMENT	30,774.79
		TOTAL NUMBER OF CLAIMS	568

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,632.75	0.00	OTHER LAB	932.75	0.00
MED/SURG SUPPLY	8,136.30	341.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	88,793.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	74,124.00	2,635.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	275,848.25	23,104.25
EKG/ECG	14,796.00	0.00	MRI SERVICES	3,201.00	0.00
IV THERAPY	27,826.00	3,499.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,582.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	354,564.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	44,973.25	4,041.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	104.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	211.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,740.50	1,302.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	629.00	0.00			
			TOTAL ANCILLARY	915,884.30	35,135.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	915,884.30	35,135.35

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE VI

Run Date: 07/23/2014  
 Run Time: 09:52:45  
 Page: 11

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,255.40	ADJUSTMENTS	0.00
COVERED CHARGES	25,604.65	CONTRACTUAL ALLOW	12,972.12
NON-COVERD CHARGES	650.75	TOTAL MEDICAID LIAB	12,632.53
		LESS: COB	12,620.52
		LESS: COPAYMENT	12.01
		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: 07/23/2014  
 Run Time: 09:52:45  
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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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 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	1,496.50	0.00
MED/SURG SUPPLY	351.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,050.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,110.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,152.25	58.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	720.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,434.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,290.00	65.25
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	527.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	25,604.65	650.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	25,604.65	650.75

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 09:52:46  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,650,985.70	ADJUSTMENTS	45,374.46
COVERED CHARGES	1,546,039.70	CONTRACTUAL ALLOW	1,338,721.65
NON-COVERD CHARGES	104,946.00	TOTAL MEDICAID LIAB	207,318.05
		LESS: COB	4,810.59
		LESS: COPAYMENT	117.58
		REIMBURSEMENT	202,389.88

TOTAL NUMBER OF CLAIMS 41



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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,502.25	0.00	OTHER LAB	4,020.75	0.00
MED/SURG SUPPLY	296,585.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	15,785.00	1,148.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,432.00	5,172.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	574.75	FEE SCHEDULE LAB	38,114.00	3,463.25
EKG/ECG	1,576.00	2,758.00	MRI SERVICES	3,512.00	3,458.00
IV THERAPY	276.00	288.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	554,433.50	29,717.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	337.50	211.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	115,394.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,833.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,838.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,121.50	48,095.25
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	287,451.00	0.00
LITHOTRIPSY	38,863.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,124.00	2,254.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	47,545.00	7,805.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,296.00	0.00			
			TOTAL ANCILLARY	1,546,039.70	104,946.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,546,039.70	104,946.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FAIRVIEW PARK HOSPITAL  
200 INDUSTRIAL BLVD  
DUBLIN,GA 31021-2981

PROVIDER NUMBER  
000001141A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/12	THROUGH	04/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,295,367.00	ADJUSTMENTS	163,635.57
COVERED CHARGES	2,210,340.00	CONTRACTUAL ALLOW	1,613,249.18
NON-COVERD CHARGES	85,027.00	TOTAL MEDICAID LIAB	597,090.82
		LESS: COB	2,036.08
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	595,054.74

TOTAL NUMBER OF ADMISSIONS 115

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	379		9	361,945.00		55,313.00
ROUTINE NURSERY	43		0	19,648.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	422		9	381,593.00		55,313.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	26		0	39,572.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	26		0	39,572.00		0.00
TOTAL ACCOMODATIONS	448		9	421,165.00		55,313.00

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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	406,428.00	0.00	OTHER LAB	4,682.00	0.00
MED/SURG SUPPLY	117,562.02	2,304.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	279,193.00	8,823.00	EDUCATION & TRAINING	2,926.00	266.00
RADIOLOGY-DIAGNOSTIC	26,227.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	80,113.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,048.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,182.00	0.00	MRI SERVICES	10,058.00	0.00
IV THERAPY	4,048.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	125,685.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,041.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	90,276.00	1,306.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,255.00	1,176.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,410.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	404,087.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,909.00	184.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	321.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,193.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	18,667.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	26,876.00	14,844.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,864.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	52,123.98	811.00			
			TOTAL ANCILLARY	1,789,175.00	29,714.00
			TOTAL ACCOMODATIONS	421,165.00	55,313.00
			TOTAL CHARGES	2,210,340.00	85,027.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

LIBERTY REGIONAL MEDICAL CENTER  
462 ELMA G MILES PKWY  
HINESVILLE,GA 31313-4000

PROVIDER NUMBER  
000001152A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	12/01/12	THROUGH	11/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:40:38  
Page: 4

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 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,425,751.51	ADJUSTMENTS	334,899.84
COVERED CHARGES	4,024,430.01	CONTRACTUAL ALLOW	3,251,755.78
NON-COVERD CHARGES	401,321.50	TOTAL MEDICAID LIAB	772,674.23
		LESS: COB	4,143.92
		LESS: COPAYMENT	2,436.00
		REIMBURSEMENT	766,094.31
		ALL OTHER	683,451.61
		FEE SCHEDULE-LAB	79,727.45
		INJECTABLE DRUGS	2,915.25

TOTAL NUMBER OF CLAIMS 2,814

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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	291,585.00	1,288.00	OTHER LAB	44,871.00	0.00
MED/SURG SUPPLY	124,288.67	171.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1.00	EDUCATION & TRAINING	0.00	2,793.00
RADIOLOGY-DIAGNOSTIC	229,810.00	5,334.00	OTHER THERAPEUTIC SVC	0.00	151.00
CT SCAN	450,495.36	33,397.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	7,190.00	3,119.00	FEE SCHEDULE LAB	890,096.00	206,266.71
EKG/ECG	26,415.00	1,463.00	MRI SERVICES	122,652.00	15,749.00
IV THERAPY	775.00	126.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	266,326.00	13,803.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,752.00	0.00	REHAB THERAPY	0.00	1,958.00
RESPIRATORY SERVICES	33,645.70	10,693.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	927,340.00	25,159.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,730.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	116,481.00	12,524.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,132.00	505.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	498.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	428.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	14,799.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	222,697.00	41,096.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,226.00	8,298.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	28,207.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,213.00	2,082.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	158,702.88	14,418.79			
			TOTAL ANCILLARY	4,024,430.01	401,321.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,024,430.01	401,321.50

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: 07/23/2014  
Run Time: 12:41:29  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LIBERTY REGIONAL MEDICAL CENTER  
462 ELMA G MILES PKWY  
HINESVILLE,GA 31313-4000

PROVIDER NUMBER  
000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	110,237.83	ADJUSTMENTS	0.00
COVERED CHARGES	88,043.83	CONTRACTUAL ALLOW	58,238.80
NON-COVERD CHARGES	22,194.00	TOTAL MEDICAID LIAB	29,805.03
		LESS: COB	29,799.03
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 53



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,886.00	475.00	OTHER LAB	799.00	0.00
MED/SURG SUPPLY	4,445.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,007.00	772.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,370.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,892.00	7,533.00
EKG/ECG	266.00	532.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	131.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,640.00	2,417.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,022.00	4,742.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,327.00	1,401.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	799.00	3,995.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,590.57	196.00			
			TOTAL ANCILLARY	88,043.83	22,194.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	88,043.83	22,194.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:41:30  
Page: 8

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 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	361,693.93	ADJUSTMENTS	1,599.02
COVERED CHARGES	339,677.93	CONTRACTUAL ALLOW	318,062.90
NON-COVERD CHARGES	22,016.00	TOTAL MEDICAID LIAB	21,615.03
		LESS: COB	1.18
		LESS: COPAYMENT	465.03
		REIMBURSEMENT	21,148.82
		TOTAL NUMBER OF CLAIMS	435

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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,737.00	85.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,775.47	24.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,912.00	551.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,386.84	1,685.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	75,661.00	11,497.00
EKG/ECG	1,995.00	133.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,589.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,166.00	548.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	184,823.00	1,286.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	180.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,744.00	507.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,372.00	5,593.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,336.62	107.00			
			TOTAL ANCILLARY	339,677.93	22,016.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	339,677.93	22,016.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:41:37  
Page: 10

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 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,663.00	ADJUSTMENTS	0.00
COVERED CHARGES	12,244.00	CONTRACTUAL ALLOW	10,228.55
NON-COVERD CHARGES	419.00	TOTAL MEDICAID LIAB	2,015.45
		LESS: COB	2,000.45
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:41:37  
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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 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	597.00	9.00	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	1,075.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,048.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,402.00	410.00
EKG/ECG	133.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,646.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	101.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	12,244.00	419.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,244.00	419.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 12:41:38  
Page: 12

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 12/01/12 THROUGH 11/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	135,656.87	ADJUSTMENTS	13,913.67
COVERED CHARGES	130,558.87	CONTRACTUAL ALLOW	112,071.27
NON-COVERD CHARGES	5,098.00	TOTAL MEDICAID LIAB	18,487.60
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	18,466.60

TOTAL NUMBER OF CLAIMS 4

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LIBERTY REGIONAL MEDICAL CENTER  
 462 ELMA G MILES PKWY  
 HINESVILLE,GA 31313-4000

PROVIDER NUMBER  
 000001152A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 12/01/12 THROUGH 11/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,403.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	31,035.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	133.00
RADIOLOGY-DIAGNOSTIC	870.00	193.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,527.00	2,322.00
EKG/ECG	399.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	43,423.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,260.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,573.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	169.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,322.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,890.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,722.47	2,281.00			
			TOTAL ANCILLARY	130,558.87	5,098.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	130,558.87	5,098.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 12:41:39  
Page: 14

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	12/01/12	THROUGH	11/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 19:13:07  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER 000001163A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	200,438.75	ADJUSTMENTS	4,873.07
COVERED CHARGES	196,592.25	CONTRACTUAL ALLOW	103,603.10
NON-COVERD CHARGES	3,846.50	TOTAL MEDICAID LIAB	92,989.15
		LESS: COB	1,430.14
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	91,559.01

TOTAL NUMBER OF ADMISSIONS 19

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	65		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	65		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	65		0	25,480.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,139.50	0.00	OTHER LAB	955.00	0.00
MED/SURG SUPPLY	14,647.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	23,555.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,732.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,998.00	3,318.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,225.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,492.50	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	9,557.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,863.50	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	5,849.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	883.50	528.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,351.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	861.00	0.00			
			TOTAL ANCILLARY	171,112.25	3,846.50
			TOTAL ACCOMODATIONS	25,480.00	0.00
			TOTAL CHARGES	196,592.25	3,846.50

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 19:13:14  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 19:13:14  
Page: 4

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	751,819.10	ADJUSTMENTS	37,591.05
COVERED CHARGES	691,435.75	CONTRACTUAL ALLOW	384,860.38
NON-COVERD CHARGES	60,383.35	TOTAL MEDICAID LIAB	306,575.37
		LESS: COB	40.47
		LESS: COPAYMENT	1,131.00
		REIMBURSEMENT	305,403.90
		ALL OTHER	278,007.89
		FEE SCHEDULE-LAB	27,127.08
		INJECTABLE DRUGS	268.93

TOTAL NUMBER OF CLAIMS 907

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 19:13:14  
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LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	54,996.50	0.00	OTHER LAB	4,816.00	0.00
MED/SURG SUPPLY	19,034.25	472.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	43,318.50	863.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	92,861.00	1,871.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,557.00	4,983.50	FEE SCHEDULE LAB	127,043.00	33,047.35
EKG/ECG	10,955.00	1,252.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,647.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,565.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	169,845.00	2,695.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,053.50	3,733.50
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	292.00	1,001.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	397.50	1,462.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	488.00
OTHER IMAGING SERVICE	4,128.00	457.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	267.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	10,780.00	7,700.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	110,520.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,359.00	357.00			
			TOTAL ANCILLARY	691,435.75	60,383.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	691,435.75	60,383.35

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: 07/23/2014  
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LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
4500	5913274000451	08/13/13 - 08/13/13	10/07/13	0.00	488.00	0.00	0.00	0.00
TOTAL				0.00	488.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 19:13:46  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 19:13:46  
Page: 8

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	69,790.25	ADJUSTMENTS	100.00
COVERED CHARGES	67,720.00	CONTRACTUAL ALLOW	60,566.00
NON-COVERD CHARGES	2,070.25	TOTAL MEDICAID LIAB	7,154.00
		LESS: COB	554.00
		LESS: COPAYMENT	213.00
		REIMBURSEMENT	6,387.00
		TOTAL NUMBER OF CLAIMS	132



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,769.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,208.00	117.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,842.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,340.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	144.50	0.00	FEE SCHEDULE LAB	9,175.25	1,586.75
EKG/ECG	939.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	677.00	0.00	PROFESSIONAL FEES	0.00	302.50
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	242.50	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	42,179.00	63.50	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	202.50	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	67,720.00	2,070.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,720.00	2,070.25

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 19:13:50  
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LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	197.00	ADJUSTMENTS	0.00
COVERED CHARGES	197.00	CONTRACTUAL ALLOW	134.59
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	62.41
		LESS: COB	62.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

LOUIS SMITH MEMORIAL HOSPITAL  
 116 W THIGPEN AVENUE  
 LAKELAND,GA 31635-1006

PROVIDER NUMBER  
 000001163A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	197.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	197.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	197.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 19:13:51  
Page: 13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOUIS SMITH MEMORIAL HOSPITAL  
116 W THIGPEN AVENUE  
LAKELAND,GA 31635-1006

PROVIDER NUMBER  
000001163A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:50:05  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
 521 HILL ST  
 THOMSON,GA 30824-0000

PROVIDER NUMBER  
 000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,012,473.58	ADJUSTMENTS	13,947.63
COVERED CHARGES	1,009,276.38	CONTRACTUAL ALLOW	537,377.08
NON-COVERD CHARGES	3,197.20	TOTAL MEDICAID LIAB	471,899.30
		LESS: COB	4,752.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	467,146.44

TOTAL NUMBER OF ADMISSIONS 55

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	163		3	91,606.00		1,686.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	163		3	91,606.00		1,686.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	163		3	91,606.00		1,686.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
 521 HILL ST  
 THOMSON,GA 30824-0000

PROVIDER NUMBER  
 000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	204,100.53	0.00	OTHER LAB	856.25	0.00
MED/SURG SUPPLY	49,249.42	71.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	56,948.95	0.00	EDUCATION & TRAINING	326.40	0.00
RADIOLOGY-DIAGNOSTIC	12,201.85	0.00	OTHER THERAPEUTIC SVC	0.00	525.90
CT SCAN	29,106.55	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,820.10	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,459.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,548.85	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,980.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,515.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,448.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,280.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,576.50	914.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,130.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,214.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,505.45	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	324,033.03	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,269.60	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,112.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,987.45	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	917,670.38	1,511.20
			TOTAL ACCOMODATIONS	91,606.00	1,686.00
			TOTAL CHARGES	1,009,276.38	3,197.20

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:50:07  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:50:07  
Page: 4

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,125,120.73	ADJUSTMENTS	144,081.78
COVERED CHARGES	1,887,538.16	CONTRACTUAL ALLOW	1,261,855.82
NON-COVERD CHARGES	237,582.57	TOTAL MEDICAID LIAB	625,682.34
		LESS: COB	312.76
		LESS: COPAYMENT	1,533.00
		REIMBURSEMENT	623,836.58
		ALL OTHER	584,097.57
		FEE SCHEDULE-LAB	30,115.35
		INJECTABLE DRUGS	9,623.66

TOTAL NUMBER OF CLAIMS 1,718

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
 521 HILL ST  
 THOMSON,GA 30824-0000

PROVIDER NUMBER  
 000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	103,844.09	71.30	OTHER LAB	9,611.60	0.00
MED/SURG SUPPLY	112,043.79	692.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	73.15	EDUCATION & TRAINING	0.00	598.20
RADIOLOGY-DIAGNOSTIC	103,712.75	4,110.70	OTHER THERAPEUTIC SVC	0.00	19,725.80
CT SCAN	103,324.40	24,710.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	179,657.84	43,601.04
EKG/ECG	16,183.70	500.55	MRI SERVICES	0.00	0.00
IV THERAPY	97,082.45	17,117.15	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	264,417.97	51,026.33	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,518.65	5,982.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,554.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	19,350.00	13,410.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	484,975.70	2,499.95	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,308.10	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	70,013.43	38,893.23
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,007.40	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,036.94	9,065.65
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	76,878.25	1,745.85			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,001.25	2,110.65			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,755.45	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	78,424.70	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	50,842.40	640.80			
			TOTAL ANCILLARY	1,887,538.16	237,582.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,887,538.16	237,582.57

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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Page: 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,421.97	ADJUSTMENTS	0.00
COVERED CHARGES	18,847.33	CONTRACTUAL ALLOW	11,839.32
NON-COVERD CHARGES	5,574.64	TOTAL MEDICAID LIAB	7,008.01
		LESS: COB	6,993.01
		LESS: COPAYMENT	15.00
		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

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 521 HILL ST 000001185A SERVICE DATES 01/01/13 THROUGH 12/31/13  
 THOMSON,GA 30824-0000 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,410.77	0.00	OTHER LAB	830.15	0.00
MED/SURG SUPPLY	1,700.46	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,271.55	0.00	OTHER THERAPEUTIC SVC	0.00	145.30
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,609.30	256.50
EKG/ECG	166.85	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,886.70	370.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	3,440.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	180.35	478.30	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,593.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	520.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,378.35	793.24
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	394.65	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,904.10	91.30			
			TOTAL ANCILLARY	18,847.33	5,574.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,847.33	5,574.64

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:50:37  
Page: 8

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	109,832.34	ADJUSTMENTS	273.70
COVERED CHARGES	101,014.59	CONTRACTUAL ALLOW	91,336.97
NON-COVERD CHARGES	8,817.75	TOTAL MEDICAID LIAB	9,677.62
		LESS: COB	0.00
		LESS: COPAYMENT	282.00
		REIMBURSEMENT	9,395.62
		TOTAL NUMBER OF CLAIMS	173

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
521 HILL ST	000001185A	SERVICE DATES	01/01/13	THROUGH	12/31/13
THOMSON,GA 30824-0000		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,826.98	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,451.49	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	40.80
RADIOLOGY-DIAGNOSTIC	2,072.00	0.00	OTHER THERAPEUTIC SVC	0.00	2,460.10
CT SCAN	4,941.80	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,177.45	2,016.85
EKG/ECG	837.40	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,407.95	480.35	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,450.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	74.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	58,552.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	401.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,803.47	2,323.40
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	14.00	1,496.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	849.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,154.40	0.00			
			TOTAL ANCILLARY	101,014.59	8,817.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	101,014.59	8,817.75

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER  
521 HILL ST  
THOMSON,GA 30824-0000

PROVIDER NUMBER  
000001185A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	56,960.60	ADJUSTMENTS	5,084.50
COVERED CHARGES	54,834.38	CONTRACTUAL ALLOW	39,562.88
NON-COVERD CHARGES	2,126.22	TOTAL MEDICAID LIAB	15,271.50
		LESS: COB	0.00
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	15,262.50
		TOTAL NUMBER OF CLAIMS	3



SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
521 HILL ST	000001185A	SERVICE DATES	01/01/13	THROUGH	12/31/13
THOMSON,GA 30824-0000		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,430.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,226.93	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	531.75	0.00	OTHER THERAPEUTIC SVC	0.00	231.90
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	440.55	FEE SCHEDULE LAB	388.60	42.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,039.30	185.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,070.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	105.30	210.60	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,065.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,010.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,279.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,001.95	1,015.67
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	12,616.95	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,067.85	0.00			
			TOTAL ANCILLARY	54,834.38	2,126.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,834.38	2,126.22

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY MCDUFFIE COUNTY REGIONAL MEDICAL CENTER	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
521 HILL ST	000001185A	SERVICE DATES	01/01/13	THROUGH	12/31/13
THOMSON,GA 30824-0000		ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:57:01  
 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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,484,852.17	ADJUSTMENTS	3,108,642.45
COVERED CHARGES	47,017,975.66	CONTRACTUAL ALLOW	30,691,921.66
NON-COVERD CHARGES	466,876.51	TOTAL MEDICAID LIAB	16,326,054.00
		LESS: COB	191,300.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	16,134,753.67

TOTAL NUMBER OF ADMISSIONS 1,803

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,638		1	4,850,308.00		26,756.00
ROUTINE NURSERY	1,939		0	1,216,884.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9,577		1	6,067,192.00		26,756.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,073		0	1,533,666.00		4,257.00
NICU	319		0	455,785.00		0.00
PED ICU	13		0	18,447.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,405		0	2,007,898.00		4,257.00
TOTAL ACCOMODATIONS	10,982		1	8,075,090.00		31,013.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,385,135.89	20,936.60	OTHER LAB	241,242.90	0.00
MED/SURG SUPPLY	4,309,623.70	52,907.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,196,137.97	92,182.44	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	941,759.70	976.05	OTHER THERAPEUTIC SVC	16,566.88	3,601.00
CT SCAN	2,014,357.30	10,691.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	394,906.00	3,590.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	665,592.40	6,780.40	MRI SERVICES	774,433.11	0.00
IV THERAPY	292,220.88	10,640.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,046,346.23	12,780.02	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	931,778.47	9,158.55	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,730,256.34	7,352.99	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	164,888.00	0.00	AMBULANCE	0.00	4,378.05
GI SERVICES	139.15	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,055,324.53	6,143.21	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	295,929.30	318.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	218,493.70	683.00	INJECTABLE DRUGS	1,021,830.05	0.00
RADIOLOGY THERAPEUTIC	208,586.95	1,167.27	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	101,368.00	1,363.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	88,139.82	432.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	144,072.00	28,152.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,308.60	28,112.48	TRAUMA RESPONSE	0.00	2,337.95
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	898,752.18	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	410,873.70	9,892.54			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,407,720.00	108,258.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	87,912.95	10,061.40			
AUDIOLOGY	64,678.87	607.80			
CARDIOLOGY	636,906.31	1,122.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	49,442.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	142,161.38	1,237.28			
			TOTAL ANCILLARY	38,942,885.66	435,863.51
			TOTAL ACCOMODATIONS	8,075,090.00	31,013.00
			TOTAL CHARGES	47,017,975.66	466,876.51

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	538,083.82	ADJUSTMENTS	0.00
COVERED CHARGES	537,783.82	CONTRACTUAL ALLOW	172,248.91
NON-COVERD CHARGES	300.00	TOTAL MEDICAID LIAB	365,534.91
		LESS: COB	365,534.91
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	124		0	80,340.00		300.00
ROUTINE NURSERY	79		0	62,388.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	203		0	142,728.00		300.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	10		0	14,190.00		0.00
PED ICU	4		0	5,676.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	14		0	19,866.00		0.00
TOTAL ACCOMODATIONS	217		0	162,594.00		300.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109,620.45	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	71,798.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	48,324.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,240.24	0.00	OTHER THERAPEUTIC SVC	404.00	0.00
CT SCAN	4,067.20	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,035.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	695.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	818.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,932.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	30,995.28	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	22,595.33	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,340.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,814.76	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,363.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,259.40	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	48.26	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,069.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,156.85	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	21,494.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	707.40	0.00			
CARDIOLOGY	2,986.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,425.00	0.00			
			TOTAL ANCILLARY	375,189.82	0.00
			TOTAL ACCOMODATIONS	162,594.00	300.00
			TOTAL CHARGES	537,783.82	300.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:57:50  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,157,137.82	ADJUSTMENTS	1,279,829.49
COVERED CHARGES	22,528,618.87	CONTRACTUAL ALLOW	16,354,042.27
NON-COVERD CHARGES	1,628,518.95	TOTAL MEDICAID LIAB	6,174,576.60
		LESS: COB	16,075.46
		LESS: COPAYMENT	23,077.23
		REIMBURSEMENT	6,135,423.91
		ALL OTHER	5,343,290.24
		FEE SCHEDULE-LAB	455,621.21
		INJECTABLE DRUGS	336,512.46

TOTAL NUMBER OF CLAIMS 16,239

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,038,839.46	7,614.60	OTHER LAB	136,150.49	534.40
MED/SURG SUPPLY	644,669.12	3,534.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	927,942.95	20,122.83	OTHER THERAPEUTIC SVC	2,338.52	128.00
CT SCAN	2,129,775.50	215,352.95	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	71,617.00	21,256.00	FEE SCHEDULE LAB	3,624,904.58	753,871.29
EKG/ECG	211,169.40	17,489.20	MRI SERVICES	591,811.14	37,891.08
IV THERAPY	1,167,677.38	19,387.57	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,179,362.57	78,160.10	DURABLE MED. EQUIP.	0.00	542.88
LABOR/DELIVERY ROOM	30,354.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	183,070.79	14,009.23	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	60,394.00	292.00	AMBULANCE	0.00	0.00
GI SERVICES	1,257.60	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,778,674.63	56,967.58	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	396,015.60	0.00	DRUG-SPECIFIC/HOME IV	782.65	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,972,047.35	226,591.50
RADIOLOGY THERAPEUTIC	663,213.02	8,335.10	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,008.00	4,227.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	714.00	1,357.49	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	18,803.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	665,340.17	36,256.46	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	121,947.12	4,278.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	179.40
OTHER IMAGING SERVICE	812,559.76	41,258.99			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	254,267.46	9,742.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	150,950.95	3,172.30			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	241,298.92	27,038.00			
AMBULATORY SURGERY	3,054.00	126.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	38,819.93	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	404,590.11	0.00			
			TOTAL ANCILLARY	22,528,618.87	1,628,518.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,528,618.87	1,628,518.95



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: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3001	5913322000325	04/30/13 - 04/30/13	11/25/13	0.00	179.40	0.00	0.00	0.00
TOTAL				0.00	179.40	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  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 12:02:06  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	430,636.31	ADJUSTMENTS	0.00
COVERED CHARGES	349,225.16	CONTRACTUAL ALLOW	127,196.42
NON-COVERD CHARGES	81,411.15	TOTAL MEDICAID LIAB	222,028.74
		LESS: COB	221,914.74
		LESS: COPAYMENT	114.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 174

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,254.90	1,619.15	OTHER LAB	1,099.36	0.00
MED/SURG SUPPLY	14,476.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	197.38	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,871.14	209.30	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,608.50	13,569.15	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	164.00	FEE SCHEDULE LAB	57,135.29	5,734.28
EKG/ECG	1,252.35	0.00	MRI SERVICES	5,158.18	0.00
IV THERAPY	30,837.23	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,797.10	8,548.12	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	198.84	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,576.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	88,115.71	3,346.37	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,274.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,981.80	34,666.05
RADIOLOGY THERAPEUTIC	0.00	890.90	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	2,980.36	1,325.15	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,952.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	102.00	0.00
OTHER IMAGING SERVICE	22,066.54	8,685.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	406.00	504.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	949.90	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,328.88	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,755.08	0.00			
			TOTAL ANCILLARY	349,225.16	81,411.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	349,225.16	81,411.15

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	1013270000207	04/08/13 - 04/08/13	10/21/13	102.00	0.00	0.00	0.00	0.00
TOTAL				102.00	0.00	0.00	0.00	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:02:11  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	657,398.01	ADJUSTMENTS	1,471.38
COVERED CHARGES	627,224.41	CONTRACTUAL ALLOW	588,936.51
NON-COVERD CHARGES	30,173.60	TOTAL MEDICAID LIAB	38,287.90
		LESS: COB	219.26
		LESS: COPAYMENT	969.03
		REIMBURSEMENT	37,099.61
		TOTAL NUMBER OF CLAIMS	682

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,029.65	239.50	OTHER LAB	409.96	0.00
MED/SURG SUPPLY	8,206.00	222.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,804.22	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,756.95	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	104,219.53	15,905.52
EKG/ECG	3,061.30	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,963.71	818.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	782.87	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,619.86	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	324,132.99	896.46	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	21,446.80	9,596.90
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	1,656.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,946.75	448.23	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	4,681.07	390.49			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,692.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,150.75	0.00			
			TOTAL ANCILLARY	627,224.41	30,173.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	627,224.41	30,173.60

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: 07/23/2014  
Run Time: 12:02:20  
Page: 13

MIDTOWN MEDICAL CENTER  
710 CENTER STREET  
COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,920.95	ADJUSTMENTS	0.00
COVERED CHARGES	15,313.41	CONTRACTUAL ALLOW	12,513.99
NON-COVERD CHARGES	2,607.54	TOTAL MEDICAID LIAB	2,799.42
		LESS: COB	2,790.41
		LESS: COPAYMENT	9.01
		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: 07/23/2014  
 Run Time: 12:02:20  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MIDTOWN MEDICAL CENTER  
 710 CENTER STREET  
 COLUMBUS,GA 31902-1527

PROVIDER NUMBER  
 000001196A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	202.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	586.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	884.89	203.55	OTHER THERAPEUTIC SVC	180.96	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,671.49	1,555.41
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	818.50	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	5,397.88	369.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,180.40	0.00
RADIOLOGY THERAPEUTIC	0.00	89.09	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	390.49	390.49			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,313.41	2,607.54
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,313.41	2,607.54



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,574,134.32	ADJUSTMENTS	373,680.17
COVERED CHARGES	4,371,255.02	CONTRACTUAL ALLOW	3,545,708.91
NON-COVERD CHARGES	202,879.30	TOTAL MEDICAID LIAB	825,546.11
		LESS: COB	0.00
		LESS: COPAYMENT	2,712.00
		REIMBURSEMENT	822,834.11

TOTAL NUMBER OF CLAIMS 152

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	95,060.65	1,213.00	OTHER LAB	4,072.13	1,504.00
MED/SURG SUPPLY	130,006.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,656.85	17,322.03	OTHER THERAPEUTIC SVC	3,604.72	334.00
CT SCAN	133,024.15	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	697.00	FEE SCHEDULE LAB	79,921.12	11,010.96
EKG/ECG	3,093.50	139.15	MRI SERVICES	10,761.41	3,111.79
IV THERAPY	339,121.83	17,791.10	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	253,495.15	9,406.33	DURABLE MED. EQUIP.	0.00	464.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	102,334.70	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,360.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,309.10	3,314.14	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,083.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,589,245.46	81,455.40
RADIOLOGY THERAPEUTIC	1,184,593.65	24,021.70	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	204.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,334.15	451.70	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	114,434.00	23,775.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	36,065.49	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	124,221.00	4,998.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,460.45	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,857.70	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	21,137.96	1,666.00			
			TOTAL ANCILLARY	4,371,255.02	202,879.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,371,255.02	202,879.30

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: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER 000001207A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	155,510,745.04	ADJUSTMENTS	9,095,950.36
COVERED CHARGES	152,437,906.74	CONTRACTUAL ALLOW	105,984,540.65
NON-COVERD CHARGES	3,072,838.30	TOTAL MEDICAID LIAB	46,453,366.09
		LESS: COB	395,439.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	46,057,926.68

TOTAL NUMBER OF ADMISSIONS 3,884

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	17,228	11	11,527,950.00	526,400.00
ROUTINE NURSERY	609	1	240,555.00	97,690.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	17,837	12	11,768,505.00	624,090.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	4,200	0	8,661,350.00	8,410.00
NICU	1,869	0	3,775,395.00	0.00
PED ICU	949	0	2,261,105.00	19,200.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	7,018	0	14,697,850.00	27,610.00
TOTAL ACCOMODATIONS	24,855	12	26,466,355.00	651,700.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	33,422,640.75	551,964.38	OTHER LAB	878,928.00	24,711.00
MED/SURG SUPPLY	9,474,665.05	253,285.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,554,650.03	292,680.90	EDUCATION & TRAINING	370.00	0.00
RADIOLOGY-DIAGNOSTIC	3,743,277.00	13,806.00	OTHER THERAPEUTIC SVC	0.00	14,179.00
CT SCAN	6,492,232.00	193,173.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	561,288.00	20,693.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	663,389.00	296.00	MRI SERVICES	1,908,952.00	12,818.00
IV THERAPY	1,714,543.00	66,602.00	PROFESSIONAL FEES	0.00	581.00
OPERATING ROOM	7,794,699.00	193,871.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,588,473.00	2,845.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,764,551.00	182,648.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,332,229.00	12,334.00	AMBULANCE	0.00	0.00
GI SERVICES	29,617.00	5,022.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,214,204.00	3,379.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,159,670.00	17,128.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	296,826.00	3,801.00	INJECTABLE DRUGS	4,380,067.91	104,479.85
RADIOLOGY THERAPEUTIC	155,471.00	3,225.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	319,549.00	12,691.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	364,969.00	9,259.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	844,310.00	190,670.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	63,697.00	TRAUMA RESPONSE	0.00	7,457.00
PSYCHIATRIC SERVICES	106,645.00	76.00	IMPL DEV CHARGE PATIENTS	7,295,552.00	27,015.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	862.00
OTHER IMAGING SERVICE	446,989.00	21,204.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,754,893.00	25,356.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	558,614.00	38,912.00			
AUDIOLOGY	468.00	0.00			
CARDIOLOGY	7,766,705.00	11,178.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	86,845.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,295,270.00	39,239.00			
			TOTAL ANCILLARY	125,971,551.74	2,421,138.30
			TOTAL ACCOMODATIONS	26,466,355.00	651,700.00
			TOTAL CHARGES	152,437,906.74	3,072,838.30

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 08:40:23  
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MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
862	2213309005670	07/01/13 - 07/08/13	11/11/13	0.00	862.00	0.00	0.00	0.00
TOTAL				0.00	862.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 08:43:35  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	661,263.85	ADJUSTMENTS	0.00
COVERED CHARGES	634,050.55	CONTRACTUAL ALLOW	488,596.51
NON-COVERD CHARGES	27,213.30	TOTAL MEDICAID LIAB	145,454.04
		LESS: COB	145,454.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	4,110.00		2,055.00
ROUTINE NURSERY	0		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	4,110.00		2,055.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	0.00		4,800.00
NICU	111		0	266,400.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	113		0	266,400.00		4,800.00
TOTAL ACCOMODATIONS	122		0	270,510.00		6,855.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,584.95	9,079.91	OTHER LAB	245.00	0.00
MED/SURG SUPPLY	27,456.00	1,770.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	24,757.62	6,151.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,485.00	894.00	OTHER THERAPEUTIC SVC	0.00	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	444.00	148.00	MRI SERVICES	0.00	0.00
IV THERAPY	388.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,531.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	985.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	152,195.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	922.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,164.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,218.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,259.98	1,801.39
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	863.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,219.00	514.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	39,250.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,343.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,216.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	18,205.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,809.00	0.00			
			TOTAL ANCILLARY	363,540.55	20,358.30
			TOTAL ACCOMODATIONS	270,510.00	6,855.00
			TOTAL CHARGES	634,050.55	27,213.30



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 08:43:42  
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MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	55,015,719.13	ADJUSTMENTS	3,547,723.80
COVERED CHARGES	49,702,075.18	CONTRACTUAL ALLOW	38,693,688.22
NON-COVERD CHARGES	5,313,643.95	TOTAL MEDICAID LIAB	11,008,386.96
		LESS: COB	34,128.84
		LESS: COPAYMENT	38,506.00
		REIMBURSEMENT	10,935,752.12
		ALL OTHER	8,921,690.97
		FEE SCHEDULE-LAB	1,124,733.29
		INJECTABLE DRUGS	889,327.86

TOTAL NUMBER OF CLAIMS 30,088

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,173,870.31	5,653.94	OTHER LAB	339,211.00	11,286.00
MED/SURG SUPPLY	1,935,242.00	14,829.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	506.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,119,031.00	98,827.00	OTHER THERAPEUTIC SVC	7,550.00	76.00
CT SCAN	3,643,087.00	174,204.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	32,361.00	8,477.00	FEE SCHEDULE LAB	8,239,406.05	1,859,302.86
EKG/ECG	301,013.00	25,012.00	MRI SERVICES	79,595.00	46,508.00
IV THERAPY	1,810,422.00	386,250.00	PROFESSIONAL FEES	0.00	943.00
OPERATING ROOM	4,529,666.00	338,574.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	313,568.00	8,585.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	270,348.00	9,349.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,014,366.00	3,220.00	AMBULANCE	0.00	0.00
GI SERVICES	86,908.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,690,827.00	12,396.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,555,549.00	2,682.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,902,931.62	1,185,545.36
RADIOLOGY THERAPEUTIC	129,863.00	10,418.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,493.00	2,222.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	38,485.00	3,351.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,862.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,754,599.00	41,990.79	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	5,230.00	152.00	IMPL DEV CHARGE PATIENTS	406,201.00	751,877.00
LITHOTRIPSY	7,707.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	537,622.00	50,286.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	556,000.00	2,285.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	699,151.00	35,965.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,443,300.00	114,110.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	129,614.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,941,858.20	105,899.00			
			TOTAL ANCILLARY	49,702,075.18	5,313,643.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	49,702,075.18	5,313,643.95

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	311,327.27	ADJUSTMENTS	0.00
COVERED CHARGES	262,543.18	CONTRACTUAL ALLOW	255,122.27
NON-COVERD CHARGES	48,784.09	TOTAL MEDICAID LIAB	7,420.91
		LESS: COB	7,236.62
		LESS: COPAYMENT	184.29
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 74

Report : CLM-0806-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEDICAL CENTER OF CENTRAL GEORGIA PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 777 HEMLOCK ST 000001207A SERVICE DATES 10/01/12 THROUGH 09/30/13  
 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	14,487.48	0.00	OTHER LAB	1,807.00	0.00
MED/SURG SUPPLY	4,223.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,835.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,659.00	4,952.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,632.00	6,107.00
EKG/ECG	1,924.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,317.00	1,800.00	PROFESSIONAL FEES	0.00	423.00
OPERATING ROOM	9,624.00	2,870.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	347.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,414.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,323.00	1,494.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,282.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	101,525.70	27,537.09
RADIOLOGY THERAPEUTIC	2,268.00	458.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,114.00	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	378.00	406.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,347.00	721.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,772.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,264.00	2,016.00			
			TOTAL ANCILLARY	262,543.18	48,784.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	262,543.18	48,784.09

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,089,473.62	ADJUSTMENTS	3,092.58
COVERED CHARGES	1,025,882.54	CONTRACTUAL ALLOW	972,950.38
NON-COVERD CHARGES	63,591.08	TOTAL MEDICAID LIAB	52,932.16
		LESS: COB	180.74
		LESS: COPAYMENT	1,968.07
		REIMBURSEMENT	50,783.35
		TOTAL NUMBER OF CLAIMS	943

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,471.93	0.00	OTHER LAB	4,583.00	0.00
MED/SURG SUPPLY	12,614.00	54.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	109.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,006.00	214.00	OTHER THERAPEUTIC SVC	76.00	0.00
CT SCAN	24,905.00	5,458.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	159,210.00	46,054.00
EKG/ECG	9,916.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	55,702.00	4,417.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	461.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	582.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,878.00	552.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	593.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,185.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	598,559.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,136.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,057.61	689.08
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	4,614.00	237.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,251.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,954.00	5,807.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,128.00	0.00			
			TOTAL ANCILLARY	1,025,882.54	63,591.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,025,882.54	63,591.08

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: 07/23/2014  
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Page: 12

MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,919.53	ADJUSTMENTS	0.00
COVERED CHARGES	9,329.53	CONTRACTUAL ALLOW	8,265.85
NON-COVERD CHARGES	590.00	TOTAL MEDICAID LIAB	1,063.68
		LESS: COB	1,060.68
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MEDICAL CENTER OF CENTRAL GEORGIA  
 777 HEMLOCK ST  
 MACON,GA 31201-2102

PROVIDER NUMBER  
 000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	372.53	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	113.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	428.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,952.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	556.00	590.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	837.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,898.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	173.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,329.53	590.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,329.53	590.00



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,865,139.52	ADJUSTMENTS	635,905.03
COVERED CHARGES	8,782,340.95	CONTRACTUAL ALLOW	7,469,536.62
NON-COVERD CHARGES	1,082,798.57	TOTAL MEDICAID LIAB	1,312,804.33
		LESS: COB	0.00
		LESS: COPAYMENT	962.95
		REIMBURSEMENT	1,311,841.38

TOTAL NUMBER OF CLAIMS 233

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
777 HEMLOCK ST	000001207A	SERVICE DATES	10/01/12	THROUGH	09/30/13
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	421,289.23	0.00	OTHER LAB	144,411.00	22,573.00
MED/SURG SUPPLY	585,623.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	237,642.00	119,087.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,770.00	16,511.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	343.00	343.00	FEE SCHEDULE LAB	172,091.30	38,091.50
EKG/ECG	11,100.00	7,252.00	MRI SERVICES	19,118.00	3,004.00
IV THERAPY	89,304.00	26,180.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	898,748.00	152,177.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	139,124.00	29,367.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	65,933.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	54,983.00	9,182.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	78,831.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,194,232.42	26,521.07
RADIOLOGY THERAPEUTIC	26,699.00	6,068.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,724.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,333.00	341.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,455,731.00	266,406.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,323.00	393.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,461.00	21,836.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	36,845.00	1,075.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	527,915.00	279,873.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,272.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	504,219.00	50,794.00			
			TOTAL ANCILLARY	8,782,340.95	1,082,798.57
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,782,340.95	1,082,798.57

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEDICAL CENTER OF CENTRAL GEORGIA  
777 HEMLOCK ST  
MACON,GA 31201-2102

PROVIDER NUMBER  
000001207A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
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

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	959,753.11	ADJUSTMENTS	97,400.11
COVERED CHARGES	930,471.11	CONTRACTUAL ALLOW	299,802.47
NON-COVERD CHARGES	29,282.00	TOTAL MEDICAID LIAB	630,668.64
		LESS: COB	3,448.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	627,220.42

TOTAL NUMBER OF ADMISSIONS 92

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	226		0	72,320.00		0.00
ROUTINE NURSERY	28		0	8,960.00		432.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	254		0	81,280.00		432.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	84		0	56,700.00		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	84		0	56,700.00		0.00
TOTAL ACCOMODATIONS	338		0	137,980.00		432.00

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	236,328.27	0.00	OTHER LAB	2,052.00	0.00
MED/SURG SUPPLY	71,251.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	199,417.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,774.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,914.00	25,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,187.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,110.00	0.00	MRI SERVICES	1,642.00	0.00
IV THERAPY	13,019.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	48,319.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,930.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	69,059.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	15,585.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,543.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,667.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	80.00	0.00	INJECTABLE DRUGS	224.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	625.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,947.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,866.00	3,250.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,278.00	0.00			
AUDIOLOGY	350.00	0.00			
CARDIOLOGY	5,658.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,664.00	0.00			
			TOTAL ANCILLARY	792,491.11	28,850.00
			TOTAL ACCOMODATIONS	137,980.00	432.00
			TOTAL CHARGES	930,471.11	29,282.00

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	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,128,152.40	ADJUSTMENTS	187,054.81
COVERED CHARGES	1,949,033.60	CONTRACTUAL ALLOW	1,299,969.54
NON-COVERD CHARGES	179,118.80	TOTAL MEDICAID LIAB	649,064.06
		LESS: COB	1,467.55
		LESS: COPAYMENT	2,229.00
		REIMBURSEMENT	645,367.51
		ALL OTHER	490,963.31
		FEE SCHEDULE-LAB	129,978.46
		INJECTABLE DRUGS	24,425.74

TOTAL NUMBER OF CLAIMS 2,133

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,569.23	691.70	OTHER LAB	13,041.00	0.00
MED/SURG SUPPLY	64,057.75	629.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105,083.00	1,055.50	OTHER THERAPEUTIC SVC	0.00	228.00
CT SCAN	223,287.00	30,800.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,491.00	2,102.00	FEE SCHEDULE LAB	569,483.50	73,615.00
EKG/ECG	17,202.00	650.00	MRI SERVICES	36,280.00	3,284.00
IV THERAPY	23,742.00	10,667.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	108,976.50	15,921.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,174.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	24,223.75	1,973.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	35,411.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	295,327.00	7,917.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,801.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	148,760.14	17,829.00
RADIOLOGY THERAPEUTIC	6,433.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,879.00	517.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	597.00	269.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,770.00	500.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,090.00	75.00	IMPL DEV CHARGE PATIENTS	807.75	3,060.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	29,176.75	2,711.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,465.00	1,500.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,442.00	0.00			
AUDIOLOGY	0.00	100.00			
CARDIOLOGY	7,128.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,500.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,833.73	3,021.90			
			TOTAL ANCILLARY	1,949,033.60	179,118.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,949,033.60	179,118.80



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,087.38	ADJUSTMENTS	0.00
COVERED CHARGES	8,206.88	CONTRACTUAL ALLOW	3,960.18
NON-COVERD CHARGES	880.50	TOTAL MEDICAID LIAB	4,246.70
		LESS: COB	4,228.70
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	91.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,953.50	0.00	OTHER THERAPEUTIC SVC	0.00	51.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,761.50	529.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	165.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,597.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	191.68	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	125.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	416.00	175.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,206.88	880.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,206.88	880.50

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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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	47,559.43	ADJUSTMENTS	437.89
COVERED CHARGES	46,530.58	CONTRACTUAL ALLOW	39,132.86
NON-COVERD CHARGES	1,028.85	TOTAL MEDICAID LIAB	7,397.72
		LESS: COB	0.00
		LESS: COPAYMENT	276.02
		REIMBURSEMENT	7,121.70
		TOTAL NUMBER OF CLAIMS	135

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	885.18	7.50	OTHER LAB	432.00	0.00
MED/SURG SUPPLY	673.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,320.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,787.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,623.00	421.50
EKG/ECG	325.00	0.00	MRI SERVICES	918.00	0.00
IV THERAPY	175.00	300.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	134.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,166.00	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	1,829.55	99.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	972.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	290.00	50.00			
			TOTAL ANCILLARY	46,530.58	1,028.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	46,530.58	1,028.85

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:22:33  
Page: 10

WASHINGTON COUNTY REGIONAL MEDICAL  
610 SPARTA ROAD  
SANDERSVILLE,GA 31082-1860

PROVIDER NUMBER  
000001218A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 11:22:34  
Page: 11

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	226,334.78	ADJUSTMENTS	36,873.54
COVERED CHARGES	226,102.48	CONTRACTUAL ALLOW	189,126.94
NON-COVERD CHARGES	232.30	TOTAL MEDICAID LIAB	36,975.54
		LESS: COB	0.00
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	36,873.54

TOTAL NUMBER OF CLAIMS 7

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,277.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,169.05	94.80	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	162.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,161.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	684.00	125.00	FEE SCHEDULE LAB	3,208.50	12.50
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	275.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,807.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,884.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	648.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	425.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	445.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	178,095.36	0.00
RADIOLOGY THERAPEUTIC	6,103.50	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	805.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	952.00	0.00			
			TOTAL ANCILLARY	226,102.48	232.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	226,102.48	232.30

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: 07/23/2014  
Run Time: 11:22:35  
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	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER 000001229A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,227,189.42	ADJUSTMENTS	372,878.08
COVERED CHARGES	14,956,259.49	CONTRACTUAL ALLOW	9,307,186.86
NON-COVERD CHARGES	270,929.93	TOTAL MEDICAID LIAB	5,649,072.63
		LESS: COB	22,945.74
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,626,126.89

TOTAL NUMBER OF ADMISSIONS 672

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,363		0	1,511,135.00		118,185.00
ROUTINE NURSERY	118		0	55,475.00		2,000.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,481		0	1,566,610.00		120,185.00
SPECIAL CARE SERVICES						
CCU	677		0	726,570.00		19,555.00
ICU	234		0	309,545.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	911		0	1,036,115.00		19,555.00
TOTAL ACCOMODATIONS	3,392		0	2,602,725.00		139,740.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,905,316.26	23,506.57	OTHER LAB	109,585.00	0.00
MED/SURG SUPPLY	1,136,954.92	17,641.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,545,065.00	10,428.00	EDUCATION & TRAINING	1,008.00	39.00
RADIOLOGY-DIAGNOSTIC	286,771.00	2,038.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	842,871.00	2,914.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	115,639.00	1,520.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	148,535.00	184.00	MRI SERVICES	262,625.00	0.00
IV THERAPY	315,733.05	1,292.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,102,663.56	1,505.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	61,812.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	794,908.00	8,884.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	162,823.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	374,354.00	728.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	55,537.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	21,007.36
LABORATORY PATHOLOGIC	39,878.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	337.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,851.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,650.00	191.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	161,596.00	7,948.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	607.00	8,857.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	451,596.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	3,007.80
OTHER IMAGING SERVICE	110,490.00	5,333.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	165,803.00	7,139.00			
ONCOLOGY	870.00	0.00			
NUCLEAR MEDICINE	161,504.00	0.00			
AUDIOLOGY	6,776.00	0.00			
CARDIOLOGY	801,219.00	594.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,349.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	207,807.00	6,433.00			
			TOTAL ANCILLARY	12,353,534.49	131,189.93
			TOTAL ACCOMODATIONS	2,602,725.00	139,740.00
			TOTAL CHARGES	14,956,259.49	270,929.93

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 11:01:26  
Page: 3

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	1013252006901	07/18/13 - 08/02/13	09/30/13	0.00	2,868.80	0.00	0.00	0.00
366	1013256000411	06/03/13 - 06/21/13	09/30/13	0.00	139.00	0.00	0.00	0.00
TOTAL				0.00	3,007.80	0.00	0.00	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
 1900 TEBEAU ST  
 WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
 000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	57,044.54	ADJUSTMENTS	0.00
COVERED CHARGES	56,731.64	CONTRACTUAL ALLOW	18,535.68
NON-COVERD CHARGES	312.90	TOTAL MEDICAID LIAB	38,195.96
		LESS: COB	38,195.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	16		0	10,445.00		275.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	16		0	10,445.00		275.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	16		0	10,445.00		275.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,697.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,353.83	37.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,607.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,122.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	552.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,515.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,662.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,866.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,528.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,511.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	393.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,967.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,512.00	0.00			
			TOTAL ANCILLARY	46,286.64	37.90
			TOTAL ACCOMODATIONS	10,445.00	275.00
			TOTAL CHARGES	56,731.64	312.90

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:01:51  
Page: 6

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC  
1900 TEBEAU ST  
WAYCROSS,GA 31501-6357

PROVIDER NUMBER  
000001229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,250,178.96	ADJUSTMENTS	1,232,909.05
COVERED CHARGES	16,484,615.70	CONTRACTUAL ALLOW	12,839,931.55
NON-COVERD CHARGES	1,765,563.26	TOTAL MEDICAID LIAB	3,644,684.15
		LESS: COB	2,190.87
		LESS: COPAYMENT	8,565.56
		REIMBURSEMENT	3,633,927.72
		ALL OTHER	2,888,968.79
		FEE SCHEDULE-LAB	355,561.12
		INJECTABLE DRUGS	389,397.81

TOTAL NUMBER OF CLAIMS 9,140

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	769,828.46	495.20	OTHER LAB	431,566.00	0.00
MED/SURG SUPPLY	662,140.06	10,496.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	136.00	EDUCATION & TRAINING	36.00	0.00
RADIOLOGY-DIAGNOSTIC	653,446.00	18,412.00	OTHER THERAPEUTIC SVC	536.00	0.00
CT SCAN	2,172,701.00	113,970.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	54,570.00	5,760.00	FEE SCHEDULE LAB	2,039,957.80	431,866.40
EKG/ECG	219,306.00	5,152.00	MRI SERVICES	701,802.00	21,382.00
IV THERAPY	643,811.00	138,032.00	PROFESSIONAL FEES	0.00	36.00
OPERATING ROOM	1,422,079.44	187,221.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	43,745.00	227.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	110,461.00	4,048.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	3,012.00	AMBULANCE	0.00	0.00
GI SERVICES	678,402.18	33,531.82	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,689,169.00	15,948.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	239,188.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	132.00	INJECTABLE DRUGS	1,505,033.49	505,921.42
RADIOLOGY THERAPEUTIC	10,876.00	432.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	12,780.00	3,607.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,509.00	191.03	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	19.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	121,851.00	28,038.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	154,230.27	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	604.00
OTHER IMAGING SERVICE	326,933.00	26,964.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	54,248.00	361.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	509,258.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	769,884.00	118,584.00			
AMBULATORY SURGERY	3,710.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,462.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	476,096.00	90,853.00			
			TOTAL ANCILLARY	16,484,615.70	1,765,432.46
			TOTAL ACCOMODATIONS	0.00	130.80
			TOTAL CHARGES	16,484,615.70	1,765,563.26

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: 07/23/2014  
Run Time: 11:01:51  
Page: 8

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC                      PROVIDER NUMBER                      PAYMENT DATES 00/00/00 THROUGH 00/00/00  
1900 TEBEAU ST    000001229A    SERVICE DATES 01/01/13 THROUGH 12/31/13  
WAYCROSS,GA 31501-6357    ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1114006003503	11/01/13 - 11/01/13	02/24/14	0.00	604.00	0.00	0.00	0.00
TOTAL				0.00	604.00	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 11:03:35  
Page: 9

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	190,306.06	ADJUSTMENTS	0.00
COVERED CHARGES	145,369.28	CONTRACTUAL ALLOW	63,047.27
NON-COVERD CHARGES	44,936.78	TOTAL MEDICAID LIAB	82,322.01
		LESS: COB	82,259.01
		LESS: COPAYMENT	63.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 102

SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,658.51	1,688.31	OTHER LAB	746.00	0.00
MED/SURG SUPPLY	5,487.71	2,319.35	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,134.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,408.90	361.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,564.00	2,764.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,805.00	6,238.00
EKG/ECG	3,641.00	184.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,863.00	2,036.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,883.00	16,843.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,502.00	227.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	480.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	4,268.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,810.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,218.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,446.66	1,502.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,828.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	171.00	195.86	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,432.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	62.00
OTHER IMAGING SERVICE	1,022.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,435.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,204.00	1,005.00			
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	7,763.00	4,109.00			
			TOTAL ANCILLARY	145,369.28	44,936.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	145,369.28	44,936.78

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC                      PROVIDER NUMBER                      PAYMENT DATES 00/00/00 THROUGH 00/00/00  
1900 TEBEAU ST    000001229A                                      SERVICE DATES 01/01/13 THROUGH 12/31/13  
WAYCROSS,GA 31501-6357    ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	1113246000978	05/23/13 - 01/01/00	09/23/13	0.00	62.00	0.00	735.81	0.00
TOTAL				0.00	62.00	0.00	735.81	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:03:40  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	747,931.44	ADJUSTMENTS	1,220.62
COVERED CHARGES	716,790.04	CONTRACTUAL ALLOW	657,718.34
NON-COVERD CHARGES	31,141.40	TOTAL MEDICAID LIAB	59,071.70
		LESS: COB	57.94
		LESS: COPAYMENT	1,926.05
		REIMBURSEMENT	57,087.71
		TOTAL NUMBER OF CLAIMS	1,056

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,675.49	0.00	OTHER LAB	11,709.00	0.00
MED/SURG SUPPLY	15,118.95	1,839.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	68,842.00	1,612.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	69,064.00	11,762.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	84,182.00	10,143.00
EKG/ECG	6,440.00	184.00	MRI SERVICES	2,935.00	0.00
IV THERAPY	44,914.00	2,003.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,555.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,320.00	80.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	351,257.00	608.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	393.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,641.60	607.20
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	2,016.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,727.00	2,303.00			
			TOTAL ANCILLARY	716,790.04	31,141.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	716,790.04	31,141.40

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,460.73	ADJUSTMENTS	0.00
COVERED CHARGES	7,385.73	CONTRACTUAL ALLOW	6,539.42
NON-COVERD CHARGES	75.00	TOTAL MEDICAID LIAB	846.31
		LESS: COB	834.31
		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: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	635.93	10.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	209.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	29.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	439.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,382.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	806.00	13.00
EKG/ECG	184.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	764.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,965.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	23.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,385.73	75.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,385.73	75.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,310,888.67	ADJUSTMENTS	127,856.85
COVERED CHARGES	1,114,565.02	CONTRACTUAL ALLOW	899,975.91
NON-COVERD CHARGES	196,323.65	TOTAL MEDICAID LIAB	214,589.11
		LESS: COB	0.00
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	214,247.11
		TOTAL NUMBER OF CLAIMS	40



SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MAYO CLINIC HEALTH SYSTEM IN WAYCROSS INC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
1900 TEBEAU ST	000001229A	SERVICE DATES	01/01/13	THROUGH	12/31/13
WAYCROSS,GA 31501-6357		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	28,696.59	16.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	62,786.57	223.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	144.00	57.00
RADIOLOGY-DIAGNOSTIC	1,560.00	195.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,958.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,744.60	3,350.20
EKG/ECG	4,219.00	552.00	MRI SERVICES	0.00	0.00
IV THERAPY	50,935.00	4,006.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	47,002.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,708.00	684.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,912.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,749.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	666,568.26	166,514.25
RADIOLOGY THERAPEUTIC	732.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	29,332.00	5,040.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	98,070.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	862.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	93,245.00	13,994.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,341.00	1,692.00			
			TOTAL ANCILLARY	1,114,565.02	196,323.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,114,565.02	196,323.65

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:08:49  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,553,898.27	ADJUSTMENTS	8,656.56
COVERED CHARGES	1,341,387.62	CONTRACTUAL ALLOW	694,654.40
NON-COVERD CHARGES	212,510.65	TOTAL MEDICAID LIAB	646,733.22
		LESS: COB	3,373.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	643,360.00

TOTAL NUMBER OF ADMISSIONS 210

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	500		0	214,147.00		173,936.60
ROUTINE NURSERY	166		0	42,289.80		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	666		0	256,436.80		173,936.60
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	666		0	256,436.80		173,936.60

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	232,087.57	0.00	OTHER LAB	35,066.50	0.00
MED/SURG SUPPLY	110,749.83	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	236,391.40	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,989.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	53,565.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,266.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,247.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	750.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,151.85	1,723.15	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	89,049.90	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,928.05	96.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,635.75	28,959.90	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	62,013.80	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,707.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	25,185.75	0.00	INJECTABLE DRUGS	18,381.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,678.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	884.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,826.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	710.00
OTHER IMAGING SERVICE	19,024.17	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	36,013.50	6,959.15			
ONCOLOGY	779.40	0.00			
NUCLEAR MEDICINE	4,594.50	125.15			
AUDIOLOGY	9,438.70	0.00			
CARDIOLOGY	5,223.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,319.00	0.00			
			TOTAL ANCILLARY	1,084,950.82	38,574.05
			TOTAL ACCOMODATIONS	256,436.80	173,936.60
			TOTAL CHARGES	1,341,387.62	212,510.65

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2312341000219	07/31/12 - 08/02/12	12/31/12	0.00	710.00	0.00	0.00	0.00
TOTAL				0.00	710.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:08:54  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,801.60	ADJUSTMENTS	0.00
COVERED CHARGES	12,238.20	CONTRACTUAL ALLOW	4,747.61
NON-COVERD CHARGES	563.40	TOTAL MEDICAID LIAB	7,490.59
		LESS: COB	7,490.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		0	856.60		563.40
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	2		0	856.60		563.40
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	2		0	856.60		563.40

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,567.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	296.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	737.75	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	121.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	317.25	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	258.75	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	83.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,381.60	0.00
			TOTAL ACCOMODATIONS	856.60	563.40
			TOTAL CHARGES	12,238.20	563.40

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: 07/23/2014  
Run Time: 10:08:54  
Page: 6

COOK MEDICAL CENTER  
706 N PARRISH AVE  
ADEL,GA 31620-1511

PROVIDER NUMBER  
000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,064,919.11	ADJUSTMENTS	5,327.09
COVERED CHARGES	1,773,979.86	CONTRACTUAL ALLOW	1,423,557.48
NON-COVERD CHARGES	290,939.25	TOTAL MEDICAID LIAB	350,422.38
		LESS: COB	6,608.85
		LESS: COPAYMENT	1,248.00
		REIMBURSEMENT	342,565.53
		ALL OTHER	296,806.30
		FEE SCHEDULE-LAB	45,516.08
		INJECTABLE DRUGS	243.15
		TOTAL NUMBER OF CLAIMS	1,700



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,466.95	18,594.50	OTHER LAB	64,899.75	2,192.00
MED/SURG SUPPLY	66,601.00	149.95	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,592.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	110,245.50	3,800.05	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	160,775.00	35,684.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,151.75	1,471.25	FEE SCHEDULE LAB	559,823.15	160,726.20
EKG/ECG	19,783.55	3,033.75	MRI SERVICES	66,303.75	2,547.00
IV THERAPY	39,915.00	11,379.95	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,380.10	5,863.40	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,100.35	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,804.70	305.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,783.30	8,489.75	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	399,056.85	7,322.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,216.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,536.75	6,610.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	100.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	41.50	415.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	71.75
OTHER IMAGING SERVICE	66,628.10	16,471.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,300.75	1,265.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,526.50	125.15			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,590.10	2,213.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,049.46	515.00			
			TOTAL ANCILLARY	1,773,979.86	290,939.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,773,979.86	290,939.25

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:08:54  
Page: 8

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8690	2212331009861	11/05/12 - 11/05/12	12/03/12	0.00	71.75	0.00	0.00	0.00
TOTAL				0.00	71.75	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 10:09:09  
Page: 9

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,621.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,310.25	CONTRACTUAL ALLOW	782.10
NON-COVERD CHARGES	310.75	TOTAL MEDICAID LIAB	1,528.15
		LESS: COB	1,528.15
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 4

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85.15	0.00	OTHER LAB	401.00	0.00
MED/SURG SUPPLY	92.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	281.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	547.25	29.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,184.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,310.25	310.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,310.25	310.75

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	188,889.90	ADJUSTMENTS	0.00
COVERED CHARGES	179,413.75	CONTRACTUAL ALLOW	161,003.91
NON-COVERD CHARGES	9,476.15	TOTAL MEDICAID LIAB	18,409.84
		LESS: COB	0.00
		LESS: COPAYMENT	618.00
		REIMBURSEMENT	17,791.84
		TOTAL NUMBER OF CLAIMS	332

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,738.45	3,258.15	OTHER LAB	3,208.00	0.00
MED/SURG SUPPLY	3,267.00	29.55	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,529.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,140.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	36,121.90	4,653.20
EKG/ECG	1,415.75	0.00	MRI SERVICES	2,547.00	0.00
IV THERAPY	0.00	250.25	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	280.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	98,342.65	558.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	75.50	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	41.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,412.50	685.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	335.00	0.00			
			TOTAL ANCILLARY	179,413.75	9,476.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	179,413.75	9,476.15

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

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,007.50	ADJUSTMENTS	0.00
COVERED CHARGES	1,007.50	CONTRACTUAL ALLOW	698.37
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	309.13
		LESS: COB	306.13
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	302.75	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	623.75	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	1,007.50	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,007.50	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

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,798.94	ADJUSTMENTS	0.00
COVERED CHARGES	22,279.03	CONTRACTUAL ALLOW	17,287.95
NON-COVERD CHARGES	7,519.91	TOTAL MEDICAID LIAB	4,991.08
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,991.08

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COOK MEDICAL CENTER  
 706 N PARRISH AVE  
 ADEL,GA 31620-1511

PROVIDER NUMBER  
 000001251A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	356.35	1,567.95	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,072.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	664.75	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	362.75	29.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	5,819.96	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,938.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	710.80	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	174.00	103.00			
			TOTAL ANCILLARY	22,279.03	7,519.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,279.03	7,519.91

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

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END 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

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,478,838.66	ADJUSTMENTS	121,482.31
COVERED CHARGES	2,442,166.31	CONTRACTUAL ALLOW	1,273,877.26
NON-COVERD CHARGES	36,672.35	TOTAL MEDICAID LIAB	1,168,289.05
		LESS: COB	1,522.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,166,766.24

TOTAL NUMBER OF ADMISSIONS 227

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	591		0	340,605.00		15,465.00
ROUTINE NURSERY	88		0	41,875.00		365.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	679		0	382,480.00		15,830.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	94		0	105,210.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	94		0	105,210.00		0.00
TOTAL ACCOMODATIONS	773		0	487,690.00		15,830.00

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	418,063.00	19.70	OTHER LAB	9,109.00	0.00
MED/SURG SUPPLY	310,872.96	991.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	355,684.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,866.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	116,596.00	927.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,984.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	18,233.00	0.00	MRI SERVICES	42,296.00	0.00
IV THERAPY	255.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	180,154.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	197,358.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108,125.00	704.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,544.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	26,320.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,428.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,336.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,471.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,405.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	845.25	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	4,305.65
OTHER IMAGING SERVICE	7,347.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	16,415.00	10,582.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,758.00	0.00			
AUDIOLOGY	3,060.00	0.00			
CARDIOLOGY	17,286.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,664.00	3,313.00			
			TOTAL ANCILLARY	1,954,476.31	20,842.35
			TOTAL ACCOMODATIONS	487,690.00	15,830.00
			TOTAL CHARGES	2,442,166.31	36,672.35

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
476	2212296005583	07/24/12 - 07/26/12	10/29/12	0.00	76.00	0.00	0.00	0.00
2550	2213079003048	02/27/13 - 03/05/13	03/25/13	0.00	4,229.65	0.00	0.00	0.00
TOTAL				0.00	4,305.65	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
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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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	790.85	ADJUSTMENTS	0.00
COVERED CHARGES	745.85	CONTRACTUAL ALLOW	745.85
NON-COVERD CHARGES	45.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1		0	555.00		45.00
ROUTINE NURSERY	0		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	555.00		45.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	555.00		45.00

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113.85	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	77.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	190.85	0.00
			TOTAL ACCOMODATIONS	555.00	45.00
			TOTAL CHARGES	745.85	45.00



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:09:30  
Page: 6

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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,183,646.28	ADJUSTMENTS	123,581.68
COVERED CHARGES	2,758,544.37	CONTRACTUAL ALLOW	2,063,292.25
NON-COVERD CHARGES	425,101.91	TOTAL MEDICAID LIAB	695,252.12
		LESS: COB	799.04
		LESS: COPAYMENT	4,584.00
		REIMBURSEMENT	689,869.08
		ALL OTHER	567,223.27
		FEE SCHEDULE-LAB	118,636.08
		INJECTABLE DRUGS	4,009.73

TOTAL NUMBER OF CLAIMS 3,720

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79,523.22	33.10	OTHER LAB	12,881.00	578.00
MED/SURG SUPPLY	154,372.68	1,520.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	222.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	231,129.00	3,164.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	267,457.00	76,878.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	48,071.00	10,571.00	FEE SCHEDULE LAB	874,826.70	181,414.50
EKG/ECG	41,410.00	2,199.00	MRI SERVICES	107,636.00	9,340.00
IV THERAPY	2,118.00	0.00	PROFESSIONAL FEES	0.00	133.00
OPERATING ROOM	224,543.64	74,457.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	735.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,855.00	1,240.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,846.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	349,374.50	9,190.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	64,590.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,644.43	35,414.95
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,154.00	7,377.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	968.00	2,190.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,721.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	250.00
OTHER IMAGING SERVICE	86,532.00	3,981.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,383.00	3,315.00			
ONCOLOGY	18.00	0.00			
NUCLEAR MEDICINE	19,435.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	22,482.00	0.00			
AMBULATORY SURGERY	0.00	19.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	25,095.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	71,743.00	1,615.00			
			TOTAL ANCILLARY	2,758,544.37	425,101.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,758,544.37	425,101.91

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:09:30  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2212153011405	05/26/12 - 05/26/12	06/04/12	0.00	12.00	0.00	0.00	0.00
363	5912314001868	10/16/12 - 10/16/12	11/12/12	0.00	165.00	0.00	0.00	0.00
30	2213116014750	03/26/13 - 03/26/13	04/29/13	0.00	73.00	0.00	0.00	0.00
TOTAL				0.00	250.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 10:10:44  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MEMORIAL HOSPITAL AND MANOR  
1500 E SHOTWELL ST  
BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER  
000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,410.20	ADJUSTMENTS	0.00
COVERED CHARGES	17,657.20	CONTRACTUAL ALLOW	10,774.50
NON-COVERD CHARGES	3,753.00	TOTAL MEDICAID LIAB	6,882.70
		LESS: COB	6,870.70
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 26

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166.20	67.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	332.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	180.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,525.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,467.00	1,073.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,676.00	2,184.00
EKG/ECG	184.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,287.00	201.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	55.00	12.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,389.00	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	576.00	36.00			
			TOTAL ANCILLARY	17,657.20	3,753.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,657.20	3,753.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	95,938.00	ADJUSTMENTS	1,101.19
COVERED CHARGES	93,370.60	CONTRACTUAL ALLOW	77,678.36
NON-COVERD CHARGES	2,567.40	TOTAL MEDICAID LIAB	15,692.24
		LESS: COB	0.00
		LESS: COPAYMENT	600.03
		REIMBURSEMENT	15,092.21
		TOTAL NUMBER OF CLAIMS	297

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

MEMORIAL HOSPITAL AND MANOR  
 1500 E SHOTWELL ST  
 BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER  
 000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,565.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	913.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,284.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,149.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,780.00	1,790.00
EKG/ECG	368.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	174.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,325.00	384.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,812.50	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	321.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	93,370.60	2,567.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	93,370.60	2,567.40

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	673.00	ADJUSTMENTS	0.00
COVERED CHARGES	673.00	CONTRACTUAL ALLOW	346.13
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	326.87
		LESS: COB	326.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1



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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 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	292.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	381.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	673.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	673.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 10:10:52  
Page: 15

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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,913.81	ADJUSTMENTS	0.00
COVERED CHARGES	16,913.81	CONTRACTUAL ALLOW	11,937.50
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	4,976.31
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	4,925.31
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MEMORIAL HOSPITAL AND MANOR  
 1500 E SHOTWELL ST  
 BAINBRIDGE,GA 39819-4256

PROVIDER NUMBER  
 000001262A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,249.69	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,377.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	3,213.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	3,074.12	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	16,913.81	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,913.81	0.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:10:53  
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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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:11:01  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER 000001273A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	116,889,970.34	ADJUSTMENTS	9,557,603.62
COVERED CHARGES	111,003,908.55	CONTRACTUAL ALLOW	77,810,028.36
NON-COVERD CHARGES	5,886,061.79	TOTAL MEDICAID LIAB	33,193,880.19
		LESS: COB	222,511.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	32,971,368.63

TOTAL NUMBER OF ADMISSIONS 3,135

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,339		390	9,934,483.20		3,246,550.00
ROUTINE NURSERY	1,868		39	3,747,736.00		55,659.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		6.00
TOTAL ROUTINE	14,207		429	13,682,219.20		3,302,215.00
SPECIAL CARE SERVICES						
CCU	373		0	1,072,375.00		0.00
ICU	3,103		28	5,880,366.40		165,040.00
NICU	1,626		0	5,119,224.00		0.00
PED ICU	459		0	1,698,616.00		26,306.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	355		0	1,020,769.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		28	0.00		27,720.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5,916		56	14,791,350.40		219,066.00
TOTAL ACCOMODATIONS	20,123		485	28,473,569.60		3,521,281.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MEMORIAL HEALTH UNIV MED CEN, INC  
 4700 WATERS AVE  
 SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
 000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,355,829.71	435,831.99	OTHER LAB	566,405.00	17,532.00
MED/SURG SUPPLY	7,650,462.99	293,601.29	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,467,814.21	297,083.19	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,535,654.00	11,085.00	OTHER THERAPEUTIC SVC	18,846.00	27,630.00
CT SCAN	4,765,245.00	2,114.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,180,562.22	11,660.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	338,923.00	1,288.00	MRI SERVICES	1,285,005.00	2,835.00
IV THERAPY	904,592.50	15,486.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,175,382.02	109,167.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	783,314.00	25,000.00	REHAB THERAPY	15,756.00	240.00
RESPIRATORY SERVICES	4,424,995.40	29,504.52	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,872,482.52	22,433.00	AMBULANCE	0.00	0.00
GI SERVICES	159,502.00	4,404.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,932,835.80	256.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,709,743.00	9,400.00	DRUG-SPECIFIC/HOME IV	0.00	125,594.60
LABORATORY PATHOLOGIC	270,766.75	874.00	INJECTABLE DRUGS	3,192,329.89	123,576.90
RADIOLOGY THERAPEUTIC	398,214.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	902,149.16	2,893.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	404,425.02	2,247.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	274,481.00	41,014.00	PATIENT CONVENIENCE	0.00	2.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	23,544.00	5,210.00	TRAUMA RESPONSE	0.00	52,968.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,385,878.93	3,258.30
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	708,800.00	23,966.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	111,438.00	540,360.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	227,989.00	124,707.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,199,124.00	1,559.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	184,800.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	103,048.83	0.00			
			TOTAL ANCILLARY	82,530,338.95	2,364,780.79
			TOTAL ACCOMODATIONS	28,473,569.60	3,521,281.00
			TOTAL CHARGES	111,003,908.55	5,886,061.79

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:12:28  
 Page: 3

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,525,291.55	ADJUSTMENTS	0.00
COVERED CHARGES	1,489,416.10	CONTRACTUAL ALLOW	881,446.60
NON-COVERD CHARGES	35,875.45	TOTAL MEDICAID LIAB	607,969.50
		LESS: COB	607,969.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	47		8	38,399.00		23,620.00
ROUTINE NURSERY	63		0	172,502.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	110		8	210,901.00		23,620.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	23		0	52,284.00		0.00
NICU	132		0	412,632.00		0.00
PED ICU	12		0	45,096.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	167		0	510,012.00		0.00
TOTAL ACCOMODATIONS	277		8	720,913.00		23,620.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76,038.03	0.00	OTHER LAB	7,586.00	0.00
MED/SURG SUPPLY	77,846.16	5,014.45	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	84,372.58	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,244.00	0.00	OTHER THERAPEUTIC SVC	0.00	188.00
CT SCAN	44,619.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,561.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	552.00	0.00	MRI SERVICES	23,232.00	0.00
IV THERAPY	5,938.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	162,964.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	31,337.00	0.00	REHAB THERAPY	156.00	0.00
RESPIRATORY SERVICES	42,367.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	43,864.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,409.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,019.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,963.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,831.00	0.00	INJECTABLE DRUGS	10,094.13	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,924.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,488.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	228.00	213.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	77,251.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,566.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	6,840.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,918.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,135.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	768,503.10	12,255.45
			TOTAL ACCOMODATIONS	720,913.00	23,620.00
			TOTAL CHARGES	1,489,416.10	35,875.45



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:12:33  
Page: 5

MEMORIAL HEALTH UNIV MED CEN, INC  
4700 WATERS AVE  
SAVANNAH,GA 31404-6220

PROVIDER NUMBER  
000001273A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	38,781,457.42	ADJUSTMENTS	1,129,685.26
COVERED CHARGES	34,251,946.81	CONTRACTUAL ALLOW	26,796,664.09
NON-COVERD CHARGES	4,529,510.61	TOTAL MEDICAID LIAB	7,455,282.72
		LESS: COB	79,473.54
		LESS: COPAYMENT	12,361.40
		REIMBURSEMENT	7,363,447.78
		ALL OTHER	6,594,085.49
		FEE SCHEDULE-LAB	372,360.58
		INJECTABLE DRUGS	397,001.71

TOTAL NUMBER OF CLAIMS 12,768

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,177,750.12	2,110.05	OTHER LAB	714,895.00	798.00
MED/SURG SUPPLY	1,735,624.43	32,681.44	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	210.00	EDUCATION & TRAINING	0.00	110.00
RADIOLOGY-DIAGNOSTIC	1,475,660.00	51,650.00	OTHER THERAPEUTIC SVC	2,829.00	31,346.00
CT SCAN	3,911,032.00	503,041.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	110,987.00	63,326.09	FEE SCHEDULE LAB	2,746,122.40	711,655.39
EKG/ECG	211,184.00	24,656.00	MRI SERVICES	1,813,675.00	236,398.00
IV THERAPY	1,290,034.00	122,352.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,439,027.33	987,888.11	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	164,772.00	19,111.00	REHAB THERAPY	0.00	1,404.00
RESPIRATORY SERVICES	164,847.00	6,032.36	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,879,251.00	6,488.00	AMBULANCE	0.00	0.00
GI SERVICES	266,219.00	22,149.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,646,883.00	47,878.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,224,886.00	2,813.00	DRUG-SPECIFIC/HOME IV	0.00	11,122.45
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,463,781.07	630,826.57
RADIOLOGY THERAPEUTIC	1,161,752.00	188,291.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	29,555.00	27,581.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,192.00	19,500.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	1,404.00	15,934.00	PATIENT CONVENIENCE	0.00	2.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	166,723.00	11,303.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	316,204.98	650.00
LITHOTRIPSY	14,683.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	958,593.00	151,582.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	439.00	125,211.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	375,112.00	232,789.15			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	247,746.00	238,902.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	69,317.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	462,766.48	1,718.92			
			TOTAL ANCILLARY	34,251,946.81	4,529,510.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,251,946.81	4,529,510.61

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 10:15:38  
Page: 7

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	993,797.56	ADJUSTMENTS	0.00
COVERED CHARGES	734,193.24	CONTRACTUAL ALLOW	446,119.44
NON-COVERD CHARGES	259,604.32	TOTAL MEDICAID LIAB	288,073.80
		LESS: COB	287,749.02
		LESS: COPAYMENT	324.78
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 283

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	31,412.45	0.00	OTHER LAB	34,134.00	881.00
MED/SURG SUPPLY	45,889.40	493.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,636.00	974.00	OTHER THERAPEUTIC SVC	0.00	304.00
CT SCAN	41,959.00	33,884.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,075.00	4,076.00	FEE SCHEDULE LAB	82,116.88	34,370.57
EKG/ECG	2,208.00	368.00	MRI SERVICES	39,869.00	23,271.00
IV THERAPY	26,506.00	1,398.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	51,330.50	62,762.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,212.00	1,978.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,736.00	149.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	53,268.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	9,591.00	4,873.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	91,712.00	1,788.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	36,611.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,824.50	34,593.15
RADIOLOGY THERAPEUTIC	88,197.00	2,059.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	766.00	1,006.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,592.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,678.00	331.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,872.70	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,350.00	12,308.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	241.00	29,626.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,924.00	2,799.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,643.00	1,918.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,430.81	1,802.00			
			TOTAL ANCILLARY	734,193.24	259,604.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	734,193.24	259,604.32

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: 07/23/2014  
Run Time: 10:15:48  
Page: 9

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	818,223.95	ADJUSTMENTS	2,792.94
COVERED CHARGES	761,749.74	CONTRACTUAL ALLOW	720,577.90
NON-COVERD CHARGES	56,474.21	TOTAL MEDICAID LIAB	41,171.84
		LESS: COB	45.81
		LESS: COPAYMENT	852.00
		REIMBURSEMENT	40,274.03
		TOTAL NUMBER OF CLAIMS	736

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,296.51	0.00	OTHER LAB	4,970.00	0.00
MED/SURG SUPPLY	8,723.31	598.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,738.00	500.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,399.00	13,864.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	383.00	0.00	FEE SCHEDULE LAB	58,625.85	18,633.00
EKG/ECG	2,392.00	0.00	MRI SERVICES	5,830.00	2,696.00
IV THERAPY	19,534.00	1,395.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	12,031.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,595.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,232.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	425.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	547,306.00	1,308.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,096.80	1,318.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	206.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,390.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,458.00	4,130.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,149.27	0.00			
			TOTAL ANCILLARY	761,749.74	56,474.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	761,749.74	56,474.21

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:16:01  
Page: 11

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,411.81	ADJUSTMENTS	0.00
COVERED CHARGES	6,411.81	CONTRACTUAL ALLOW	4,012.95
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,398.86
		LESS: COB	2,389.86
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	113.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	53.06	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	394.00	0.00
EKG/ECG	184.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	4,945.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,411.81	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,411.81	0.00



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 10:16:07  
Page: 13

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,888,908.19	ADJUSTMENTS	276,014.11
COVERED CHARGES	8,683,074.84	CONTRACTUAL ALLOW	7,453,925.09
NON-COVERD CHARGES	1,205,833.35	TOTAL MEDICAID LIAB	1,229,149.75
		LESS: COB	3,529.15
		LESS: COPAYMENT	2,247.00
		REIMBURSEMENT	1,223,373.60

TOTAL NUMBER OF CLAIMS 218

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	330,126.21	0.00	OTHER LAB	7,143.00	13,697.00
MED/SURG SUPPLY	794,125.53	6,469.35	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	74,279.00	41,823.00	OTHER THERAPEUTIC SVC	20,520.00	7,639.00
CT SCAN	171,746.00	18,850.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	589.00	6,574.00	FEE SCHEDULE LAB	128,785.80	112,542.00
EKG/ECG	7,360.00	2,208.00	MRI SERVICES	43,946.00	9,692.00
IV THERAPY	61,197.00	7,352.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,369,329.72	622,725.23	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	1,002.00	REHAB THERAPY	0.00	312.00
RESPIRATORY SERVICES	3,228.00	1,275.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	491,340.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,814.00	128.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	234,077.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,072.75
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	866,141.10	84,361.02
RADIOLOGY THERAPEUTIC	1,133,345.00	157,069.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,532.00	84.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	266.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	508.00	2,073.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,437.00	1,420.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,753,199.56	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,229.00	7,711.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	340.00	8,834.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	44,185.00	7,979.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	57,668.00	81,910.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	765.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	35,883.92	0.00			
			TOTAL ANCILLARY	8,683,074.84	1,205,833.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,683,074.84	1,205,833.35

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:16:17  
Page: 15

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	274,842.60	ADJUSTMENTS	0.00
COVERED CHARGES	231,161.25	CONTRACTUAL ALLOW	145,403.12
NON-COVERD CHARGES	43,681.35	TOTAL MEDICAID LIAB	85,758.13
		LESS: COB	85,758.13
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,662.55	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	20,354.64	17,000.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,340.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,234.00	26,666.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,674.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,870.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	101.70	15.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	183,924.36	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	231,161.25	43,681.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	231,161.25	43,681.35

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:24:48  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MERIWETHER HEALTHCARE, LLC  
 5995 SPRING ST  
 WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER 000001284A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	209,332.82	ADJUSTMENTS	0.00
COVERED CHARGES	204,123.82	CONTRACTUAL ALLOW	79,152.70
NON-COVERD CHARGES	5,209.00	TOTAL MEDICAID LIAB	124,971.12
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	124,971.12

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	78		0	40,560.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	78		0	40,560.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	78		0	40,560.00		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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,036.00	0.00	OTHER LAB	1,963.00	0.00
MED/SURG SUPPLY	11,614.32	43.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	40,190.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,168.00	0.00	OTHER THERAPEUTIC SVC	0.00	758.00
CT SCAN	22,528.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	388.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,620.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	732.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,260.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	762.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,566.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,101.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,233.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	315.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,152.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,173.00	842.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,728.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	600.00	0.00			
			TOTAL ANCILLARY	163,563.82	5,209.00
			TOTAL ACCOMODATIONS	40,560.00	0.00
			TOTAL CHARGES	204,123.82	5,209.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:24:49  
Page: 4

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	824,028.36	ADJUSTMENTS	11,108.52
COVERED CHARGES	650,211.76	CONTRACTUAL ALLOW	445,609.72
NON-COVERD CHARGES	173,816.60	TOTAL MEDICAID LIAB	204,602.04
		LESS: COB	539.52
		LESS: COPAYMENT	495.00
		REIMBURSEMENT	203,567.52
		ALL OTHER	182,304.43
		FEE SCHEDULE-LAB	16,380.87
		INJECTABLE DRUGS	4,882.22

TOTAL NUMBER OF CLAIMS 752



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,884.92	12,112.50	OTHER LAB	5,223.00	0.00
MED/SURG SUPPLY	18,497.55	1,291.60	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	10.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,709.00	406.00	OTHER THERAPEUTIC SVC	0.00	29,923.00
CT SCAN	67,724.00	48,220.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	139,970.00	26,716.00
EKG/ECG	24,384.00	762.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,116.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,228.00	1,228.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,163.00	23.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	31,238.00	7,784.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	232,785.00	804.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,893.29	41,560.50
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	19,259.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	782.00	842.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	400.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,546.00	1,182.00			
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	13,440.00	552.00			
			TOTAL ANCILLARY	650,211.76	173,816.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	650,211.76	173,816.60

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MERIWETHER HEALTHCARE, LLC  
5995 SPRING ST  
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER  
000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,122.40	ADJUSTMENTS	0.00
COVERED CHARGES	3,528.00	CONTRACTUAL ALLOW	679.53
NON-COVERD CHARGES	1,594.40	TOTAL MEDICAID LIAB	2,848.47
		LESS: COB	2,848.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26.00	48.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	485.00	0.00	OTHER THERAPEUTIC SVC	0.00	72.00
CT SCAN	0.00	1,177.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	748.00	60.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,239.00	217.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	23.00	19.50
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	3,528.00	1,594.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,528.00	1,594.40

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:25:05  
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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	108,799.40	ADJUSTMENTS	235.00
COVERED CHARGES	97,114.00	CONTRACTUAL ALLOW	87,214.00
NON-COVERD CHARGES	11,685.40	TOTAL MEDICAID LIAB	9,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	390.00
		REIMBURSEMENT	9,510.00
		TOTAL NUMBER OF CLAIMS	198

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	753.00	1,168.00	OTHER LAB	584.00	0.00
MED/SURG SUPPLY	871.00	156.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,716.00	0.00	OTHER THERAPEUTIC SVC	0.00	7,333.00
CT SCAN	9,030.00	1,177.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,908.00	1,171.00
EKG/ECG	762.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,603.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	220.00	23.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	64,656.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,011.00	656.50
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	97,114.00	11,685.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	97,114.00	11,685.40

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:25:08  
Page: 10

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	875.00	ADJUSTMENTS	0.00
COVERED CHARGES	875.00	CONTRACTUAL ALLOW	237.33
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	637.67
		LESS: COB	637.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:25:08  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

MERIWETHER HEALTHCARE, LLC  
 5995 SPRING ST  
 WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER  
 000001284A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 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	8.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	867.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	875.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	875.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 11:25:08  
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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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:25:09  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MERIWETHER HEALTHCARE, LLC  
5995 SPRING ST  
WARM SPRINGS,GA 31830-2149

PROVIDER NUMBER  
000001284A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:08:05  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL  
 209 N CUTHBERT ST  
 COLQUITT,GA 39837-3518

PROVIDER NUMBER 000001317A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,109,432.70	ADJUSTMENTS	17,507.57
COVERED CHARGES	1,094,899.70	CONTRACTUAL ALLOW	667,888.18
NON-COVERD CHARGES	14,533.00	TOTAL MEDICAID LIAB	427,011.52
		LESS: COB	2,797.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	424,214.11

TOTAL NUMBER OF ADMISSIONS 77

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	284		0	107,800.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	284		0	107,800.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	284		0	107,800.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MILLER COUNTY HOSPITAL  
 209 N CUTHBERT ST  
 COLQUITT,GA 39837-3518

PROVIDER NUMBER 000001317A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	317,356.10	0.00	OTHER LAB	1,215.00	0.00
MED/SURG SUPPLY	164,864.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	146,555.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	23,416.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	80,540.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	19,789.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	6,976.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	31,911.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	92,566.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	46,256.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,003.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	935.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,899.00	0.00			
BLOOD	1,661.00	0.00			
BLOOD STORAGE & PRO.	26,990.00	14,384.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	530.00	149.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,166.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,128.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,342.65	0.00			
			TOTAL ANCILLARY	987,099.70	14,533.00
			TOTAL ACCOMODATIONS	107,800.00	0.00
			TOTAL CHARGES	1,094,899.70	14,533.00

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,648,836.17	ADJUSTMENTS	41,080.62
COVERED CHARGES	1,458,218.77	CONTRACTUAL ALLOW	969,626.46
NON-COVERD CHARGES	190,617.40	TOTAL MEDICAID LIAB	488,592.31
		LESS: COB	739.10
		LESS: COPAYMENT	1,371.00
		REIMBURSEMENT	486,482.21
		ALL OTHER	420,457.77
		FEE SCHEDULE-LAB	66,024.44
		INJECTABLE DRUGS	0.00
		TOTAL NUMBER OF CLAIMS	2,232

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,461.66	49.40	OTHER LAB	25,220.00	0.00
MED/SURG SUPPLY	106,596.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	43.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	99,469.00	5,025.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	125,937.00	4,299.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	209.00	698.00	FEE SCHEDULE LAB	403,496.50	94,574.00
EKG/ECG	10,742.00	1,853.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,856.00	1,000.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	335,664.00	36,325.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,194.00	3,032.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	114,263.00	7,984.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,761.00	335.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	628.00	1,256.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	160.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	66.00
OTHER IMAGING SERVICE	33,931.00	1,155.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,616.00	4,176.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,313.00	447.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,752.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	82,949.55	28,300.00			
			TOTAL ANCILLARY	1,458,218.77	190,617.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,458,218.77	190,617.40

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: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213095010193	04/01/13 - 04/01/13	04/08/13	0.00	66.00	0.00	0.00	0.00
TOTAL				0.00	66.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,864.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,344.00	CONTRACTUAL ALLOW	668.33
NON-COVERD CHARGES	520.00	TOTAL MEDICAID LIAB	1,675.67
		LESS: COB	1,669.67
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	488.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,856.00	520.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,344.00	520.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,344.00	520.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,486.85	ADJUSTMENTS	338.00
COVERED CHARGES	47,597.85	CONTRACTUAL ALLOW	42,652.85
NON-COVERD CHARGES	1,889.00	TOTAL MEDICAID LIAB	4,945.00
		LESS: COB	0.00
		LESS: COPAYMENT	183.00
		REIMBURSEMENT	4,762.00
		TOTAL NUMBER OF CLAIMS	100

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,206.40	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,023.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,038.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,486.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,857.00	665.00
EKG/ECG	109.00	109.00	MRI SERVICES	0.00	0.00
IV THERAPY	489.00	40.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,292.00	612.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	380.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,639.00	78.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	333.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,265.00	385.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	480.00	0.00			
			TOTAL ANCILLARY	47,597.85	1,889.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	47,597.85	1,889.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:08:42  
Page: 11

MILLER COUNTY HOSPITAL  
209 N CUTHBERT ST  
COLQUITT,GA 39837-3518

PROVIDER NUMBER  
000001317A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

MILLER COUNTY HOSPITAL  
209 N CUTHBERT ST  
COLQUITT,GA 39837-3518

PROVIDER NUMBER  
000001317A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,327.00	ADJUSTMENTS	0.00
COVERED CHARGES	29,089.00	CONTRACTUAL ALLOW	24,780.78
NON-COVERD CHARGES	2,238.00	TOTAL MEDICAID LIAB	4,308.22
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,308.22

TOTAL NUMBER OF CLAIMS 1

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	28,788.00	1,492.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	301.00	746.00			
			TOTAL ANCILLARY	29,089.00	2,238.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	29,089.00	2,238.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	285,771.34	ADJUSTMENTS	0.00
COVERED CHARGES	258,252.44	CONTRACTUAL ALLOW	132,366.93
NON-COVERD CHARGES	27,518.90	TOTAL MEDICAID LIAB	125,885.51
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	125,885.51

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	86		0	60,400.00		25,600.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	86		0	60,400.00		25,600.00
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	86		0	60,400.00		25,600.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,127.64	0.00	OTHER LAB	1,297.34	0.00
MED/SURG SUPPLY	5,164.29	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	49,431.59	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,994.51	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,922.67	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,819.73	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,198.20	0.00	MRI SERVICES	5,047.12	0.00
IV THERAPY	7,777.28	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25.88	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,799.30	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	10,462.77	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	491.91	0.00	INJECTABLE DRUGS	32,502.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	373.12	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	1,918.90			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,918.89	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,497.72	0.00			
			TOTAL ANCILLARY	197,852.44	1,918.90
			TOTAL ACCOMODATIONS	60,400.00	25,600.00
			TOTAL CHARGES	258,252.44	27,518.90

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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 08:56:58  
Page: 4

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,046,312.02	ADJUSTMENTS	12,449.97
COVERED CHARGES	844,607.62	CONTRACTUAL ALLOW	474,655.24
NON-COVERD CHARGES	201,704.40	TOTAL MEDICAID LIAB	369,952.38
		LESS: COB	108.55
		LESS: COPAYMENT	711.18
		REIMBURSEMENT	369,132.65
		ALL OTHER	344,062.33
		FEE SCHEDULE-LAB	21,354.09
		INJECTABLE DRUGS	3,716.23

TOTAL NUMBER OF CLAIMS 854

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,229.32	7,153.27	OTHER LAB	9,994.37	0.00
MED/SURG SUPPLY	22,728.00	301.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	439.04	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	59,077.56	1,252.15	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	116,285.78	53,130.70	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,076.57	11,536.11	FEE SCHEDULE LAB	184,780.00	45,369.13
EKG/ECG	11,193.70	639.64	MRI SERVICES	34,931.95	0.00
IV THERAPY	55,929.36	6,792.20	PROFESSIONAL FEES	0.00	2,247.15
OPERATING ROOM	45,040.98	32,227.08	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	336.44	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,659.37	395.63	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	12,578.24	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	160,368.91	3,564.57	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,918.17	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	27,880.34	6,250.05
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,677.96	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,624.62	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	255.86	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,915.88	3,982.69			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	383.78			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,558.52	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,446.54	1,159.23			
			TOTAL ANCILLARY	844,607.62	192,704.40
			TOTAL ACCOMODATIONS	0.00	9,000.00
			TOTAL CHARGES	844,607.62	201,704.40

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 08:57:16  
Page: 6

SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GOOD SAMARITAN HOSPITAL INC  
5401 LAKE OCONEE PARKWAY  
GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,659.79	ADJUSTMENTS	0.00
COVERED CHARGES	6,495.17	CONTRACTUAL ALLOW	1,466.04
NON-COVERD CHARGES	4,164.62	TOTAL MEDICAID LIAB	5,029.13
		LESS: COB	5,023.13
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	210.01	13.46	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	86.22	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	945.86	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,279.05	382.77
EKG/ECG	159.91	0.00	MRI SERVICES	2,010.37	2,039.93
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	1,705.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	492.52	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	511.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	703.59	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	95.94	22.78
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	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,495.17	4,164.62
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,495.17	4,164.62

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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Page: 8

GOOD SAMARITAN HOSPITAL INC  
5401 LAKE OCONEE PARKWAY  
GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	101,749.61	ADJUSTMENTS	144.00
COVERED CHARGES	96,121.13	CONTRACTUAL ALLOW	87,571.13
NON-COVERD CHARGES	5,628.48	TOTAL MEDICAID LIAB	8,550.00
		LESS: COB	0.00
		LESS: COPAYMENT	252.00
		REIMBURSEMENT	8,298.00
		TOTAL NUMBER OF CLAIMS	171

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,715.72	183.04	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	827.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,368.11	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,140.41	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,545.09	5,060.22
EKG/ECG	1,119.37	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,212.70	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	211.92	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	44,082.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,044.48	385.22
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,739.83	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,113.89	0.00			
			TOTAL ANCILLARY	96,121.13	5,628.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	96,121.13	5,628.48



Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,764.62	ADJUSTMENTS	0.00
COVERED CHARGES	1,748.42	CONTRACTUAL ALLOW	666.08
NON-COVERD CHARGES	16.20	TOTAL MEDICAID LIAB	1,082.34
		LESS: COB	1,082.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	426.52	16.20
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	255.85	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,066.05	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,748.42	16.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,748.42	16.20

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,275.53	ADJUSTMENTS	0.00
COVERED CHARGES	11,900.00	CONTRACTUAL ALLOW	7,525.68
NON-COVERD CHARGES	1,375.53	TOTAL MEDICAID LIAB	4,374.32
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	4,371.32

TOTAL NUMBER OF CLAIMS 1

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

GOOD SAMARITAN HOSPITAL INC  
 5401 LAKE OCONEE PARKWAY  
 GREENSBORO,GA 30642-4232

PROVIDER NUMBER  
 000001328A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	659.55	26.92	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,071.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	349.12	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,661.83	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	1,250.28	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	887.49	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	270.75	98.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,900.00	1,375.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,900.00	1,375.53

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:25:32  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL  
 90 E STEPHENS ST  
 CAMILLA,GA 31730-1836

PROVIDER NUMBER 000001339A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	334,772.60	ADJUSTMENTS	11,483.30
COVERED CHARGES	330,697.60	CONTRACTUAL ALLOW	161,425.29
NON-COVERD CHARGES	4,075.00	TOTAL MEDICAID LIAB	169,272.31
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	169,272.31

TOTAL NUMBER OF ADMISSIONS 33

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	151		0	82,337.00		3,451.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	151		0	82,337.00		3,451.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	151		0	82,337.00		3,451.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92,159.60	0.00	OTHER LAB	304.00	0.00
MED/SURG SUPPLY	9,829.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	61,258.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,173.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	35,070.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,207.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	701.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,951.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,125.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,663.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,340.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	95.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	389.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,990.00	529.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,033.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	168.00	0.00			
			TOTAL ANCILLARY	248,360.60	624.00
			TOTAL ACCOMODATIONS	82,337.00	3,451.00
			TOTAL CHARGES	330,697.60	4,075.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 10:25:34  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

MITCHELL COUNTY HOSPITAL  
90 E STEPHENS ST  
CAMILLA,GA 31730-1836

PROVIDER NUMBER  
000001339A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:25:34  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,082,783.31	ADJUSTMENTS	76,146.40
COVERED CHARGES	1,850,930.32	CONTRACTUAL ALLOW	1,393,942.18
NON-COVERD CHARGES	231,852.99	TOTAL MEDICAID LIAB	456,988.14
		LESS: COB	147.58
		LESS: COPAYMENT	2,451.00
		REIMBURSEMENT	454,389.56
		ALL OTHER	392,294.13
		FEE SCHEDULE-LAB	57,680.39
		INJECTABLE DRUGS	4,415.04
		TOTAL NUMBER OF CLAIMS	2,389

SUMMARY TYPE III  
 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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	150,084.00	19,591.40	OTHER LAB	6,368.00	0.00
MED/SURG SUPPLY	26,642.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,291.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	126,871.00	190.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	268,430.00	54,458.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	51,922.00	12,492.00	FEE SCHEDULE LAB	509,433.37	78,830.59
EKG/ECG	14,274.00	1,120.00	MRI SERVICES	36,366.00	2,585.00
IV THERAPY	96,692.00	15,387.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	625.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,710.00	17,337.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	398,349.00	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	44,563.95	13,369.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,059.00	9,694.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	8,311.00	2,273.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	564.00	237.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	304.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,251.00	326.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,240.00	385.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,297.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,574.00	464.00			
			TOTAL ANCILLARY	1,850,930.32	231,736.99
			TOTAL ACCOMODATIONS	0.00	116.00
			TOTAL CHARGES	1,850,930.32	231,852.99

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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Page: 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

MITCHELL COUNTY HOSPITAL  
90 E STEPHENS ST  
CAMILLA,GA 31730-1836

PROVIDER NUMBER  
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,072.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,785.00	CONTRACTUAL ALLOW	-1,730.22
NON-COVERD CHARGES	3,287.00	TOTAL MEDICAID LIAB	6,515.22
		LESS: COB	6,512.22
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	131.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	324.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,107.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	967.00	117.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	964.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	206.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,576.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	208.00	63.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	326.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,785.00	3,287.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,785.00	3,287.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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Page: 8

MITCHELL COUNTY HOSPITAL  
90 E STEPHENS ST  
CAMILLA,GA 31730-1836

PROVIDER NUMBER  
000001339A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	112,452.15	ADJUSTMENTS	538.00
COVERED CHARGES	106,335.94	CONTRACTUAL ALLOW	96,885.94
NON-COVERD CHARGES	6,116.21	TOTAL MEDICAID LIAB	9,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	306.02
		REIMBURSEMENT	9,143.98
		TOTAL NUMBER OF CLAIMS	189

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,020.00	55.00	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	6,839.00	203.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,034.00	3,107.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,075.89	2,058.91
EKG/ECG	147.00	34.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,785.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	80.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,983.00	70.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,929.05	262.30
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	326.00	326.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	106,335.94	6,116.21
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	106,335.94	6,116.21

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	206.00	ADJUSTMENTS	0.00
COVERED CHARGES	206.00	CONTRACTUAL ALLOW	142.60
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	63.40
		LESS: COB	60.40
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	206.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	206.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	206.00	0.00



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,370.38	ADJUSTMENTS	0.00
COVERED CHARGES	59,101.93	CONTRACTUAL ALLOW	46,178.62
NON-COVERD CHARGES	1,268.45	TOTAL MEDICAID LIAB	12,923.31
		LESS: COB	0.00
		LESS: COPAYMENT	56.98
		REIMBURSEMENT	12,866.33
		TOTAL NUMBER OF CLAIMS	3

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,812.00	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	1,119.45	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	414.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,475.93	149.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,400.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	59,101.93	1,268.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,101.93	1,268.45

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: 07/23/2014  
Run Time: 10:26:13  
Page: 14

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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:25:05  
 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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	291,962.82	ADJUSTMENTS	0.00
COVERED CHARGES	283,258.82	CONTRACTUAL ALLOW	134,301.16
NON-COVERD CHARGES	8,704.00	TOTAL MEDICAID LIAB	148,957.66
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	148,957.66

TOTAL NUMBER OF ADMISSIONS 26

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	77		0	35,805.00		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	77		0	35,805.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	21		0	19,068.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	21		0	19,068.00		0.00
TOTAL ACCOMODATIONS	98		0	54,873.00		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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,511.14	0.00	OTHER LAB	1,035.00	0.00
MED/SURG SUPPLY	20,251.36	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	51,798.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,992.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	42,694.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,900.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	16,540.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,399.00	4,375.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	15,213.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	3,625.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,646.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,880.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,360.00	0.00	INJECTABLE DRUGS	4,843.32	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	268.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,377.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,296.00	704.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,023.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,359.00	0.00			
			TOTAL ANCILLARY	228,385.82	8,704.00
			TOTAL ACCOMODATIONS	54,873.00	0.00
			TOTAL CHARGES	283,258.82	8,704.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:25:07  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	631,438.53	ADJUSTMENTS	2,784.21
COVERED CHARGES	584,131.48	CONTRACTUAL ALLOW	382,018.60
NON-COVERD CHARGES	47,307.05	TOTAL MEDICAID LIAB	202,112.88
		LESS: COB	14.02
		LESS: COPAYMENT	792.00
		REIMBURSEMENT	201,306.86
		ALL OTHER	190,601.17
		FEE SCHEDULE-LAB	9,990.68
		INJECTABLE DRUGS	715.01

TOTAL NUMBER OF CLAIMS 709

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 10:25:07  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,533.19	0.00	OTHER LAB	9,933.00	522.00
MED/SURG SUPPLY	7,137.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	899.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,461.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	101,752.00	11,441.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	208.00	0.05	FEE SCHEDULE LAB	114,107.16	15,432.00
EKG/ECG	7,543.00	901.00	MRI SERVICES	78,956.00	0.00
IV THERAPY	274.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,433.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,782.00	964.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	15,225.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	133,421.00	14.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	15,395.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,757.56	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	427.00
OTHER IMAGING SERVICE	23,034.00	1,005.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,023.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	381.00	477.00			
			TOTAL ANCILLARY	584,131.48	47,307.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	584,131.48	47,307.05



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
3011	2213221015589	08/04/13 - 08/04/13	08/12/13	0.00	427.00	0.00	0.00	0.00
TOTAL				0.00	427.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 10:25:21  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,378.95	ADJUSTMENTS	0.00
COVERED CHARGES	2,505.95	CONTRACTUAL ALLOW	2,093.52
NON-COVERD CHARGES	1,873.00	TOTAL MEDICAID LIAB	412.43
		LESS: COB	409.43
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	105.95	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	360.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,468.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,068.00	405.00
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	810.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,505.95	1,873.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,505.95	1,873.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,561.94	ADJUSTMENTS	0.00
COVERED CHARGES	65,276.94	CONTRACTUAL ALLOW	57,026.94
NON-COVERD CHARGES	1,285.00	TOTAL MEDICAID LIAB	8,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	279.00
		REIMBURSEMENT	7,971.00
		TOTAL NUMBER OF CLAIMS	165

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,492.33	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	231.69	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	88.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,508.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,392.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,284.00	1,178.00
EKG/ECG	972.00	0.00	MRI SERVICES	2,014.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,956.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	426.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	19.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	65,276.94	1,285.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	65,276.94	1,285.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:25:21  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213126010289	04/27/13 - 04/27/13	05/13/13	0.00	19.00	0.00	0.00	0.00
TOTAL				0.00	19.00	0.00	0.00	0.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:25:25  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:23:29  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER 000001383A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	354,891.98	ADJUSTMENTS	0.00
COVERED CHARGES	351,640.72	CONTRACTUAL ALLOW	190,331.57
NON-COVERD CHARGES	3,251.26	TOTAL MEDICAID LIAB	161,309.15
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	161,309.15

TOTAL NUMBER OF ADMISSIONS 23

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	73		0	65,989.00		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	73		0	65,989.00		660.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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		0	65,989.00		660.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,549.28	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	19,154.24	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	77,724.23	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,959.29	0.00	OTHER THERAPEUTIC SVC	0.00	2,534.46
CT SCAN	29,714.16	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,784.73	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,975.85	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,976.73	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53,117.32	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,792.53	0.00	AMBULANCE	0.00	56.80
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,001.04	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,124.58	0.00	INJECTABLE DRUGS	16,861.25	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	2,399.76	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	629.88	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,886.85	0.00			
			TOTAL ANCILLARY	285,651.72	2,591.26
			TOTAL ACCOMODATIONS	65,989.00	660.00
			TOTAL CHARGES	351,640.72	3,251.26

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,015,620.55	ADJUSTMENTS	171,887.15
COVERED CHARGES	2,623,788.37	CONTRACTUAL ALLOW	2,175,791.60
NON-COVERD CHARGES	391,832.18	TOTAL MEDICAID LIAB	447,996.77
		LESS: COB	96.67
		LESS: COPAYMENT	862.79
		REIMBURSEMENT	447,037.31
		ALL OTHER	398,944.33
		FEE SCHEDULE-LAB	45,327.06
		INJECTABLE DRUGS	2,765.92

TOTAL NUMBER OF CLAIMS 1,598

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 10:23:30  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75,711.67	3,336.67	OTHER LAB	20,485.76	1,031.25
MED/SURG SUPPLY	48,662.92	1,475.54	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	307.09	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	199,919.24	1,283.10	OTHER THERAPEUTIC SVC	0.00	2,861.07
CT SCAN	354,646.56	120,063.93	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	817,238.14	165,366.34
EKG/ECG	63,230.21	3,926.17	MRI SERVICES	67,619.36	16,904.84
IV THERAPY	137,330.71	13,076.01	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	49,808.28	8,269.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	71,648.72	12,893.43	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,706.91	398.06	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	574,550.35	904.44	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,115.32	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,394.90	37,335.41
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	23.98	287.76	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,285.18	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	44,650.05	234.42			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	629.88	1,206.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,067.62	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	62,062.61	670.88			
			TOTAL ANCILLARY	2,623,788.37	391,832.18
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,623,788.37	391,832.18

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	30,037.75	ADJUSTMENTS	0.00
COVERED CHARGES	27,730.64	CONTRACTUAL ALLOW	11,885.83
NON-COVERD CHARGES	2,307.11	TOTAL MEDICAID LIAB	15,844.81
		LESS: COB	15,829.81
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 23

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	342.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	223.82	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,498.58	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,836.04	1,875.44	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,770.71	431.67
EKG/ECG	518.76	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	587.49	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,907.60	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	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	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,730.64	2,307.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,730.64	2,307.11



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:23:59  
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HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	313,858.76	ADJUSTMENTS	2,547.11
COVERED CHARGES	303,329.60	CONTRACTUAL ALLOW	280,338.26
NON-COVERD CHARGES	10,529.16	TOTAL MEDICAID LIAB	22,991.34
		LESS: COB	0.00
		LESS: COPAYMENT	906.03
		REIMBURSEMENT	22,085.31

TOTAL NUMBER OF CLAIMS 411

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,827.97	344.17	OTHER LAB	920.06	0.00
MED/SURG SUPPLY	1,245.26	60.31	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,642.11	0.00	OTHER THERAPEUTIC SVC	0.00	1,599.43
CT SCAN	10,823.19	3,750.88	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	83,724.37	3,557.52
EKG/ECG	518.76	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,276.41	458.76	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,958.24	73.26	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	162,855.21	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,160.65	684.83
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	377.37	0.00			
			TOTAL ANCILLARY	303,329.60	10,529.16
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	303,329.60	10,529.16

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 10:24:05  
Page: 10

SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER 000001383A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,486.97	ADJUSTMENTS	0.00
COVERED CHARGES	2,482.97	CONTRACTUAL ALLOW	1,478.06
NON-COVERD CHARGES	4.00	TOTAL MEDICAID LIAB	1,004.91
		LESS: COB	998.91
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
 707 OLD DALTON ELLIJAY RD  
 CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
 000001383A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	21.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	272.08	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	432.90	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	114.69	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,565.70	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	29.15	4.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,482.97	4.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,482.97	4.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 10:24:06  
Page: 12

SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:24:06  
Page: 13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF MURRAY COUNTY  
707 OLD DALTON ELLIJAY RD  
CHATSWORTH,GA 30705-2029

PROVIDER NUMBER  
000001383A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER 000001394A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,019,745.59	ADJUSTMENTS	53,150.60
COVERED CHARGES	7,688,857.57	CONTRACTUAL ALLOW	4,730,760.19
NON-COVERD CHARGES	330,888.02	TOTAL MEDICAID LIAB	2,958,097.38
		LESS: COB	74,447.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,883,650.04

TOTAL NUMBER OF ADMISSIONS 501

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,050		19	599,956.71		23,578.67
ROUTINE NURSERY	331		0	185,917.20		264,155.88
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,381		19	785,873.91		287,734.55
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	183		1	233,846.55		1,277.85
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	183		1	233,846.55		1,277.85
TOTAL ACCOMODATIONS	1,564		20	1,019,720.46		289,012.40

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,238,162.81	0.00	OTHER LAB	46,569.01	0.00
MED/SURG SUPPLY	569,238.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,020,370.70	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	122,864.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	528,472.37	28,956.27	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	107,410.34	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	47,611.60	0.00	MRI SERVICES	43,098.08	0.00
IV THERAPY	96,866.38	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	627,413.65	1,286.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	96,874.19	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	180,783.06	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,128.22	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,470.33	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	335,965.81	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	239,430.74	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	24,719.88	0.00	INJECTABLE DRUGS	189,203.07	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,794.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	20,076.16	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,972.68	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	593,290.12	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	64,265.79	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	152,535.96	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	15,646.83	11,632.50			
AUDIOLOGY	11,113.44	0.00			
CARDIOLOGY	197,240.19	0.00			
AMBULATORY SURGERY	38,489.47	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,386.52	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,673.07	0.00			
			TOTAL ANCILLARY	6,669,137.11	41,875.62
			TOTAL ACCOMODATIONS	1,019,720.46	289,012.40
			TOTAL CHARGES	7,688,857.57	330,888.02



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 08:50:54  
 Page: 3

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,577.02	ADJUSTMENTS	0.00
COVERED CHARGES	14,099.08	CONTRACTUAL ALLOW	6,380.70
NON-COVERD CHARGES	3,477.94	TOTAL MEDICAID LIAB	7,718.38
		LESS: COB	7,718.38
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	0	0	0.00	0.00
ROUTINE NURSERY	10	0	5,552.48	3,477.94
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	10	0	5,552.48	3,477.94
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	0	0	0.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	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	5,552.48	3,477.94

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	535.30	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	618.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,635.63	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	877.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	117.54	0.00	FREE STANDING CLINIC	0.00	0.00
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	2,976.39	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	465.67	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	320.58	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,546.60	0.00
			TOTAL ACCOMODATIONS	5,552.48	3,477.94
			TOTAL CHARGES	14,099.08	3,477.94

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 08:50:55  
Page: 5

NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,991,749.25	ADJUSTMENTS	224,341.76
COVERED CHARGES	9,682,254.97	CONTRACTUAL ALLOW	7,707,099.40
NON-COVERD CHARGES	1,309,494.28	TOTAL MEDICAID LIAB	1,975,155.57
		LESS: COB	13,357.12
		LESS: COPAYMENT	4,818.05
		REIMBURSEMENT	1,956,980.40
		ALL OTHER	1,640,728.22
		FEE SCHEDULE-LAB	140,086.55
		INJECTABLE DRUGS	176,165.63

TOTAL NUMBER OF CLAIMS 4,954

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	313,581.59	1,398.11	OTHER LAB	55,230.29	0.00
MED/SURG SUPPLY	404,125.38	4,957.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	301.48	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	426,512.87	41,356.90	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,553,569.13	151,292.48	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	57,696.20	29,896.96	FEE SCHEDULE LAB	1,591,896.47	475,827.47
EKG/ECG	78,300.10	18,532.87	MRI SERVICES	330,336.70	16,584.99
IV THERAPY	108,648.10	86,317.53	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	909,757.69	107,728.53	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,834.65	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,909.47	2,647.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,128.22	0.00	AMBULANCE	0.00	638.92
GI SERVICES	6,231.37	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,813,620.79	33,918.78	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	134,499.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	287.97	INJECTABLE DRUGS	791,224.05	197,620.73
RADIOLOGY THERAPEUTIC	56,611.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	197.97	197.97	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	609.21	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	50,938.17	1,582.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	271,153.53	56,081.35			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,109.06	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	39,655.63	24,428.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	103,954.67	43,249.57			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	120,501.17	688.14			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	395,030.95	13,348.92			
			TOTAL ANCILLARY	9,682,254.97	1,309,494.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,682,254.97	1,309,494.28

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 08:52:22  
Page: 7

SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	180,437.40	ADJUSTMENTS	0.00
COVERED CHARGES	120,088.25	CONTRACTUAL ALLOW	62,464.05
NON-COVERD CHARGES	60,349.15	TOTAL MEDICAID LIAB	57,624.20
		LESS: COB	57,492.20
		LESS: COPAYMENT	132.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 101

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,361.64	0.00	OTHER LAB	242.98	0.00
MED/SURG SUPPLY	4,280.32	417.70	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,889.78	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	24,498.89	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,609.77	3,182.46	FEE SCHEDULE LAB	19,419.76	4,928.14
EKG/ECG	818.30	0.00	MRI SERVICES	2,266.60	2,266.60
IV THERAPY	4,245.27	2,036.02	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	24,847.07	5,363.77	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	483.40	169.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	25,347.69	417.33	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,515.19	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,033.40	528.93
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	58.02	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	124.68	10,429.86
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,641.19	4,020.26			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,961.21	2,032.17			
			TOTAL ANCILLARY	120,088.25	60,349.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	120,088.25	60,349.15

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 08:52:25  
Page: 9

NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,048,269.75	ADJUSTMENTS	1,279.32
COVERED CHARGES	956,908.22	CONTRACTUAL ALLOW	905,379.04
NON-COVERD CHARGES	91,361.53	TOTAL MEDICAID LIAB	51,529.18
		LESS: COB	60.93
		LESS: COPAYMENT	1,737.03
		REIMBURSEMENT	49,731.22
		TOTAL NUMBER OF CLAIMS	924

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,441.44	143.56	OTHER LAB	8,579.87	0.00
MED/SURG SUPPLY	13,219.19	85.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	58,185.34	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	132,190.99	18,370.33	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	194,519.62	55,734.97
EKG/ECG	8,510.32	163.66	MRI SERVICES	2,266.60	0.00
IV THERAPY	9,307.20	8,199.20	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	930.26	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,379.62	58.77	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	478,506.84	1,946.03	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,768.37	1,038.56
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,290.32	5,620.96			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	812.24	0.00			
			TOTAL ANCILLARY	956,908.22	91,361.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	956,908.22	91,361.53





SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,099.11	0.00	OTHER LAB	490.44	0.00
MED/SURG SUPPLY	369.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,715.41	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,202.57	1,320.64
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	443.20	221.60	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	250.84	35.43	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	447.70
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,282.43	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	769.20	46.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	686.17	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,308.91	2,071.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,308.91	2,071.37

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: 07/23/2014  
Run Time: 08:52:39  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	238,496.61	ADJUSTMENTS	0.00
COVERED CHARGES	189,224.48	CONTRACTUAL ALLOW	144,492.86
NON-COVERD CHARGES	49,272.13	TOTAL MEDICAID LIAB	44,731.62
		LESS: COB	0.00
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	44,710.62

TOTAL NUMBER OF CLAIMS 9

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER  
 5126 HOSPITAL DR NE  
 COVINGTON,GA 30014-2566

PROVIDER NUMBER  
 000001394A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,070.48	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,044.92	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,191.23	1,209.23	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,216.00	101.25
EKG/ECG	0.00	163.66	MRI SERVICES	0.00	0.00
IV THERAPY	443.20	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	34,341.10	5,219.38	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	638.92	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,795.28	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	98,116.47	40,484.58
RADIOLOGY THERAPEUTIC	11,547.11	1,846.96	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,173.29	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,646.48	247.07			
			TOTAL ANCILLARY	189,224.48	49,272.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	189,224.48	49,272.13

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 08:52:40  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NEWTON MEDICAL CENTER  
5126 HOSPITAL DR NE  
COVINGTON,GA 30014-2566

PROVIDER NUMBER  
000001394A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:26:19  
 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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	90,670,325.19	ADJUSTMENTS	11,758,177.66
COVERED CHARGES	84,940,708.31	CONTRACTUAL ALLOW	62,175,313.64
NON-COVERD CHARGES	5,729,616.88	TOTAL MEDICAID LIAB	22,765,394.67
		LESS: COB	316,807.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	22,448,587.30

TOTAL NUMBER OF ADMISSIONS 4,020

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7,490		5	7,068,858.00		554,659.00
ROUTINE NURSERY	6,985		193	9,082,909.00		2,820,516.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	14,475		198	16,151,767.00		3,375,175.00
SPECIAL CARE SERVICES						
CCU	7		0	23,247.00		0.00
ICU	2,025		32	6,277,282.00		157,869.00
NICU	998		0	5,015,421.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,030		32	11,315,950.00		157,869.00
TOTAL ACCOMODATIONS	17,505		230	27,467,717.00		3,533,044.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHSIDE HOSPITAL  
 1000 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1606

PROVIDER NUMBER  
 000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,199,575.84	203,224.58	OTHER LAB	332,046.00	0.00
MED/SURG SUPPLY	3,369,836.91	145,411.37	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	8,918,494.74	142,611.42	EDUCATION & TRAINING	8,855.00	393.00
RADIOLOGY-DIAGNOSTIC	1,100,211.50	1,224.00	OTHER THERAPEUTIC SVC	0.00	33,611.00
CT SCAN	1,082,306.00	18,543.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	436,481.00	5,937.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	150,704.00	271.00	MRI SERVICES	572,937.00	0.00
IV THERAPY	131,558.00	14,398.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,264,586.00	206,914.00	DURABLE MED. EQUIP.	0.00	976.00
LABOR/DELIVERY ROOM	5,441,630.00	130,266.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,052,439.05	26,599.01	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	660,035.00	7,203.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	921,525.00	49,672.00	SPECIAL SERVICES	0.00	18,220.00
RECOVERY ROOM	721,962.00	8,824.00	DRUG-SPECIFIC/HOME IV	0.00	11,404.50
LABORATORY PATHOLOGIC	850,676.00	5,533.00	INJECTABLE DRUGS	15,487,201.64	470,600.00
RADIOLOGY THERAPEUTIC	172,731.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	292,498.00	2,705.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	113,209.00	273.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	227,695.00	12,726.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	192.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	372,968.00	3,138.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	472,449.00	87,389.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,644,080.00	563,285.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	140,101.00	16,475.00			
AUDIOLOGY	436,684.00	0.00			
CARDIOLOGY	725,345.00	8,376.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	52,055.00	0.00			
ORGAN ACQUISITION	83,263.63	0.00			
TREATMENT/OBSERV. RM	36,660.00	370.00			
			TOTAL ANCILLARY	57,472,991.31	2,196,572.88
			TOTAL ACCOMODATIONS	27,467,717.00	3,533,044.00
			TOTAL CHARGES	84,940,708.31	5,729,616.88

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 10:26:19  
Page: 3

NORTHSIDE HOSPITAL  
1000 JOHNSON FERRY RD NE  
ATLANTA,GA 30342-1606

PROVIDER NUMBER  
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9713144957091	12/21/12 - 12/23/12	06/03/13	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:27:40  
 Page: 4

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,872,801.43	ADJUSTMENTS	0.00
COVERED CHARGES	10,211,103.43	CONTRACTUAL ALLOW	4,201,693.39
NON-COVERD CHARGES	661,698.00	TOTAL MEDICAID LIAB	6,009,410.04
		LESS: COB	6,009,410.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 145

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	295		0	281,289.00		41,464.00
ROUTINE NURSERY	785		7	1,939,609.00		562,593.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,080		7	2,220,898.00		604,057.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	157		0	467,532.00		0.00
NICU	595		0	3,053,288.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	752		0	3,520,820.00		0.00
TOTAL ACCOMODATIONS	1,832		7	5,741,718.00		604,057.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	520,403.93	0.00	OTHER LAB	71,181.00	0.00
MED/SURG SUPPLY	368,447.00	257.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	612,169.00	0.00	EDUCATION & TRAINING	1,108.00	0.00
RADIOLOGY-DIAGNOSTIC	144,412.00	0.00	OTHER THERAPEUTIC SVC	695.00	11,838.00
CT SCAN	27,658.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	45,522.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,252.00	0.00	MRI SERVICES	7,192.00	0.00
IV THERAPY	6,108.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	255,081.00	14,676.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	287,393.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	675,138.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,780.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,580.00	0.00	SPECIAL SERVICES	0.00	30,870.00
RECOVERY ROOM	40,228.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	19,822.00	0.00	INJECTABLE DRUGS	974,229.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	69,060.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	27,547.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	34,366.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	82,935.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,784.00	0.00			
AUDIOLOGY	36,013.00	0.00			
CARDIOLOGY	101,858.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,780.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	643.00	0.00			
			TOTAL ANCILLARY	4,469,385.43	57,641.00
			TOTAL ACCOMODATIONS	5,741,718.00	604,057.00
			TOTAL CHARGES	10,211,103.43	661,698.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:27:46  
Page: 6

NORTHSIDE HOSPITAL  
1000 JOHNSON FERRY RD NE  
ATLANTA,GA 30342-1606

PROVIDER NUMBER  
000001405A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,251,787.50	ADJUSTMENTS	1,393,007.92
COVERED CHARGES	30,252,245.76	CONTRACTUAL ALLOW	24,797,339.86
NON-COVERD CHARGES	3,999,541.74	TOTAL MEDICAID LIAB	5,454,905.90
		LESS: COB	32,723.22
		LESS: COPAYMENT	21,387.64
		REIMBURSEMENT	5,400,795.04
		ALL OTHER	3,035,191.63
		FEE SCHEDULE-LAB	424,332.68
		INJECTABLE DRUGS	1,941,270.73

TOTAL NUMBER OF CLAIMS 8,544

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	484,771.03	4,882.30	OTHER LAB	117,762.00	1,806.00
MED/SURG SUPPLY	590,485.14	22,419.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	831.00	EDUCATION & TRAINING	7,813.00	1,212.00
RADIOLOGY-DIAGNOSTIC	323,252.00	8,987.00	OTHER THERAPEUTIC SVC	612.00	43,825.00
CT SCAN	1,137,006.00	100,012.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	11,409.00	10,979.00	FEE SCHEDULE LAB	6,022,492.87	883,697.70
EKG/ECG	95,121.00	10,569.00	MRI SERVICES	454,717.00	31,246.00
IV THERAPY	2,028,261.50	80,443.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,768,706.00	355,094.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	207,100.00	1,703.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	29,276.00	2,720.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	376,678.00	24,948.00	AMBULANCE	0.00	0.00
GI SERVICES	40,781.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,389,634.67	97,241.00	SPECIAL SERVICES	0.00	152.00
RECOVERY ROOM	410,115.00	880.00	DRUG-SPECIFIC/HOME IV	0.00	1,124.50
LABORATORY PATHOLOGIC	0.00	776.00	INJECTABLE DRUGS	10,425,731.48	1,925,240.24
RADIOLOGY THERAPEUTIC	504,650.00	15,896.00	HOME HEALTH SERVICES	0.00	159.00
OCCUPATIONAL THERAPY	4,395.00	4,420.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,498.00	996.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	42,315.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,228.00	1,888.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	120,719.00	18,721.00	IMPL DEV CHARGE PATIENTS	118,172.00	15,960.00
LITHOTRIPSY	54,888.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,302,730.00	209,313.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	478,584.00	26,362.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	58,344.00	9,817.00			
AUDIOLOGY	4,875.00	2,374.00			
CARDIOLOGY	116,678.00	20,726.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,338.00	0.00			
ORGAN ACQUISITION	0.00	4,030.00			
TREATMENT/OBSERV. RM	562,422.07	15,777.00			
			TOTAL ANCILLARY	30,252,245.76	3,999,541.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,252,245.76	3,999,541.74

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: 07/23/2014  
Run Time: 10:29:43  
Page: 8

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,307,030.29	ADJUSTMENTS	0.00
COVERED CHARGES	926,769.92	CONTRACTUAL ALLOW	356,182.40
NON-COVERD CHARGES	380,260.37	TOTAL MEDICAID LIAB	570,587.52
		LESS: COB	570,195.22
		LESS: COPAYMENT	392.30
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 335

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51,579.38	2,006.50	OTHER LAB	2,831.00	101.00
MED/SURG SUPPLY	26,719.50	297.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	783.00	484.00
RADIOLOGY-DIAGNOSTIC	11,285.00	1,614.00	OTHER THERAPEUTIC SVC	612.00	2,754.00
CT SCAN	23,217.00	15,708.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	189,440.00	37,019.00
EKG/ECG	2,710.00	0.00	MRI SERVICES	15,210.00	4,422.00
IV THERAPY	48,226.00	2,691.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	81,932.00	60,300.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	34,790.00	859.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,271.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	29,376.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	101,772.00	4,921.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	30,659.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	138,968.04	204,908.87
RADIOLOGY THERAPEUTIC	6,683.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,961.00	0.00	IMPL DEV CHARGE PATIENTS	5,502.00	7,760.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	80,432.00	29,870.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,656.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,990.00			
AUDIOLOGY	684.00	256.00			
CARDIOLOGY	1,958.00	1,958.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,513.00	341.00			
			TOTAL ANCILLARY	926,769.92	380,260.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	926,769.92	380,260.37

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:29:51  
Page: 10

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	515,560.71	ADJUSTMENTS	1,780.02
COVERED CHARGES	481,918.52	CONTRACTUAL ALLOW	465,248.41
NON-COVERD CHARGES	33,642.19	TOTAL MEDICAID LIAB	16,670.11
		LESS: COB	11.50
		LESS: COPAYMENT	576.04
		REIMBURSEMENT	16,082.57
		TOTAL NUMBER OF CLAIMS	298

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,567.03	104.00	OTHER LAB	1,386.00	0.00
MED/SURG SUPPLY	4,188.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,912.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,296.00	2,177.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	84,030.00	9,656.00
EKG/ECG	6,233.00	271.00	MRI SERVICES	8,018.00	0.00
IV THERAPY	470.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,889.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,214.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,143.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	275,803.00	6,053.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,190.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,745.49	3,637.19
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	2,015.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,252.00	9,729.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,582.00	0.00			
			TOTAL ANCILLARY	481,918.52	33,642.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	481,918.52	33,642.19



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: 07/23/2014  
Run Time: 10:30:01  
Page: 12

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,729.50	ADJUSTMENTS	0.00
COVERED CHARGES	33,437.50	CONTRACTUAL ALLOW	21,537.07
NON-COVERD CHARGES	2,292.00	TOTAL MEDICAID LIAB	11,900.43
		LESS: COB	11,882.42
		LESS: COPAYMENT	18.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	14

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	583.50	0.00	OTHER LAB	693.00	0.00
MED/SURG SUPPLY	228.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,176.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,681.00	545.00
EKG/ECG	542.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	155.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	17,872.00	201.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	711.00	72.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,796.00	1,474.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,437.50	2,292.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,437.50	2,292.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 10:30:04  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,120,896.42	ADJUSTMENTS	620,922.89
COVERED CHARGES	11,399,258.01	CONTRACTUAL ALLOW	9,667,226.54
NON-COVERD CHARGES	721,638.41	TOTAL MEDICAID LIAB	1,732,031.47
		LESS: COB	3,965.50
		LESS: COPAYMENT	2,233.54
		REIMBURSEMENT	1,725,832.43
		TOTAL NUMBER OF CLAIMS	342

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	231,084.98	1,147.89	OTHER LAB	2,188.00	0.00
MED/SURG SUPPLY	174,544.27	19,686.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	107,118.00	47,570.00	OTHER THERAPEUTIC SVC	306.00	11,169.00
CT SCAN	61,144.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,560.00	FEE SCHEDULE LAB	390,715.00	62,321.00
EKG/ECG	5,420.00	2,439.00	MRI SERVICES	20,458.00	0.00
IV THERAPY	702,133.00	17,453.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	713,804.00	57,534.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	112.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,315.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	92,535.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,354.00	1,865.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,868.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,662,864.76	349,440.52
RADIOLOGY THERAPEUTIC	228,911.00	399.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	2,480.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	32.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	718,791.00	138,451.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,055.00	1,354.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	102,461.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,486.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	27,938.00	2,646.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	65,764.00	2,979.00			
			TOTAL ANCILLARY	11,399,258.01	721,638.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,399,258.01	721,638.41

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:30:12  
Page: 16

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	235,573.75	ADJUSTMENTS	0.00
COVERED CHARGES	234,150.75	CONTRACTUAL ALLOW	103,488.62
NON-COVERD CHARGES	1,423.00	TOTAL MEDICAID LIAB	130,662.13
		LESS: COB	130,611.13
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	6

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,456.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	9,039.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	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	5,680.00	163.00
EKG/ECG	271.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,964.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	38,974.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,536.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,070.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	154,987.25	495.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,173.00	0.00			
			TOTAL ANCILLARY	234,150.75	1,423.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	234,150.75	1,423.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:04:30  
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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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	169,067.56	ADJUSTMENTS	5,175.02
COVERED CHARGES	162,577.56	CONTRACTUAL ALLOW	85,748.37
NON-COVERD CHARGES	6,490.00	TOTAL MEDICAID LIAB	76,829.19
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	76,829.19

TOTAL NUMBER OF ADMISSIONS 18

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	55		0	27,445.00		200.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	55		0	27,445.00		200.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	55		0	27,445.00		200.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	36,370.71	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,112.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	32,670.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,060.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,897.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	502.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,280.00	0.00	MRI SERVICES	2,250.00	0.00
IV THERAPY	850.00	0.00	PROFESSIONAL FEES	0.00	3,594.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,282.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,245.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,435.75	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	194.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,090.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,420.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,705.00	2,696.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	958.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,811.10	0.00			
			TOTAL ANCILLARY	135,132.56	6,290.00
			TOTAL ACCOMODATIONS	27,445.00	200.00
			TOTAL CHARGES	162,577.56	6,490.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 09:04:31  
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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	08/01/12	THROUGH	07/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:04:32  
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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	678,224.22	ADJUSTMENTS	12,313.19
COVERED CHARGES	584,466.62	CONTRACTUAL ALLOW	408,132.51
NON-COVERD CHARGES	93,757.60	TOTAL MEDICAID LIAB	176,334.11
		LESS: COB	0.00
		LESS: COPAYMENT	339.00
		REIMBURSEMENT	175,995.11
		ALL OTHER	149,887.37
		FEE SCHEDULE-LAB	22,678.27
		INJECTABLE DRUGS	3,429.47

TOTAL NUMBER OF CLAIMS 848

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 09:04:32  
 Page: 5

SOUTHWEST GEORGIA REGIONAL MEDICAL  
 361 RANDOLPH ST  
 CUTHBERT,GA 39840-6127

PROVIDER NUMBER  
 000001427A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,737.13	400.00	OTHER LAB	4,262.00	0.00
MED/SURG SUPPLY	21,935.51	267.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,839.13	1,074.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,503.00	21,048.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,328.00	3,937.00	FEE SCHEDULE LAB	175,083.20	51,460.60
EKG/ECG	10,640.00	570.00	MRI SERVICES	5,580.00	0.00
IV THERAPY	3,094.00	0.00	PROFESSIONAL FEES	0.00	4,817.00
OPERATING ROOM	18,876.00	3,433.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	496.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,594.00	946.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,973.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	129,331.86	523.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,624.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,241.22	917.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	194.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,270.00	1,090.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,432.00	414.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,944.62	742.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,788.00	318.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,916.00	592.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	22,191.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,592.10	1,209.00			
			TOTAL ANCILLARY	584,466.62	93,757.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	584,466.62	93,757.60

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,615.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,414.00	CONTRACTUAL ALLOW	1,115.97
NON-COVERD CHARGES	201.00	TOTAL MEDICAID LIAB	3,298.03
		LESS: COB	3,298.03
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 6

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	122.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	152.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	543.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	775.00	201.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	217.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,238.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	367.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,414.00	201.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,414.00	201.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:04:54  
Page: 8

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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	84,242.26	ADJUSTMENTS	398.00
COVERED CHARGES	80,992.26	CONTRACTUAL ALLOW	73,226.25
NON-COVERD CHARGES	3,250.00	TOTAL MEDICAID LIAB	7,766.01
		LESS: COB	0.00
		LESS: COPAYMENT	309.00
		REIMBURSEMENT	7,457.01
		TOTAL NUMBER OF CLAIMS	178

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,169.20	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,602.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,007.78	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,276.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,163.00	2,522.00
EKG/ECG	760.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,152.00	365.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,766.78	116.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,485.50	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	1,560.00	247.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	80,992.26	3,250.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	80,992.26	3,250.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	599.00	ADJUSTMENTS	0.00
COVERED CHARGES	599.00	CONTRACTUAL ALLOW	109.90
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	489.10
		LESS: COB	489.10
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	35.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	440.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	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

Run Date: 07/23/2014  
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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	08/01/12	THROUGH	07/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 09:04:58  
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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	08/01/12	THROUGH	07/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 12:11:08  
 Page: 1

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,683,832.78	ADJUSTMENTS	113,755.36
COVERED CHARGES	3,618,815.78	CONTRACTUAL ALLOW	2,557,650.08
NON-COVERD CHARGES	65,017.00	TOTAL MEDICAID LIAB	1,061,165.70
		LESS: COB	1,667.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,059,497.74

TOTAL NUMBER OF ADMISSIONS 145

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	219		23	222,066.00		23,322.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	219		23	222,066.00		23,322.00
SPECIAL CARE SERVICES						
CCU	164		6	229,928.00		8,412.00
ICU	53		3	137,800.00		7,800.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	217		9	367,728.00		16,212.00
TOTAL ACCOMODATIONS	436		32	589,794.00		39,534.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR PAULDING HOSPITAL  
 2518 JIMMY LEE SMITH PKWY  
 HIRAM,GA 30141-2068

PROVIDER NUMBER  
 000001438A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	505,393.78	82.00	OTHER LAB	24,311.00	0.00
MED/SURG SUPPLY	101,708.00	402.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	623,886.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	122,131.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	441,830.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,406.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	39,470.00	0.00	MRI SERVICES	24,346.00	0.00
IV THERAPY	151,831.00	4,694.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	87,206.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	416,552.00	502.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,913.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	285,559.00	418.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,169.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,952.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	684.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	957.00	17,957.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,608.00	0.00	IMPL DEV CHARGE PATIENTS	7,111.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	17,837.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,161.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	25,475.00	1,428.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	70,331.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,194.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,029,021.78	25,483.00
			TOTAL ACCOMODATIONS	589,794.00	39,534.00
			TOTAL CHARGES	3,618,815.78	65,017.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

WELLSTAR 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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:11:16  
Page: 4

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,281,444.93	ADJUSTMENTS	217,034.32
COVERED CHARGES	7,907,371.83	CONTRACTUAL ALLOW	6,320,482.36
NON-COVERD CHARGES	374,073.10	TOTAL MEDICAID LIAB	1,586,889.47
		LESS: COB	4,650.23
		LESS: COPAYMENT	2,053.79
		REIMBURSEMENT	1,580,185.45
		ALL OTHER	1,499,513.75
		FEE SCHEDULE-LAB	76,093.29
		INJECTABLE DRUGS	4,578.41
		TOTAL NUMBER OF CLAIMS	3,066

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165,435.28	19,226.00	OTHER LAB	51,074.00	0.00
MED/SURG SUPPLY	49,571.00	758.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	456.00	0.00
RADIOLOGY-DIAGNOSTIC	558,431.00	2,056.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,653,480.00	42,136.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	299.00	FEE SCHEDULE LAB	1,145,934.11	142,231.20
EKG/ECG	117,553.00	2,907.00	MRI SERVICES	422,519.00	38,221.00
IV THERAPY	334,796.00	572.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	141,644.00	36,542.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75,860.00	30,377.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	72,287.00	509.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,366,935.00	18,953.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	52,525.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	36,955.75	11,849.90
RADIOLOGY THERAPEUTIC	139,312.00	993.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,448.00	2,942.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,442.00	0.00	IMPL DEV CHARGE PATIENTS	3,673.00	1,713.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	250,524.00	20,506.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,525.00	1,000.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,109.00	282.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	72,752.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	100,916.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36,214.69	0.00			
			TOTAL ANCILLARY	7,907,371.83	374,073.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,907,371.83	374,073.10



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

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	134,267.25	ADJUSTMENTS	0.00
COVERED CHARGES	111,611.25	CONTRACTUAL ALLOW	17,819.82
NON-COVERD CHARGES	22,656.00	TOTAL MEDICAID LIAB	93,791.43
		LESS: COB	93,755.43
		LESS: COPAYMENT	36.00
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,133.75	453.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	472.00	4.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	207.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,463.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,436.00	10,214.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	23,051.00	1,503.00
EKG/ECG	1,615.00	0.00	MRI SERVICES	4,934.00	4,934.00
IV THERAPY	7,576.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	1,650.00	0.00
RESPIRATORY SERVICES	218.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	50,446.00	420.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	714.50	481.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	174.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,902.00	4,266.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	111,611.25	22,656.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	111,611.25	22,656.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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Page: 8

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	752,568.75	ADJUSTMENTS	582.34
COVERED CHARGES	727,681.00	CONTRACTUAL ALLOW	699,431.30
NON-COVERD CHARGES	24,887.75	TOTAL MEDICAID LIAB	28,249.70
		LESS: COB	0.00
		LESS: COPAYMENT	855.03
		REIMBURSEMENT	27,394.67
		TOTAL NUMBER OF CLAIMS	505

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,874.00	1,296.00	OTHER LAB	3,854.00	3,252.00
MED/SURG SUPPLY	1,419.00	69.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,347.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	59,568.00	4,488.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	131,788.00	9,855.00
EKG/ECG	9,432.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	25,045.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,856.00	871.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	400,551.00	945.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,652.00	461.75
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	87.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	402.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,893.00	3,563.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	727,681.00	24,887.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	727,681.00	24,887.75

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,458.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,535.00	CONTRACTUAL ALLOW	2,314.81
NON-COVERD CHARGES	923.00	TOTAL MEDICAID LIAB	4,220.19
		LESS: COB	4,220.19
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15.00	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	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	806.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	365.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,180.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	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	551.00	923.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,535.00	923.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,535.00	923.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR 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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	631,274.25	ADJUSTMENTS	0.00
COVERED CHARGES	627,695.25	CONTRACTUAL ALLOW	549,467.40
NON-COVERD CHARGES	3,579.00	TOTAL MEDICAID LIAB	78,227.85
		LESS: COB	0.00
		LESS: COPAYMENT	348.00
		REIMBURSEMENT	77,879.85
		TOTAL NUMBER OF CLAIMS	15

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	654.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	417.00	93.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	844.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	117,652.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,492.00	662.00
EKG/ECG	646.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,589.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,756.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	37,735.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	275.75	1,687.00
RADIOLOGY THERAPEUTIC	449,679.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,055.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,900.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,137.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	627,695.25	3,579.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	627,695.25	3,579.00



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 12:11:50  
Page: 14

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:35:57  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
 1960 HIGHWAY 247 CONNECTOR  
 BYRON,GA 31008-5663

PROVIDER NUMBER 000001449A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	364,404.00	ADJUSTMENTS	10,894.88
COVERED CHARGES	361,292.00	CONTRACTUAL ALLOW	131,216.19
NON-COVERD CHARGES	3,112.00	TOTAL MEDICAID LIAB	230,075.81
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	230,075.81

TOTAL NUMBER OF ADMISSIONS 45

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	152		0	55,420.00		2,020.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	152		0	55,420.00		2,020.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	152		0	55,420.00		2,020.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
 1960 HIGHWAY 247 CONNECTOR  
 BYRON,GA 31008-5663

PROVIDER NUMBER  
 000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	60,990.00	0.00	OTHER LAB	2,023.00	0.00
MED/SURG SUPPLY	13,324.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	93,838.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,437.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	15,608.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	726.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,169.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	935.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,359.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,303.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	260.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	54,896.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,401.00	0.00			
BLOOD	728.00	0.00			
BLOOD STORAGE & PRO.	3,260.00	1,092.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,180.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	435.00	0.00			
			TOTAL ANCILLARY	305,872.00	1,092.00
			TOTAL ACCOMODATIONS	55,420.00	2,020.00
			TOTAL CHARGES	361,292.00	3,112.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,946.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,342.00	CONTRACTUAL ALLOW	7,634.10
NON-COVERD CHARGES	3,604.00	TOTAL MEDICAID LIAB	11,707.90
		LESS: COB	11,707.90
		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		9	0.00		3,240.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	0		9	0.00		3,240.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	0		9	0.00		3,240.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
 1960 HIGHWAY 247 CONNECTOR  
 BYRON,GA 31008-5663

PROVIDER NUMBER  
 000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,226.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,445.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,075.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	96.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,291.00	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	25.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	3,472.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	868.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	844.00	364.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,342.00	364.00
			TOTAL ACCOMODATIONS	0.00	3,240.00
			TOTAL CHARGES	19,342.00	3,604.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,184,952.00	ADJUSTMENTS	116,664.43
COVERED CHARGES	1,023,279.50	CONTRACTUAL ALLOW	703,897.78
NON-COVERD CHARGES	161,672.50	TOTAL MEDICAID LIAB	319,381.72
		LESS: COB	853.34
		LESS: COPAYMENT	2,010.00
		REIMBURSEMENT	316,518.38
		ALL OTHER	260,370.63
		FEE SCHEDULE-LAB	53,090.34
		INJECTABLE DRUGS	3,057.41

TOTAL NUMBER OF CLAIMS 1,537

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 01/01/13 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	38,571.00	5,334.00	OTHER LAB	8,819.00	256.00
MED/SURG SUPPLY	39,005.00	135.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	36.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	66,894.00	706.00	OTHER THERAPEUTIC SVC	0.00	78.00
CT SCAN	96,632.00	5,619.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,504.00	932.00	FEE SCHEDULE LAB	314,023.50	117,584.50
EKG/ECG	17,902.00	856.00	MRI SERVICES	14,378.00	1,437.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	48,966.00	789.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	6,803.00	2,103.00	FREE STANDING CLINIC	40,277.00	1,213.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	196,159.00	5,349.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,406.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33,420.00	12,648.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	127.00	580.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,134.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	120.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	33,094.00	2,736.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,202.00	728.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,426.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,711.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,826.00	1,693.00			
			TOTAL ANCILLARY	1,023,279.50	160,932.50
			TOTAL ACCOMODATIONS	0.00	740.00
			TOTAL CHARGES	1,023,279.50	161,672.50

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE MEDICAL CENTER 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 01/01/13 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,494.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,042.00	CONTRACTUAL ALLOW	4,458.79
NON-COVERD CHARGES	2,452.00	TOTAL MEDICAID LIAB	1,583.21
		LESS: COB	1,576.92
		LESS: COPAYMENT	6.29
		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 01/01/13 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	255.00	421.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	349.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	371.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	874.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,635.00	492.00
EKG/ECG	658.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,142.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	354.00	423.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	253.00	242.00			
			TOTAL ANCILLARY	6,042.00	2,452.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,042.00	2,452.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	75,274.00	ADJUSTMENTS	551.02
COVERED CHARGES	70,356.00	CONTRACTUAL ALLOW	59,817.41
NON-COVERD CHARGES	4,918.00	TOTAL MEDICAID LIAB	10,538.59
		LESS: COB	30.00
		LESS: COPAYMENT	432.02
		REIMBURSEMENT	10,076.57

TOTAL NUMBER OF CLAIMS 241

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 01/01/13 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,980.00	92.00	OTHER LAB	321.00	0.00
MED/SURG SUPPLY	889.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	99.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,196.00	0.00	OTHER THERAPEUTIC SVC	0.00	26.00
CT SCAN	1,799.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	14,377.00	3,700.00
EKG/ECG	1,070.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,227.00	251.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,975.00	670.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	80.00
OTHER IMAGING SERVICE	1,418.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	70,356.00	4,918.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	70,356.00	4,918.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:36:22  
Page: 11

THE MEDICAL CENTER OF PEACH COUNTY, INC.  
1960 HIGHWAY 247 CONNECTOR  
BYRON,GA 31008-5663

PROVIDER NUMBER  
000001449A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
696	2214191005686	05/31/13 - 05/31/13	07/14/14	0.00	80.00	0.00	0.00	0.00
TOTAL				0.00	80.00	0.00	0.00	0.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:36:25  
Page: 12

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 01/01/13 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	697.00	ADJUSTMENTS	0.00
COVERED CHARGES	679.00	CONTRACTUAL ALLOW	452.26
NON-COVERD CHARGES	18.00	TOTAL MEDICAID LIAB	226.74
		LESS: COB	223.74
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	301.00	18.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	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	679.00	18.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	679.00	18.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	01/01/13	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	01/01/13	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:59:07  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PERRY HOSPITAL  
 1120 MORNINGSIDE DR  
 PERRY,GA 31069-2906

PROVIDER NUMBER  
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,083,924.36	ADJUSTMENTS	12,043.09
COVERED CHARGES	1,073,273.38	CONTRACTUAL ALLOW	642,826.18
NON-COVERD CHARGES	10,650.98	TOTAL MEDICAID LIAB	430,447.20
		LESS: COB	6,276.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	424,171.00

TOTAL NUMBER OF ADMISSIONS 66

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	273		0	169,365.00		5,082.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	273		0	169,365.00		5,082.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	17		0	32,232.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	17		0	32,232.00		0.00
TOTAL ACCOMODATIONS	290		0	201,597.00		5,082.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155,315.33	0.00	OTHER LAB	16,200.00	0.00
MED/SURG SUPPLY	13,535.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	283,999.79	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,644.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	85,268.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,288.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	24,734.00	0.00	MRI SERVICES	13,280.00	0.00
IV THERAPY	3,535.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	40,014.58	4,848.98	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	40,169.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,746.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,903.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,398.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,495.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,113.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	270.00	720.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,856.93	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,295.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,304.30	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	38,256.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	917.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,139.40	0.00			
			TOTAL ANCILLARY	871,676.38	5,568.98
			TOTAL ACCOMODATIONS	201,597.00	5,082.00
			TOTAL CHARGES	1,073,273.38	10,650.98

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:59:10  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,316,189.91	ADJUSTMENTS	62,880.92
COVERED CHARGES	2,069,058.47	CONTRACTUAL ALLOW	1,657,516.08
NON-COVERD CHARGES	247,131.44	TOTAL MEDICAID LIAB	411,542.39
		LESS: COB	940.42
		LESS: COPAYMENT	1,403.91
		REIMBURSEMENT	409,198.06
		ALL OTHER	356,148.16
		FEE SCHEDULE-LAB	39,482.00
		INJECTABLE DRUGS	13,567.90
		TOTAL NUMBER OF CLAIMS	1,328

PERRY HOSPITAL  
 1120 MORNINGSIDE DR  
 PERRY,GA 31069-2906

PROVIDER NUMBER  
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,202.66	3.50	OTHER LAB	43,762.00	0.00
MED/SURG SUPPLY	11,221.85	1,659.69	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	120,609.00	1,481.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	336,255.66	57,457.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,346.00	FEE SCHEDULE LAB	437,473.63	112,079.43
EKG/ECG	40,822.00	4,768.00	MRI SERVICES	80,395.00	3,081.00
IV THERAPY	18,500.00	123.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	188,169.24	27,136.73	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,707.00	2,254.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,955.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	514,781.00	3,336.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	31,106.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53,081.64	25,058.81
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	998.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	258.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	600.00	IMPL DEV CHARGE PATIENTS	3,356.68	506.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	42,813.48	3,544.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,460.42	1,068.73			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	64,557.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,419.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,412.21	370.00			
			TOTAL ANCILLARY	2,069,058.47	247,131.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,069,058.47	247,131.44

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:59:10  
Page: 6

PERRY HOSPITAL  
1120 MORNINGSIDE DR  
PERRY,GA 31069-2906

PROVIDER NUMBER  
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5013186950018	01/18/13 - 01/01/00	07/15/13	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

Run Date: 07/23/2014  
Run Time: 10:59:28  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	114,632.48	ADJUSTMENTS	0.00
COVERED CHARGES	81,582.96	CONTRACTUAL ALLOW	7,880.86
NON-COVERD CHARGES	33,049.52	TOTAL MEDICAID LIAB	73,702.10
		LESS: COB	73,645.10
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 67

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PERRY HOSPITAL  
 1120 MORNINGSIDE DR  
 PERRY,GA 31069-2906

PROVIDER NUMBER  
 000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	964.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	350.44	175.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,795.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,792.00	23,378.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,448.09	2,998.00
EKG/ECG	2,086.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	373.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	4,886.98	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,645.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	32,585.00	1,388.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	352.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,481.71	222.97
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,934.68	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	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	384.20	0.00			
			TOTAL ANCILLARY	81,582.96	33,049.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	81,582.96	33,049.52



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:59:31  
Page: 9

PERRY HOSPITAL  
1120 MORNINGSIDE DR  
PERRY,GA 31069-2906

PROVIDER NUMBER  
000001471A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	98,323.79	ADJUSTMENTS	703.22
COVERED CHARGES	95,229.26	CONTRACTUAL ALLOW	87,285.78
NON-COVERD CHARGES	3,094.53	TOTAL MEDICAID LIAB	7,943.48
		LESS: COB	0.00
		LESS: COPAYMENT	234.00
		REIMBURSEMENT	7,709.48
		TOTAL NUMBER OF CLAIMS	142

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	99.33	63.53	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,694.00	462.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,746.85	2,524.00
EKG/ECG	596.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	182.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	395.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	78,506.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	913.33	45.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	95,229.26	3,094.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	95,229.26	3,094.53

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 10:59:33  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,916.38	ADJUSTMENTS	0.00
COVERED CHARGES	4,950.38	CONTRACTUAL ALLOW	1,102.15
NON-COVERD CHARGES	966.00	TOTAL MEDICAID LIAB	3,848.23
		LESS: COB	3,845.23
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:59:33  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52.18	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	339.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,689.00	48.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,405.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10.20	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	455.00	906.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,950.38	966.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,950.38	966.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 10:59:33  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PERRY HOSPITAL  
1120 MORNINGSIDE DR  
PERRY,GA 31069-2906

PROVIDER NUMBER  
000001471A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:53:48  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,404,737.36	ADJUSTMENTS	4,773,820.68
COVERED CHARGES	73,372,968.11	CONTRACTUAL ALLOW	48,947,741.64
NON-COVERD CHARGES	4,031,769.25	TOTAL MEDICAID LIAB	24,425,226.47
		LESS: COB	48,171.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	24,377,054.76

TOTAL NUMBER OF ADMISSIONS 2,587

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	11,951		0	5,634,285.00		1,262,271.00
ROUTINE NURSERY	1,780		2	814,002.00		20,608.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13,731		2	6,448,287.00		1,282,879.00
SPECIAL CARE SERVICES						
CCU	532		0	708,992.00		0.00
ICU	1,584		0	2,042,892.00		0.00
NICU	1,081		0	1,380,210.00		6,810.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		8	0.00		4,064.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3,197		8	4,132,094.00		10,874.00
TOTAL ACCOMODATIONS	16,928		10	10,580,381.00		1,293,753.00

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,148,143.13	251,708.46	OTHER LAB	351,094.00	910.00
MED/SURG SUPPLY	6,571,632.14	194,441.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,764,602.20	128,280.00	EDUCATION & TRAINING	756.00	0.00
RADIOLOGY-DIAGNOSTIC	1,372,278.00	12,471.00	OTHER THERAPEUTIC SVC	0.00	38,007.00
CT SCAN	1,101,705.00	815,358.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	448,032.00	5,810.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	298,158.00	0.00	MRI SERVICES	570,987.00	0.00
IV THERAPY	156,940.93	3,000.85	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,831,307.30	74,852.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	192,553.00	1,000.00	REHAB THERAPY	14,110.00	0.00
RESPIRATORY SERVICES	3,076,464.00	39,984.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	488,387.00	3,427.00	AMBULANCE	0.00	0.00
GI SERVICES	292,080.00	6,830.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,072,268.00	16,265.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	961,036.30	9,823.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	205,876.00	2,056.00	INJECTABLE DRUGS	4,002,862.07	63,788.62
RADIOLOGY THERAPEUTIC	435,194.00	14,918.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	215,092.00	2,363.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	85,880.00	718.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	227,084.00	31,044.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	60.00	73,046.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	323,550.00	0.00	IMPL DEV CHARGE PATIENTS	3,304,795.01	28,513.00
LITHOTRIPSY	16,718.00	0.00	NO CC/INVALID REV CODE	0.00	45,591.00
OTHER IMAGING SERVICE	328,039.00	5,434.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	984,590.00	828,832.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	216,332.00	2,910.00			
AUDIOLOGY	68,038.00	6,101.00			
CARDIOLOGY	1,695,107.00	7,037.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	48,594.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	922,242.03	23,497.00			
			TOTAL ANCILLARY	62,792,587.11	2,738,016.25
			TOTAL ACCOMODATIONS	10,580,381.00	1,293,753.00
			TOTAL CHARGES	73,372,968.11	4,031,769.25



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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012240010695	08/09/12 - 08/20/12	09/03/12	0.00	2,171.00	0.00	0.00	0.00
615	2012275032289	09/18/12 - 09/24/12	10/08/12	0.00	2,171.00	0.00	0.00	0.00
615	2012303010500	10/09/12 - 10/11/12	11/05/12	0.00	2,171.00	0.00	0.00	0.00
615	5912307002039	08/26/12 - 08/28/12	11/05/12	0.00	2,171.00	0.00	0.00	0.00
615	2013030075489	12/16/12 - 12/18/12	02/04/13	0.00	2,171.00	0.00	0.00	0.00
615	2013072070760	02/03/13 - 02/05/13	03/18/13	0.00	2,171.00	0.00	0.00	0.00
615	2013081010580	02/01/13 - 02/05/13	03/25/13	0.00	2,171.00	0.00	0.00	0.00
615	2013106066551	01/17/13 - 01/22/13	04/22/13	0.00	2,171.00	0.00	0.00	0.00
615	2013106066560	03/15/13 - 04/03/13	04/22/13	0.00	2,171.00	0.00	0.00	0.00
615	2213169001182	12/16/12 - 12/21/12	06/24/13	0.00	2,171.00	0.00	0.00	0.00
615	2013192067165	09/25/12 - 09/28/12	07/15/13	0.00	2,171.00	0.00	0.00	0.00
615	2013197047772	05/23/13 - 05/31/13	07/22/13	0.00	2,171.00	0.00	0.00	0.00
615	2013204047945	03/20/13 - 03/23/13	07/29/13	0.00	2,171.00	0.00	0.00	0.00
615	2013219074908	12/27/12 - 01/18/13	08/12/13	0.00	2,171.00	0.00	0.00	0.00
615	2213224006301	03/09/13 - 03/12/13	08/19/13	0.00	2,171.00	0.00	0.00	0.00
615	2013226064857	04/05/13 - 04/07/13	08/19/13	0.00	2,171.00	0.00	0.00	0.00
615	2013308011433	07/31/13 - 08/12/13	11/11/13	0.00	2,171.00	0.00	0.00	0.00
615	9114006007326	06/28/13 - 07/03/13	02/24/14	0.00	2,171.00	0.00	1,203.40	0.00
615	2014114082262	09/17/12 - 09/21/12	04/28/14	0.00	2,171.00	0.00	0.00	0.00
615	2014142091690	04/01/13 - 04/04/13	05/26/14	0.00	2,171.00	0.00	0.00	0.00
615	2014199068007	03/18/13 - 04/01/13	01/01/00	0.00	2,171.00	0.00	0.00	0.00
TOTAL				0.00	45,591.00	0.00	1,203.40	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PHOEBE 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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	316,854.04	ADJUSTMENTS	0.00
COVERED CHARGES	314,083.04	CONTRACTUAL ALLOW	87,052.12
NON-COVERD CHARGES	2,771.00	TOTAL MEDICAID LIAB	227,030.92
		LESS: COB	227,030.92
		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	56		0	26,230.00		0.00
ROUTINE NURSERY	2		0	468.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	58		0	26,698.00		0.00
SPECIAL CARE SERVICES						
CCU	3		0	3,960.00		0.00
ICU	2		0	2,640.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	5		0	6,600.00		0.00
TOTAL ACCOMODATIONS	63		0	33,298.00		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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	148,284.68	0.00	OTHER LAB	1,013.00	0.00
MED/SURG SUPPLY	21,749.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	26,239.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,319.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,481.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,286.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	930.00	0.00	MRI SERVICES	3,042.00	0.00
IV THERAPY	2,649.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,592.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,947.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,253.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,830.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,670.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,874.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	776.00	0.00	INJECTABLE DRUGS	11,502.59	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,812.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	80.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,870.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	130.00	0.00			
BLOOD STORAGE & PRO.	2,140.00	2,691.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	350.00	0.00			
CARDIOLOGY	11,059.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,986.75	0.00			
			TOTAL ANCILLARY	280,785.04	2,771.00
			TOTAL ACCOMODATIONS	33,298.00	0.00
			TOTAL CHARGES	314,083.04	2,771.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,711,317.61	ADJUSTMENTS	1,290,964.21
COVERED CHARGES	34,510,947.64	CONTRACTUAL ALLOW	26,194,647.17
NON-COVERD CHARGES	2,200,369.97	TOTAL MEDICAID LIAB	8,316,300.47
		LESS: COB	4,644.33
		LESS: COPAYMENT	31,957.51
		REIMBURSEMENT	8,279,698.63
		ALL OTHER	6,875,022.45
		FEE SCHEDULE-LAB	504,677.88
		INJECTABLE DRUGS	899,998.30
		TOTAL NUMBER OF CLAIMS	18,405

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,626,846.20	2,338.84	OTHER LAB	158,385.00	24,378.00
MED/SURG SUPPLY	2,642,620.49	2,033.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,063.00	EDUCATION & TRAINING	1,330.00	0.00
RADIOLOGY-DIAGNOSTIC	960,196.00	30,901.00	OTHER THERAPEUTIC SVC	0.00	1,029.00
CT SCAN	2,172,370.00	139,777.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	80,020.00	23,114.00	FEE SCHEDULE LAB	2,964,950.34	607,637.40
EKG/ECG	225,995.00	23,368.00	MRI SERVICES	655,054.00	28,501.00
IV THERAPY	825,696.00	25,280.88	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,330,150.20	273,787.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	112,612.00	426.00	REHAB THERAPY	2,210.00	0.00
RESPIRATORY SERVICES	295,846.00	49,960.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	416,893.00	1,570.00	AMBULANCE	0.00	0.00
GI SERVICES	780,921.00	38,805.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,197,724.00	144,206.00	SPECIAL SERVICES	0.00	239.00
RECOVERY ROOM	905,085.90	1,595.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,236,026.10	476,071.35
RADIOLOGY THERAPEUTIC	1,969,627.00	19,099.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	18,928.00	9,525.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	24,992.00	6,698.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	914,211.00	102,406.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	355,580.00	0.00	IMPL DEV CHARGE PATIENTS	388,522.01	252.00
LITHOTRIPSY	50,154.00	0.00	NO CC/INVALID REV CODE	0.00	527.00
OTHER IMAGING SERVICE	933,075.00	52,851.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	136,846.00	2,164.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	724,050.00	2,870.00			
AUDIOLOGY	3,923.00	770.00			
CARDIOLOGY	474,209.00	83,237.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	549,716.00	658.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	376,183.40	22,885.50			
			TOTAL ANCILLARY	34,510,947.64	2,200,022.97
			TOTAL ACCOMODATIONS	0.00	347.00
			TOTAL CHARGES	34,510,947.64	2,200,369.97

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
9636	5912333000671	08/14/12 - 08/14/12	12/03/12	0.00	406.00	0.00	0.00	0.00
-1	2313182000022	01/16/13 - 01/16/13	08/05/13	0.00	121.00	0.00	0.00	0.00
TOTAL				0.00	527.00	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

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	406,190.97	ADJUSTMENTS	0.00
COVERED CHARGES	344,250.18	CONTRACTUAL ALLOW	144,931.68
NON-COVERD CHARGES	61,940.79	TOTAL MEDICAID LIAB	199,318.50
		LESS: COB	199,004.05
		LESS: COPAYMENT	314.45
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 175

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,390.36	40.00	OTHER LAB	1,591.00	2,530.00
MED/SURG SUPPLY	50,582.90	89.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	559.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,244.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,412.00	12,684.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,405.00	1,136.09	FEE SCHEDULE LAB	32,282.80	5,128.00
EKG/ECG	3,415.00	374.00	MRI SERVICES	2,488.00	0.00
IV THERAPY	12,286.77	204.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,376.00	16,500.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,216.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	84.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,383.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,140.00	1,570.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,029.00	4,411.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,010.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	57,422.85	3,923.70
RADIOLOGY THERAPEUTIC	567.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,208.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	470.00	3,038.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	186.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,674.00	239.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	797.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	70.00
OTHER IMAGING SERVICE	6,270.00	6,002.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,668.00	1,705.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,136.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,909.50	344.00			
			TOTAL ANCILLARY	344,250.18	61,940.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	344,250.18	61,940.79



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	1113154005308	03/21/13 - 03/21/13	07/15/13	0.00	70.00	0.00	1,454.96	0.00
TOTAL				0.00	70.00	0.00	1,454.96	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	654,708.40	ADJUSTMENTS	871.04
COVERED CHARGES	635,864.20	CONTRACTUAL ALLOW	589,434.00
NON-COVERD CHARGES	18,844.20	TOTAL MEDICAID LIAB	46,430.20
		LESS: COB	0.00
		LESS: COPAYMENT	1,737.02
		REIMBURSEMENT	44,693.18
		TOTAL NUMBER OF CLAIMS	830

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,506.55	0.00	OTHER LAB	1,218.00	0.00
MED/SURG SUPPLY	20,258.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,143.00	893.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	18,443.00	1,403.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	43,864.00	8,839.00
EKG/ECG	3,720.00	558.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,875.00	165.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,950.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	504.00	419.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	550.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	446,599.00	3,171.00	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	12,572.70	1,511.20
RADIOLOGY THERAPEUTIC	7,814.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	902.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,867.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,429.00	1,885.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	110.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,548.25	0.00			
			TOTAL ANCILLARY	635,864.20	18,844.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	635,864.20	18,844.20

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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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,485.50	ADJUSTMENTS	0.00
COVERED CHARGES	31,632.80	CONTRACTUAL ALLOW	25,183.78
NON-COVERD CHARGES	10,852.70	TOTAL MEDICAID LIAB	6,449.02
		LESS: COB	6,404.02
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	18

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,208.10	1,322.10	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,302.00	264.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	186.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,903.00	615.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,721.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,634.00	2,096.00
EKG/ECG	744.00	372.00	MRI SERVICES	0.00	0.00
IV THERAPY	406.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	132.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,349.00	2,126.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	429.70	698.60
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	1,007.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,091.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	765.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	794.00	1,320.00			
			TOTAL ANCILLARY	31,632.80	10,852.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	31,632.80	10,852.70

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL  
417 W 3RD AVE  
ALBANY,GA 31701-1943

PROVIDER NUMBER  
000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,596,219.48	ADJUSTMENTS	371,128.19
COVERED CHARGES	9,153,820.53	CONTRACTUAL ALLOW	7,972,794.62
NON-COVERD CHARGES	442,398.95	TOTAL MEDICAID LIAB	1,181,025.91
		LESS: COB	2,500.00
		LESS: COPAYMENT	1,595.22
		REIMBURSEMENT	1,176,930.69
		TOTAL NUMBER OF CLAIMS	218

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	235,595.18	0.00	OTHER LAB	853.00	4,067.00
MED/SURG SUPPLY	372,936.62	174.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	122.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,693.00	23,206.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,758.00	3,482.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,911.00	FEE SCHEDULE LAB	72,939.00	11,946.00
EKG/ECG	9,300.00	5,394.00	MRI SERVICES	0.00	2,658.00
IV THERAPY	268,946.00	6,715.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	608,932.10	60,374.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	63,253.00	84.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,900.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,570.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,453.00	927.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	89,993.60	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,065,137.73	71,569.95
RADIOLOGY THERAPEUTIC	264,942.00	6,788.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	116.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	25,063.00	1,819.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,252,278.00	0.00
LITHOTRIPSY	71,634.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,465.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,081.00	897.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,081.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	596,660.00	232,095.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	4,336.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	40,356.30	2,718.00			
			TOTAL ANCILLARY	9,153,820.53	442,398.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,153,820.53	442,398.95

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: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,303.00	ADJUSTMENTS	0.00
COVERED CHARGES	81,832.00	CONTRACTUAL ALLOW	18,123.67
NON-COVERD CHARGES	471.00	TOTAL MEDICAID LIAB	63,708.33
		LESS: COB	63,708.33
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1



SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE PUTNEY MEMORIAL HOSPITAL  
 417 W 3RD AVE  
 ALBANY,GA 31701-1943

PROVIDER NUMBER  
 000001482A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	75,447.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,450.00	471.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	285.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,410.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	240.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	81,832.00	471.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	81,832.00	471.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
 1266 HIGHWAY 515 S  
 JASPER,GA 30143-4872

PROVIDER NUMBER  
 000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,887,580.94	ADJUSTMENTS	206,240.31
COVERED CHARGES	5,842,470.94	CONTRACTUAL ALLOW	4,072,966.89
NON-COVERD CHARGES	45,110.00	TOTAL MEDICAID LIAB	1,769,504.05
		LESS: COB	6,292.56
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,763,211.49

TOTAL NUMBER OF ADMISSIONS 242

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	608		0	550,240.00		950.00
ROUTINE NURSERY	49		0	30,135.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	657		0	580,375.00		950.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	168		0	373,934.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	168		0	373,934.00		0.00
TOTAL ACCOMODATIONS	825		0	954,309.00		950.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
 1266 HIGHWAY 515 S  
 JASPER,GA 30143-4872

PROVIDER NUMBER  
 000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,030,521.99	0.00	OTHER LAB	33,978.00	0.00
MED/SURG SUPPLY	93,342.06	786.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	855,752.00	2,022.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	141,412.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	529,957.00	5,480.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,212.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	60,204.00	0.00	MRI SERVICES	70,884.00	0.00
IV THERAPY	92,657.00	1,518.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	347,951.00	6,109.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	98,748.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	397,892.00	144.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	49,001.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	40,565.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	382,280.00	2,281.00	SPECIAL SERVICES	0.00	626.00
RECOVERY ROOM	93,223.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,004.20	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	2,086.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,557.00	279.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	128,844.16	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	27,044.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	105,295.00	18,512.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	46,868.00	5,927.00			
AUDIOLOGY	8,740.00	0.00			
CARDIOLOGY	119,568.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	99,575.53	476.00			
			TOTAL ANCILLARY	4,888,161.94	44,160.00
			TOTAL ACCOMODATIONS	954,309.00	950.00
			TOTAL CHARGES	5,842,470.94	45,110.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 11:12:37  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
1266 HIGHWAY 515 S  
JASPER,GA 30143-4872

PROVIDER NUMBER  
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:12:39  
Page: 4

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,347,978.27	ADJUSTMENTS	400,380.41
COVERED CHARGES	8,514,689.10	CONTRACTUAL ALLOW	6,809,993.90
NON-COVERD CHARGES	833,289.17	TOTAL MEDICAID LIAB	1,704,695.20
		LESS: COB	3,941.61
		LESS: COPAYMENT	2,574.00
		REIMBURSEMENT	1,698,179.59
		ALL OTHER	1,574,032.78
		FEE SCHEDULE-LAB	101,011.87
		INJECTABLE DRUGS	23,134.94

TOTAL NUMBER OF CLAIMS 2,947

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 11:12:39  
 Page: 5

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
 1266 HIGHWAY 515 S  
 JASPER,GA 30143-4872

PROVIDER NUMBER  
 000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	282,637.67	10,342.06	OTHER LAB	82,139.00	0.00
MED/SURG SUPPLY	160,984.11	4,944.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,030.00	EDUCATION & TRAINING	123.00	0.00
RADIOLOGY-DIAGNOSTIC	408,509.00	10,914.00	OTHER THERAPEUTIC SVC	0.00	1,745.00
CT SCAN	1,788,702.00	125,040.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	629.00	FEE SCHEDULE LAB	1,336,240.66	189,106.80
EKG/ECG	104,146.00	2,768.00	MRI SERVICES	450,158.00	28,966.00
IV THERAPY	74,414.00	820.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	859,713.50	156,112.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	47,536.00	0.00	REHAB THERAPY	0.00	5,167.00
RESPIRATORY SERVICES	35,360.00	16,446.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	128,849.00	1,408.00	AMBULANCE	0.00	0.00
GI SERVICES	121,637.00	33,335.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,334,486.00	88,866.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	265,924.00	1,824.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	98,957.04	49,665.08
RADIOLOGY THERAPEUTIC	5,417.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,365.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	6,960.00	1,382.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	36,805.17	20,827.33
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	388.00
OTHER IMAGING SERVICE	169,484.00	13,150.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	27,258.00	2,314.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	225,939.00	22,333.00			
AUDIOLOGY	380.00	0.00			
CARDIOLOGY	164,692.00	19,633.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	150,786.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	146,451.95	22,768.40			
			TOTAL ANCILLARY	8,514,689.10	833,289.17
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,514,689.10	833,289.17

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:12:39  
Page: 6

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
28	2212310004709	10/08/12 - 10/08/12	11/12/12	0.00	304.00	0.00	0.00	0.00
3	2213028005100	12/29/12 - 12/31/12	02/04/13	0.00	0.00	0.00	0.00	0.00
2550	2213028005100	12/31/12 - 12/31/12	02/04/13	0.00	84.00	0.00	0.00	0.00
TOTAL				0.00	388.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 11:13:09  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
1266 HIGHWAY 515 S  
JASPER,GA 30143-4872

PROVIDER NUMBER  
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	185,389.88	ADJUSTMENTS	0.00
COVERED CHARGES	151,755.44	CONTRACTUAL ALLOW	85,455.66
NON-COVERD CHARGES	33,634.44	TOTAL MEDICAID LIAB	66,299.78
		LESS: COB	66,275.78
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 56



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,535.75	150.00	OTHER LAB	3,148.00	0.00
MED/SURG SUPPLY	4,311.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	24.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,387.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,642.00	14,225.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,007.00	7,280.00
EKG/ECG	1,384.00	0.00	MRI SERVICES	4,604.00	0.00
IV THERAPY	2,164.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	19,029.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,888.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	171.00	147.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,604.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,413.00	5,322.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	29,880.00	2,442.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,856.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	140.00	217.44
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	575.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	279.00	508.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,548.00	2,046.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,030.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,581.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,153.69	698.00			
			TOTAL ANCILLARY	151,755.44	33,634.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	151,755.44	33,634.44

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	604,322.28	ADJUSTMENTS	1,273.54
COVERED CHARGES	579,720.68	CONTRACTUAL ALLOW	557,792.20
NON-COVERD CHARGES	24,601.60	TOTAL MEDICAID LIAB	21,928.48
		LESS: COB	0.00
		LESS: COPAYMENT	807.06
		REIMBURSEMENT	21,121.42
		TOTAL NUMBER OF CLAIMS	392

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,282.61	76.00	OTHER LAB	5,649.00	0.00
MED/SURG SUPPLY	838.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,161.00	429.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	99,797.00	2,519.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	106,813.00	6,828.00
EKG/ECG	8,304.00	0.00	MRI SERVICES	3,833.00	3,941.00
IV THERAPY	1,341.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,002.00	294.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	281,700.00	8,049.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,388.72	481.60
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	12,943.00	1,476.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,668.15	508.00			
			TOTAL ANCILLARY	579,720.68	24,601.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	579,720.68	24,601.60

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

PIEDMONT 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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,186.11	ADJUSTMENTS	0.00
COVERED CHARGES	17,624.11	CONTRACTUAL ALLOW	13,642.63
NON-COVERD CHARGES	4,562.00	TOTAL MEDICAID LIAB	3,981.48
		LESS: COB	3,969.48
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	227.11	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	24.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,518.00	2,518.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,583.00	314.00
EKG/ECG	692.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,598.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,706.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	17,624.11	4,562.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,624.11	4,562.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
1266 HIGHWAY 515 S  
JASPER,GA 30143-4872

PROVIDER NUMBER  
000001493A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	491,557.22	ADJUSTMENTS	40,934.44
COVERED CHARGES	482,217.22	CONTRACTUAL ALLOW	395,174.16
NON-COVERD CHARGES	9,340.00	TOTAL MEDICAID LIAB	87,043.06
		LESS: COB	0.00
		LESS: COPAYMENT	75.00
		REIMBURSEMENT	86,968.06

TOTAL NUMBER OF CLAIMS 17

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,250.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	45,011.55	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,820.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	27,785.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	263.00	FEE SCHEDULE LAB	15,525.00	2,480.00
EKG/ECG	2,422.00	346.00	MRI SERVICES	0.00	0.00
IV THERAPY	19,135.00	444.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	175,563.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,285.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,186.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,752.00	2,926.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,439.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,967.70	808.00
RADIOLOGY THERAPEUTIC	4,056.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	19,304.87	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,632.00	526.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,268.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,814.20	1,547.00			
			TOTAL ANCILLARY	482,217.22	9,340.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	482,217.22	9,340.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:13:18  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT MOUNTAINSIDE HOSPITAL INC  
1266 HIGHWAY 515 S  
JASPER,GA 30143-4872

PROVIDER NUMBER  
000001493A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:49:30  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER 000001504A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	54,750,495.19	ADJUSTMENTS	4,743,631.67
COVERED CHARGES	53,341,779.26	CONTRACTUAL ALLOW	39,683,459.66
NON-COVERD CHARGES	1,408,715.93	TOTAL MEDICAID LIAB	13,658,319.60
		LESS: COB	79,246.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,579,072.78

TOTAL NUMBER OF ADMISSIONS 775

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,439		3	5,068,480.00		56,389.00
ROUTINE NURSERY	316		0	461,685.00		10,850.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5,755		3	5,530,165.00		67,239.00
SPECIAL CARE SERVICES						
CCU	376		0	911,800.00		0.00
ICU	804		0	1,981,655.00		0.00
NICU	113		0	274,590.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,293		0	3,168,045.00		0.00
TOTAL ACCOMODATIONS	7,048		3	8,698,210.00		67,239.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,477,368.38	193,896.93	OTHER LAB	447,307.00	1,398.00
MED/SURG SUPPLY	1,902,251.17	188,702.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,907,035.00	265,730.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,848,026.00	2,991.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,513,792.00	6,278.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	395,628.00	6,227.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	325,768.00	758.00	MRI SERVICES	861,937.00	0.00
IV THERAPY	409.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,961,184.00	178,793.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	96,492.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,214,370.00	16,410.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	614,708.00	6,828.00	AMBULANCE	0.00	0.00
GI SERVICES	459,548.00	16,692.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,126,374.00	43,960.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	479,629.50	4,107.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	327,106.00	0.00	INJECTABLE DRUGS	228,598.18	283.00
RADIOLOGY THERAPEUTIC	197,301.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	137,187.02	3,396.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	91,480.00	591.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	661,829.00	162,327.00	PATIENT CONVENIENCE	0.00	340.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	346.00	9,381.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,862,166.80	40,274.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	291,004.00	18,078.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	883,622.00	146,049.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	237,669.00	26,375.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,171,989.00	1,330.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	24,916.00	0.00			
ORGAN ACQUISITION	755,590.00	0.00			
TREATMENT/OBSERV. RM	140,938.21	282.00			
			TOTAL ANCILLARY	44,643,569.26	1,341,476.93
			TOTAL ACCOMODATIONS	8,698,210.00	67,239.00
			TOTAL CHARGES	53,341,779.26	1,408,715.93

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 10:49:30  
Page: 3

PIEDMONT HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
73	2214055010579	04/25/13 - 04/30/13	03/03/14	0.00	0.00	0.00	0.00	0.00
TOTAL				0.00	0.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 10:49:56  
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PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER 000001504A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,672,889.32	ADJUSTMENTS	0.00
COVERED CHARGES	1,672,249.32	CONTRACTUAL ALLOW	597,758.07
NON-COVERD CHARGES	640.00	TOTAL MEDICAID LIAB	1,074,491.25
		LESS: COB	1,074,491.25
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	24

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	118		0	110,920.00		0.00
ROUTINE NURSERY	65		0	111,645.00		640.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	183		0	222,565.00		640.00
SPECIAL CARE SERVICES						
CCU	4		0	9,700.00		0.00
ICU	5		0	10,575.00		0.00
NICU	149		0	362,070.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	158		0	382,345.00		0.00
TOTAL ACCOMODATIONS	341		0	604,910.00		640.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	306,849.62	0.00	OTHER LAB	3,376.00	0.00
MED/SURG SUPPLY	41,670.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	206,307.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	82,809.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,939.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,411.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,221.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	59,781.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	199,053.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,318.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,671.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	37,560.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,082.00	0.00	INJECTABLE DRUGS	399.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	502.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	289.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,172.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	23,273.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,664.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,868.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,842.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,281.95	0.00			
			TOTAL ANCILLARY	1,067,339.32	0.00
			TOTAL ACCOMODATIONS	604,910.00	640.00
			TOTAL CHARGES	1,672,249.32	640.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:49:59  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,119,802.28	ADJUSTMENTS	422,882.38
COVERED CHARGES	13,283,975.12	CONTRACTUAL ALLOW	10,670,075.43
NON-COVERD CHARGES	3,835,827.16	TOTAL MEDICAID LIAB	2,613,899.69
		LESS: COB	20,920.25
		LESS: COPAYMENT	5,343.23
		REIMBURSEMENT	2,587,636.21
		ALL OTHER	2,246,471.43
		FEE SCHEDULE-LAB	224,618.39
		INJECTABLE DRUGS	116,546.39

TOTAL NUMBER OF CLAIMS 4,213

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER  
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	512,477.03	4,051.80	OTHER LAB	166,040.00	0.00
MED/SURG SUPPLY	485,777.01	4,724.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	842.00	EDUCATION & TRAINING	351.00	0.00
RADIOLOGY-DIAGNOSTIC	712,129.00	46,144.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,593,847.00	282,110.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,157.00	8,020.00	FEE SCHEDULE LAB	2,533,724.60	611,945.79
EKG/ECG	215,787.00	7,580.00	MRI SERVICES	424,148.00	39,753.00
IV THERAPY	39,257.00	2,019.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	898,376.00	273,239.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,335.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	71,698.00	9,387.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	94,193.00	568.00	AMBULANCE	0.00	0.00
GI SERVICES	296,668.00	85,251.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,667,155.00	150,323.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	204,812.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	583,839.04	479,436.57
RADIOLOGY THERAPEUTIC	305,751.00	55,570.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	357.00	1,347.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,525.00	2,778.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	28,154.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	265,669.00	27,252.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	32,343.62	930,544.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	324,936.00	28,710.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	75,687.00	5,790.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	367,594.00	55,285.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	979,136.00	691,229.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	205,470.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	204,735.82	1,894.00			
			TOTAL ANCILLARY	13,283,975.12	3,833,947.16
			TOTAL ACCOMODATIONS	0.00	1,880.00
			TOTAL CHARGES	13,283,975.12	3,835,827.16

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 10:51:03  
Page: 8

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	244,545.86	ADJUSTMENTS	0.00
COVERED CHARGES	167,032.16	CONTRACTUAL ALLOW	103,972.52
NON-COVERD CHARGES	77,513.70	TOTAL MEDICAID LIAB	63,059.64
		LESS: COB	62,986.30
		LESS: COPAYMENT	73.34
		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

PIEDMONT HOSPITAL  
 1968 PEACHTREE RD NW  
 ATLANTA,GA 30309-1281

PROVIDER NUMBER  
 000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,905.70	0.00	OTHER LAB	7,784.00	0.00
MED/SURG SUPPLY	6,031.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	104.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,005.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,814.00	34,634.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	42,467.20	10,330.70
EKG/ECG	2,653.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,108.00	9,054.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,702.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	838.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,012.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	3,121.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,455.00	1,134.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,328.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	98.00	4,265.00
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	4,591.00	750.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,911.00	4,967.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,850.00	9,154.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	921.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,557.29	0.00			
			TOTAL ANCILLARY	167,032.16	77,513.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	167,032.16	77,513.70

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:51:06  
Page: 10

PIEDMONT HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	312,174.55	ADJUSTMENTS	261.69
COVERED CHARGES	294,483.35	CONTRACTUAL ALLOW	284,358.21
NON-COVERD CHARGES	17,691.20	TOTAL MEDICAID LIAB	10,125.14
		LESS: COB	0.00
		LESS: COPAYMENT	480.02
		REIMBURSEMENT	9,645.12
		TOTAL NUMBER OF CLAIMS	181

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,603.80	0.00	OTHER LAB	7,772.00	0.00
MED/SURG SUPPLY	861.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,899.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,004.00	6,934.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	51,926.00	4,700.00
EKG/ECG	7,959.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	600.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	142,455.00	5,959.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	704.30	98.20
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	2,819.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,880.00	0.00			
			TOTAL ANCILLARY	294,483.35	17,691.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	294,483.35	17,691.20

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:51:10  
Page: 12

PIEDMONT HOSPITAL  
1968 PEACHTREE RD NW  
ATLANTA,GA 30309-1281

PROVIDER NUMBER  
000001504A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,237.60	ADJUSTMENTS	0.00
COVERED CHARGES	11,550.60	CONTRACTUAL ALLOW	4,795.44
NON-COVERD CHARGES	6,687.00	TOTAL MEDICAID LIAB	6,755.16
		LESS: COB	6,743.16
		LESS: COPAYMENT	12.00
		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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	363.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,274.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	5,804.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,288.00	78.00
EKG/ECG	758.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,867.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	805.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	11,550.60	6,687.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,550.60	6,687.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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Page: 14

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,343,794.10	ADJUSTMENTS	157,384.17
COVERED CHARGES	3,114,302.18	CONTRACTUAL ALLOW	2,672,358.81
NON-COVERD CHARGES	1,229,491.92	TOTAL MEDICAID LIAB	441,943.37
		LESS: COB	10,499.97
		LESS: COPAYMENT	843.00
		REIMBURSEMENT	430,600.40
		TOTAL NUMBER OF CLAIMS	78

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,860.70	332.02	OTHER LAB	12,472.00	0.00
MED/SURG SUPPLY	350,832.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	77,279.00	35,863.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	180,974.00	1,555.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	714.00	FEE SCHEDULE LAB	79,951.90	27,487.10
EKG/ECG	20,087.00	6,822.00	MRI SERVICES	9,530.00	0.00
IV THERAPY	7,883.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	304,412.00	75,886.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,441.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	24,248.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,241.00	2,217.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	45,115.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	371,070.22	70,915.80
RADIOLOGY THERAPEUTIC	664,447.00	118,354.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	156,992.00	646,275.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,915.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,693.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	38,114.00	3,731.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	632,920.00	239,340.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	500.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,323.56	0.00			
			TOTAL ANCILLARY	3,114,302.18	1,229,491.92
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,114,302.18	1,229,491.92

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:51:15  
Page: 16

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 11:09:56  
 Page: 1

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER 000001526A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,225.75	ADJUSTMENTS	0.00
COVERED CHARGES	79,449.75	CONTRACTUAL ALLOW	59,016.54
NON-COVERD CHARGES	2,776.00	TOTAL MEDICAID LIAB	20,433.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	20,433.21

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	27		0	14,850.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	27		0	14,850.00		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	14,850.00		0.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:09:56  
 Page: 2

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,655.50	0.00	OTHER LAB	623.00	0.00
MED/SURG SUPPLY	8,544.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	16,610.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,443.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,900.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	195.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,013.00	2,776.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	64.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,668.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,714.25	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	2,357.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	263.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	550.00	0.00			
			TOTAL ANCILLARY	64,599.75	2,776.00
			TOTAL ACCOMODATIONS	14,850.00	0.00
			TOTAL CHARGES	79,449.75	2,776.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 11:09:58  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:09:59  
Page: 4

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,554,940.87	ADJUSTMENTS	210,445.37
COVERED CHARGES	3,181,097.07	CONTRACTUAL ALLOW	2,506,063.91
NON-COVERD CHARGES	373,843.80	TOTAL MEDICAID LIAB	675,033.16
		LESS: COB	235.19
		LESS: COPAYMENT	468.00
		REIMBURSEMENT	674,329.97
		ALL OTHER	611,204.04
		FEE SCHEDULE-LAB	56,542.82
		INJECTABLE DRUGS	6,583.11

TOTAL NUMBER OF CLAIMS 2,239

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,333.50	0.00	OTHER LAB	7,260.00	0.00
MED/SURG SUPPLY	71,500.32	4,016.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,265.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	240,939.00	3,179.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	198,165.00	126,704.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,142.00	287.00	FEE SCHEDULE LAB	655,977.00	187,781.80
EKG/ECG	23,595.00	195.00	MRI SERVICES	5,098.00	0.00
IV THERAPY	9,396.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,013.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,550.00	658.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,761,371.00	28,976.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	102,301.25	16,958.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	374.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,334.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	20,680.00	524.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,384.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,684.00	3,300.00			
			TOTAL ANCILLARY	3,181,097.07	373,843.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,181,097.07	373,843.80

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,985.50	ADJUSTMENTS	0.00
COVERED CHARGES	24,352.50	CONTRACTUAL ALLOW	9,789.64
NON-COVERD CHARGES	633.00	TOTAL MEDICAID LIAB	14,562.86
		LESS: COB	14,562.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 18

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	132.50	0.00	OTHER LAB	623.00	0.00
MED/SURG SUPPLY	516.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,165.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,508.00	413.00
EKG/ECG	195.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,791.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	190.00	220.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,232.00	0.00			
			TOTAL ANCILLARY	24,352.50	633.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,352.50	633.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	530,267.00	ADJUSTMENTS	6,476.99
COVERED CHARGES	521,244.00	CONTRACTUAL ALLOW	496,544.00
NON-COVERD CHARGES	9,023.00	TOTAL MEDICAID LIAB	24,700.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,005.03
		REIMBURSEMENT	23,694.97
		TOTAL NUMBER OF CLAIMS	494



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,592.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,789.00	85.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	50.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	30,945.00	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	40,678.00	7,660.00
EKG/ECG	1,950.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	640.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	421,673.00	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	14,246.00	618.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	51.00	211.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	521,244.00	9,023.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	521,244.00	9,023.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,727.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,727.00	CONTRACTUAL ALLOW	1,509.17
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	2,217.83
		LESS: COB	2,214.83
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF FLOYD COUNTY  
 424 N MAIN ST  
 CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
 000001526A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	3,667.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,727.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,727.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:10:37  
Page: 13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF FLOYD COUNTY  
424 N MAIN ST  
CEDARTOWN,GA 30125-2644

PROVIDER NUMBER  
000001526A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL  
 101 LAKE OCONEE PARKWAY  
 EATONTON,GA 31024-6054

PROVIDER NUMBER 000001537A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	367,079.49	ADJUSTMENTS	13,425.68
COVERED CHARGES	360,830.90	CONTRACTUAL ALLOW	156,306.39
NON-COVERD CHARGES	6,248.59	TOTAL MEDICAID LIAB	204,524.51
		LESS: COB	3,475.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	201,049.51

TOTAL NUMBER OF ADMISSIONS 43

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	112		0	39,200.00		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	112		0	39,200.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	17		0	11,475.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	17		0	11,475.00		0.00
TOTAL ACCOMODATIONS	129		0	50,675.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PUTNAM GENERAL HOSPITAL  
 101 LAKE OCONEE PARKWAY  
 EATONTON,GA 31024-6054

PROVIDER NUMBER  
 000001537A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	107,913.88	0.00	OTHER LAB	1,906.75	0.00
MED/SURG SUPPLY	33,974.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	54,877.47	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,202.63	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	23,362.89	4,270.38	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	7,815.27	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	963.65	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	37,019.91	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	23,656.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	430.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	200.44	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	321.36	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,928.16	814.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,654.07	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,094.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,997.81	0.00			
			TOTAL ANCILLARY	310,155.90	6,248.59
			TOTAL ACCOMODATIONS	50,675.00	0.00
			TOTAL CHARGES	360,830.90	6,248.59

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	878,022.92	ADJUSTMENTS	44,604.40
COVERED CHARGES	785,322.12	CONTRACTUAL ALLOW	466,984.16
NON-COVERD CHARGES	92,700.80	TOTAL MEDICAID LIAB	318,337.96
		LESS: COB	246.24
		LESS: COPAYMENT	552.00
		REIMBURSEMENT	317,539.72
		ALL OTHER	295,880.69
		FEE SCHEDULE-LAB	19,880.46
		INJECTABLE DRUGS	1,778.57

TOTAL NUMBER OF CLAIMS 981

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,297.54	8,756.44	OTHER LAB	70,631.87	996.24
MED/SURG SUPPLY	31,753.38	1,239.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,751.94	1,913.77	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	130,850.50	18,210.42	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,615.62	468.00	FEE SCHEDULE LAB	117,871.56	30,214.40
EKG/ECG	7,441.64	2,361.88	MRI SERVICES	28,041.43	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	22,662.29	5,059.98	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,339.23	685.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	20,100.38	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	236,404.70	7,205.98	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,170.58	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,762.04	11,278.31
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	350.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	361.13	787.83	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	24,739.90	2,250.60			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,277.38	814.12			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	598.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,301.01	457.59			
			TOTAL ANCILLARY	785,322.12	92,700.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	785,322.12	92,700.80

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,698.62	ADJUSTMENTS	0.00
COVERED CHARGES	10,689.86	CONTRACTUAL ALLOW	3,678.06
NON-COVERD CHARGES	1,008.76	TOTAL MEDICAID LIAB	7,011.80
		LESS: COB	7,008.80
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16.00	262.00	OTHER LAB	696.28	0.00
MED/SURG SUPPLY	804.34	21.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	230.31	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,423.46	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,054.53	107.39
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	1,786.45	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,024.96	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,743.68	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	430.03	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	335.00	618.20
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	10,689.86	1,008.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,689.86	1,008.76



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,256.98	454.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,579.83	21.17	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,679.17	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,356.64	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,544.79	1,559.05
EKG/ECG	434.46	0.00	MRI SERVICES	4,139.13	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	445.60	292.86	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	55,891.90	829.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,821.00	701.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,657.67	644.78			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,285.44	203.53			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	348.37	0.00			
			TOTAL ANCILLARY	85,440.98	4,706.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	85,440.98	4,706.10

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,038.54	ADJUSTMENTS	0.00
COVERED CHARGES	2,004.26	CONTRACTUAL ALLOW	1,115.23
NON-COVERD CHARGES	34.28	TOTAL MEDICAID LIAB	889.03
		LESS: COB	883.03
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	127.44	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	327.54	34.28
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,364.28	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	104.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,004.26	34.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,004.26	34.28



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:17:59  
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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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,920,400.08	ADJUSTMENTS	16,369.99
COVERED CHARGES	1,901,053.08	CONTRACTUAL ALLOW	953,629.42
NON-COVERD CHARGES	19,347.00	TOTAL MEDICAID LIAB	947,423.66
		LESS: COB	7,609.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	939,813.71

TOTAL NUMBER OF ADMISSIONS 157

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	408		0	207,795.00		8,962.00
ROUTINE NURSERY	44		0	22,540.00		1,490.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	452		0	230,335.00		10,452.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	135		0	167,008.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	135		0	167,008.00		0.00
TOTAL ACCOMODATIONS	587		0	397,343.00		10,452.00

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	277,091.98	0.00	OTHER LAB	9,622.50	0.00
MED/SURG SUPPLY	115,895.35	604.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	258,484.50	0.00	EDUCATION & TRAINING	3.00	0.00
RADIOLOGY-DIAGNOSTIC	36,567.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	51,627.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	24,321.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,705.50	0.00	MRI SERVICES	52,381.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	123,909.50	4,754.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	14,188.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	68,069.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,313.00	0.00	AMBULANCE	0.00	1,918.50
GI SERVICES	11,822.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	86,792.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,709.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,089.00	0.00	INJECTABLE DRUGS	211,569.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,394.50	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	440.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	15,164.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	44.00
OTHER IMAGING SERVICE	8,199.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,644.00	1,574.00			
AUDIOLOGY	5,850.00	0.00			
CARDIOLOGY	42,736.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	17,121.50	0.00			
			TOTAL ANCILLARY	1,503,710.08	8,895.00
			TOTAL ACCOMODATIONS	397,343.00	10,452.00
			TOTAL CHARGES	1,901,053.08	19,347.00

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 09:17:59  
Page: 3

TAYLOR REGIONAL HOSPITAL  
222 PERRY HWY  
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013218048052	12/18/12 - 12/28/12	08/12/13	0.00	44.00	0.00	0.00	0.00
TOTAL				0.00	44.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:18:10  
 Page: 4

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,560.00	ADJUSTMENTS	0.00
COVERED CHARGES	9,153.00	CONTRACTUAL ALLOW	4,239.26
NON-COVERD CHARGES	407.00	TOTAL MEDICAID LIAB	4,913.74
		LESS: COB	4,913.74
		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	1,035.00		407.00
ROUTINE NURSERY	0		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	1,035.00		407.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	1,035.00		407.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:18:10  
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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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	380.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	607.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	401.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,425.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	212.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	145.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	718.50	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	553.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	339.00	0.00	INJECTABLE DRUGS	335.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	8,118.00	0.00
			TOTAL ACCOMODATIONS	1,035.00	407.00
			TOTAL CHARGES	9,153.00	407.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:18:11  
Page: 6

TAYLOR REGIONAL HOSPITAL  
222 PERRY HWY  
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,937,772.15	ADJUSTMENTS	52,803.82
COVERED CHARGES	1,716,802.12	CONTRACTUAL ALLOW	1,284,850.04
NON-COVERD CHARGES	220,970.03	TOTAL MEDICAID LIAB	431,952.08
		LESS: COB	2,531.49
		LESS: COPAYMENT	2,466.76
		REIMBURSEMENT	426,953.83
		ALL OTHER	354,956.22
		FEE SCHEDULE-LAB	67,217.21
		INJECTABLE DRUGS	4,780.40

TOTAL NUMBER OF CLAIMS 2,132



TAYLOR REGIONAL HOSPITAL  
 222 PERRY HWY  
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	59,001.30	4,311.50	OTHER LAB	16,751.50	1,112.50
MED/SURG SUPPLY	47,868.67	1,142.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	147.00	EDUCATION & TRAINING	0.00	1.00
RADIOLOGY-DIAGNOSTIC	105,675.00	1,479.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	131,392.00	22,215.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	462.00	737.00	FEE SCHEDULE LAB	409,120.55	135,191.98
EKG/ECG	17,319.50	3,580.50	MRI SERVICES	83,433.00	4,580.00
IV THERAPY	11,294.00	1,397.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	145,679.50	2,860.00	DURABLE MED. EQUIP.	0.00	17.00
LABOR/DELIVERY ROOM	4,767.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,153.50	1,847.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	61,578.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	63,225.00	200.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	294,493.60	5,722.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	23,433.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,585.00	17,458.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	552.50	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	14,917.00	1,076.50	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	69,385.00	2,852.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	2,910.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	34,674.50	8,702.50			
AUDIOLOGY	0.00	877.50			
CARDIOLOGY	26,922.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	40,671.00	0.00			
			TOTAL ANCILLARY	1,716,802.12	220,970.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,716,802.12	220,970.03

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 09:19:04  
Page: 8

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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,088.75	ADJUSTMENTS	0.00
COVERED CHARGES	26,188.25	CONTRACTUAL ALLOW	11,041.99
NON-COVERD CHARGES	9,900.50	TOTAL MEDICAID LIAB	15,146.26
		LESS: COB	15,119.26
		LESS: COPAYMENT	27.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 39

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TAYLOR REGIONAL HOSPITAL  
 222 PERRY HWY  
 HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
 000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	824.50	455.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	600.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,187.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,152.00	2,797.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,176.00	2,310.00
EKG/ECG	216.50	84.50	MRI SERVICES	0.00	2,795.00
IV THERAPY	40.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	801.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	762.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	458.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,937.50	104.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	443.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	933.00	553.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,286.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,817.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,353.00	0.00			
			TOTAL ANCILLARY	26,188.25	9,900.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	26,188.25	9,900.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:19:06  
Page: 10

TAYLOR REGIONAL HOSPITAL  
222 PERRY HWY  
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
000001548A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	93,923.25	ADJUSTMENTS	780.18
COVERED CHARGES	88,245.75	CONTRACTUAL ALLOW	79,867.97
NON-COVERD CHARGES	5,677.50	TOTAL MEDICAID LIAB	8,377.78
		LESS: COB	27.95
		LESS: COPAYMENT	285.01
		REIMBURSEMENT	8,064.82
		TOTAL NUMBER OF CLAIMS	167

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,137.50	10.50	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	372.25	119.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,589.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,101.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,527.00	4,377.50
EKG/ECG	528.00	0.00	MRI SERVICES	2,795.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	533.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,710.50	249.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,923.50	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	44.00
OTHER IMAGING SERVICE	1,626.00	406.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	401.50	0.00			
			TOTAL ANCILLARY	88,245.75	5,677.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	88,245.75	5,677.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:19:06  
Page: 12

TAYLOR REGIONAL HOSPITAL  
222 PERRY HWY  
HAWKINSVILLE,GA 31036-6748

PROVIDER NUMBER  
000001548A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012156037784	05/26/12 - 05/26/12	06/11/12	0.00	44.00	0.00	0.00	0.00
TOTAL				0.00	44.00	0.00	0.00	0.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:19:10  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,701.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,667.00	CONTRACTUAL ALLOW	1,831.10
NON-COVERD CHARGES	34.00	TOTAL MEDICAID LIAB	835.90
		LESS: COB	829.90
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	53.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	32.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	586.50	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	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	1,540.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL 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	2,667.00	34.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,667.00	34.00



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 09:19:11  
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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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 10:24:13  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	288,858.32	ADJUSTMENTS	9,305.82
COVERED CHARGES	269,904.32	CONTRACTUAL ALLOW	139,051.91
NON-COVERD CHARGES	18,954.00	TOTAL MEDICAID LIAB	130,852.41
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	130,852.41
TOTAL NUMBER OF ADMISSIONS			22

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	78		0	33,696.00		18,954.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	78		0	33,696.00		18,954.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	78		0	33,696.00		18,954.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	47,458.67	0.00	OTHER LAB	3,067.00	0.00
MED/SURG SUPPLY	20,943.39	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	63,934.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,856.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,345.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,940.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,187.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,000.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,558.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,462.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,038.42	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,267.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,508.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,552.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,091.84	0.00			
			TOTAL ANCILLARY	236,208.32	0.00
			TOTAL ACCOMODATIONS	33,696.00	18,954.00
			TOTAL CHARGES	269,904.32	18,954.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:24:15  
Page: 4

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	733,013.64	ADJUSTMENTS	92,640.11
COVERED CHARGES	599,581.67	CONTRACTUAL ALLOW	375,976.39
NON-COVERD CHARGES	133,431.97	TOTAL MEDICAID LIAB	223,605.28
		LESS: COB	920.27
		LESS: COPAYMENT	1,020.00
		REIMBURSEMENT	221,665.01
		ALL OTHER	200,252.96
		FEE SCHEDULE-LAB	19,350.08
		INJECTABLE DRUGS	2,061.97

TOTAL NUMBER OF CLAIMS 808

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 10:24:15  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,382.12	13,431.40	OTHER LAB	8,276.74	689.00
MED/SURG SUPPLY	33,482.20	140.68	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	37,744.00	1,794.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,277.00	42,148.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	116.00	267.00	FEE SCHEDULE LAB	155,749.00	39,767.00
EKG/ECG	7,490.00	840.00	MRI SERVICES	25,212.00	0.00
IV THERAPY	24,492.00	1,513.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	46,000.00	15,654.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,073.00	924.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	112,668.50	720.00	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	22,103.32	9,046.57
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	1,409.50
OTHER IMAGING SERVICE	6,893.00	1,577.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	290.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,920.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,702.79	3,220.82			
			TOTAL ANCILLARY	599,581.67	133,431.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	599,581.67	133,431.97

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:24:15  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013115057716	04/17/13 - 04/17/13	04/29/13	0.00	27.50	0.00	0.00	0.00
392	5913126000892	02/20/13 - 02/20/13	05/13/13	0.00	1,382.00	0.00	0.00	0.00
TOTAL				0.00	1,409.50	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 10:24:30  
Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,542.04	ADJUSTMENTS	0.00
COVERED CHARGES	2,405.20	CONTRACTUAL ALLOW	1,262.34
NON-COVERD CHARGES	136.84	TOTAL MEDICAID LIAB	1,142.86
		LESS: COB	1,142.86
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	20.04	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	45.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	932.00	50.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,420.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7.68	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	2,405.20	136.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,405.20	136.84

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:24:30  
Page: 9

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	42,481.05	ADJUSTMENTS	523.00
COVERED CHARGES	38,222.29	CONTRACTUAL ALLOW	34,572.29
NON-COVERD CHARGES	4,258.76	TOTAL MEDICAID LIAB	3,650.00
		LESS: COB	0.00
		LESS: COPAYMENT	120.00
		REIMBURSEMENT	3,530.00
		TOTAL NUMBER OF CLAIMS	73

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,158.06	664.85	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,853.06	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,686.00	92.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,042.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,938.00	731.00
EKG/ECG	420.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	22,522.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	908.17	378.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	450.00	290.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,128.00	60.00			
			TOTAL ANCILLARY	38,222.29	4,258.76
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	38,222.29	4,258.76

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:24:32  
Page: 11

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 10:24:32  
Page: 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PROFESSIONAL RESOURCES MANAGEMENT OF RABUN  
196 RIDGECREST CIR  
CLAYTON,GA 30525-4111

PROVIDER NUMBER  
000001559A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,791.61	ADJUSTMENTS	9,123.58
COVERED CHARGES	42,896.49	CONTRACTUAL ALLOW	33,769.91
NON-COVERD CHARGES	895.12	TOTAL MEDICAID LIAB	9,126.58
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	9,123.58

TOTAL NUMBER OF CLAIMS 2

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13.84	623.80	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,301.33	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	319.00	25.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	153.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,000.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	762.32	93.32
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	42,896.49	895.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	42,896.49	895.12

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:24:33  
Page: 14

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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:08:35  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

REDMOND REGIONAL MEDICAL CENTER  
 501 REDMOND RD  
 ROME,GA 30165-1415

PROVIDER NUMBER  
 000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,275,374.84	ADJUSTMENTS	408,181.62
COVERED CHARGES	25,892,375.21	CONTRACTUAL ALLOW	19,722,041.79
NON-COVERD CHARGES	382,999.63	TOTAL MEDICAID LIAB	6,170,333.42
		LESS: COB	33,690.99
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,136,642.43

TOTAL NUMBER OF ADMISSIONS 517

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,483		0	1,354,854.97		202,127.93
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,483		0	1,354,854.97		202,127.93
SPECIAL CARE SERVICES						
CCU	195		0	323,220.00		0.00
ICU	200		0	354,463.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	395		0	677,683.00		0.00
TOTAL ACCOMODATIONS	2,878		0	2,032,537.97		202,127.93

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,149,772.98	1,572.00	OTHER LAB	150,871.00	0.00
MED/SURG SUPPLY	2,132,310.65	2,633.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,424,830.00	111.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	744,537.00	1,368.00	OTHER THERAPEUTIC SVC	0.00	9,328.00
CT SCAN	1,087,526.00	24,359.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	410,256.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	304,505.00	0.00	MRI SERVICES	226,128.00	0.00
IV THERAPY	59,551.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,548,540.00	4,565.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	848,356.00	1,150.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	416,831.00	0.00	AMBULANCE	0.00	2,739.00
GI SERVICES	42,438.00	1,221.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	884,670.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	250,571.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	168,804.00	0.00	INJECTABLE DRUGS	2,518,768.61	61.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	277,073.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	95,645.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	158,925.00	5,933.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,190.00	270.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,524,037.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	109,696.00	2,987.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	194,527.00	42,702.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	294,511.00	79,872.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,792,872.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	13,989.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,106.00	0.00			
			TOTAL ANCILLARY	23,859,837.24	180,871.70
			TOTAL ACCOMODATIONS	2,032,537.97	202,127.93
			TOTAL CHARGES	25,892,375.21	382,999.63

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:08:43  
 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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	50,186.35	ADJUSTMENTS	0.00
COVERED CHARGES	49,551.35	CONTRACTUAL ALLOW	19,454.50
NON-COVERD CHARGES	635.00	TOTAL MEDICAID LIAB	30,096.85
		LESS: COB	30,096.85
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	5,460.00		635.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	5,460.00		635.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,657.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	1,657.00		0.00
TOTAL ACCOMODATIONS	11		0	7,117.00		635.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,494.75	0.00	OTHER LAB	2,534.00	0.00
MED/SURG SUPPLY	5,000.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	14,984.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,133.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	1,193.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	656.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,232.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,792.60	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,599.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	816.00	0.00			
			TOTAL ANCILLARY	42,434.35	0.00
			TOTAL ACCOMODATIONS	7,117.00	635.00
			TOTAL CHARGES	49,551.35	635.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:08:44  
Page: 5

REDMOND REGIONAL MEDICAL CENTER  
501 REDMOND RD  
ROME,GA 30165-1415

PROVIDER NUMBER  
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,155,188.92	ADJUSTMENTS	170,837.59
COVERED CHARGES	11,644,842.64	CONTRACTUAL ALLOW	9,502,003.30
NON-COVERD CHARGES	1,510,346.28	TOTAL MEDICAID LIAB	2,142,839.34
		LESS: COB	983.97
		LESS: COPAYMENT	5,122.35
		REIMBURSEMENT	2,136,733.02
		ALL OTHER	1,989,752.61
		FEE SCHEDULE-LAB	94,112.78
		INJECTABLE DRUGS	52,867.63

TOTAL NUMBER OF CLAIMS 3,007

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	217,420.70	1,042.64	OTHER LAB	54,334.00	0.00
MED/SURG SUPPLY	563,553.59	1,870.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	821,993.00	26,885.00	OTHER THERAPEUTIC SVC	0.00	7,178.00
CT SCAN	1,636,785.00	128,539.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	124,712.00	84,092.00	FEE SCHEDULE LAB	2,363,390.20	424,565.40
EKG/ECG	218,801.00	19,305.00	MRI SERVICES	189,790.00	28,771.00
IV THERAPY	331,561.00	79,284.39	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	747,015.12	165,375.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,939.00	156.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	264,080.00	3,050.00	AMBULANCE	0.00	0.00
GI SERVICES	78,342.00	9,768.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,955,684.00	821.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	249,559.00	1,765.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	332,379.57	123,969.47
RADIOLOGY THERAPEUTIC	14,921.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	49,565.00	41,507.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,764.00	5,259.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	245.00	3,585.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	53,196.00	3,394.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	150,211.00	997.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	37,994.00	5,382.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	251,259.00	74,218.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	608,193.50	264,738.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,095.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	317,059.96	4,828.00			
			TOTAL ANCILLARY	11,644,842.64	1,510,346.28
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	11,644,842.64	1,510,346.28

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

REDMOND REGIONAL MEDICAL CENTER  
501 REDMOND RD  
ROME,GA 30165-1415

PROVIDER NUMBER  
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	192,306.95	ADJUSTMENTS	0.00
COVERED CHARGES	147,791.69	CONTRACTUAL ALLOW	87,183.81
NON-COVERD CHARGES	44,515.26	TOTAL MEDICAID LIAB	60,607.88
		LESS: COB	60,495.10
		LESS: COPAYMENT	112.78
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 42

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,729.75	27.86	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	12,082.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,589.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,437.00	20,792.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	48,013.00	7,069.00
EKG/ECG	2,417.00	816.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,955.00	1,327.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,452.00	9,433.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,693.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,334.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,614.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,765.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,171.94	147.40
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	9,250.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,884.00	1,661.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,739.00	908.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	147,791.69	44,515.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	147,791.69	44,515.26



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	960,071.12	ADJUSTMENTS	1,011.86
COVERED CHARGES	911,882.17	CONTRACTUAL ALLOW	879,436.98
NON-COVERD CHARGES	48,188.95	TOTAL MEDICAID LIAB	32,445.19
		LESS: COB	0.00
		LESS: COPAYMENT	1,365.07
		REIMBURSEMENT	31,080.12
		TOTAL NUMBER OF CLAIMS	580

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,467.62	0.00	OTHER LAB	1,218.00	0.00
MED/SURG SUPPLY	9,457.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	76,072.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	94,486.00	9,625.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	508.00	FEE SCHEDULE LAB	181,718.00	26,305.00
EKG/ECG	13,939.00	0.00	MRI SERVICES	6,837.00	0.00
IV THERAPY	40,406.00	6,028.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,419.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	308.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	459,655.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18,251.55	4,665.95
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	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	2,328.00	997.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,320.00	0.00			
			TOTAL ANCILLARY	911,882.17	48,188.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	911,882.17	48,188.95

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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Page: 11

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,553.73	ADJUSTMENTS	0.00
COVERED CHARGES	12,510.40	CONTRACTUAL ALLOW	9,629.69
NON-COVERD CHARGES	43.33	TOTAL MEDICAID LIAB	2,880.71
		LESS: COB	2,868.71
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3.80	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	126.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,143.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,573.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,759.00	0.00
EKG/ECG	408.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,254.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,987.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	256.60	43.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	12,510.40	43.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,510.40	43.33

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

REDMOND REGIONAL MEDICAL CENTER  
501 REDMOND RD  
ROME,GA 30165-1415

PROVIDER NUMBER  
000001581A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,317,543.17	ADJUSTMENTS	27,200.10
COVERED CHARGES	4,086,848.69	CONTRACTUAL ALLOW	3,613,585.93
NON-COVERD CHARGES	230,694.48	TOTAL MEDICAID LIAB	473,262.76
		LESS: COB	8,404.68
		LESS: COPAYMENT	424.36
		REIMBURSEMENT	464,433.72
		TOTAL NUMBER OF CLAIMS	87

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	63,897.34	270.96	OTHER LAB	2,643.00	0.00
MED/SURG SUPPLY	337,195.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	57,337.00	4,021.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	48,338.00	4,573.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	835.00	1,324.00	FEE SCHEDULE LAB	115,287.00	23,492.00
EKG/ECG	16,330.00	9,637.00	MRI SERVICES	4,633.00	4,633.00
IV THERAPY	13,840.00	4,175.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	665,767.03	54,669.97	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,221.00	75.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	73,418.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,652.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	92,104.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	82,030.15	33,369.89
RADIOLOGY THERAPEUTIC	4,711.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	626.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	120.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,510,048.00	0.00
LITHOTRIPSY	429,750.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	193.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	18,069.00	4,248.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	475,459.31	72,688.66			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	53,090.86	12,771.00			
			TOTAL ANCILLARY	4,086,848.69	230,694.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,086,848.69	230,694.48

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: 07/23/2014  
Run Time: 11:09:21  
Page: 15

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,166.70	ADJUSTMENTS	0.00
COVERED CHARGES	95,632.56	CONTRACTUAL ALLOW	58,165.97
NON-COVERD CHARGES	6,534.14	TOTAL MEDICAID LIAB	37,466.59
		LESS: COB	37,457.59
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE VIII

Run Date: 07/23/2014  
 Run Time: 11:09:21  
 Page: 16

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,688.59	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,156.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	731.00	0.00
EKG/ECG	408.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,651.00	6,131.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,283.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,530.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	39.97	403.14
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	55,064.00	0.00
LITHOTRIPSY	29,081.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	95,632.56	6,534.14
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	95,632.56	6,534.14



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER 000001603A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,422,078.74	ADJUSTMENTS	3,040,128.95
COVERED CHARGES	27,775,850.73	CONTRACTUAL ALLOW	19,312,310.43
NON-COVERD CHARGES	646,228.01	TOTAL MEDICAID LIAB	8,463,540.30
		LESS: COB	66,070.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,397,469.96

TOTAL NUMBER OF ADMISSIONS 1,018

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,266		3	1,181,736.00		43,308.84
ROUTINE NURSERY	599		10	921,741.00		46,323.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,865		13	2,103,477.00		89,631.84
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1,097		0	1,296,400.00		0.00
NICU	976		1	4,932,660.00		5,223.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,073		1	6,229,060.00		5,223.00
TOTAL ACCOMODATIONS	4,938		14	8,332,537.00		94,854.84

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,853,124.85	5,233.48	OTHER LAB	144,383.17	0.00
MED/SURG SUPPLY	1,515,918.07	34,691.79	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,514,162.17	31,118.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	342,088.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	948,281.00	2,572.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	57,116.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	113,052.00	0.00	MRI SERVICES	178,565.00	0.00
IV THERAPY	316,024.00	0.00	PROFESSIONAL FEES	0.00	673.00
OPERATING ROOM	926,776.79	38,901.15	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,365,679.00	71,286.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,305,323.00	39,681.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	359,241.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	53,591.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	793,813.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	297,537.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	148,748.00	0.00	INJECTABLE DRUGS	1,218,894.47	213.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	40,386.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,081.03	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	292,122.00	36,079.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	34,918.00	1,290.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,251,617.50	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	48,513.00
OTHER IMAGING SERVICE	260,980.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	481,529.00	228,103.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	94,105.00	13,018.00			
AUDIOLOGY	23,980.00	0.00			
CARDIOLOGY	449,578.68	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,246.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	40,453.00	0.00			
			TOTAL ANCILLARY	19,443,313.73	551,373.17
			TOTAL ACCOMODATIONS	8,332,537.00	94,854.84
			TOTAL CHARGES	27,775,850.73	646,228.01

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012293040597	10/04/12 - 10/06/12	10/29/12	0.00	2,074.00	0.00	0.00	0.00
615	2013014031042	01/06/13 - 01/08/13	01/21/13	0.00	2,178.00	0.00	0.00	0.00
615	2013064043194	11/27/12 - 01/31/13	03/11/13	0.00	4,997.00	0.00	0.00	0.00
614	2013098014807	03/06/13 - 03/28/13	04/15/13	0.00	2,518.00	0.00	0.00	0.00
615	2013098014807	03/06/13 - 03/28/13	04/15/13	0.00	2,131.00	0.00	0.00	0.00
615	2013121049363	03/08/13 - 03/20/13	05/06/13	0.00	2,178.00	0.00	0.00	0.00
615	2013150050788	05/16/13 - 05/20/13	06/03/13	0.00	2,178.00	0.00	0.00	0.00
615	2013168021818	06/05/13 - 06/10/13	06/24/13	0.00	2,178.00	0.00	0.00	0.00
614	2013176036952	06/16/13 - 06/19/13	07/01/13	0.00	4,904.00	0.00	0.00	0.00
615	2013189015622	06/26/13 - 07/03/13	07/15/13	0.00	4,309.00	0.00	0.00	0.00
614	2013231042088	07/12/13 - 07/17/13	08/26/13	0.00	2,549.00	0.00	0.00	0.00
614	9713262957017	10/25/12 - 10/30/12	09/23/13	0.00	2,442.00	0.00	0.00	0.00
614	2013277061828	09/21/13 - 09/28/13	10/07/13	0.00	2,694.00	0.00	0.00	0.00
615	2013284050466	03/07/13 - 03/13/13	10/14/13	0.00	4,309.00	0.00	0.00	0.00
615	2013284050627	06/30/13 - 07/03/13	10/14/13	0.00	4,309.00	0.00	0.00	0.00
614	9714104965047	04/10/13 - 04/21/13	04/28/14	0.00	2,565.00	0.00	0.00	0.00
TOTAL				0.00	48,513.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 11:07:01  
 Page: 4

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER 000001603A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	312,663.71	ADJUSTMENTS	0.00
COVERED CHARGES	306,831.71	CONTRACTUAL ALLOW	172,918.08
NON-COVERD CHARGES	5,832.00	TOTAL MEDICAID LIAB	133,913.63
		LESS: COB	133,913.63
		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	33		0	17,366.00		488.00
ROUTINE NURSERY	5		0	5,543.00		408.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	38		0	22,909.00		896.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	19		0	24,802.00		0.00
NICU	5		0	24,870.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	24		0	49,672.00		0.00
TOTAL ACCOMODATIONS	62		0	72,581.00		896.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,090.51	0.00	OTHER LAB	979.00	0.00
MED/SURG SUPPLY	22,657.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	38,971.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,764.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,021.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,044.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	516.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	532.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	14,791.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	67,561.00	3,959.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,196.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,376.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,119.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,524.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	2,580.00	0.00	INJECTABLE DRUGS	15,954.45	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	686.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	776.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,203.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,005.00	977.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	369.00	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	234,250.71	4,936.00
			TOTAL ACCOMODATIONS	72,581.00	896.00
			TOTAL CHARGES	306,831.71	5,832.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:07:03  
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ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,573,695.52	ADJUSTMENTS	199,878.81
COVERED CHARGES	12,185,592.84	CONTRACTUAL ALLOW	9,905,266.40
NON-COVERD CHARGES	1,388,102.68	TOTAL MEDICAID LIAB	2,280,326.44
		LESS: COB	4,100.91
		LESS: COPAYMENT	3,596.24
		REIMBURSEMENT	2,272,629.29
		ALL OTHER	2,095,884.99
		FEE SCHEDULE-LAB	162,562.08
		INJECTABLE DRUGS	14,182.22

TOTAL NUMBER OF CLAIMS 4,959

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	311,536.21	29,978.15	OTHER LAB	154,625.00	5,186.00
MED/SURG SUPPLY	384,236.48	13,860.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	37.00
RADIOLOGY-DIAGNOSTIC	387,076.00	6,138.00	OTHER THERAPEUTIC SVC	0.00	234.00
CT SCAN	1,426,317.50	127,159.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	15,718.00	5,646.00	FEE SCHEDULE LAB	2,697,332.31	569,994.94
EKG/ECG	154,365.00	6,760.00	MRI SERVICES	379,086.38	16,501.00
IV THERAPY	469,806.00	118,653.00	PROFESSIONAL FEES	0.00	121.00
OPERATING ROOM	731,841.86	34,604.22	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,604.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	72,229.00	19,333.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	246,709.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	256,986.00	26,081.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,806,444.00	6,463.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	236,096.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	92,598.14	32,896.27
RADIOLOGY THERAPEUTIC	1,088.00	310.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,372.00	1,838.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,619.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	33,551.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	60,167.00	6,302.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	111,166.64	59,531.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	7,379.00
OTHER IMAGING SERVICE	535,620.00	52,664.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	44,972.00	6,106.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	134,724.00	47,594.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	94,768.02	150,934.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,953.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	357,536.30	2,247.00			
			TOTAL ANCILLARY	12,185,592.84	1,388,102.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	12,185,592.84	1,388,102.68

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: 07/23/2014  
Run Time: 11:07:03  
Page: 8

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013114048608	03/05/13 - 03/05/13	04/29/13	0.00	2,131.00	0.00	0.00	0.00
615	2013218041266	07/30/13 - 07/30/13	08/12/13	0.00	5,248.00	0.00	0.00	0.00
TOTAL				0.00	7,379.00	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 11:08:13  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	220,616.59	ADJUSTMENTS	0.00
COVERED CHARGES	175,435.40	CONTRACTUAL ALLOW	112,033.34
NON-COVERD CHARGES	45,181.19	TOTAL MEDICAID LIAB	63,402.06
		LESS: COB	63,372.06
		LESS: COPAYMENT	30.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 80

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,137.77	155.94	OTHER LAB	4,789.00	0.00
MED/SURG SUPPLY	8,788.50	124.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,722.00	184.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,910.00	17,414.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	52,915.46	8,722.00
EKG/ECG	2,077.00	258.00	MRI SERVICES	0.00	0.00
IV THERAPY	9,263.00	1,049.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,353.50	7,003.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	159.00	242.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,893.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	49,698.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,283.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	332.17	1,660.75
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	888.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,634.00	5,850.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,220.00	72.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	835.00	2,446.00			
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	5,537.00	0.00			
			TOTAL ANCILLARY	175,435.40	45,181.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	175,435.40	45,181.19

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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Page: 11

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	793,475.77	ADJUSTMENTS	267.69
COVERED CHARGES	704,737.34	CONTRACTUAL ALLOW	670,390.18
NON-COVERD CHARGES	88,738.43	TOTAL MEDICAID LIAB	34,347.16
		LESS: COB	0.00
		LESS: COPAYMENT	843.01
		REIMBURSEMENT	33,504.15
		TOTAL NUMBER OF CLAIMS	614

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,707.13	256.34	OTHER LAB	15,983.00	995.00
MED/SURG SUPPLY	3,732.00	276.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,763.00	813.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,648.00	2,021.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	174,078.46	66,131.00
EKG/ECG	6,359.00	0.00	MRI SERVICES	2,846.00	0.00
IV THERAPY	33,411.00	5,489.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,454.00	460.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	365,801.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,114.75	5,642.09
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	78.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,487.00	6,577.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	827.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,526.00	0.00			
			TOTAL ANCILLARY	704,737.34	88,738.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	704,737.34	88,738.43

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	39,572.40	ADJUSTMENTS	0.00
COVERED CHARGES	32,617.10	CONTRACTUAL ALLOW	23,495.13
NON-COVERD CHARGES	6,955.30	TOTAL MEDICAID LIAB	9,121.97
		LESS: COB	9,109.97
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	22

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:08:23  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	441.28	26.86	OTHER LAB	2,544.00	326.00
MED/SURG SUPPLY	250.00	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	12,354.00	3,839.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	971.00	198.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	14,397.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	108.82	60.44
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	1,367.00	2,505.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,617.10	6,955.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,617.10	6,955.30

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	818,214.89	ADJUSTMENTS	20,054.16
COVERED CHARGES	644,018.24	CONTRACTUAL ALLOW	568,747.64
NON-COVERD CHARGES	174,196.65	TOTAL MEDICAID LIAB	75,270.60
		LESS: COB	0.00
		LESS: COPAYMENT	57.00
		REIMBURSEMENT	75,213.60

TOTAL NUMBER OF CLAIMS 15

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE MEDICAL CENTER  
 1412 MILSTEAD RD NE  
 CONYERS,GA 30012-0000

PROVIDER NUMBER  
 000001603A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	62,252.64	816.13	OTHER LAB	937.00	3,456.00
MED/SURG SUPPLY	114,056.20	28,908.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,909.00	2,818.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,741.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,232.00	2,169.00
EKG/ECG	748.00	271.00	MRI SERVICES	5,725.00	0.00
IV THERAPY	1,114.00	1,254.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	138,754.31	5,056.20	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	20,258.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,332.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,945.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,678.59	1,313.32
RADIOLOGY THERAPEUTIC	552.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	109,704.50	41,580.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,162.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,223.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	94,461.00	86,555.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,074.00	0.00			
			TOTAL ANCILLARY	644,018.24	174,196.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	644,018.24	174,196.65



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:08:27  
Page: 17

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ROCKDALE MEDICAL CENTER  
1412 MILSTEAD RD NE  
CONYERS,GA 30012-0000

PROVIDER NUMBER  
000001603A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:39:42  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CARTERSVILLE MEDICAL CENTER  
 960 JOE FRANK HARRIS PKWY SE  
 CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER 000001625A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,814,745.80	ADJUSTMENTS	1,585,927.90
COVERED CHARGES	34,841,677.00	CONTRACTUAL ALLOW	28,607,233.15
NON-COVERD CHARGES	973,068.80	TOTAL MEDICAID LIAB	6,234,443.85
		LESS: COB	38,901.69
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,195,542.16

TOTAL NUMBER OF ADMISSIONS 733

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,528		19	2,958,971.00		363,014.50
ROUTINE NURSERY	198		6	237,950.00		39,945.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,726		25	3,196,921.00		402,959.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	634		0	2,024,880.00		32,450.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	634		0	2,024,880.00		32,450.00
TOTAL ACCOMODATIONS	3,360		25	5,221,801.00		435,409.50

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 10/01/12 THROUGH 09/30/13  
 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	3,263,551.70	18,290.30	OTHER LAB	145,342.50	2,086.50
MED/SURG SUPPLY	1,353,607.75	37,010.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,923,018.97	92,752.30	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	648,291.50	6,425.75	OTHER THERAPEUTIC SVC	0.00	1,434.75
CT SCAN	1,609,850.50	46,924.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	232,455.75	677.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	265,130.75	0.00	MRI SERVICES	471,274.50	0.00
IV THERAPY	73,048.25	3,310.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,893,850.75	15,695.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	552,266.75	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,966,497.00	41,901.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	803,275.25	3,437.50	AMBULANCE	0.00	0.00
GI SERVICES	129,286.25	6,432.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,007,893.50	7,314.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	353,043.25	3,539.50	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	117,123.00	296.75	INJECTABLE DRUGS	5,574,966.33	129,735.20
RADIOLOGY THERAPEUTIC	175,431.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	62,793.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	49,005.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	22,584.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,441.75	261.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	306,564.50	0.00
LITHOTRIPSY	11,089.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	203,236.75	13,572.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	204,190.50	67,558.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	217,403.75	15,962.75			
AUDIOLOGY	0.00	12,035.00			
CARDIOLOGY	902,298.00	10,943.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,450.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	51,612.50	60.50			
			TOTAL ANCILLARY	29,619,876.00	537,659.30
			TOTAL ACCOMODATIONS	5,221,801.00	435,409.50
			TOTAL CHARGES	34,841,677.00	973,068.80

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	201,534.10	ADJUSTMENTS	0.00
COVERED CHARGES	198,976.60	CONTRACTUAL ALLOW	148,935.64
NON-COVERD CHARGES	2,557.50	TOTAL MEDICAID LIAB	50,040.96
		LESS: COB	50,040.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	13		0	15,275.00		2,030.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13		0	15,275.00		2,030.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	3,245.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	3,245.00		0.00
TOTAL ACCOMODATIONS	14		0	18,520.00		2,030.00

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 10/01/12 THROUGH 09/30/13  
 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	16,847.25	0.00	OTHER LAB	1,295.25	0.00
MED/SURG SUPPLY	17,047.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	22,669.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,168.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,439.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,740.75	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	684.75	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	26,825.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,745.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	380.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	14,984.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,543.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,479.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,103.00	0.00	INJECTABLE DRUGS	24,825.35	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	32.25	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	2,758.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,733.00	527.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,154.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	180,456.60	527.50
			TOTAL ACCOMODATIONS	18,520.00	2,030.00
			TOTAL CHARGES	198,976.60	2,557.50

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:39:57  
Page: 5

CARTERSVILLE MEDICAL CENTER  
960 JOE FRANK HARRIS PKWY SE  
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER  
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,822,916.37	ADJUSTMENTS	137,540.74
COVERED CHARGES	17,829,732.32	CONTRACTUAL ALLOW	14,697,371.69
NON-COVERD CHARGES	1,993,184.05	TOTAL MEDICAID LIAB	3,132,360.63
		LESS: COB	13,571.17
		LESS: COPAYMENT	4,419.00
		REIMBURSEMENT	3,114,370.46
		ALL OTHER	2,912,360.08
		FEE SCHEDULE-LAB	157,863.88
		INJECTABLE DRUGS	44,146.50

TOTAL NUMBER OF CLAIMS 4,825

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/12 THROUGH 09/30/13  
 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	543,626.00	3,638.75	OTHER LAB	157,157.00	1,039.25
MED/SURG SUPPLY	482,283.50	192.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	378.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	990,585.25	23,159.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,797,977.75	129,586.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	16,661.00	16,181.53	FEE SCHEDULE LAB	4,318,043.92	924,486.35
EKG/ECG	326,686.25	21,469.25	MRI SERVICES	454,887.00	40,993.75
IV THERAPY	429,404.75	80,919.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	695,307.40	118,276.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	51,069.00	34,591.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	54,523.00	3,338.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	591,374.25	2,402.25	AMBULANCE	0.00	0.00
GI SERVICES	235,531.62	18,151.37	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,442,153.75	3,807.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	421,758.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	385,676.38	399,097.95
RADIOLOGY THERAPEUTIC	204,532.75	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	3,117.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,000.25	3,976.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	13,835.25	3,686.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	38,121.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	485,226.50	84,344.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	46,767.50	1,482.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	257,876.75	38,811.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	212,165.75	34,736.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	55,232.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	119,268.75	1,320.25			
			TOTAL ANCILLARY	17,829,732.32	1,993,184.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	17,829,732.32	1,993,184.05

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	377,554.95	ADJUSTMENTS	0.00
COVERED CHARGES	291,678.57	CONTRACTUAL ALLOW	191,361.00
NON-COVERD CHARGES	85,876.38	TOTAL MEDICAID LIAB	100,317.57
		LESS: COB	100,245.57
		LESS: COPAYMENT	72.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 80



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CARTERSVILLE MEDICAL CENTER PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 960 JOE FRANK HARRIS PKWY SE 000001625A SERVICE DATES 10/01/12 THROUGH 09/30/13  
 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	15,589.85	72.75	OTHER LAB	2,869.75	0.00
MED/SURG SUPPLY	21,463.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	13,288.75	389.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,029.25	30,500.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	65,025.00	14,497.00
EKG/ECG	8,123.50	580.25	MRI SERVICES	0.00	0.00
IV THERAPY	23,722.50	855.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,611.62	34,517.63	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	617.75	2,090.50	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,420.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	34,110.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	61,627.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,736.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,246.35	968.50
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	132.50	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	3,196.75	1,272.25			
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	291,678.57	85,876.38
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	291,678.57	85,876.38

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: 07/23/2014  
Run Time: 11:40:43  
Page: 9

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,744,387.35	ADJUSTMENTS	797.11
COVERED CHARGES	1,648,326.10	CONTRACTUAL ALLOW	1,607,437.40
NON-COVERD CHARGES	96,061.25	TOTAL MEDICAID LIAB	40,888.70
		LESS: COB	0.00
		LESS: COPAYMENT	1,682.04
		REIMBURSEMENT	39,206.66
		TOTAL NUMBER OF CLAIMS	732

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 10/01/12 THROUGH 09/30/13  
 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	33,538.90	150.50	OTHER LAB	4,964.25	0.00
MED/SURG SUPPLY	13,936.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	120,079.25	449.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	128,257.75	10,317.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	396,744.75	74,977.25
EKG/ECG	27,852.00	0.00	MRI SERVICES	18,862.50	0.00
IV THERAPY	35,833.00	4,652.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,993.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,823.25	499.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	800.75	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	712,481.75	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	29,757.45	2,839.25
RADIOLOGY THERAPEUTIC	100,689.25	1,176.75	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	198.75	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	17,919.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,592.75	0.00			
			TOTAL ANCILLARY	1,648,326.10	96,061.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,648,326.10	96,061.25

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	60,167.22	ADJUSTMENTS	0.00
COVERED CHARGES	53,857.97	CONTRACTUAL ALLOW	28,601.41
NON-COVERD CHARGES	6,309.25	TOTAL MEDICAID LIAB	25,256.56
		LESS: COB	25,241.56
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	26

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	619.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	174.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,503.75	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,439.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,446.22	2,807.00
EKG/ECG	580.25	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	181.50	63.25	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	190.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,152.75	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	465.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,544.50	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	53,857.97	6,309.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	53,857.97	6,309.25

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CARTERSVILLE MEDICAL CENTER  
960 JOE FRANK HARRIS PKWY SE  
CARTERSVILLE,GA 30120-2129

PROVIDER NUMBER  
000001625A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,727,705.14	ADJUSTMENTS	40,437.84
COVERED CHARGES	4,483,370.30	CONTRACTUAL ALLOW	3,855,614.48
NON-COVERD CHARGES	244,334.84	TOTAL MEDICAID LIAB	627,755.82
		LESS: COB	0.00
		LESS: COPAYMENT	938.35
		REIMBURSEMENT	626,817.47
		TOTAL NUMBER OF CLAIMS	124

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 10/01/12 THROUGH 09/30/13  
 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	155,612.50	1,395.00	OTHER LAB	6,009.75	1,086.00
MED/SURG SUPPLY	499,444.50	95.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	45,260.50	11,874.75	OTHER THERAPEUTIC SVC	0.00	680.00
CT SCAN	97,875.50	3,894.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,003.00	FEE SCHEDULE LAB	170,963.96	29,237.00
EKG/ECG	6,382.75	8,703.75	MRI SERVICES	0.00	0.00
IV THERAPY	24,265.00	7,216.25	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,381,135.34	135,210.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	655.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	707,280.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	11,784.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,127.75	293.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	277,653.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	131,462.60	9,672.00
RADIOLOGY THERAPEUTIC	540,768.25	8,237.25	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	3,352.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	257,420.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,706.75	1,432.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,600.50	741.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	43,064.00	5,231.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	45,560.25	18,331.50			
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	22,984.90	0.00			
			TOTAL ANCILLARY	4,483,370.30	244,334.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,483,370.30	244,334.84

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: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:43:40  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	145,238,785.97	ADJUSTMENTS	30,747,343.84
COVERED CHARGES	140,233,505.76	CONTRACTUAL ALLOW	83,925,262.89
NON-COVERD CHARGES	5,005,280.21	TOTAL MEDICAID LIAB	56,308,242.87
		LESS: COB	201,791.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	56,106,450.93

TOTAL NUMBER OF ADMISSIONS 2,832

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12,507		4	12,007,092.00		4,185,655.00
ROUTINE NURSERY	1,699		0	3,549,127.50		12,490.50
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	14,206		4	15,556,219.50		4,198,145.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	1,297		0	6,093,935.00		0.00
PED ICU	3,942		0	14,065,272.50		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	5,239		0	20,159,207.50		0.00
TOTAL ACCOMODATIONS	19,445		4	35,715,427.00		4,198,145.50

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHILDREN'S HEALTHCARE OF ATLANTA  
 1001 JOHNSON FERRY RD NE  
 ATLANTA,GA 30342-1605

PROVIDER NUMBER  
 000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,371,958.15	99,799.60	OTHER LAB	263,642.50	0.00
MED/SURG SUPPLY	7,834,982.02	109,158.09	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,365,795.25	159,408.48	EDUCATION & TRAINING	481.00	0.00
RADIOLOGY-DIAGNOSTIC	1,870,342.00	1,076.00	OTHER THERAPEUTIC SVC	28,242.50	112,235.00
CT SCAN	1,706,663.50	5,308.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	601,231.50	1,660.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	51,872.00	0.00	MRI SERVICES	1,370,035.50	0.00
IV THERAPY	61,089.00	9,404.50	PROFESSIONAL FEES	0.00	27,851.00
OPERATING ROOM	9,489,695.25	21,834.49	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	16,002,060.98	61,576.77	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,089,375.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	21,606.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,146,433.50	69,876.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	954,103.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	662,961.50	368.00	INJECTABLE DRUGS	103,211.50	0.00
RADIOLOGY THERAPEUTIC	231,850.00	1,092.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	258,920.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	309,278.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	22,704.00	PATIENT CONVENIENCE	0.00	81.74
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	628.00	38,466.00	TRAUMA RESPONSE	0.00	43,825.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	10,480,743.61	55.04
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	6,350.00
OTHER IMAGING SERVICE	306,735.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	801,531.00	10,101.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	74,508.50	2,060.50			
AUDIOLOGY	55,232.00	0.00			
CARDIOLOGY	674,226.50	2,843.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,200,329.50	0.00			
ORGAN ACQUISITION	4,472.50	0.00			
TREATMENT/OBSERV. RM	123,841.00	0.00			
			TOTAL ANCILLARY	104,518,078.76	807,134.71
			TOTAL ACCOMODATIONS	35,715,427.00	4,198,145.50
			TOTAL CHARGES	140,233,505.76	5,005,280.21

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013031040518	01/07/13 - 01/23/13	02/04/13	0.00	635.00	0.00	0.00	0.00
614	2013060034753	02/14/13 - 02/18/13	03/04/13	0.00	635.00	0.00	0.00	0.00
614	5213150000142	02/07/13 - 03/04/13	06/03/13	0.00	635.00	0.00	0.00	0.00
614	5213156000169	01/25/13 - 03/29/13	06/10/13	0.00	635.00	0.00	0.00	0.00
614	5213184000050	01/23/13 - 04/12/13	07/08/13	0.00	635.00	0.00	0.00	0.00
614	2013254043517	08/26/13 - 08/31/13	09/16/13	0.00	635.00	0.00	0.00	0.00
614	2013290012864	09/21/13 - 09/27/13	10/21/13	0.00	635.00	0.00	0.00	0.00
614	5213316000120	08/14/13 - 09/10/13	11/18/13	0.00	635.00	0.00	0.00	0.00
614	2013336028870	11/22/13 - 11/24/13	12/09/13	0.00	635.00	0.00	0.00	0.00
614	5213352000118	09/18/13 - 10/18/13	12/23/13	0.00	635.00	0.00	0.00	0.00
TOTAL				0.00	6,350.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:45:24  
 Page: 4

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,568,117.72	ADJUSTMENTS	0.00
COVERED CHARGES	8,285,803.72	CONTRACTUAL ALLOW	1,219,423.52
NON-COVERD CHARGES	282,314.00	TOTAL MEDICAID LIAB	7,066,380.20
		LESS: COB	7,066,380.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 183

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	582		0	556,056.00		138,231.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	582		0	556,056.00		138,231.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	53		0	247,987.00		0.00
PED ICU	258		0	915,477.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		13	0.00		33,943.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	311		13	1,163,464.00		33,943.00
TOTAL ACCOMODATIONS	893		13	1,719,520.00		172,174.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,868,648.50	0.00	OTHER LAB	10,613.00	0.00
MED/SURG SUPPLY	418,627.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	779,547.12	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	126,840.00	0.00	OTHER THERAPEUTIC SVC	75.00	4,864.50
CT SCAN	89,653.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,628.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,784.00	0.00	MRI SERVICES	80,463.00	0.00
IV THERAPY	1,102.00	0.00	PROFESSIONAL FEES	0.00	98,765.50
OPERATING ROOM	449,977.67	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,056,722.88	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	206,466.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	273,444.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	59,271.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	42,764.50	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	1,932.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,794.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	7,908.50	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	1,584.00	TRAUMA RESPONSE	0.00	2,436.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	568,272.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	635.00
OTHER IMAGING SERVICE	17,680.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	143,051.50	929.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,510.00	925.50			
AUDIOLOGY	735.00	0.00			
CARDIOLOGY	36,665.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	270,131.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,975.00	0.00			
			TOTAL ANCILLARY	6,566,283.72	110,140.00
			TOTAL ACCOMODATIONS	1,719,520.00	172,174.00
			TOTAL CHARGES	8,285,803.72	282,314.00

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

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013172040083	03/20/13 - 04/19/13	06/24/13	0.00	635.00	0.00	160,522.57	0.00
TOTAL				0.00	635.00	0.00	160,522.57	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	44,243,770.76	ADJUSTMENTS	3,520,828.85
COVERED CHARGES	41,742,253.26	CONTRACTUAL ALLOW	28,682,172.81
NON-COVERD CHARGES	2,501,517.50	TOTAL MEDICAID LIAB	13,060,080.45
		LESS: COB	87,154.25
		LESS: COPAYMENT	183.00
		REIMBURSEMENT	12,972,743.20
		ALL OTHER	11,675,645.69
		FEE SCHEDULE-LAB	413,705.25
		INJECTABLE DRUGS	883,392.26

TOTAL NUMBER OF CLAIMS 21,202

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,936,856.75	7,136.50	OTHER LAB	190,934.50	0.00
MED/SURG SUPPLY	2,329,298.01	1,811.97	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	130.00	EDUCATION & TRAINING	2,405.00	0.00
RADIOLOGY-DIAGNOSTIC	1,505,239.00	21,395.50	OTHER THERAPEUTIC SVC	0.00	2,162.00
CT SCAN	2,138,054.00	70,263.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,073,765.50	115,883.50	FEE SCHEDULE LAB	5,222,780.17	913,391.93
EKG/ECG	20,416.00	1,160.00	MRI SERVICES	3,021,395.50	99,631.50
IV THERAPY	957,345.50	2,498.00	PROFESSIONAL FEES	0.00	36,529.00
OPERATING ROOM	4,429,645.67	231,240.83	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	265,560.11	6,245.51	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,593,690.00	696.00	AMBULANCE	0.00	0.00
GI SERVICES	75,012.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,716,358.00	81,600.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	738,071.00	716.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,867,768.50	591,634.75
RADIOLOGY THERAPEUTIC	379,079.50	2,196.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	459,936.00	88,426.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	588,556.50	19,738.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	3.01
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,145,157.00	134,035.00	TRAUMA RESPONSE	0.00	28,436.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	190,298.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	621,396.50	1,084.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	618,128.05	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	192,587.50	18,465.50			
AUDIOLOGY	280,658.50	0.00			
CARDIOLOGY	84,807.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,478,971.00	2,153.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	618,082.00	22,853.00			
			TOTAL ANCILLARY	41,742,253.26	2,501,517.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	41,742,253.26	2,501,517.50



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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5913212000626	06/26/13 - 06/26/13	08/05/13	0.00	0.00	0.00	370.00	0.00
932	5913212000626	06/27/13 - 06/27/13	08/05/13	0.00	0.00	0.00	370.00	0.00
932	5913212000626	06/28/13 - 06/28/13	08/05/13	0.00	0.00	0.00	370.00	0.00
TOTAL				0.00	0.00	0.00	1,110.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA  
1001 JOHNSON FERRY RD NE  
ATLANTA,GA 30342-1605

PROVIDER NUMBER  
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,378,884.80	ADJUSTMENTS	0.00
COVERED CHARGES	2,946,075.82	CONTRACTUAL ALLOW	398,809.23
NON-COVERD CHARGES	432,808.98	TOTAL MEDICAID LIAB	2,547,266.59
		LESS: COB	2,547,248.59
		LESS: COPAYMENT	18.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 679

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	202,437.00	582.00	OTHER LAB	3,750.50	0.00
MED/SURG SUPPLY	269,598.04	912.23	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,540.50	19,498.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	120,769.00	17,459.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,510.50	21,391.00	FEE SCHEDULE LAB	298,165.78	36,904.50
EKG/ECG	696.00	0.00	MRI SERVICES	353,155.00	38,797.50
IV THERAPY	5,650.00	544.00	PROFESSIONAL FEES	0.00	60,570.00
OPERATING ROOM	526,663.50	109,950.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,980.50	2,580.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	347,828.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,808.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	149,642.00	3,053.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	92,510.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	170,956.50	27,485.25
RADIOLOGY THERAPEUTIC	36,023.00	7,418.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,371.50	16,108.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	18,628.00	17,781.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,189.50	5,092.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	37,861.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,022.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	29,739.00	7,725.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	44,416.00	5,493.50			
AUDIOLOGY	11,942.00	0.00			
CARDIOLOGY	6,504.50	861.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	42,991.50	1,322.50			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	52,725.50	31,280.00			
			TOTAL ANCILLARY	2,946,075.82	432,808.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,946,075.82	432,808.98

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHILDREN'S HEALTHCARE OF ATLANTA PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 1001 JOHNSON FERRY RD NE 000001636A SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ATLANTA,GA 30342-1605 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
932	2013234045795	07/01/13 - 07/01/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/02/13 - 07/02/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/03/13 - 07/03/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/08/13 - 07/08/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/09/13 - 07/09/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/10/13 - 07/10/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/11/13 - 07/11/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/12/13 - 07/12/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/15/13 - 07/15/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/16/13 - 07/16/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/17/13 - 07/17/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/18/13 - 07/18/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/19/13 - 07/19/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/22/13 - 07/22/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/23/13 - 07/23/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/24/13 - 07/24/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/25/13 - 07/25/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013234045795	07/26/13 - 07/26/13	08/26/13	0.00	0.00	0.00	4,085.25	0.00
932	2013261018911	08/20/13 - 08/20/13	09/23/13	0.00	0.00	0.00	195.47	0.00
932	2013261018915	08/02/13 - 08/02/13	09/23/13	0.00	0.00	0.00	621.85	0.00
932	2013261018915	08/05/13 - 08/05/13	09/23/13	0.00	0.00	0.00	621.85	0.00
932	2013261018919	08/08/13 - 08/08/13	09/23/13	0.00	0.00	0.00	4,688.56	0.00
932	2013261018919	08/09/13 - 08/09/13	09/23/13	0.00	0.00	0.00	4,688.56	0.00
932	2013261018919	08/12/13 - 08/12/13	09/23/13	0.00	0.00	0.00	4,688.56	0.00
932	2013261018919	08/13/13 - 08/13/13	09/23/13	0.00	0.00	0.00	4,688.56	0.00
932	2013261018919	08/15/13 - 08/15/13	09/23/13	0.00	0.00	0.00	4,688.56	0.00
932	2013261018919	08/16/13 - 08/16/13	09/23/13	0.00	0.00	0.00	4,688.56	0.00
932	2013261018919	08/19/13 - 08/19/13	09/23/13	0.00	0.00	0.00	4,688.56	0.00
932	2013261018925	08/21/13 - 08/21/13	09/23/13	0.00	0.00	0.00	195.47	0.00
932	2013261018926	08/01/13 - 08/01/13	09/23/13	0.00	0.00	0.00	426.38	0.00
932	2013298024995	06/19/13 - 06/19/13	10/28/13	0.00	0.00	0.00	1,985.56	0.00
932	2013298024995	06/20/13 - 06/20/13	10/28/13	0.00	0.00	0.00	1,985.56	0.00
932	2013298024995	06/21/13 - 06/21/13	10/28/13	0.00	0.00	0.00	1,985.56	0.00
932	2013298024995	06/24/13 - 06/24/13	10/28/13	0.00	0.00	0.00	1,985.56	0.00
932	2013298024995	06/25/13 - 06/25/13	10/28/13	0.00	0.00	0.00	1,985.56	0.00
932	2013298024995	06/26/13 - 06/26/13	10/28/13	0.00	0.00	0.00	1,985.56	0.00
932	2013298024995	06/27/13 - 06/27/13	10/28/13	0.00	0.00	0.00	1,985.56	0.00
932	2013298024995	06/28/13 - 06/28/13	10/28/13	0.00	0.00	0.00	1,985.56	0.00
932	2013312042639	05/01/13 - 05/01/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00
932	2013312042639	05/02/13 - 05/02/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00
932	2013312042639	05/03/13 - 05/03/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00
932	2013312042639	05/06/13 - 05/06/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM	CLM
932	2013312042639	05/07/13 - 05/07/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00	
932	2013312042639	05/08/13 - 05/08/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00	
932	2013312042639	05/09/13 - 05/09/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00	
932	2013312042639	05/10/13 - 05/10/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00	
932	2013312042639	05/14/13 - 05/14/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00	
932	2013312042639	05/15/13 - 05/15/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00	
932	2013312042639	05/16/13 - 05/16/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00	
932	2013312042639	05/17/13 - 05/17/13	11/11/13	0.00	0.00	0.00	13,666.12	0.00	
932	2013352048928	04/09/13 - 04/09/13	12/23/13	0.00	0.00	0.00	1,089.27	0.00	
932	2013352048930	04/10/13 - 04/10/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/11/13 - 04/11/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/12/13 - 04/12/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/16/13 - 04/16/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/17/13 - 04/17/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/18/13 - 04/18/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/19/13 - 04/19/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/22/13 - 04/22/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/23/13 - 04/23/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/24/13 - 04/24/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/25/13 - 04/25/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/26/13 - 04/26/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/29/13 - 04/29/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
932	2013352048930	04/30/13 - 04/30/13	12/23/13	0.00	0.00	0.00	16,122.80	0.00	
TOTAL				0.00	0.00	0.00	515,101.83	0.00	

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:49:33  
Page: 14

CHILDREN'S HEALTHCARE OF ATLANTA  
1001 JOHNSON FERRY RD NE  
ATLANTA,GA 30342-1605

PROVIDER NUMBER  
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,053,757.56	ADJUSTMENTS	2,125.72
COVERED CHARGES	1,002,271.56	CONTRACTUAL ALLOW	937,884.63
NON-COVERD CHARGES	51,486.00	TOTAL MEDICAID LIAB	64,386.93
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	64,386.93
		TOTAL NUMBER OF CLAIMS	1,151

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,776.50	560.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	15,903.81	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,493.50	237.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,298.50	3,249.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	155,847.00	38,006.00
EKG/ECG	1,160.00	0.00	MRI SERVICES	2,006.00	1,947.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	5,306.50
OPERATING ROOM	9,934.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,144.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	928.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	671,450.50	2,035.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	537.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,164.75	101.75
RADIOLOGY THERAPEUTIC	546.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,513.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,344.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	7,225.00	42.50			
			TOTAL ANCILLARY	1,002,271.56	51,486.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,002,271.56	51,486.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	78,954.76	ADJUSTMENTS	0.00
COVERED CHARGES	67,035.76	CONTRACTUAL ALLOW	9,566.97
NON-COVERD CHARGES	11,919.00	TOTAL MEDICAID LIAB	57,468.79
		LESS: COB	57,468.79
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	27



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:49:45  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 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	0.00	0.00
MED/SURG SUPPLY	5,805.26	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,952.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,993.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,818.50	1,222.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	9,043.50
OPERATING ROOM	9,813.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	66.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,668.50	856.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	582.50	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	501.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,353.50	797.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	680.00	0.00			
			TOTAL ANCILLARY	67,035.76	11,919.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,035.76	11,919.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA  
1001 JOHNSON FERRY RD NE  
ATLANTA,GA 30342-1605

PROVIDER NUMBER  
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,356,501.50	ADJUSTMENTS	598,790.47
COVERED CHARGES	7,202,474.25	CONTRACTUAL ALLOW	5,914,097.89
NON-COVERD CHARGES	154,027.25	TOTAL MEDICAID LIAB	1,288,376.36
		LESS: COB	17,124.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,271,251.77
		TOTAL NUMBER OF CLAIMS	186

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	249,491.00	687.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	633,614.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,177.00	1,386.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	41,746.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	46,190.50	9,283.50	FEE SCHEDULE LAB	70,812.50	4,422.00
EKG/ECG	696.00	0.00	MRI SERVICES	61,488.50	0.00
IV THERAPY	27,634.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,006,032.50	99,576.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,023.00	1,665.50	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	500,423.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	5,358.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	43,691.50	3,039.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	96,363.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,648,306.70	12,589.00
RADIOLOGY THERAPEUTIC	45,024.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	54,474.00	5,967.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	47,356.00	1,658.50	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	3,186.00	3,115.00	TRAUMA RESPONSE	0.00	1,621.50
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,524,255.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,471.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,948.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,652.00	132.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,981.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,936.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	52,141.50	8,882.50			
			TOTAL ANCILLARY	7,202,474.25	154,027.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,202,474.25	154,027.25

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:49:59  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

CHILDREN'S HEALTHCARE OF ATLANTA  
1001 JOHNSON FERRY RD NE  
ATLANTA,GA 30342-1605

PROVIDER NUMBER  
000001636A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	886,711.51	ADJUSTMENTS	0.00
COVERED CHARGES	859,979.76	CONTRACTUAL ALLOW	84,425.34
NON-COVERD CHARGES	26,731.75	TOTAL MEDICAID LIAB	775,554.42
		LESS: COB	775,554.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 22

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	91,005.00	352.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	60,730.51	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,538.50	221.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,456.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,434.50	504.00
EKG/ECG	0.00	0.00	MRI SERVICES	10,367.50	2,006.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	726.50
OPERATING ROOM	171,726.50	5,271.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,758.00	1,941.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	80,743.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,480.50	159.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,602.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	31,719.75	4,731.50
RADIOLOGY THERAPEUTIC	2,587.50	2,479.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	396.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	346,257.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,707.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	12,795.50	925.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,981.50	1,421.50			
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	4,693.00	5,992.50			
			TOTAL ANCILLARY	859,979.76	26,731.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	859,979.76	26,731.75

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	213,729.59	ADJUSTMENTS	10,166.30
COVERED CHARGES	176,186.44	CONTRACTUAL ALLOW	71,372.76
NON-COVERD CHARGES	37,543.15	TOTAL MEDICAID LIAB	104,813.68
		LESS: COB	751.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	104,061.87

TOTAL NUMBER OF ADMISSIONS 22

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	54		3	40,446.00		36,557.75
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	54		3	40,446.00		36,557.75
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	54		3	40,446.00		36,557.75

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	58,482.55	0.00	OTHER LAB	1,251.80	0.00
MED/SURG SUPPLY	13,601.61	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	21,973.12	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,341.40	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,793.60	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,896.95	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,611.17	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	5,354.39	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,120.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,138.70	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,372.80	985.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,801.60	0.00			
			TOTAL ANCILLARY	135,740.44	985.40
			TOTAL ACCOMODATIONS	40,446.00	36,557.75
			TOTAL CHARGES	176,186.44	37,543.15

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 19:14:05  
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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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 19:14:05  
Page: 4

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	664,278.19	ADJUSTMENTS	8,699.84
COVERED CHARGES	593,232.84	CONTRACTUAL ALLOW	363,066.83
NON-COVERD CHARGES	71,045.35	TOTAL MEDICAID LIAB	230,166.01
		LESS: COB	15.30
		LESS: COPAYMENT	1,617.00
		REIMBURSEMENT	228,533.71
		ALL OTHER	201,037.39
		FEE SCHEDULE-LAB	27,476.39
		INJECTABLE DRUGS	19.93
		TOTAL NUMBER OF CLAIMS	1,045

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86,568.00	3,042.60	OTHER LAB	3,531.30	0.00
MED/SURG SUPPLY	8,190.73	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	296.48	EDUCATION & TRAINING	95.44	0.00
RADIOLOGY-DIAGNOSTIC	47,510.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,122.05	6,385.60	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	348.96	288.27	FEE SCHEDULE LAB	137,206.10	48,367.80
EKG/ECG	14,485.80	517.35	MRI SERVICES	0.00	0.00
IV THERAPY	30,205.68	943.86	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	45,962.35	9,703.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,783.35	689.44	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	132,890.60	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	99.00	72.90
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	17.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,742.16	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	30,590.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	915.20	592.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	128.15			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,985.02	0.00			
			TOTAL ANCILLARY	593,232.84	71,045.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	593,232.84	71,045.35

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,589.33	ADJUSTMENTS	0.00
COVERED CHARGES	2,359.73	CONTRACTUAL ALLOW	1,211.71
NON-COVERD CHARGES	229.60	TOTAL MEDICAID LIAB	1,148.02
		LESS: COB	1,145.02
		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

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	119.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	331.20	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	964.08	229.60
EKG/ECG	172.45	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	133.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	639.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,359.73	229.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,359.73	229.60

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	89,393.66	ADJUSTMENTS	50.00
COVERED CHARGES	84,191.78	CONTRACTUAL ALLOW	74,941.78
NON-COVERD CHARGES	5,201.88	TOTAL MEDICAID LIAB	9,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	342.00
		REIMBURSEMENT	8,908.00
		TOTAL NUMBER OF CLAIMS	185

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,357.15	39.00	OTHER LAB	539.90	0.00
MED/SURG SUPPLY	495.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,047.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,172.26	5,162.88
EKG/ECG	1,379.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,966.27	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	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	54,506.15	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	568.40	0.00			
			TOTAL ANCILLARY	84,191.78	5,201.88
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	84,191.78	5,201.88

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SCREVEN COUNTY HOSPITAL, LLC  
215 MIMS RD  
SYLVANIA,GA 30467-1994

PROVIDER NUMBER  
000001647A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE VII

Run Date: 07/23/2014  
 Run Time: 19:14:39  
 Page: 11

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	93,028.43	ADJUSTMENTS	4,428.50
COVERED CHARGES	92,545.71	CONTRACTUAL ALLOW	70,388.21
NON-COVERD CHARGES	482.72	TOTAL MEDICAID LIAB	22,157.50
		LESS: COB	0.00
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	22,067.50

TOTAL NUMBER OF CLAIMS 5



SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SCREVEN COUNTY HOSPITAL, LLC  
 215 MIMS RD  
 SYLVANIA,GA 30467-1994

PROVIDER NUMBER  
 000001647A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,300.10	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,455.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	291.25	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	3,604.42	482.72
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	57,469.62	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	53.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	199.74	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	92,545.71	482.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	92,545.71	482.72

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 19:14:39  
Page: 13

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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER 000001702A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,668,988.35	ADJUSTMENTS	6,797.93
COVERED CHARGES	1,591,096.53	CONTRACTUAL ALLOW	916,778.32
NON-COVERD CHARGES	77,891.82	TOTAL MEDICAID LIAB	674,318.21
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	674,318.21

TOTAL NUMBER OF ADMISSIONS 82

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	283		0	231,277.00		875.96
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	283		0	231,277.00		875.96
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	48		0	96,245.76		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	48		0	96,245.76		0.00
TOTAL ACCOMODATIONS	331		0	327,522.76		875.96

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,090.32	0.00	OTHER LAB	14,033.74	0.00
MED/SURG SUPPLY	25,967.09	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	290,945.56	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	36,387.80	0.00	OTHER THERAPEUTIC SVC	0.00	3,962.19
CT SCAN	90,229.40	67,531.67	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,481.95	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	44,406.11	0.00	MRI SERVICES	25,043.15	0.00
IV THERAPY	29,751.64	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,691.82	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	108,949.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,381.67	0.00	AMBULANCE	0.00	0.00
GI SERVICES	29,056.51	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	130,246.52	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,915.48	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,149.82	0.00	INJECTABLE DRUGS	170,240.69	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	822.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,431.84	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,289.00	3,684.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	144.62	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,926.38	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,423.77	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,280.39	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	35,349.92	1,838.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	49,385.11	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,947.22	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,603.60	0.00			
			TOTAL ANCILLARY	1,263,573.77	77,015.86
			TOTAL ACCOMODATIONS	327,522.76	875.96
			TOTAL CHARGES	1,591,096.53	77,891.82

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 09:48:46  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:48:47  
Page: 4

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,325,530.45	ADJUSTMENTS	8,597.07
COVERED CHARGES	3,698,303.86	CONTRACTUAL ALLOW	2,933,331.25
NON-COVERD CHARGES	627,226.59	TOTAL MEDICAID LIAB	764,972.61
		LESS: COB	2,916.23
		LESS: COPAYMENT	696.00
		REIMBURSEMENT	761,360.38
		ALL OTHER	706,003.77
		FEE SCHEDULE-LAB	51,066.38
		INJECTABLE DRUGS	4,290.23

TOTAL NUMBER OF CLAIMS 1,600

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	32,229.98	8,878.04	OTHER LAB	28,469.02	0.00
MED/SURG SUPPLY	103,616.35	129.38	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	106,609.76	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	222,740.34	3,629.62	OTHER THERAPEUTIC SVC	0.00	15,633.65
CT SCAN	384,978.95	188,333.09	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	5,736.99	FEE SCHEDULE LAB	555,992.36	62,740.79
EKG/ECG	50,052.05	4,277.32	MRI SERVICES	71,487.01	29,638.06
IV THERAPY	91,740.50	8,028.06	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	183,272.26	46,055.94	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	45,037.36	4,575.98	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	89,673.68	311.29	AMBULANCE	0.00	0.00
GI SERVICES	78,101.17	24,073.03	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,253,069.50	15,838.41	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	62,066.62	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11,728.13	31,230.78
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	362.97	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	384.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	921.00	PATIENT CONVENIENCE	0.00	366.82
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,458.18	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,688.00	0.00	IMPL DEV CHARGE PATIENTS	10,770.54	25,235.59
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	169.00
OTHER IMAGING SERVICE	95,434.70	25,190.62			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	9,837.13	2,827.96			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	107,756.22	11,955.13			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	48,794.69	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	86,661.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	72,106.30	0.00			
			TOTAL ANCILLARY	3,698,303.86	625,591.71
			TOTAL ACCOMODATIONS	0.00	1,634.88
			TOTAL CHARGES	3,698,303.86	627,226.59

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:48:47  
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EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	9713364966081	06/03/13 - 06/03/13	03/10/14	0.00	169.00	0.00	0.00	0.00
TOTAL				0.00	169.00	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 09:49:13  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	99,411.28	ADJUSTMENTS	0.00
COVERED CHARGES	68,039.17	CONTRACTUAL ALLOW	33,977.76
NON-COVERD CHARGES	31,372.11	TOTAL MEDICAID LIAB	34,061.41
		LESS: COB	34,049.41
		LESS: COPAYMENT	12.00
		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

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	660.51	1,207.89	OTHER LAB	0.00	993.00
MED/SURG SUPPLY	1,103.53	143.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,430.84	289.71	OTHER THERAPEUTIC SVC	0.00	195.49
CT SCAN	0.00	11,847.15	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,665.62	2,607.92
EKG/ECG	232.78	465.56	MRI SERVICES	0.00	3,042.51
IV THERAPY	1,604.39	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,007.77	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	114.58	114.58	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,937.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,511.39	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,131.33	1,474.56	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,086.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	355.78	468.23
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	13,337.31	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,611.20	1,834.86			
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	2,448.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,524.00	800.75			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,235.52	926.64			
			TOTAL ANCILLARY	68,039.17	31,372.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	68,039.17	31,372.11

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:49:14  
Page: 9

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	501,946.52	ADJUSTMENTS	52.94
COVERED CHARGES	461,088.15	CONTRACTUAL ALLOW	439,159.67
NON-COVERD CHARGES	40,858.37	TOTAL MEDICAID LIAB	21,928.48
		LESS: COB	18.79
		LESS: COPAYMENT	663.02
		REIMBURSEMENT	21,246.67
		TOTAL NUMBER OF CLAIMS	392

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	926.28	768.06	OTHER LAB	1,065.05	0.00
MED/SURG SUPPLY	2,371.73	179.67	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,799.64	579.42	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,430.90	19,007.84	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	80,434.87	10,867.00
EKG/ECG	4,801.08	436.46	MRI SERVICES	0.00	0.00
IV THERAPY	11,155.46	989.99	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,454.22	939.18	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	295,828.76	2,343.36	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,194.63	600.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	116.18
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,625.53	4,031.04			
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	461,088.15	40,858.37
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	461,088.15	40,858.37

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,442.79	ADJUSTMENTS	0.00
COVERED CHARGES	9,254.79	CONTRACTUAL ALLOW	7,491.72
NON-COVERD CHARGES	188.00	TOTAL MEDICAID LIAB	1,763.07
		LESS: COB	1,757.07
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25.79	63.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	42.70	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	3,137.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,555.70	125.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	139.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,454.65	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	6.01	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	893.14	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,254.79	188.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,254.79	188.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	61,495.32	ADJUSTMENTS	0.00
COVERED CHARGES	59,007.05	CONTRACTUAL ALLOW	48,680.99
NON-COVERD CHARGES	2,488.27	TOTAL MEDICAID LIAB	10,326.06
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	10,323.06

TOTAL NUMBER OF CLAIMS 2

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL  
 3949 S COBB DR SE  
 SMYRNA,GA 30080-6342

PROVIDER NUMBER  
 000001702A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,320.00	104.14	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,304.04	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	428.97	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	825.58	191.90
EKG/ECG	0.00	232.78	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,412.75	473.92	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,800.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,246.81	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	142.90
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	11,668.80	1,342.63
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	59,007.05	2,488.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,007.05	2,488.27



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY-ADVENTIST HOSPITAL  
3949 S COBB DR SE  
SMYRNA,GA 30080-6342

PROVIDER NUMBER  
000001702A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:39:38  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER 000001713A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,102,162.19	ADJUSTMENTS	3,294,455.88
COVERED CHARGES	69,403,197.75	CONTRACTUAL ALLOW	57,006,024.89
NON-COVERD CHARGES	1,698,964.44	TOTAL MEDICAID LIAB	12,397,172.86
		LESS: COB	94,661.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,302,511.15

TOTAL NUMBER OF ADMISSIONS 2,313

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,978		78	7,213,673.00		519,620.95
ROUTINE NURSERY	1,625		0	1,873,952.14		638,529.29
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		3,488.00
TOTAL ROUTINE	7,603		78	9,087,625.14		1,161,638.24
SPECIAL CARE SERVICES						
CCU	1,896		0	4,106,398.80		0.00
ICU	392		0	1,419,492.85		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,288		0	5,525,891.65		0.00
TOTAL ACCOMODATIONS	9,891		78	14,613,516.79		1,161,638.24

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,813,501.20	3,996.69	OTHER LAB	352,402.08	0.00
MED/SURG SUPPLY	5,214,741.21	92,888.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,791,066.45	6,853.56	EDUCATION & TRAINING	7,354.72	221.38
RADIOLOGY-DIAGNOSTIC	958,301.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,082,100.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	117,227.95	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	430,800.44	0.00	MRI SERVICES	754,126.78	0.00
IV THERAPY	65,388.00	521.76	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,557,355.58	14,144.41	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,348,713.34	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,779,516.00	4,472.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,775,103.88	0.00	AMBULANCE	0.00	0.00
GI SERVICES	165,168.06	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,921,244.47	52,642.36	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,287,659.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	319,371.60	0.00	INJECTABLE DRUGS	3,133.53	0.00
RADIOLOGY THERAPEUTIC	20,313.70	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	57,220.77	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	65,481.91	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	521,736.78	34,391.85	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	37,736.78	2,497.93	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	527,095.01	40,569.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	720,980.31	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	620,317.78	279,669.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	430,774.10	1,134.00			
AUDIOLOGY	159,218.85	0.00			
CARDIOLOGY	712,482.88	3,322.17			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,392.47	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	115,652.77	0.00			
			TOTAL ANCILLARY	54,789,680.96	537,326.20
			TOTAL ACCOMODATIONS	14,613,516.79	1,161,638.24
			TOTAL CHARGES	69,403,197.75	1,698,964.44

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,651.23	ADJUSTMENTS	0.00
COVERED CHARGES	75,762.95	CONTRACTUAL ALLOW	43,639.43
NON-COVERD CHARGES	888.28	TOTAL MEDICAID LIAB	32,123.52
		LESS: COB	32,123.52
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	12		0	14,820.00		888.28
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	14,820.00		888.28
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	12		0	14,820.00		888.28

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,367.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,068.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	15,989.11	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	360.81	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	178.24	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,255.51	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,998.11	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	556.31	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	168.19	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	60,942.95	0.00
			TOTAL ACCOMODATIONS	14,820.00	888.28
			TOTAL CHARGES	75,762.95	888.28

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:42:04  
Page: 5

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,834,681.15	ADJUSTMENTS	1,073,223.38
COVERED CHARGES	23,308,302.33	CONTRACTUAL ALLOW	19,196,832.22
NON-COVERD CHARGES	2,526,378.82	TOTAL MEDICAID LIAB	4,111,470.11
		LESS: COB	6,654.07
		LESS: COPAYMENT	5,019.00
		REIMBURSEMENT	4,099,797.04
		ALL OTHER	3,883,630.20
		FEE SCHEDULE-LAB	173,879.60
		INJECTABLE DRUGS	42,287.24
		TOTAL NUMBER OF CLAIMS	6,327

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	765,601.58	28,342.99	OTHER LAB	226,207.56	2,117.73
MED/SURG SUPPLY	1,021,431.40	17,854.41	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	836.28	0.00
RADIOLOGY-DIAGNOSTIC	1,397,747.46	32,379.72	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,406,154.91	331,993.19	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,375.25	6,939.13	FEE SCHEDULE LAB	4,997,894.01	1,009,982.64
EKG/ECG	386,074.36	11,027.80	MRI SERVICES	739,222.75	39,268.71
IV THERAPY	497,359.71	39,400.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	701,176.99	184,129.79	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,377.98	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	82,043.46	26,233.11	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	751,751.22	2,515.59	AMBULANCE	0.00	0.00
GI SERVICES	536,933.58	36,944.48	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,846,739.23	50,062.11	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	148,970.55	2,090.88	DRUG-SPECIFIC/HOME IV	0.00	2,926.20
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	881,732.68	373,676.55
RADIOLOGY THERAPEUTIC	167,120.52	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	319.12	817.93	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	6,544.48	2,787.29	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	13,586.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,372.35	11,857.20	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	26,420.10
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,687,990.82	168,699.03			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	22,375.28	49,825.10			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	351,625.58	2,098.72			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	177,463.22	11,918.88			
AMBULATORY SURGERY	12,056.25	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	164,650.98	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	289,152.77	40,481.89			
			TOTAL ANCILLARY	23,308,302.33	2,526,378.82
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,308,302.33	2,526,378.82

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: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	110,264.90	ADJUSTMENTS	0.00
COVERED CHARGES	93,063.17	CONTRACTUAL ALLOW	31,705.24
NON-COVERD CHARGES	17,201.73	TOTAL MEDICAID LIAB	61,357.93
		LESS: COB	61,357.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 20



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,483.70	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,063.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,419.37	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,160.10	8,326.74	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,079.20	6,732.53
EKG/ECG	3,238.64	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,661.74	168.19	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,128.63	1,323.69	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,529.99	650.58
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,214.03	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,084.20	0.00			
			TOTAL ANCILLARY	93,063.17	17,201.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	93,063.17	17,201.73

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:44:57  
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ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,618,109.49	ADJUSTMENTS	2,165.58
COVERED CHARGES	1,497,600.93	CONTRACTUAL ALLOW	1,443,898.54
NON-COVERD CHARGES	120,508.56	TOTAL MEDICAID LIAB	53,702.39
		LESS: COB	0.00
		LESS: COPAYMENT	1,875.07
		REIMBURSEMENT	51,827.32
		TOTAL NUMBER OF CLAIMS	960

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	37,318.71	46.00	OTHER LAB	6,901.29	0.00
MED/SURG SUPPLY	20,745.39	1,429.65	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	85,048.25	917.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	65,697.03	26,530.46	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	325,970.13	63,542.48
EKG/ECG	18,529.96	1,065.88	MRI SERVICES	0.00	0.00
IV THERAPY	27,999.87	534.38	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	972.96	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,135.84	764.72	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,332.34	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,163.93	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	807,131.12	845.84	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	43,681.50	12,288.76
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	47,269.66	10,933.30			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,702.95	1,610.03			
			TOTAL ANCILLARY	1,497,600.93	120,508.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,497,600.93	120,508.56

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:45:17  
Page: 11

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,253.41	ADJUSTMENTS	0.00
COVERED CHARGES	4,253.41	CONTRACTUAL ALLOW	4,062.09
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	191.32
		LESS: COB	185.32
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	501.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	919.72	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	511.62	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,274.28	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	46.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,253.41	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,253.41	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/11 THROUGH 05/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,096,197.77	ADJUSTMENTS	224,187.72
COVERED CHARGES	3,449,198.17	CONTRACTUAL ALLOW	2,959,681.69
NON-COVERD CHARGES	646,999.60	TOTAL MEDICAID LIAB	489,516.48
		LESS: COB	0.00
		LESS: COPAYMENT	426.00
		REIMBURSEMENT	489,090.48

TOTAL NUMBER OF CLAIMS 96

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/11 THROUGH 05/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	155,605.89	6,635.82	OTHER LAB	7,636.92	0.00
MED/SURG SUPPLY	540,316.59	11,096.32	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	774.83
RADIOLOGY-DIAGNOSTIC	59,829.38	21,490.85	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	47,416.00	14,205.17	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	780.55	FEE SCHEDULE LAB	318,647.20	43,283.64
EKG/ECG	28,799.32	3,874.08	MRI SERVICES	41,867.95	0.00
IV THERAPY	10,681.63	1,968.44	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,090,147.70	261,823.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	281.78	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	9,469.05	1,675.59	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	536,907.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	39,571.68	171.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	168,313.73	0.00	DRUG-SPECIFIC/HOME IV	0.00	5,766.51
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	99,693.63	120,526.39
RADIOLOGY THERAPEUTIC	37,366.43	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	865.38	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	556.31	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	2,390.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	133,391.34
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,840.69	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,388.60	1,865.85			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	95,250.76	137.09			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	54,268.99	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	92,897.00	13,224.48			
			TOTAL ANCILLARY	3,449,198.17	646,503.66
			TOTAL ACCOMODATIONS	0.00	495.94
			TOTAL CHARGES	3,449,198.17	646,999.60

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:45:26  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	06/01/11	THROUGH	05/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:45:36  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER 000001713A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,133,243.65	ADJUSTMENTS	1,259,996.97
COVERED CHARGES	27,417,735.63	CONTRACTUAL ALLOW	22,607,407.88
NON-COVERD CHARGES	715,508.02	TOTAL MEDICAID LIAB	4,810,327.75
		LESS: COB	53,642.71
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,756,685.04

TOTAL NUMBER OF ADMISSIONS 883

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,884		100	3,710,294.16		277,528.84
ROUTINE NURSERY	147		0	144,203.64		34,530.36
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,031		100	3,854,497.80		312,059.20
SPECIAL CARE SERVICES						
CCU	773		0	1,763,117.00		0.00
ICU	154		0	580,820.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	927		0	2,343,937.00		0.00
TOTAL ACCOMODATIONS	3,958		100	6,198,434.80		312,059.20

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,277,020.81	46,892.59	OTHER LAB	120,108.27	3,489.64
MED/SURG SUPPLY	1,492,355.12	73,400.81	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,738,964.99	29,909.42	EDUCATION & TRAINING	1,438.97	0.00
RADIOLOGY-DIAGNOSTIC	384,726.48	5,098.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,143,375.93	4,861.56	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	40,135.45	629.39	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	308,182.55	581.11	MRI SERVICES	313,044.62	0.00
IV THERAPY	7,520.92	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,141,686.16	1,427.85	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	334,692.88	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,032,035.05	1,554.28	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	423,618.92	1,783.78	AMBULANCE	0.00	0.00
GI SERVICES	71,110.20	2,547.79	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,197,186.79	12,657.43	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	215,430.16	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	110,684.55	3,279.81	INJECTABLE DRUGS	6,174.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	10,104.24	335.08	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	16,957.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	287,630.53	31,296.59	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	35,244.29	672.76	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	101,122.13	0.00	IMPL DEV CHARGE PATIENTS	213,847.28	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	325,255.04	1,898.77			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	107,652.86	178,844.89			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	310,544.06	0.00			
AUDIOLOGY	19,793.70	0.00			
CARDIOLOGY	324,386.17	2,286.67			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	26,176.96	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	81,092.79	0.00			
			TOTAL ANCILLARY	21,219,300.83	403,448.82
			TOTAL ACCOMODATIONS	6,198,434.80	312,059.20
			TOTAL CHARGES	27,417,735.63	715,508.02

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 10:45:52  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	06/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:45:53  
Page: 4

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,219,264.67	ADJUSTMENTS	517,277.98
COVERED CHARGES	13,821,355.36	CONTRACTUAL ALLOW	11,375,282.72
NON-COVERD CHARGES	1,397,909.31	TOTAL MEDICAID LIAB	2,446,072.64
		LESS: COB	6,606.91
		LESS: COPAYMENT	2,289.00
		REIMBURSEMENT	2,437,176.73
		ALL OTHER	2,324,832.30
		FEE SCHEDULE-LAB	97,044.96
		INJECTABLE DRUGS	15,299.47

TOTAL NUMBER OF CLAIMS 3,769

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	435,179.65	16,507.14	OTHER LAB	144,116.34	0.00
MED/SURG SUPPLY	574,870.24	10,684.62	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	922,631.84	6,842.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,357,348.50	168,459.18	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	25,744.33	3,615.22	FEE SCHEDULE LAB	2,997,219.74	441,725.88
EKG/ECG	238,144.90	10,127.94	MRI SERVICES	454,155.41	19,308.17
IV THERAPY	497,465.74	111,937.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	485,977.35	181,139.14	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,029.93	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	41,716.94	21,438.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	434,694.01	0.00	AMBULANCE	0.00	0.00
GI SERVICES	271,744.47	17,852.40	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,873,569.85	22,364.46	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	110,457.36	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,762.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	388,974.87	211,148.91
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,072.54	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,174.28	612.61	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	2,292.79	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	8,905.26	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	46,668.25	0.00	IMPL DEV CHARGE PATIENTS	1,336.84	12,581.71
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	988,022.98	80,403.05			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,457.02	15,370.79			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	217,642.82	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	84,272.14	7,151.33			
AMBULATORY SURGERY	852.42	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,630.18	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	148,184.42	23,678.11			
			TOTAL ANCILLARY	13,821,355.36	1,397,909.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,821,355.36	1,397,909.31

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,255.08	ADJUSTMENTS	0.00
COVERED CHARGES	36,569.53	CONTRACTUAL ALLOW	22,397.44
NON-COVERD CHARGES	29,685.55	TOTAL MEDICAID LIAB	14,172.09
		LESS: COB	14,169.09
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	475.65	21.13	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,512.59	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,398.57	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,721.26	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,420.75	1,576.94
EKG/ECG	553.44	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	569.82	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	22,777.52	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,502.09	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,522.51	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,783.78	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	125.08	588.70
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,705.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	36,569.53	29,685.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	36,569.53	29,685.55

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: 07/23/2014  
Run Time: 10:46:39  
Page: 8

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	938,394.47	ADJUSTMENTS	1,518.30
COVERED CHARGES	889,570.56	CONTRACTUAL ALLOW	853,545.21
NON-COVERD CHARGES	48,823.91	TOTAL MEDICAID LIAB	36,025.35
		LESS: COB	0.00
		LESS: COPAYMENT	1,203.09
		REIMBURSEMENT	34,822.26
		TOTAL NUMBER OF CLAIMS	644



SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	22,470.82	0.00	OTHER LAB	4,772.94	0.00
MED/SURG SUPPLY	10,622.19	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,906.66	1,195.98	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,678.95	14,339.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	184,094.43	18,290.01
EKG/ECG	11,898.94	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	39,613.86	3,341.64	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,029.02	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	503,212.03	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	26,932.24	5,257.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	3,733.46	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	25,605.02	6,400.10			
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	889,570.56	48,823.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	889,570.56	48,823.91

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,909.84	ADJUSTMENTS	0.00
COVERED CHARGES	2,909.84	CONTRACTUAL ALLOW	1,664.14
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,245.70
		LESS: COB	1,245.70
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	188.41	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	378.85	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	303.31	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	2,039.27	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,909.84	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,909.84	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

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 06/01/12 THROUGH 12/31/12  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,796,881.58	ADJUSTMENTS	50,985.30
COVERED CHARGES	1,511,822.43	CONTRACTUAL ALLOW	1,293,130.84
NON-COVERD CHARGES	285,059.15	TOTAL MEDICAID LIAB	218,691.59
		LESS: COB	0.00
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	218,553.59

TOTAL NUMBER OF CLAIMS 43

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
 1170 CLEVELAND AVE  
 EAST POINT,GA 30344-3615

PROVIDER NUMBER  
 000001713A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 06/01/12 THROUGH 12/31/12  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	84,950.00	1,986.67	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	191,722.72	9,799.23	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,760.07	8,515.99	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	86,389.23	5,103.05	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	176,371.24	40,571.06
EKG/ECG	17,378.00	2,822.54	MRI SERVICES	11,514.84	6,384.57
IV THERAPY	10,714.59	4,661.85	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	404,879.98	64,847.63	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,710.61	1,491.37	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	169,729.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,518.35	7,833.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	54,545.76	0.00	DRUG-SPECIFIC/HOME IV	0.00	15,048.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	57,682.21	46,273.99
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	1,051.19	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,183.92	22,176.34
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,007.29	1,254.92			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,777.20	3,731.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	93,393.55	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	41,225.99	14,302.66			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,367.88	27,202.69			
			TOTAL ANCILLARY	1,511,822.43	285,059.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,511,822.43	285,059.15

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ATLANTA MEDICAL CENTER- SOUTH CAMPUS  
1170 CLEVELAND AVE  
EAST POINT,GA 30344-3615

PROVIDER NUMBER  
000001713A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	06/01/12	THROUGH	12/31/12
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTH GEORGIA MEDICAL CENTER  
 2501 N PATTERSON ST  
 VALDOSTA,GA 31602-1735

PROVIDER NUMBER 000001724A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	28,020,416.74	ADJUSTMENTS	1,531,946.60
COVERED CHARGES	26,901,700.61	CONTRACTUAL ALLOW	16,677,183.36
NON-COVERD CHARGES	1,118,716.13	TOTAL MEDICAID LIAB	10,224,517.25
		LESS: COB	122,743.93
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	10,101,773.32

TOTAL NUMBER OF ADMISSIONS 1,300

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5,193		1	3,134,460.00		708,832.00
ROUTINE NURSERY	289		0	162,510.00		10,790.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		2,010.00
TOTAL ROUTINE	5,482		1	3,296,970.00		721,632.00
SPECIAL CARE SERVICES						
CCU	137		0	203,730.00		0.00
ICU	916		0	1,360,071.50		0.00
NICU	71		0	95,850.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,124		0	1,659,651.50		0.00
TOTAL ACCOMODATIONS	6,606		1	4,956,621.50		721,632.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SOUTH GEORGIA MEDICAL CENTER  
 2501 N PATTERSON ST  
 VALDOSTA,GA 31602-1735

PROVIDER NUMBER  
 000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,972,672.86	3,985.25	OTHER LAB	107,769.00	0.00
MED/SURG SUPPLY	2,464,091.00	56,622.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,682,206.50	4,571.00	EDUCATION & TRAINING	16,479.00	1,576.00
RADIOLOGY-DIAGNOSTIC	319,944.25	0.00	OTHER THERAPEUTIC SVC	0.00	114.50
CT SCAN	1,109,253.00	7,061.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	117,732.50	174.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	261,701.00	0.00	MRI SERVICES	251,110.00	0.00
IV THERAPY	247,751.50	2,865.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,114,690.25	3,652.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	192,806.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,270,248.50	4,206.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	136,193.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	19,680.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	517,352.50	1,000.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	185,537.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	78,727.25	0.00	INJECTABLE DRUGS	1,593,616.00	0.00
RADIOLOGY THERAPEUTIC	101,194.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	25,630.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	36,444.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	119,121.50	6,956.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	27,220.50	916.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	46,305.00	2,506.00	IMPL DEV CHARGE PATIENTS	1,026,571.50	0.00
LITHOTRIPSY	38,755.50	0.00	NO CC/INVALID REV CODE	0.00	1,824.00
OTHER IMAGING SERVICE	110,832.25	19,322.00			
BLOOD	342,713.50	1,367.00			
BLOOD STORAGE & PRO.	20,536.50	264,477.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,298.00	1,749.50			
AUDIOLOGY	11,788.00	0.00			
CARDIOLOGY	647,098.50	1,507.50			
AMBULATORY SURGERY	253,807.25	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	29,555.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	386,645.00	10,629.75			
			TOTAL ANCILLARY	21,945,079.11	397,084.13
			TOTAL ACCOMODATIONS	4,956,621.50	721,632.00
			TOTAL CHARGES	26,901,700.61	1,118,716.13



Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 11:17:46  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012300065449	10/17/12 - 10/19/12	10/29/12	0.00	1,824.00	0.00	0.00	0.00
TOTAL				0.00	1,824.00	0.00	0.00	0.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	683,705.61	ADJUSTMENTS	0.00
COVERED CHARGES	659,227.61	CONTRACTUAL ALLOW	156,324.31
NON-COVERD CHARGES	24,478.00	TOTAL MEDICAID LIAB	502,903.30
		LESS: COB	502,903.30
		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	124		0	75,090.00		17,700.00
ROUTINE NURSERY	8		0	4,640.00		600.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	132		0	79,730.00		18,300.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	7		0	10,430.00		0.00
NICU	7		0	9,450.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	14		0	19,880.00		0.00
TOTAL ACCOMODATIONS	146		0	99,610.00		18,300.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	102,634.36	0.00	OTHER LAB	1,988.50	0.00
MED/SURG SUPPLY	67,402.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	51,871.50	0.00	EDUCATION & TRAINING	171.00	0.00
RADIOLOGY-DIAGNOSTIC	9,422.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	21,188.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,841.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,030.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	550.00
OPERATING ROOM	46,201.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	12,379.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	7,623.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,480.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,166.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,652.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,004.50	0.00	INJECTABLE DRUGS	52,705.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	276.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	17,390.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	767.50	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	567.00	0.00	IMPL DEV CHARGE PATIENTS	71,659.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,202.00	0.00			
BLOOD	6,404.00	0.00			
BLOOD STORAGE & PRO.	352.00	5,628.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	447.50	0.00			
CARDIOLOGY	30,188.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	443.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	20,160.00	0.00			
			TOTAL ANCILLARY	559,617.61	6,178.00
			TOTAL ACCOMODATIONS	99,610.00	18,300.00
			TOTAL CHARGES	659,227.61	24,478.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:18:18  
Page: 6

SOUTH GEORGIA MEDICAL CENTER  
2501 N PATTERSON ST  
VALDOSTA,GA 31602-1735

PROVIDER NUMBER  
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,190,112.36	ADJUSTMENTS	639,962.98
COVERED CHARGES	15,578,043.52	CONTRACTUAL ALLOW	11,242,105.06
NON-COVERD CHARGES	1,612,068.84	TOTAL MEDICAID LIAB	4,335,938.46
		LESS: COB	3,677.89
		LESS: COPAYMENT	11,893.30
		REIMBURSEMENT	4,320,367.27
		ALL OTHER	3,643,949.32
		FEE SCHEDULE-LAB	324,200.65
		INJECTABLE DRUGS	352,217.30

TOTAL NUMBER OF CLAIMS 9,697

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,777,307.63	2,194.00	OTHER LAB	104,863.50	1,358.00
MED/SURG SUPPLY	1,030,489.50	6,215.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	263.25	EDUCATION & TRAINING	1,721.50	1,321.00
RADIOLOGY-DIAGNOSTIC	559,151.00	18,551.00	OTHER THERAPEUTIC SVC	0.00	215.00
CT SCAN	1,787,549.50	107,075.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,216.00	FEE SCHEDULE LAB	1,638,787.50	408,526.25
EKG/ECG	166,007.00	14,392.50	MRI SERVICES	265,290.00	20,117.50
IV THERAPY	585,188.00	53,324.50	PROFESSIONAL FEES	0.00	465.00
OPERATING ROOM	973,916.39	156,811.09	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	112,814.75	18,942.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	233,316.00	1,906.00	AMBULANCE	0.00	0.00
GI SERVICES	12,513.00	666.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,257,305.25	4,256.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	364,292.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,220,553.00	332,284.00
RADIOLOGY THERAPEUTIC	445,643.50	2,259.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	663.50	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	466.00	2,989.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	91,842.00	12,036.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	29,714.00	1,831.50	IMPL DEV CHARGE PATIENTS	90,781.50	220,315.50
LITHOTRIPSY	77,511.00	0.00	NO CC/INVALID REV CODE	0.00	246.00
OTHER IMAGING SERVICE	416,980.00	27,451.50			
BLOOD	71,093.50	0.00			
BLOOD STORAGE & PRO.	3,341.00	64,305.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	113,961.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	255,517.50	66,052.50			
AMBULATORY SURGERY	277,746.50	49,061.50			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	56,576.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	555,804.50	13,756.50			
			TOTAL ANCILLARY	15,578,043.52	1,612,068.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,578,043.52	1,612,068.84

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:18:18  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5913154000038	05/01/13 - 05/01/13	06/10/13	0.00	61.50	0.00	0.00	0.00
780	2013154023173	05/01/13 - 05/01/13	06/10/13	0.00	61.50	0.00	0.00	0.00
780	2013176038683	05/20/13 - 05/20/13	07/01/13	0.00	61.50	0.00	0.00	0.00
780	2013178050116	05/15/13 - 05/15/13	07/01/13	0.00	61.50	0.00	0.00	0.00
TOTAL				0.00	246.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SOUTH GEORGIA MEDICAL CENTER  
2501 N PATTERSON ST  
VALDOSTA,GA 31602-1735

PROVIDER NUMBER  
000001724A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	126,537.50	ADJUSTMENTS	0.00
COVERED CHARGES	100,794.25	CONTRACTUAL ALLOW	21,028.58
NON-COVERD CHARGES	25,743.25	TOTAL MEDICAID LIAB	79,765.67
		LESS: COB	79,669.67
		LESS: COPAYMENT	96.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 80

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,797.00	646.50	OTHER LAB	780.00	0.00
MED/SURG SUPPLY	6,260.00	412.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	87.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,188.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,764.50	9,933.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,031.75	2,291.75
EKG/ECG	606.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,154.50	80.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,770.00	5,917.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	210.00	70.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,342.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,375.50	623.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,269.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,027.50	996.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	196.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,620.00
LITHOTRIPSY	25,837.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,976.00	331.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	724.50	109.50			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	1,529.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,679.50	900.50			
			TOTAL ANCILLARY	100,794.25	25,743.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	100,794.25	25,743.25



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	815,617.39	ADJUSTMENTS	1,686.14
COVERED CHARGES	764,314.89	CONTRACTUAL ALLOW	703,396.23
NON-COVERD CHARGES	51,302.50	TOTAL MEDICAID LIAB	60,918.66
		LESS: COB	47.77
		LESS: COPAYMENT	1,866.10
		REIMBURSEMENT	59,004.79
		TOTAL NUMBER OF CLAIMS	1,089

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,703.64	0.00	OTHER LAB	10,075.00	0.00
MED/SURG SUPPLY	39,547.75	408.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	61.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	61,757.00	380.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	73,659.00	11,097.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	129,180.75	29,533.00
EKG/ECG	10,605.00	606.00	MRI SERVICES	0.00	0.00
IV THERAPY	42,347.50	2,937.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,450.00	747.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	307,627.00	346.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,016.25	872.50
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	323.00	155.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	246.00
OTHER IMAGING SERVICE	21,006.00	2,754.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	738.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,158.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,279.00	0.00			
			TOTAL ANCILLARY	764,314.89	51,302.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	764,314.89	51,302.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013142062130	05/14/13 - 05/14/13	05/27/13	0.00	61.50	0.00	0.00	0.00
780	2013171061043	05/20/13 - 05/20/13	06/24/13	0.00	61.50	0.00	0.00	0.00
780	2013179058598	04/26/13 - 04/26/13	07/01/13	0.00	61.50	0.00	0.00	0.00
780	2013205074523	06/11/13 - 06/11/13	07/29/13	0.00	61.50	0.00	0.00	0.00
TOTAL				0.00	246.00	0.00	0.00	0.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,452.75	ADJUSTMENTS	0.00
COVERED CHARGES	6,058.25	CONTRACTUAL ALLOW	987.49
NON-COVERD CHARGES	1,394.50	TOTAL MEDICAID LIAB	5,070.76
		LESS: COB	5,070.76
		LESS: COPAYMENT	0.00
		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: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	382.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	461.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	153.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,220.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,200.50	174.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	163.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,258.50	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	19.50	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	420.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,058.25	1,394.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,058.25	1,394.50

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,929,437.09	ADJUSTMENTS	131,220.00
COVERED CHARGES	2,758,202.14	CONTRACTUAL ALLOW	2,225,106.20
NON-COVERD CHARGES	171,234.95	TOTAL MEDICAID LIAB	533,095.94
		LESS: COB	0.00
		LESS: COPAYMENT	1,509.76
		REIMBURSEMENT	531,586.18
		TOTAL NUMBER OF CLAIMS	105

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	338,309.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	92,083.50	4,183.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	108.50	48.50
RADIOLOGY-DIAGNOSTIC	15,471.50	153.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	40,092.50	1,220.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,496.25	5,363.95
EKG/ECG	4,090.50	1,212.00	MRI SERVICES	0.00	0.00
IV THERAPY	116,396.00	1,349.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	80,995.50	23,303.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,324.25	1,083.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,042.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,964.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,237.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,052,404.00	78,721.00
RADIOLOGY THERAPEUTIC	381,581.00	1,994.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	405,572.00	24,092.50
LITHOTRIPSY	38,755.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,830.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	686.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	30,475.00	28,510.50			
AMBULATORY SURGERY	7,765.50	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	42,520.50	0.00			
			TOTAL ANCILLARY	2,758,202.14	171,234.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,758,202.14	171,234.95

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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SOUTH GEORGIA MEDICAL CENTER  
2501 N PATTERSON ST  
VALDOSTA,GA 31602-1735

PROVIDER NUMBER  
000001724A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:46:56  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
 4280 N VALDOSTA ROAD  
 VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
 000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,617,378.62	ADJUSTMENTS	85,388.67
COVERED CHARGES	1,558,722.37	CONTRACTUAL ALLOW	927,478.44
NON-COVERD CHARGES	58,656.25	TOTAL MEDICAID LIAB	631,243.93
		LESS: COB	7,846.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	623,397.33

TOTAL NUMBER OF ADMISSIONS 141

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	313		0	187,800.00		32,290.00
ROUTINE NURSERY	102		0	56,296.00		920.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	415		0	244,096.00		33,210.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	37		0	52,670.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	37		0	52,670.00		0.00
TOTAL ACCOMODATIONS	452		0	296,766.00		33,210.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
 4280 N VALDOSTA ROAD  
 VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
 000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	214,020.37	1,162.75	OTHER LAB	5,384.00	0.00
MED/SURG SUPPLY	140,347.00	1,782.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	174,674.50	407.00	EDUCATION & TRAINING	1,131.50	48.50
RADIOLOGY-DIAGNOSTIC	14,991.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	73,091.00	2,859.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	9,426.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,943.50	0.00	MRI SERVICES	6,129.50	0.00
IV THERAPY	1,729.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	90,885.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	23,892.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	33,856.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,671.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	23,772.25	89.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,205.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,185.50	0.00	INJECTABLE DRUGS	149,524.25	0.00
RADIOLOGY THERAPEUTIC	590.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,271.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,215.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	11,303.50	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,300.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	152,241.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,824.00
OTHER IMAGING SERVICE	11,392.00	0.00			
BLOOD	9,638.50	0.00			
BLOOD STORAGE & PRO.	528.00	17,274.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,902.00	0.00			
AUDIOLOGY	1,879.50	0.00			
CARDIOLOGY	18,455.00	0.00			
AMBULATORY SURGERY	8,719.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	23,660.50	0.00			
			TOTAL ANCILLARY	1,261,956.37	25,446.25
			TOTAL ACCOMODATIONS	296,766.00	33,210.00
			TOTAL CHARGES	1,558,722.37	58,656.25

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 10:46:56  
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HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
4280 N VALDOSTA ROAD  
VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013112018965	04/06/13 - 04/10/13	04/29/13	0.00	1,824.00	0.00	0.00	0.00
TOTAL				0.00	1,824.00	0.00	0.00	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
 4280 N VALDOSTA ROAD  
 VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
 000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	66,311.00	ADJUSTMENTS	0.00
COVERED CHARGES	64,980.50	CONTRACTUAL ALLOW	17,406.21
NON-COVERD CHARGES	1,330.50	TOTAL MEDICAID LIAB	47,574.29
		LESS: COB	47,574.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 5

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	6,000.00		1,040.00
ROUTINE NURSERY	2		0	1,100.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	12		0	7,100.00		1,040.00
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	12		0	7,100.00		1,040.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
 4280 N VALDOSTA ROAD  
 VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
 000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,461.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,765.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,808.50	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	529.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	151.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,586.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,580.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,041.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,528.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,574.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	606.00	0.00	INJECTABLE DRUGS	917.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	150.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	18,464.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	290.50
OTHER IMAGING SERVICE	427.50	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	89.50	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,000.00	0.00			
			TOTAL ANCILLARY	57,880.50	290.50
			TOTAL ACCOMODATIONS	7,100.00	1,040.00
			TOTAL CHARGES	64,980.50	1,330.50

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
4280 N VALDOSTA ROAD  
VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213231005340	07/15/13 - 07/17/13	08/26/13	0.00	290.50	0.00	6,039.91	0.00
TOTAL				0.00	290.50	0.00	6,039.91	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: 07/23/2014  
Run Time: 10:46:59  
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HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
4280 N VALDOSTA ROAD  
VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,896,620.47	ADJUSTMENTS	73,140.42
COVERED CHARGES	1,724,265.97	CONTRACTUAL ALLOW	1,215,494.86
NON-COVERD CHARGES	172,354.50	TOTAL MEDICAID LIAB	508,771.11
		LESS: COB	266.73
		LESS: COPAYMENT	1,191.00
		REIMBURSEMENT	507,313.38
		ALL OTHER	471,042.08
		FEE SCHEDULE-LAB	34,948.54
		INJECTABLE DRUGS	1,322.76

TOTAL NUMBER OF CLAIMS 1,483

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
 4280 N VALDOSTA ROAD  
 VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
 000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	143,838.72	5,529.25	OTHER LAB	8,018.00	0.00
MED/SURG SUPPLY	139,242.50	434.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	180.00	0.00
RADIOLOGY-DIAGNOSTIC	101,176.25	1,064.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	119,404.00	23,274.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,996.00	FEE SCHEDULE LAB	174,301.75	29,903.75
EKG/ECG	14,130.00	454.50	MRI SERVICES	32,666.00	2,880.00
IV THERAPY	53,247.75	4,803.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	373,246.25	74,396.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,333.50	770.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	71,944.50	600.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	184,700.50	1,112.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	92,247.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	29,434.75	705.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,256.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	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	610.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	31,448.50	0.00
LITHOTRIPSY	12,918.50	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	41,216.50	6,730.50			
BLOOD	3,591.00	0.00			
BLOOD STORAGE & PRO.	198.00	4,286.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,062.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	11,585.00	1,158.50			
AMBULATORY SURGERY	15,231.00	8,578.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,529.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	54,972.50	1,811.50			
			TOTAL ANCILLARY	1,724,265.97	172,354.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,724,265.97	172,354.50



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: 07/23/2014  
Run Time: 10:47:23  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
4280 N VALDOSTA ROAD  
VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,062.25	ADJUSTMENTS	0.00
COVERED CHARGES	10,162.75	CONTRACTUAL ALLOW	3,552.25
NON-COVERD CHARGES	899.50	TOTAL MEDICAID LIAB	6,610.50
		LESS: COB	6,610.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 8

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
 4280 N VALDOSTA ROAD  
 VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
 000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	880.00	82.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,191.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	278.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	176.00	FEE SCHEDULE LAB	1,169.50	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	1,203.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,008.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,260.00	178.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	892.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	112.50	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	67.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,009.00	439.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,090.50	0.00			
			TOTAL ANCILLARY	10,162.75	899.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,162.75	899.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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Page: 11

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
4280 N VALDOSTA ROAD  
VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	125,863.89	ADJUSTMENTS	647.28
COVERED CHARGES	119,065.89	CONTRACTUAL ALLOW	105,919.99
NON-COVERD CHARGES	6,798.00	TOTAL MEDICAID LIAB	13,145.90
		LESS: COB	0.00
		LESS: COPAYMENT	525.06
		REIMBURSEMENT	12,620.84
		TOTAL NUMBER OF CLAIMS	235

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
 4280 N VALDOSTA ROAD  
 VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
 000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,126.64	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,136.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,054.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,776.00	3,746.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,711.00	1,338.50
EKG/ECG	1,212.00	0.00	MRI SERVICES	1,919.50	0.00
IV THERAPY	11,078.00	937.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	420.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	57,516.50	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	5,050.25	239.50
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	6,338.00	420.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	727.50	0.00			
			TOTAL ANCILLARY	119,065.89	6,798.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	119,065.89	6,798.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
4280 N VALDOSTA ROAD  
VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	878.75	ADJUSTMENTS	0.00
COVERED CHARGES	770.25	CONTRACTUAL ALLOW	767.25
NON-COVERD CHARGES	108.50	TOTAL MEDICAID LIAB	3.00
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
 4280 N VALDOSTA ROAD  
 VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
 000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 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	108.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	183.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	178.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	350.50	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	58.25	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	770.25	108.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	770.25	108.50

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
4280 N VALDOSTA ROAD  
VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	136,299.00	ADJUSTMENTS	10,174.00
COVERED CHARGES	125,834.75	CONTRACTUAL ALLOW	95,303.75
NON-COVERD CHARGES	10,464.25	TOTAL MEDICAID LIAB	30,531.00
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	30,516.00
		TOTAL NUMBER OF CLAIMS	6

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
 4280 N VALDOSTA ROAD  
 VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
 000001724G

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,286.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	14,498.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,670.25	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	562.50	20.00
EKG/ECG	303.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,196.00	10,444.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	70.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,711.50	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	6,700.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	661.25	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	55,175.50	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	125,834.75	10,464.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	125,834.75	10,464.25



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HOSPITAL AUTHORITY OF VALDOSTA AND LOWNDES COUNTY  
4280 N VALDOSTA ROAD  
VALDOSTA,GA 31602-6814

PROVIDER NUMBER  
000001724G

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 08:59:49  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,429,724.33	ADJUSTMENTS	117,368.62
COVERED CHARGES	18,324,491.08	CONTRACTUAL ALLOW	11,494,594.83
NON-COVERD CHARGES	2,105,233.25	TOTAL MEDICAID LIAB	6,829,896.25
		LESS: COB	62,155.05
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,767,741.20

TOTAL NUMBER OF ADMISSIONS 1,043

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	6,834		6	4,030,360.00		2,052,010.00
ROUTINE NURSERY	25		1	13,790.00		774.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6,859		7	4,044,150.00		2,052,784.00
SPECIAL CARE SERVICES						
CCU	104		0	137,800.00		0.00
ICU	436		0	577,700.00		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	540		0	715,500.00		0.00
TOTAL ACCOMODATIONS	7,399		7	4,759,650.00		2,052,784.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,307,611.24	0.00	OTHER LAB	40,959.75	0.00
MED/SURG SUPPLY	1,300,585.39	1,462.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,322,103.70	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	216,554.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	416,070.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	143,764.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	146,919.00	0.00	MRI SERVICES	178,244.25	0.00
IV THERAPY	77,793.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,418,259.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	62,218.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	617,288.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	360,322.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	130,493.25	3,939.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	400,738.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	75,821.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	168,041.85	0.00	INJECTABLE DRUGS	20,520.10	0.00
RADIOLOGY THERAPEUTIC	182.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	72,237.50	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	46,200.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	35,397.75	24,940.75	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	76.00	1,490.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,069,757.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	39,949.25	3,997.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	164,969.75	7,339.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	48,232.50	9,279.00			
AUDIOLOGY	4,508.00	0.00			
CARDIOLOGY	585,650.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,777.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	72,594.80	0.00			
			TOTAL ANCILLARY	13,564,841.08	52,449.25
			TOTAL ACCOMODATIONS	4,759,650.00	2,052,784.00
			TOTAL CHARGES	18,324,491.08	2,105,233.25

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	172,882.34	ADJUSTMENTS	0.00
COVERED CHARGES	154,882.34	CONTRACTUAL ALLOW	67,019.90
NON-COVERD CHARGES	18,000.00	TOTAL MEDICAID LIAB	87,862.44
		LESS: COB	87,862.44
		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	67		0	39,530.00		18,000.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	67		0	39,530.00		18,000.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	4		0	5,300.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	4		0	5,300.00		0.00
TOTAL ACCOMODATIONS	71		0	44,830.00		18,000.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	48,124.34	0.00	OTHER LAB	543.75	0.00
MED/SURG SUPPLY	7,710.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,719.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,655.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,057.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,168.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,166.00	0.00	MRI SERVICES	2,027.50	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,335.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	273.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,969.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,959.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	1,164.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	212.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,035.50	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	684.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,046.25	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,145.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,056.00	0.00			
			TOTAL ANCILLARY	110,052.34	0.00
			TOTAL ACCOMODATIONS	44,830.00	18,000.00
			TOTAL CHARGES	154,882.34	18,000.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:00:09  
Page: 5

ST FRANCIS HOSPITAL, INC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,873,651.97	ADJUSTMENTS	226,862.04
COVERED CHARGES	6,338,028.78	CONTRACTUAL ALLOW	4,821,395.38
NON-COVERD CHARGES	535,623.19	TOTAL MEDICAID LIAB	1,516,633.40
		LESS: COB	6,088.79
		LESS: COPAYMENT	4,774.63
		REIMBURSEMENT	1,505,769.98
		ALL OTHER	1,388,060.54
		FEE SCHEDULE-LAB	115,841.83
		INJECTABLE DRUGS	1,867.61
		TOTAL NUMBER OF CLAIMS	4,188

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	396,343.66	957.59	OTHER LAB	20,142.50	520.00
MED/SURG SUPPLY	458,052.50	1,339.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	298.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	262,014.75	5,229.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	440,386.25	15,078.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	52,324.75	15,700.50	FEE SCHEDULE LAB	991,082.08	179,243.33
EKG/ECG	127,841.75	2,332.00	MRI SERVICES	171,736.50	3,002.25
IV THERAPY	85,166.25	5,559.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	855,919.48	104,404.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,340.25	9,013.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	171,275.50	279.50	AMBULANCE	0.00	0.00
GI SERVICES	92,818.13	984.87	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,140,592.06	52,217.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	77,143.25	0.00	DRUG-SPECIFIC/HOME IV	8,577.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	16,644.25	28,222.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	8,151.75	1,947.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,179.25	1,891.25	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,333.75	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	61,259.00	1,520.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	52.00	208.00	IMPL DEV CHARGE PATIENTS	46,410.00	1,632.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	164.50
OTHER IMAGING SERVICE	106,123.13	6,718.37			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,844.00	2,705.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	58,864.75	20,177.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	445,681.75	63,751.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	85,051.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	47,011.24	9,192.00			
			TOTAL ANCILLARY	6,338,028.78	535,623.19
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,338,028.78	535,623.19

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: 07/23/2014  
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ST FRANCIS HOSPITAL, INC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8005	5914007001378	09/19/13 - 09/19/13	01/13/14	0.00	164.50	0.00	0.00	0.00
TOTAL				0.00	164.50	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST FRANCIS HOSPITAL, INC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	230,210.76	ADJUSTMENTS	0.00
COVERED CHARGES	120,342.36	CONTRACTUAL ALLOW	37,384.88
NON-COVERD CHARGES	109,868.40	TOTAL MEDICAID LIAB	82,957.48
		LESS: COB	82,786.48
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 90

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,087.19	157.75	OTHER LAB	722.00	0.00
MED/SURG SUPPLY	16,441.25	116.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,016.00	121.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,247.00	10,394.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	212.75	FEE SCHEDULE LAB	18,389.24	3,834.50
EKG/ECG	3,166.00	0.00	MRI SERVICES	2,514.25	0.00
IV THERAPY	2,061.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,722.50	32,769.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	915.00	31,990.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,266.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,241.50	1,969.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	19,974.93	416.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,606.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	8,909.25
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	639.00	6,858.15
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	377.75	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	5,663.75	281.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,971.50	615.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,605.75	522.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,202.25	840.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	9,482.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,120.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,770.25	0.00			
			TOTAL ANCILLARY	120,342.36	109,868.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	120,342.36	109,868.40

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER 000001768A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	249,993.86	ADJUSTMENTS	382.58
COVERED CHARGES	238,335.11	CONTRACTUAL ALLOW	215,399.71
NON-COVERD CHARGES	11,658.75	TOTAL MEDICAID LIAB	22,935.40
		LESS: COB	41.09
		LESS: COPAYMENT	828.01
		REIMBURSEMENT	22,066.30
		TOTAL NUMBER OF CLAIMS	410

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,565.61	0.00	OTHER LAB	399.50	0.00
MED/SURG SUPPLY	5,597.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,949.75	121.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,320.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	320.25	86.50	FEE SCHEDULE LAB	53,242.25	10,173.00
EKG/ECG	3,789.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,042.50	264.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,706.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	119.75	318.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	637.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	130,834.75	334.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	476.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	100.00	200.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,004.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,229.25	160.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	238,335.11	11,658.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	238,335.11	11,658.75

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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ST FRANCIS HOSPITAL, INC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,037.23	ADJUSTMENTS	0.00
COVERED CHARGES	1,037.23	CONTRACTUAL ALLOW	527.84
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	509.39
		LESS: COB	509.39
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:00:59  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 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	376.50	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	660.73	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,037.23	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,037.23	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 09:01:00  
Page: 14

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,522,966.81	ADJUSTMENTS	146,200.77
COVERED CHARGES	2,377,579.33	CONTRACTUAL ALLOW	2,139,720.22
NON-COVERD CHARGES	145,387.48	TOTAL MEDICAID LIAB	237,859.11
		LESS: COB	0.00
		LESS: COPAYMENT	258.00
		REIMBURSEMENT	237,601.11

TOTAL NUMBER OF CLAIMS 47

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC  
 2122 MANCHESTER EXPY  
 COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
 000001768A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	189,244.39	100.00	OTHER LAB	0.00	27.00
MED/SURG SUPPLY	189,686.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,433.25	11,938.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,706.75	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,098.56	FEE SCHEDULE LAB	28,520.49	10,590.17
EKG/ECG	1,603.25	3,352.25	MRI SERVICES	0.00	0.00
IV THERAPY	7,413.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	759,747.41	22,262.47	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,554.00	402.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	37,403.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	370.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,143.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,400.00	1,700.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	838.03	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	817,334.25	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	607.50	202.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	202,848.62	79,620.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	118,564.17	13,255.50			
			TOTAL ANCILLARY	2,377,579.33	145,387.48
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,377,579.33	145,387.48



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: 07/23/2014  
Run Time: 09:01:02  
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST FRANCIS HOSPITAL, INC  
2122 MANCHESTER EXPY  
COLUMBUS,GA 31904-6878

PROVIDER NUMBER  
000001768A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,437,823.35	ADJUSTMENTS	44,373.63
COVERED CHARGES	5,362,340.20	CONTRACTUAL ALLOW	4,002,180.95
NON-COVERD CHARGES	75,483.15	TOTAL MEDICAID LIAB	1,360,159.25
		LESS: COB	4,022.55
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,356,136.70

TOTAL NUMBER OF ADMISSIONS 187

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	311		0	384,587.00		38,627.00
ROUTINE NURSERY	47		5	35,092.00		5,234.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	358		5	419,679.00		43,861.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	195		0	351,040.00		0.00
NICU	58		0	121,193.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	253		0	472,233.00		0.00
TOTAL ACCOMODATIONS	611		5	891,912.00		43,861.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

TRINITY HOSPITAL OF AUGUSTA  
 2260 WRIGHTSBORO RD  
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER  
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	546,779.74	0.00	OTHER LAB	13,253.65	0.00
MED/SURG SUPPLY	861,873.91	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	284,536.67	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	58,942.76	1,476.91	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	53,544.88	2,295.39	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	20,910.30	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,368.75	0.00	MRI SERVICES	8,378.95	0.00
IV THERAPY	4,784.15	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	780,789.01	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	242,468.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	162,481.13	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	340,423.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	21,491.77	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	244,726.33	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	161,477.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	20,213.38	0.00	INJECTABLE DRUGS	26,405.71	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,025.61	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	30,169.21	21,390.10	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	132.51	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	372,598.43	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,482.29	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	38,283.50	1,526.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	9,747.81	4,933.25			
AUDIOLOGY	13,980.85	0.00			
CARDIOLOGY	97,817.23	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,341.90	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	24,998.81	0.00			
			TOTAL ANCILLARY	4,470,428.20	31,622.15
			TOTAL ACCOMODATIONS	891,912.00	43,861.00
			TOTAL CHARGES	5,362,340.20	75,483.15

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:13:46  
 Page: 3

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	34,936.92	ADJUSTMENTS	0.00
COVERED CHARGES	34,384.92	CONTRACTUAL ALLOW	27,376.31
NON-COVERD CHARGES	552.00	TOTAL MEDICAID LIAB	7,008.61
		LESS: COB	7,008.61
		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	4,868.00		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	4		0	4,868.00		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	4		0	4,868.00		552.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

TRINITY HOSPITAL OF AUGUSTA  
 2260 WRIGHTSBORO RD  
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER  
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,768.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	681.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,788.25	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	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	19,377.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	1,245.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	142.71	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	513.73	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	29,516.92	0.00
			TOTAL ACCOMODATIONS	4,868.00	552.00
			TOTAL CHARGES	34,384.92	552.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:13:47  
Page: 5

TRINITY HOSPITAL OF AUGUSTA  
2260 WRIGHTSBORO RD  
AUGUSTA,GA 30904-4764

PROVIDER NUMBER  
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,072,149.70	ADJUSTMENTS	467,798.05
COVERED CHARGES	5,710,087.65	CONTRACTUAL ALLOW	4,501,838.58
NON-COVERD CHARGES	362,062.05	TOTAL MEDICAID LIAB	1,208,249.07
		LESS: COB	9,356.67
		LESS: COPAYMENT	2,616.00
		REIMBURSEMENT	1,196,276.40
		ALL OTHER	1,131,412.61
		FEE SCHEDULE-LAB	57,922.16
		INJECTABLE DRUGS	6,941.63
		TOTAL NUMBER OF CLAIMS	2,368

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	128,699.64	11,274.31	OTHER LAB	162,765.63	0.00
MED/SURG SUPPLY	98,438.21	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	172,936.88	10,395.89	OTHER THERAPEUTIC SVC	271,136.47	3,480.05
CT SCAN	170,880.53	48,271.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,478.14	845.93	FEE SCHEDULE LAB	459,878.85	61,205.02
EKG/ECG	42,796.18	3,678.46	MRI SERVICES	20,559.53	0.00
IV THERAPY	268,254.40	27,814.38	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	591,591.44	76,071.77	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,815.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	19,794.35	1,272.07	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	543,096.92	0.00	AMBULANCE	0.00	0.00
GI SERVICES	418,920.88	49,774.22	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,198,561.52	18,191.21	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	413,528.31	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	136,026.25	9,121.61
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	25,070.72	1,754.84	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	60,433.11	24,858.41
LITHOTRIPSY	15,153.01	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	138,254.16	4,855.43			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	829.57	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	52,018.79	1,795.26			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	155,806.74	0.00			
AMBULATORY SURGERY	13,636.20	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	118,726.22	7,401.64			
			TOTAL ANCILLARY	5,710,087.65	362,062.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,710,087.65	362,062.05

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	73,375.99	ADJUSTMENTS	0.00
COVERED CHARGES	59,449.97	CONTRACTUAL ALLOW	31,413.14
NON-COVERD CHARGES	13,926.02	TOTAL MEDICAID LIAB	28,036.83
		LESS: COB	28,020.72
		LESS: COPAYMENT	16.11
		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

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	525.72	387.77	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	5,521.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,444.01	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,046.21	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,220.41	84.03
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,473.58	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,343.78	3,300.18	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	308.38	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	9,141.57	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,575.04	6,390.80	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,257.77	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,417.70	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,574.46	243.23
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	2,473.80
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	337.69	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	308.00	0.00			
			TOTAL ANCILLARY	59,449.97	13,926.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,449.97	13,926.02

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

Run Date: 07/23/2014  
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Page: 9

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	226,131.98	ADJUSTMENTS	1,073.79
COVERED CHARGES	223,158.25	CONTRACTUAL ALLOW	208,893.55
NON-COVERD CHARGES	2,973.73	TOTAL MEDICAID LIAB	14,264.70
		LESS: COB	0.00
		LESS: COPAYMENT	435.01
		REIMBURSEMENT	13,829.69
		TOTAL NUMBER OF CLAIMS	255

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

TRINITY HOSPITAL OF AUGUSTA  
 2260 WRIGHTSBORO RD  
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER  
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,457.56	284.58	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,609.42	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	11,101.92	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	16,769.96	798.82
EKG/ECG	1,058.96	0.00	MRI SERVICES	1,942.66	0.00
IV THERAPY	9,770.65	1,766.48	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,042.63	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	167,409.66	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	2,656.85	123.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	132.51	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,205.47	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	223,158.25	2,973.73
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	223,158.25	2,973.73

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TRINITY HOSPITAL OF AUGUSTA  
2260 WRIGHTSBORO RD  
AUGUSTA,GA 30904-4764

PROVIDER NUMBER  
000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,533.41	ADJUSTMENTS	0.00
COVERED CHARGES	14,553.88	CONTRACTUAL ALLOW	13,085.32
NON-COVERD CHARGES	4,979.53	TOTAL MEDICAID LIAB	1,468.56
		LESS: COB	1,456.56
		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

Run Date: 07/23/2014  
 Run Time: 09:14:49  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TRINITY HOSPITAL OF AUGUSTA  
 2260 WRIGHTSBORO RD  
 AUGUSTA,GA 30904-4764

PROVIDER NUMBER  
 000001779A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	387.05	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	260.84	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	996.39	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	448.06	FEE SCHEDULE LAB	1,586.59	1,684.93
EKG/ECG	210.75	0.00	MRI SERVICES	0.00	1,850.15
IV THERAPY	1,006.17	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	13.46	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,643.21	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	743.81	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,702.00	0.00			
			TOTAL ANCILLARY	14,553.88	4,979.53
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,553.88	4,979.53

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,839,564.07	ADJUSTMENTS	175,656.02
COVERED CHARGES	1,631,270.23	CONTRACTUAL ALLOW	1,439,979.49
NON-COVERD CHARGES	208,293.84	TOTAL MEDICAID LIAB	191,290.74
		LESS: COB	0.00
		LESS: COPAYMENT	130.66
		REIMBURSEMENT	191,160.08

TOTAL NUMBER OF CLAIMS 37

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,596.43	1,861.20	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	94,254.95	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	141,259.78	4,933.37	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,028.24	2,092.44	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,400.10	9,077.46
EKG/ECG	3,060.34	2,695.26	MRI SERVICES	0.00	0.00
IV THERAPY	31,452.06	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	316,546.10	101,522.13	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	110,390.48	0.00	AMBULANCE	0.00	0.00
GI SERVICES	3,640.00	1.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,867.83	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	78,264.06	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,465.43	2,983.29
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	304,866.75	0.00
LITHOTRIPSY	15,153.01	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,468.35	442.74			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,153.96	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	381,231.86	82,684.95			
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	37,170.50	0.00			
			TOTAL ANCILLARY	1,631,270.23	208,293.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,631,270.23	208,293.84

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: 07/23/2014  
Run Time: 09:14:52  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 08:57:26  
 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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,985,479.89	ADJUSTMENTS	703,599.09
COVERED CHARGES	31,910,741.49	CONTRACTUAL ALLOW	24,107,183.19
NON-COVERD CHARGES	1,074,738.40	TOTAL MEDICAID LIAB	7,803,558.30
		LESS: COB	91,684.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,711,874.08

TOTAL NUMBER OF ADMISSIONS 563

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,505		0	1,250,930.00		51,035.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,505		0	1,250,930.00		51,035.00
SPECIAL CARE SERVICES						
CCU	360		0	1,055,160.00		0.00
ICU	2,344		0	4,240,925.00		8,793.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2,704		0	5,296,085.00		8,793.00
TOTAL ACCOMODATIONS	4,209		0	6,547,015.00		59,828.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,801,586.00	62,925.00	OTHER LAB	149,614.00	3,162.00
MED/SURG SUPPLY	1,840,388.44	22,207.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,762,856.00	30,968.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,142,858.00	12,605.00	OTHER THERAPEUTIC SVC	0.00	54,985.00
CT SCAN	927,943.00	24,238.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	328,837.00	8,299.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	86,552.00	0.00	MRI SERVICES	365,407.00	4,244.00
IV THERAPY	141,228.00	858.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,289,533.00	43,966.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,870.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,890,751.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	636,701.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	117,726.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	401,866.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	371,106.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	118,810.00	0.00	INJECTABLE DRUGS	3,148,543.00	288,745.00
RADIOLOGY THERAPEUTIC	48,690.00	792.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	151,612.00	4,260.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	151,548.00	5,474.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	220,039.00	22,230.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	642.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	2,092,603.05	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	147,634.00	502.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,009,661.00	289,234.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	100,710.00	135,216.00			
AUDIOLOGY	2,412.00	0.00			
CARDIOLOGY	761,206.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	103,524.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	46,270.00	0.00			
			TOTAL ANCILLARY	25,363,726.49	1,014,910.40
			TOTAL ACCOMODATIONS	6,547,015.00	59,828.00
			TOTAL CHARGES	31,910,741.49	1,074,738.40

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 08:57:45  
 Page: 3

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	101,495.00	ADJUSTMENTS	0.00
COVERED CHARGES	101,495.00	CONTRACTUAL ALLOW	80,878.37
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	20,616.63
		LESS: COB	20,616.63
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1		0	865.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1		0	865.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	3,522.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	3,522.00		0.00
TOTAL ACCOMODATIONS	4		0	4,387.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

ST JOSEPH'S HOSPITAL SAVANNAH  
 11705 MERCY BLVD  
 SAVANNAH,GA 31419-1711

PROVIDER NUMBER  
 000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	363.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,509.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	396.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	124.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	882.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	93,834.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	97,108.00	0.00
			TOTAL ACCOMODATIONS	4,387.00	0.00
			TOTAL CHARGES	101,495.00	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 08:57:46  
Page: 5

ST JOSEPH'S HOSPITAL SAVANNAH  
11705 MERCY BLVD  
SAVANNAH,GA 31419-1711

PROVIDER NUMBER  
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,916,984.09	ADJUSTMENTS	209,640.66
COVERED CHARGES	5,350,602.15	CONTRACTUAL ALLOW	4,230,368.65
NON-COVERD CHARGES	566,381.94	TOTAL MEDICAID LIAB	1,120,233.50
		LESS: COB	6,374.85
		LESS: COPAYMENT	1,584.00
		REIMBURSEMENT	1,112,274.65
		ALL OTHER	1,009,405.77
		FEE SCHEDULE-LAB	95,944.39
		INJECTABLE DRUGS	6,924.49
		TOTAL NUMBER OF CLAIMS	2,557

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	165,143.00	65,008.00	OTHER LAB	48,051.00	433.00
MED/SURG SUPPLY	204,839.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	460,402.00	31,318.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	589,979.00	39,561.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	53,001.00	26,621.00	FEE SCHEDULE LAB	646,368.20	145,495.90
EKG/ECG	51,564.00	1,612.00	MRI SERVICES	123,226.00	20,182.00
IV THERAPY	283,233.00	40,191.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	469,721.12	55,381.88	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	13,025.00	869.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	119,062.00	408.00	AMBULANCE	0.00	0.00
GI SERVICES	20,760.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	997,551.00	327.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	266,155.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	142,953.00	12,704.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,341.00	4,632.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,040.00	1,372.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,525.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	642.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	100,975.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	71,837.00	12,435.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,754.00	4,242.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	49,634.00	0.00			
AUDIOLOGY	120,803.00	25,135.00			
CARDIOLOGY	294,038.84	74,506.16			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,234.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	33,911.49	1,781.00			
			TOTAL ANCILLARY	5,350,602.15	566,381.94
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,350,602.15	566,381.94

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	77,405.00	ADJUSTMENTS	0.00
COVERED CHARGES	52,622.00	CONTRACTUAL ALLOW	30,509.22
NON-COVERD CHARGES	24,783.00	TOTAL MEDICAID LIAB	22,112.78
		LESS: COB	22,107.09
		LESS: COPAYMENT	5.69
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 32

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	774.00	223.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,140.00	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	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,359.00	12,993.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,759.00	1,493.00
EKG/ECG	868.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,408.00	595.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,467.00	2,406.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,091.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,320.00	150.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	397.00	753.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	3,635.00	6,170.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	52,622.00	24,783.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,622.00	24,783.00



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 08:58:47  
Page: 9

ST JOSEPH'S HOSPITAL SAVANNAH  
11705 MERCY BLVD  
SAVANNAH,GA 31419-1711

PROVIDER NUMBER  
000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	332,565.00	ADJUSTMENTS	1,347.49
COVERED CHARGES	323,740.00	CONTRACTUAL ALLOW	307,964.94
NON-COVERD CHARGES	8,825.00	TOTAL MEDICAID LIAB	15,775.06
		LESS: COB	0.00
		LESS: COPAYMENT	552.05
		REIMBURSEMENT	15,223.01
		TOTAL NUMBER OF CLAIMS	282

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 08:58:47  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

ST JOSEPH'S HOSPITAL SAVANNAH  
 11705 MERCY BLVD  
 SAVANNAH,GA 31419-1711

PROVIDER NUMBER  
 000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,998.00	721.00	OTHER LAB	1,964.00	0.00
MED/SURG SUPPLY	156.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	35,422.00	432.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,071.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	35,369.00	4,613.00
EKG/ECG	3,100.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	30,970.00	2,493.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,320.00	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	164,726.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,221.00	264.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,423.00	302.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	323,740.00	8,825.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	323,740.00	8,825.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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ST 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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,505.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,615.00	CONTRACTUAL ALLOW	876.88
NON-COVERD CHARGES	3,890.00	TOTAL MEDICAID LIAB	738.12
		LESS: COB	735.12
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	3,875.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	197.00	15.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,090.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	50.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	278.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,615.00	3,890.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,615.00	3,890.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,283,892.96	ADJUSTMENTS	23,421.48
COVERED CHARGES	1,217,625.16	CONTRACTUAL ALLOW	1,088,893.65
NON-COVERD CHARGES	66,267.80	TOTAL MEDICAID LIAB	128,731.51
		LESS: COB	8,792.68
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	119,845.83
		TOTAL NUMBER OF CLAIMS	22

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST JOSEPH'S HOSPITAL SAVANNAH  
 11705 MERCY BLVD  
 SAVANNAH,GA 31419-1711

PROVIDER NUMBER  
 000001801A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,405.00	11,055.00	OTHER LAB	954.00	2,064.00
MED/SURG SUPPLY	106,791.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	20,895.00	12,405.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,875.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	518.00	FEE SCHEDULE LAB	7,013.00	950.00
EKG/ECG	1,116.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	883.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	143,340.16	9,441.80	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	51,914.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,210.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	84,106.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,050.00	1,470.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	617,037.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,820.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	152,314.00	23,094.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,660.00	512.00			
			TOTAL ANCILLARY	1,217,625.16	66,267.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,217,625.16	66,267.80

Report : CLM-0814-0  
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Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER 000001812A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,687,285.17	ADJUSTMENTS	13,820.27
COVERED CHARGES	17,304,622.52	CONTRACTUAL ALLOW	12,632,839.74
NON-COVERD CHARGES	382,662.65	TOTAL MEDICAID LIAB	4,671,782.78
		LESS: COB	155,564.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,516,218.32

TOTAL NUMBER OF ADMISSIONS 405

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,253		0	2,549,405.00		65,065.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,253		0	2,549,405.00		65,065.00
SPECIAL CARE SERVICES						
CCU	169		0	588,093.25		0.00
ICU	462		29	1,460,945.50		99,564.25
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	631		29	2,049,038.75		99,564.25
TOTAL ACCOMODATIONS	2,884		29	4,598,443.75		164,629.25



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 08:59:02  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,069,928.27	0.00	OTHER LAB	101,453.00	0.00
MED/SURG SUPPLY	897,540.29	17,809.84	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,664,774.05	0.00	EDUCATION & TRAINING	1,960.50	0.00
RADIOLOGY-DIAGNOSTIC	395,149.00	271.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	775,717.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	73,058.65	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	74,793.50	0.00	MRI SERVICES	285,541.00	0.00
IV THERAPY	79,922.00	0.00	PROFESSIONAL FEES	0.00	639.75
OPERATING ROOM	1,222,465.00	3,702.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	759,778.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	143,809.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	98,429.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	331,795.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	107,122.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	45,431.06
LABORATORY PATHOLOGIC	107,251.50	0.00	INJECTABLE DRUGS	408,437.08	0.00
RADIOLOGY THERAPEUTIC	56,096.50	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	20,532.39	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	23,587.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	208,181.50	15,376.50	PATIENT CONVENIENCE	0.00	65,312.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	121.25	441.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	8,052.00	607.00	IMPL DEV CHARGE PATIENTS	598,657.29	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,982.00
OTHER IMAGING SERVICE	78,155.25	29,349.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	172,335.00	30,114.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	95,927.75	2,997.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	811,164.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,838.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,603.25	0.00			
			TOTAL ANCILLARY	12,706,178.77	218,033.40
			TOTAL ACCOMODATIONS	4,598,443.75	164,629.25
			TOTAL CHARGES	17,304,622.52	382,662.65

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 08:59:02  
Page: 3

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013284024804	05/06/13 - 05/17/13	10/14/13	0.00	5,982.00	0.00	0.00	0.00
TOTAL				0.00	5,982.00	0.00	0.00	0.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 08:59:15  
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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	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 08:59:15  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,243,866.68	ADJUSTMENTS	27,307.01
COVERED CHARGES	3,012,943.97	CONTRACTUAL ALLOW	2,377,332.96
NON-COVERD CHARGES	1,230,922.71	TOTAL MEDICAID LIAB	635,611.01
		LESS: COB	3,468.25
		LESS: COPAYMENT	1,614.00
		REIMBURSEMENT	630,528.76
		ALL OTHER	579,702.54
		FEE SCHEDULE-LAB	46,571.90
		INJECTABLE DRUGS	4,254.32
		TOTAL NUMBER OF CLAIMS	1,130

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	136,049.82	39,429.62	OTHER LAB	57,860.50	1,149.50
MED/SURG SUPPLY	110,810.50	45,499.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	119.00
RADIOLOGY-DIAGNOSTIC	162,760.25	17,621.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	334,459.25	300,040.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,113.50	FEE SCHEDULE LAB	372,075.15	57,416.65
EKG/ECG	29,294.00	3,442.50	MRI SERVICES	138,536.50	34,836.50
IV THERAPY	69,954.75	15,071.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	302,817.75	86,545.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,900.25	3,825.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	52,351.50	3,852.50	AMBULANCE	0.00	0.00
GI SERVICES	22,358.00	11,631.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	444,114.00	14,771.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	84,418.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,600.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	28,168.45	45,598.94
RADIOLOGY THERAPEUTIC	73,569.75	111,839.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,864.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,010.50	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	29,477.50	PATIENT CONVENIENCE	0.00	9,615.50
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	8,480.75	533.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	220.00	441.00	IMPL DEV CHARGE PATIENTS	37,008.20	111,119.55
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	137,560.00	20,165.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,023.00	734.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	92,615.25	18,305.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	187,189.25	235,632.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,941.25	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	108,407.10	3,621.00			
			TOTAL ANCILLARY	3,012,943.97	1,230,922.71
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,012,943.97	1,230,922.71

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	70,204.33	ADJUSTMENTS	0.00
COVERED CHARGES	34,456.09	CONTRACTUAL ALLOW	22,581.00
NON-COVERD CHARGES	35,748.24	TOTAL MEDICAID LIAB	11,875.09
		LESS: COB	11,848.09
		LESS: COPAYMENT	27.00
		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

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	811.81	106.41	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,041.00	128.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,117.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	441.00	5,087.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	592.00	FEE SCHEDULE LAB	3,359.00	483.00
EKG/ECG	372.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	583.00	27,877.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,312.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,134.00	206.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,744.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	838.28	568.83
RADIOLOGY THERAPEUTIC	1,137.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	700.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	566.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	34,456.09	35,748.24
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	34,456.09	35,748.24

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: 07/23/2014  
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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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	84,386.85	ADJUSTMENTS	0.00
COVERED CHARGES	77,063.07	CONTRACTUAL ALLOW	72,699.75
NON-COVERD CHARGES	7,323.78	TOTAL MEDICAID LIAB	4,363.32
		LESS: COB	0.00
		LESS: COPAYMENT	192.00
		REIMBURSEMENT	4,171.32
		TOTAL NUMBER OF CLAIMS	78



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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,936.50	215.14	OTHER LAB	460.75	0.00
MED/SURG SUPPLY	435.75	129.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,939.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,634.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	15,005.00	998.75
EKG/ECG	658.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,925.50	853.50	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	304.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,571.50	418.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	343.57	171.39
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,067.00	4,538.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,782.50	0.00			
			TOTAL ANCILLARY	77,063.07	7,323.78
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	77,063.07	7,323.78

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

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,980.24	ADJUSTMENTS	0.00
COVERED CHARGES	18,877.24	CONTRACTUAL ALLOW	18,871.24
NON-COVERD CHARGES	103.00	TOTAL MEDICAID LIAB	6.00
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SAINT JOSEPH'S HOSPITAL OF ATLANTA  
 5665 PEACHTREE DUNWOODY RD NE  
 ATLANTA,GA 30342-1701

PROVIDER NUMBER  
 000001812A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	430.00	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	165.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	17,544.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	727.00	103.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	11.24	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,877.24	103.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,877.24	103.00

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

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 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,583,031.17	ADJUSTMENTS	17,059.68
COVERED CHARGES	1,046,716.62	CONTRACTUAL ALLOW	923,343.47
NON-COVERD CHARGES	536,314.55	TOTAL MEDICAID LIAB	123,373.15
		LESS: COB	0.00
		LESS: COPAYMENT	177.00
		REIMBURSEMENT	123,196.15

TOTAL NUMBER OF CLAIMS 22

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	67,996.73	30,537.96	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25,295.50	48,778.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,251.25	481.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,503.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,299.75	2,350.20
EKG/ECG	515.00	3,070.50	MRI SERVICES	0.00	0.00
IV THERAPY	7,076.75	588.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	236,112.25	298.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	372.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,633.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,864.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	18,043.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,688.14	1,212.89
RADIOLOGY THERAPEUTIC	54,714.00	7,340.25	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	1,234.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	140.25	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	390,563.75	364,771.25
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	2,656.50	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	148,967.75	75,650.50			
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	46,022.50	0.00			
			TOTAL ANCILLARY	1,046,716.62	536,314.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,046,716.62	536,314.55

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: 07/23/2014  
Run Time: 08:59:42  
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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	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER 000001823A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,326,004.67	ADJUSTMENTS	706,966.19
COVERED CHARGES	12,088,055.99	CONTRACTUAL ALLOW	7,846,451.74
NON-COVERD CHARGES	1,237,948.68	TOTAL MEDICAID LIAB	4,241,604.25
		LESS: COB	29,668.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,211,935.84

TOTAL NUMBER OF ADMISSIONS 438

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,044		0	678,600.00		342,577.00
ROUTINE NURSERY	105		0	81,837.00		1,041.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,149		0	760,437.00		343,618.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	767		0	1,366,170.00		18,568.00
NICU	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	6,552.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		271	0.00		262,683.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	771		271	1,372,722.00		281,251.00
TOTAL ACCOMODATIONS	1,920		271	2,133,159.00		624,869.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,506,209.43	46,254.46	OTHER LAB	124,013.00	0.00
MED/SURG SUPPLY	494,485.42	8,844.22	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	747,950.30	15,545.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	299,107.00	3,466.00	OTHER THERAPEUTIC SVC	0.00	152.00
CT SCAN	0.00	444,870.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	169,826.00	10,261.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	72,819.00	0.00	MRI SERVICES	227,767.00	2,930.00
IV THERAPY	237,601.11	10,405.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,080,165.00	10,386.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	136,160.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	602,475.00	22,877.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	265,659.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	63,032.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	371,360.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	174,600.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	43,463.00	0.00	INJECTABLE DRUGS	2,267.59	0.00
RADIOLOGY THERAPEUTIC	5,566.54	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	139,341.00	7,861.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	110,047.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	179,546.00	6,886.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	177.00	527.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,035,147.60	0.00
LITHOTRIPSY	16,361.00	0.00	NO CC/INVALID REV CODE	0.00	6,882.00
OTHER IMAGING SERVICE	95,288.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	149,564.00	3,732.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	35,456.00	11,201.00			
AUDIOLOGY	4,830.00	0.00			
CARDIOLOGY	533,454.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	28,970.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,189.00	0.00			
			TOTAL ANCILLARY	9,954,896.99	613,079.68
			TOTAL ACCOMODATIONS	2,133,159.00	624,869.00
			TOTAL CHARGES	12,088,055.99	1,237,948.68



Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012325064822	07/21/12 - 07/24/12	11/26/12	0.00	2,184.00	0.00	0.00	0.00
780	5214113000136	03/03/13 - 03/27/13	04/28/14	0.00	4,698.00	0.00	0.00	0.00
TOTAL				0.00	6,882.00	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 08:54:31  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	125,763.96	ADJUSTMENTS	0.00
COVERED CHARGES	124,855.96	CONTRACTUAL ALLOW	45,423.96
NON-COVERD CHARGES	908.00	TOTAL MEDICAID LIAB	79,432.00
		LESS: COB	79,432.00
		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	1,300.00		626.00
ROUTINE NURSERY	0		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	1,300.00		626.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	1		0	1,984.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1		0	1,984.00		0.00
TOTAL ACCOMODATIONS	3		0	3,284.00		626.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,011.06	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,211.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,450.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,812.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	653.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,040.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,875.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,756.00	0.00	SPECIAL SERVICES	0.00	282.00
RECOVERY ROOM	2,198.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,527.90	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	376.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	87,662.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	121,571.96	282.00
			TOTAL ACCOMODATIONS	3,284.00	626.00
			TOTAL CHARGES	124,855.96	908.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 08:54:32  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,215,363.71	ADJUSTMENTS	269,505.94
COVERED CHARGES	9,142,448.15	CONTRACTUAL ALLOW	7,036,421.20
NON-COVERD CHARGES	1,072,915.56	TOTAL MEDICAID LIAB	2,106,026.95
		LESS: COB	48,745.85
		LESS: COPAYMENT	4,545.00
		REIMBURSEMENT	2,052,736.10
		ALL OTHER	1,808,694.80
		FEE SCHEDULE-LAB	150,619.66
		INJECTABLE DRUGS	93,421.64
		TOTAL NUMBER OF CLAIMS	4,837

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

ST MARY'S HOSPITAL  
 1230 BAXTER ST  
 ATHENS,GA 30606-3712

PROVIDER NUMBER  
 000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	247,627.06	291.26	OTHER LAB	71,663.00	683.00
MED/SURG SUPPLY	175,120.00	80,097.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	297.00	EDUCATION & TRAINING	610.00	0.00
RADIOLOGY-DIAGNOSTIC	608,077.00	21,390.00	OTHER THERAPEUTIC SVC	0.00	16,096.00
CT SCAN	700,953.00	34,605.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	55,818.00	9,144.00	FEE SCHEDULE LAB	648,093.66	115,308.20
EKG/ECG	122,211.00	9,565.00	MRI SERVICES	315,068.00	20,570.00
IV THERAPY	640,224.67	80,418.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,021,953.00	124,897.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	77,850.00	21,110.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	373,042.00	514.00	AMBULANCE	0.00	0.00
GI SERVICES	24,752.00	3,722.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,638,073.80	43,293.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	446,521.00	2,262.24	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	613,917.46	189,590.06
RADIOLOGY THERAPEUTIC	8,493.00	0.00	HOME HEALTH SERVICES	0.00	5,835.00
OCCUPATIONAL THERAPY	9,914.00	4,716.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	13,411.50	10,752.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	1,696.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	99,085.00	3,075.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	16,948.00	1,700.00	IMPL DEV CHARGE PATIENTS	5,506.00	76,648.00
LITHOTRIPSY	32,722.00	0.00	NO CC/INVALID REV CODE	0.00	169.80
OTHER IMAGING SERVICE	218,933.00	21,749.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	32,940.00	25,411.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	193,559.00	46,580.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	463,958.00	97,020.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	132,226.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	133,178.00	2,864.00			
			TOTAL ANCILLARY	9,142,448.15	1,072,068.56
			TOTAL ACCOMODATIONS	0.00	847.00
			TOTAL CHARGES	9,142,448.15	1,072,915.56

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213133006776	01/21/13 - 01/21/13	05/20/13	0.00	134.00	0.00	0.00	0.00
616	1113148006413	04/10/13 - 04/10/13	06/24/13	0.00	35.80	0.00	0.00	0.00
TOTAL				0.00	169.80	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	139,771.62	ADJUSTMENTS	0.00
COVERED CHARGES	115,272.30	CONTRACTUAL ALLOW	64,558.02
NON-COVERD CHARGES	24,499.32	TOTAL MEDICAID LIAB	50,714.28
		LESS: COB	50,690.77
		LESS: COPAYMENT	23.51
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	940.93	134.00	OTHER LAB	295.00	0.00
MED/SURG SUPPLY	4,574.00	556.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	254.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,827.00	349.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,916.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	8,701.00	2,043.00
EKG/ECG	1,194.00	0.00	MRI SERVICES	0.00	188.00
IV THERAPY	10,743.90	2,980.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,383.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,918.00	157.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,104.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,913.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	24,214.00	719.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,632.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,266.47	3,557.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,012.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,561.00	231.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,186.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	211.50
OTHER IMAGING SERVICE	3,563.00	1,364.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	205.00			
NUCLEAR MEDICINE	881.00	161.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,141.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,487.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	834.00	0.00			
			TOTAL ANCILLARY	115,272.30	24,125.32
			TOTAL ACCOMODATIONS	0.00	374.00
			TOTAL CHARGES	115,272.30	24,499.32



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
837	2312333000047	09/19/12 - 09/19/12	12/03/12	0.00	23.50	0.00	173.49	0.00
30	2213163000806	05/03/13 - 05/03/13	06/17/13	0.00	188.00	0.00	345.97	0.00
TOTAL				0.00	211.50	0.00	519.46	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 08:56:36  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	493,784.66	ADJUSTMENTS	1,294.54
COVERED CHARGES	465,614.33	CONTRACTUAL ALLOW	432,050.37
NON-COVERD CHARGES	28,170.33	TOTAL MEDICAID LIAB	33,563.96
		LESS: COB	15.10
		LESS: COPAYMENT	1,122.07
		REIMBURSEMENT	32,426.79
		TOTAL NUMBER OF CLAIMS	600

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,069.11	0.00	OTHER LAB	1,520.00	0.00
MED/SURG SUPPLY	150.00	1,214.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	62,761.00	436.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,923.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,511.00	5,559.00
EKG/ECG	2,876.00	225.00	MRI SERVICES	0.00	2,719.00
IV THERAPY	38,632.00	5,217.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,185.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,139.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	270,672.00	3,120.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,121.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	19,501.22	7,976.33
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	352.00	340.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,509.00	1,364.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	693.00	0.00			
			TOTAL ANCILLARY	465,614.33	28,170.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	465,614.33	28,170.33

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,862.79	ADJUSTMENTS	0.00
COVERED CHARGES	4,426.79	CONTRACTUAL ALLOW	1,426.49
NON-COVERD CHARGES	436.00	TOTAL MEDICAID LIAB	3,000.30
		LESS: COB	2,988.30
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	8

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	51.79	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	73.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	46.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	307.00	307.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	270.00	10.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,798.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,426.79	436.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,426.79	436.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

ST MARY'S HOSPITAL  
1230 BAXTER ST  
ATHENS,GA 30606-3712

PROVIDER NUMBER  
000001823A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,132,316.17	ADJUSTMENTS	32,445.12
COVERED CHARGES	776,126.43	CONTRACTUAL ALLOW	678,629.07
NON-COVERD CHARGES	356,189.74	TOTAL MEDICAID LIAB	97,497.36
		LESS: COB	0.00
		LESS: COPAYMENT	116.46
		REIMBURSEMENT	97,380.90
		TOTAL NUMBER OF CLAIMS	18

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,473.87	0.00	OTHER LAB	2,723.00	3,487.00
MED/SURG SUPPLY	60,306.00	4,769.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,734.00	2,396.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,653.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	676.00	FEE SCHEDULE LAB	6,133.00	245.00
EKG/ECG	2,658.00	450.00	MRI SERVICES	0.00	2,719.00
IV THERAPY	30,161.00	10,496.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	466,907.00	54,131.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	256.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	44,325.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,771.00	111.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	41,867.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45,635.56	7,287.74
RADIOLOGY THERAPEUTIC	2,032.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,093.00	265,513.00
LITHOTRIPSY	16,361.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,009.00	1,256.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,681.00	0.00			
			TOTAL ANCILLARY	776,126.43	356,189.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	776,126.43	356,189.74

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL  
 163 HOSPITAL DR  
 TOCCOA,GA 30577-6820

PROVIDER NUMBER 000001834A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,291,080.54	ADJUSTMENTS	14,516.07
COVERED CHARGES	3,258,503.14	CONTRACTUAL ALLOW	1,893,303.87
NON-COVERD CHARGES	32,577.40	TOTAL MEDICAID LIAB	1,365,199.27
		LESS: COB	5,890.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,359,308.60

TOTAL NUMBER OF ADMISSIONS 206

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	431		0	236,035.00		18,290.00
ROUTINE NURSERY	67		0	29,040.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	498		0	265,075.00		18,290.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	338		0	395,431.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	338		0	395,431.00		0.00
TOTAL ACCOMODATIONS	836		0	660,506.00		18,290.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

STEPHENS COUNTY HOSPITAL  
 163 HOSPITAL DR  
 TOCCOA,GA 30577-6820

PROVIDER NUMBER  
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	478,358.57	0.00	OTHER LAB	12,935.25	0.00
MED/SURG SUPPLY	673,317.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	367,658.76	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	66,985.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	130,729.75	8,137.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,710.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	18,829.75	0.00	MRI SERVICES	19,592.25	0.00
IV THERAPY	17,855.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	95,219.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	38,212.44	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	239,265.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	32,472.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	4,900.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	73,414.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	22,904.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	5,531.25	0.00	INJECTABLE DRUGS	71,173.85	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	112.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	21,675.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6,019.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,424.50
OTHER IMAGING SERVICE	10,709.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	18,118.25	679.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	23,741.00	4,045.90			
AUDIOLOGY	2,286.00	0.00			
CARDIOLOGY	20,383.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	81,886.26	0.00			
			TOTAL ANCILLARY	2,597,997.14	14,287.40
			TOTAL ACCOMODATIONS	660,506.00	18,290.00
			TOTAL CHARGES	3,258,503.14	32,577.40

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 08:53:03  
Page: 3

STEPHENS COUNTY HOSPITAL  
163 HOSPITAL DR  
TOCCOA,GA 30577-6820

PROVIDER NUMBER  
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012364005518	11/24/12 - 12/17/12	01/07/13	0.00	1,424.50	0.00	0.00	0.00
TOTAL				0.00	1,424.50	0.00	0.00	0.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	24,672.96	ADJUSTMENTS	0.00
COVERED CHARGES	24,462.96	CONTRACTUAL ALLOW	7,989.28
NON-COVERD CHARGES	210.00	TOTAL MEDICAID LIAB	16,473.68
		LESS: COB	16,473.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	2,765.00		210.00
ROUTINE NURSERY	1		0	440.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	6		0	3,205.00		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	6		0	3,205.00		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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,050.39	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	7,481.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,440.50	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	134.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	480.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,992.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,492.87	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	717.25	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	621.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	227.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	63.50	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	556.86	0.00			
			TOTAL ANCILLARY	21,257.96	0.00
			TOTAL ACCOMODATIONS	3,205.00	210.00
			TOTAL CHARGES	24,462.96	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: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,245,412.49	ADJUSTMENTS	127,625.26
COVERED CHARGES	2,979,526.23	CONTRACTUAL ALLOW	1,930,242.42
NON-COVERD CHARGES	265,886.26	TOTAL MEDICAID LIAB	1,049,283.81
		LESS: COB	813.29
		LESS: COPAYMENT	3,037.98
		REIMBURSEMENT	1,045,432.54
		ALL OTHER	978,662.68
		FEE SCHEDULE-LAB	64,383.85
		INJECTABLE DRUGS	2,386.01

TOTAL NUMBER OF CLAIMS 2,504

STEPHENS COUNTY HOSPITAL  
 163 HOSPITAL DR  
 TOCCOA,GA 30577-6820

PROVIDER NUMBER  
 000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	218,966.25	40,768.49	OTHER LAB	26,199.00	0.00
MED/SURG SUPPLY	419,923.30	186.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	147,271.25	10,448.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	374,444.75	16,483.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	135,787.50	16,462.00	FEE SCHEDULE LAB	389,231.54	63,192.68
EKG/ECG	33,974.00	2,196.00	MRI SERVICES	123,703.75	1,426.50
IV THERAPY	40,270.00	3,335.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	123,539.98	16,723.52	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	251.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,205.00	13,893.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	69,054.75	0.00	AMBULANCE	0.00	0.00
GI SERVICES	35,025.00	1,125.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	381,461.10	16,186.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	85,622.50	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,181.04	7,239.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,717.25	1,019.28	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	11,500.59
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,369.25
OTHER IMAGING SERVICE	56,173.50	3,119.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,949.75	6,533.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	75,521.00	19,172.07			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	8,764.00	2,511.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	545.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	173,743.02	9,995.63			
			TOTAL ANCILLARY	2,979,526.23	265,886.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,979,526.23	265,886.26

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: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012336027156	11/13/12 - 11/13/12	12/10/12	0.00	2,369.25	0.00	0.00	0.00
TOTAL				0.00	2,369.25	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL  
163 HOSPITAL DR  
TOCCOA,GA 30577-6820

PROVIDER NUMBER  
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,473.94	ADJUSTMENTS	0.00
COVERED CHARGES	70,465.22	CONTRACTUAL ALLOW	18,317.34
NON-COVERD CHARGES	12,008.72	TOTAL MEDICAID LIAB	52,147.88
		LESS: COB	52,126.88
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 56

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,463.32	1,244.47	OTHER LAB	2,850.50	0.00
MED/SURG SUPPLY	9,101.97	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,134.25	125.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,978.75	1,600.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	280.50	316.75	FEE SCHEDULE LAB	7,985.50	1,040.50
EKG/ECG	0.00	0.00	MRI SERVICES	10,235.00	2,852.75
IV THERAPY	1,055.00	245.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,294.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,028.37	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	900.00	275.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,042.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,940.75	797.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,484.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	307.00	3,198.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	134.25	0.00
OTHER IMAGING SERVICE	1,701.75	235.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,547.81	78.25			
			TOTAL ANCILLARY	70,465.22	12,008.72
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	70,465.22	12,008.72

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEPHENS COUNTY HOSPITAL  
163 HOSPITAL DR  
TOCCOA,GA 30577-6820

PROVIDER NUMBER  
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
0	1113037005202	12/04/12 - 12/04/12	03/18/13	134.25	0.00	0.00	265.85	0.00
TOTAL				134.25	0.00	0.00	265.85	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	140,955.84	ADJUSTMENTS	594.34
COVERED CHARGES	132,893.37	CONTRACTUAL ALLOW	111,132.71
NON-COVERD CHARGES	8,062.47	TOTAL MEDICAID LIAB	21,760.66
		LESS: COB	29.48
		LESS: COPAYMENT	603.00
		REIMBURSEMENT	21,128.18
		TOTAL NUMBER OF CLAIMS	389

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,421.01	3,359.97	OTHER LAB	620.25	0.00
MED/SURG SUPPLY	429.86	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,440.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,624.75	1,298.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,056.75	819.00	FEE SCHEDULE LAB	21,977.50	2,109.75
EKG/ECG	1,658.75	185.00	MRI SERVICES	0.00	0.00
IV THERAPY	425.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	181.25	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	84,992.25	290.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	998.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	67.50	0.00			
			TOTAL ANCILLARY	132,893.37	8,062.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	132,893.37	8,062.47

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

STEPHENS COUNTY HOSPITAL  
163 HOSPITAL DR  
TOCCOA,GA 30577-6820

PROVIDER NUMBER  
000001834A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,104.01	ADJUSTMENTS	0.00
COVERED CHARGES	4,877.32	CONTRACTUAL ALLOW	1,808.59
NON-COVERD CHARGES	226.69	TOTAL MEDICAID LIAB	3,068.73
		LESS: COB	3,059.73
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	10

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	90.07	5.94	OTHER LAB	201.25	0.00
MED/SURG SUPPLY	0.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	217.75	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	1,173.25	220.75
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	2,666.25	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	528.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,877.32	226.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,877.32	226.69

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 08:53:59  
Page: 16

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	347,176.44	ADJUSTMENTS	14,917.96
COVERED CHARGES	336,092.58	CONTRACTUAL ALLOW	226,572.62
NON-COVERD CHARGES	11,083.86	TOTAL MEDICAID LIAB	109,519.96
		LESS: COB	0.00
		LESS: COPAYMENT	87.43
		REIMBURSEMENT	109,432.53
		TOTAL NUMBER OF CLAIMS	22



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,175.92	1,751.81	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	142,302.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,394.00	1,575.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	186.75	FEE SCHEDULE LAB	6,278.21	360.50
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	42,482.47	1,935.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	816.00	68.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	19,874.50	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	16,164.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	52,683.00	18.05
RADIOLOGY THERAPEUTIC	1,315.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	5,187.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	39,606.94	0.00			
			TOTAL ANCILLARY	336,092.58	11,083.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	336,092.58	11,083.86

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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Page: 18

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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 08:52:48  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER 000001845A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	125,657.22	ADJUSTMENTS	0.00
COVERED CHARGES	125,327.22	CONTRACTUAL ALLOW	51,922.31
NON-COVERD CHARGES	330.00	TOTAL MEDICAID LIAB	73,404.91
		LESS: COB	1,443.11
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	71,961.80

TOTAL NUMBER OF ADMISSIONS 14

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	71		0	35,500.00		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	71		0	35,500.00		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	71		0	35,500.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER  
 000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	30,461.43	0.00	OTHER LAB	828.86	0.00
MED/SURG SUPPLY	10,172.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,870.26	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,458.92	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	16,454.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	879.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	594.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	500.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	612.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	126.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,486.40	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	893.76	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	464.76	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,025.00	330.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	89,827.22	330.00
			TOTAL ACCOMODATIONS	35,500.00	0.00
			TOTAL CHARGES	125,327.22	330.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 08:52:49  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 08:52:49  
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STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	167,482.21	ADJUSTMENTS	0.00
COVERED CHARGES	152,631.56	CONTRACTUAL ALLOW	86,059.76
NON-COVERD CHARGES	14,850.65	TOTAL MEDICAID LIAB	66,571.80
		LESS: COB	0.00
		LESS: COPAYMENT	510.00
		REIMBURSEMENT	66,061.80
		ALL OTHER	61,050.87
		FEE SCHEDULE-LAB	5,010.93
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 206

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER  
 000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,369.42	0.00	OTHER LAB	8,250.00	0.00
MED/SURG SUPPLY	11,482.10	932.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,429.53	265.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,040.00	2,822.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,967.00	2,720.00	FEE SCHEDULE LAB	25,182.61	7,169.14
EKG/ECG	891.00	495.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,984.75	0.00	PROFESSIONAL FEES	0.00	75.00
OPERATING ROOM	3,539.36	321.76	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,334.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,150.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	726.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,692.45	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,150.08	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	50.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,721.51	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	693.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,027.50	0.00			
			TOTAL ANCILLARY	152,631.56	14,850.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	152,631.56	14,850.65

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 08:52:55  
Page: 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,201.88	ADJUSTMENTS	0.00
COVERED CHARGES	851.88	CONTRACTUAL ALLOW	476.88
NON-COVERD CHARGES	350.00	TOTAL MEDICAID LIAB	375.00
		LESS: COB	375.00
		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

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER  
 000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	26.13	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	297.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	350.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	528.75	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	851.88	350.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	851.88	350.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 08:52:56  
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STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	25,570.23	ADJUSTMENTS	0.00
COVERED CHARGES	23,903.19	CONTRACTUAL ALLOW	22,653.19
NON-COVERD CHARGES	1,667.04	TOTAL MEDICAID LIAB	1,250.00
		LESS: COB	0.00
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	1,205.00
		TOTAL NUMBER OF CLAIMS	25

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

STEWART WEBSTER HOSPITAL  
 580 ALSTON ST  
 RICHLAND,GA 31825-6012

PROVIDER NUMBER  
 000001845A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,119.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	965.22	126.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,820.92	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,303.83	1,540.54
EKG/ECG	495.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	379.50	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	200.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,818.95	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
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	4,800.00	0.00			
			TOTAL ANCILLARY	23,903.19	1,667.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,903.19	1,667.04

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: 07/23/2014  
Run Time: 08:52:56  
Page: 10

STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 08:52:56  
Page: 11

SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 08:52:56  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

STEWART WEBSTER HOSPITAL  
580 ALSTON ST  
RICHLAND,GA 31825-6012

PROVIDER NUMBER  
000001845A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER 000001856A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	45,124.45	ADJUSTMENTS	8,177.95
COVERED CHARGES	43,483.17	CONTRACTUAL ALLOW	30,082.93
NON-COVERD CHARGES	1,641.28	TOTAL MEDICAID LIAB	13,400.24
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	13,400.24

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7		0	6,309.00		1,641.28
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	7		0	6,309.00		1,641.28
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	7		0	6,309.00		1,641.28

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,162.81	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	740.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,466.79	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,227.14	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	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	503.88	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,222.53	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	109.82	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	740.55	0.00			
			TOTAL ANCILLARY	37,174.17	0.00
			TOTAL ACCOMODATIONS	6,309.00	1,641.28
			TOTAL CHARGES	43,483.17	1,641.28



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 11:24:21  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:24:22  
Page: 4

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,878,720.68	ADJUSTMENTS	37,223.64
COVERED CHARGES	1,673,314.82	CONTRACTUAL ALLOW	1,389,346.53
NON-COVERD CHARGES	205,405.86	TOTAL MEDICAID LIAB	283,968.29
		LESS: COB	0.00
		LESS: COPAYMENT	255.00
		REIMBURSEMENT	283,713.29
		ALL OTHER	268,694.31
		FEE SCHEDULE-LAB	13,363.60
		INJECTABLE DRUGS	1,655.38

TOTAL NUMBER OF CLAIMS 978

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	39,656.57	914.32	OTHER LAB	2,023.40	0.00
MED/SURG SUPPLY	40,025.54	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	184,160.14	1,205.45	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	142,730.83	102,084.16	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,853.32	1,475.22	FEE SCHEDULE LAB	246,765.01	70,609.12
EKG/ECG	21,922.22	441.98	MRI SERVICES	0.00	0.00
IV THERAPY	61,850.72	5,743.55	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,956.79	10,081.73	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	819,498.16	2,079.14	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	82,061.19	9,767.97
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	67.08	104.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,944.51	795.12			
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	103.51			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	799.34	0.00			
			TOTAL ANCILLARY	1,673,314.82	205,405.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,673,314.82	205,405.86

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 11:24:36  
Page: 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,253.76	ADJUSTMENTS	0.00
COVERED CHARGES	22,953.11	CONTRACTUAL ALLOW	13,065.61
NON-COVERD CHARGES	12,300.65	TOTAL MEDICAID LIAB	9,887.50
		LESS: COB	9,887.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 11

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,018.95	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	708.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,425.91	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	10,250.98	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,417.66	823.68
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,620.03	205.12	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	10,987.76	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	2,774.72	1,020.87
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,953.11	12,300.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,953.11	12,300.65

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:24:36  
Page: 8

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	297,979.84	ADJUSTMENTS	748.99
COVERED CHARGES	270,123.89	CONTRACTUAL ALLOW	258,173.89
NON-COVERD CHARGES	27,855.95	TOTAL MEDICAID LIAB	11,950.00
		LESS: COB	0.00
		LESS: COPAYMENT	480.03
		REIMBURSEMENT	11,469.97
		TOTAL NUMBER OF CLAIMS	239

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,683.80	9.24	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,353.02	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,349.45	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,463.62	20,429.99	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	25,401.64	5,461.24
EKG/ECG	883.96	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	11,880.66	690.01	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	864.26	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	193,297.26	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,946.22	870.52
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	394.95			
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	270,123.89	27,855.95
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	270,123.89	27,855.95

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:24:40  
Page: 10

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,237.81	ADJUSTMENTS	0.00
COVERED CHARGES	2,985.30	CONTRACTUAL ALLOW	858.10
NON-COVERD CHARGES	252.51	TOTAL MEDICAID LIAB	2,127.20
		LESS: COB	2,127.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:24:40  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

SYLVAN GROVE HOSPITAL  
 1050 MCDONOUGH RD  
 JACKSON,GA 30233-1524

PROVIDER NUMBER  
 000001856A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 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	1,834.09	252.51
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,151.21	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,985.30	252.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,985.30	252.51

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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Page: 12

SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:24:41  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

SYLVAN GROVE HOSPITAL  
1050 MCDONOUGH RD  
JACKSON,GA 30233-1524

PROVIDER NUMBER  
000001856A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:22:42  
 Page: 1

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,999,307.99	ADJUSTMENTS	465,822.34
COVERED CHARGES	15,684,201.22	CONTRACTUAL ALLOW	10,812,000.94
NON-COVERD CHARGES	315,106.77	TOTAL MEDICAID LIAB	4,872,200.28
		LESS: COB	27,098.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,845,102.08

TOTAL NUMBER OF ADMISSIONS 613

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,467		3	1,280,426.00		123,482.00
ROUTINE NURSERY	252		0	143,082.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,719		3	1,423,508.00		123,482.00
SPECIAL CARE SERVICES						
CCU	530		5	774,206.00		20,804.00
ICU	237		0	537,516.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	767		5	1,311,722.00		20,804.00
TOTAL ACCOMODATIONS	2,486		8	2,735,230.00		144,286.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,226,101.05	15,006.68	OTHER LAB	110,594.18	1,069.00
MED/SURG SUPPLY	1,030,855.56	5,362.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,945,907.00	18,971.00	EDUCATION & TRAINING	3,387.00	42.00
RADIOLOGY-DIAGNOSTIC	212,985.42	1,086.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	580,967.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	104,487.05	450.88	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	117,288.00	0.00	MRI SERVICES	125,096.00	0.00
IV THERAPY	205,589.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,659,706.23	6,185.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	303,670.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	627,069.00	4,715.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	21,556.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	88,648.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	324,810.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,128.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	8,934.16
LABORATORY PATHOLOGIC	37,449.00	0.00	INJECTABLE DRUGS	719,175.38	40,553.05
RADIOLOGY THERAPEUTIC	209,981.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	35,487.10	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	15,587.48	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	92,170.00	52,838.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	16,197.00	1,389.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	933,420.77	552.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	43,127.00	5,247.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	184,046.00	4,270.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	130,248.00	4,150.00			
AUDIOLOGY	9,435.00	0.00			
CARDIOLOGY	743,413.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,056.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	85,334.00	0.00			
			TOTAL ANCILLARY	12,948,971.22	170,820.77
			TOTAL ACCOMODATIONS	2,735,230.00	144,286.00
			TOTAL CHARGES	15,684,201.22	315,106.77

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	138,030.82	ADJUSTMENTS	0.00
COVERED CHARGES	45,957.24	CONTRACTUAL ALLOW	34,433.39
NON-COVERD CHARGES	92,073.58	TOTAL MEDICAID LIAB	11,523.85
		LESS: COB	11,523.85
		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	13		0	5,358.00		7,057.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	13		0	5,358.00		7,057.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	4,536.00		2,268.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	4,536.00		2,268.00
TOTAL ACCOMODATIONS	16		0	9,894.00		9,325.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER - CARROLLTON  
 705 DIXIE ST  
 CARROLLTON,GA 30117-3818

PROVIDER NUMBER  
 000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12,402.00	15,576.54	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	2,789.25	6,581.38	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,923.00	11,299.00	EDUCATION & TRAINING	0.00	42.00
RADIOLOGY-DIAGNOSTIC	213.00	972.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,289.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	590.99	926.84	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	3,096.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,635.00	10,793.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,664.00	8,059.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,160.00	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	409.82	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	50.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	25,418.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	545.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,080.00	1,040.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,581.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	676.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	36,063.24	82,748.58
			TOTAL ACCOMODATIONS	9,894.00	9,325.00
			TOTAL CHARGES	45,957.24	92,073.58

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: 07/23/2014  
Run Time: 11:22:56  
Page: 5

TANNER MEDICAL CENTER - CARROLLTON  
705 DIXIE ST  
CARROLLTON,GA 30117-3818

PROVIDER NUMBER  
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,176,204.82	ADJUSTMENTS	658,474.69
COVERED CHARGES	15,045,926.01	CONTRACTUAL ALLOW	11,782,656.36
NON-COVERD CHARGES	1,130,278.81	TOTAL MEDICAID LIAB	3,263,269.65
		LESS: COB	5,421.25
		LESS: COPAYMENT	10,171.07
		REIMBURSEMENT	3,247,677.33
		ALL OTHER	2,861,370.38
		FEE SCHEDULE-LAB	162,083.43
		INJECTABLE DRUGS	224,223.52

TOTAL NUMBER OF CLAIMS 6,426



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	712,521.36	4,219.74	OTHER LAB	133,062.00	0.00
MED/SURG SUPPLY	596,679.99	16,170.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	1,520.00
RADIOLOGY-DIAGNOSTIC	690,854.00	18,123.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,682,633.00	87,745.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,832.34	FEE SCHEDULE LAB	1,854,935.10	326,958.00
EKG/ECG	172,035.00	22,080.00	MRI SERVICES	768,154.00	32,964.00
IV THERAPY	562,260.00	86,329.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,166,217.25	112,735.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	11,093.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	174,286.00	25,451.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,951.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	186,912.00	19,800.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,755,077.92	9,950.58	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,356.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	973.43
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	893,715.88	126,302.73
RADIOLOGY THERAPEUTIC	884,116.00	36,287.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,432.82	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,267.26	2,041.42	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	14,576.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	103,581.00	22,826.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	811,305.00	7,260.00	IMPL DEV CHARGE PATIENTS	65,227.25	6,765.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	481,821.00	29,841.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	48,236.00	1,830.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	264,779.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	458,585.00	89,065.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	95,812.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	435,453.00	23,200.00			
			TOTAL ANCILLARY	15,045,926.01	1,130,278.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,045,926.01	1,130,278.81

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TANNER MEDICAL CENTER - CARROLLTON  
705 DIXIE ST  
CARROLLTON,GA 30117-3818

PROVIDER NUMBER  
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	64,298.27	ADJUSTMENTS	0.00
COVERED CHARGES	56,018.15	CONTRACTUAL ALLOW	35,078.23
NON-COVERD CHARGES	8,280.12	TOTAL MEDICAID LIAB	20,939.92
		LESS: COB	20,906.92
		LESS: COPAYMENT	33.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 25

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,427.15	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,511.00	999.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,580.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,744.00	1,744.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	13,912.00	1,859.00
EKG/ECG	920.00	230.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,149.00	491.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,648.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	278.00	102.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,168.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,934.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	856.12
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	48.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	6,655.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	545.00	633.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,799.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	748.00	1,318.00			
			TOTAL ANCILLARY	56,018.15	8,280.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	56,018.15	8,280.12

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	695,548.47	ADJUSTMENTS	623.28
COVERED CHARGES	677,198.36	CONTRACTUAL ALLOW	631,886.96
NON-COVERD CHARGES	18,350.11	TOTAL MEDICAID LIAB	45,311.40
		LESS: COB	11.60
		LESS: COPAYMENT	1,473.00
		REIMBURSEMENT	43,826.80
		TOTAL NUMBER OF CLAIMS	810

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	20,266.96	0.00	OTHER LAB	1,352.00	0.00
MED/SURG SUPPLY	8,888.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,775.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	66,817.00	1,744.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	461.00	FEE SCHEDULE LAB	119,702.00	8,150.00
EKG/ECG	9,430.00	460.00	MRI SERVICES	9,898.00	3,706.00
IV THERAPY	36,161.00	3,354.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,412.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	312,990.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,927.40	45.11
RADIOLOGY THERAPEUTIC	17,984.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	136.00	48.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,787.00	382.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,672.00	0.00			
			TOTAL ANCILLARY	677,198.36	18,350.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	677,198.36	18,350.11

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER - CARROLLTON  
705 DIXIE ST  
CARROLLTON,GA 30117-3818

PROVIDER NUMBER  
000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	725.00	ADJUSTMENTS	0.00
COVERED CHARGES	725.00	CONTRACTUAL ALLOW	295.00
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	430.00
		LESS: COB	430.00
		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: 07/23/2014  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

TANNER MEDICAL CENTER - CARROLLTON  
 705 DIXIE ST  
 CARROLLTON,GA 30117-3818

PROVIDER NUMBER  
 000001867A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	71.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	654.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	725.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	725.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,470,666.25	ADJUSTMENTS	224,482.25
COVERED CHARGES	3,199,319.34	CONTRACTUAL ALLOW	2,658,465.51
NON-COVERD CHARGES	271,346.91	TOTAL MEDICAID LIAB	540,853.83
		LESS: COB	0.00
		LESS: COPAYMENT	930.00
		REIMBURSEMENT	539,923.83
		TOTAL NUMBER OF CLAIMS	103



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	143,268.15	0.00	OTHER LAB	8,010.14	5,360.74
MED/SURG SUPPLY	273,603.83	6,078.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	126.00	800.00
RADIOLOGY-DIAGNOSTIC	22,487.40	10,850.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,942.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,098.77	FEE SCHEDULE LAB	49,668.40	12,907.50
EKG/ECG	7,381.00	3,910.00	MRI SERVICES	6,942.00	0.00
IV THERAPY	96,947.68	13,401.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	385,941.82	50,027.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87,254.00	411.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,483.00	288.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,379.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	932,413.83	78,241.40
RADIOLOGY THERAPEUTIC	334,968.00	14,840.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	565.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,980.00	1,225.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	163,350.00	0.00	IMPL DEV CHARGE PATIENTS	450,617.09	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,319.00	5,247.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,714.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,578.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	165,208.00	64,918.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,737.00	178.00			
			TOTAL ANCILLARY	3,199,319.34	271,346.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,199,319.34	271,346.91

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TANNER MEDICAL CENTER - CARROLLTON  
705 DIXIE ST  
CARROLLTON,GA 30117-3818

PROVIDER NUMBER  
000001867A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DOCTORS HOSPITAL OF TATTNALL  
 247 S MAIN ST  
 REIDSVILLE,GA 30453-4605

PROVIDER NUMBER 000001878A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,105,924.59	ADJUSTMENTS	55,754.68
COVERED CHARGES	4,038,053.68	CONTRACTUAL ALLOW	3,621,648.62
NON-COVERD CHARGES	67,870.91	TOTAL MEDICAID LIAB	416,405.06
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	416,405.06

TOTAL NUMBER OF ADMISSIONS 42

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	130		3	95,872.00		44,219.01
ROUTINE NURSERY	0		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		3	95,872.00		44,219.01
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	130		3	95,872.00		44,219.01

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	111,506.08	0.00	OTHER LAB	3,491.72	0.00
MED/SURG SUPPLY	57,042.08	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	52,790.23	0.00	EDUCATION & TRAINING	381.76	0.00
RADIOLOGY-DIAGNOSTIC	33,843.20	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,298.39	1,889.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	18,426.27	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,917.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,193.88	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,160,490.24	17,443.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	10,109.29	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,000.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,453.15	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	23,104.34	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,697.30	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,435,354.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,411.65	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	8,673.90	4,319.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,996.80	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,942,181.68	23,651.90
			TOTAL ACCOMODATIONS	95,872.00	44,219.01
			TOTAL CHARGES	4,038,053.68	67,870.91

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:47:39  
 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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	165,321.03	ADJUSTMENTS	0.00
COVERED CHARGES	163,448.53	CONTRACTUAL ALLOW	96,877.96
NON-COVERD CHARGES	1,872.50	TOTAL MEDICAID LIAB	66,570.57
		LESS: COB	66,570.57
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	5		0	3,745.00		1,872.50
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	3,745.00		1,872.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	5		0	3,745.00		1,872.50

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,605.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,448.28	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,314.88	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,472.57	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	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	46,320.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	352.30	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	159,703.53	0.00
			TOTAL ACCOMODATIONS	3,745.00	1,872.50
			TOTAL CHARGES	163,448.53	1,872.50

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:47:40  
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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,380,906.71	ADJUSTMENTS	217,984.48
COVERED CHARGES	3,807,832.02	CONTRACTUAL ALLOW	3,082,425.97
NON-COVERD CHARGES	573,074.69	TOTAL MEDICAID LIAB	725,406.05
		LESS: COB	4,337.00
		LESS: COPAYMENT	2,622.00
		REIMBURSEMENT	718,447.05
		ALL OTHER	682,951.26
		FEE SCHEDULE-LAB	35,357.72
		INJECTABLE DRUGS	138.07
		TOTAL NUMBER OF CLAIMS	1,679

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	92,142.82	3,539.73	OTHER LAB	74,870.14	500.00
MED/SURG SUPPLY	14,239.87	120.78	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	95.44
RADIOLOGY-DIAGNOSTIC	172,888.02	24,288.40	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	159,713.50	27,978.47	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,608.36	7,101.54	FEE SCHEDULE LAB	366,475.37	112,437.44
EKG/ECG	20,374.60	689.80	MRI SERVICES	189,422.93	6,428.40
IV THERAPY	29,221.60	9,509.54	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,425,377.04	356,814.32	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,345.37	3,034.20	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	500.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	156,395.92	50.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	453.67	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	764.66	113.46
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,844.53	6,301.58	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	7,345.35	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,173.85	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	31,126.78	3,373.62			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	915.20	392.70			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	7,156.62	1,455.64			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,321.17	1,003.68			
			TOTAL ANCILLARY	3,807,832.02	573,074.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,807,832.02	573,074.69



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS HOSPITAL OF TATTNALL  
247 S MAIN ST  
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	152,284.13	ADJUSTMENTS	0.00
COVERED CHARGES	102,132.28	CONTRACTUAL ALLOW	66,212.98
NON-COVERD CHARGES	50,151.85	TOTAL MEDICAID LIAB	35,919.30
		LESS: COB	35,901.30
		LESS: COPAYMENT	18.00
		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

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,710.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	55.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,684.60	1,200.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,475.47	1,200.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,141.48	727.04
EKG/ECG	0.00	0.00	MRI SERVICES	1,946.28	2,784.81
IV THERAPY	190.56	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	81,528.00	44,240.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	6,080.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	102,132.28	50,151.85
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	102,132.28	50,151.85

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:48:09  
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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	114,838.85	ADJUSTMENTS	1,005.00
COVERED CHARGES	107,692.62	CONTRACTUAL ALLOW	100,242.62
NON-COVERD CHARGES	7,146.23	TOTAL MEDICAID LIAB	7,450.00
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	7,177.00
		TOTAL NUMBER OF CLAIMS	149

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,205.08	817.75	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,339.17	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,172.91	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,746.34	1,503.81	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	19,740.62	3,217.72
EKG/ECG	1,005.85	0.00	MRI SERVICES	1,948.38	0.00
IV THERAPY	6,492.14	1,341.72	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,168.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	773.10	118.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	42,684.40	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	365.73	45.18
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	50.90	101.80			
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	0.00	0.00			
			TOTAL ANCILLARY	107,692.62	7,146.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	107,692.62	7,146.23

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

DOCTORS HOSPITAL OF TATTNALL  
247 S MAIN ST  
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	715.69	ADJUSTMENTS	0.00
COVERED CHARGES	691.69	CONTRACTUAL ALLOW	554.43
NON-COVERD CHARGES	24.00	TOTAL MEDICAID LIAB	137.26
		LESS: COB	137.25
		LESS: COPAYMENT	0.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89.17	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	282.96	24.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	319.56	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	691.69	24.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	691.69	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

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL  
247 S MAIN ST  
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,968,744.38	ADJUSTMENTS	87,623.32
COVERED CHARGES	2,885,690.74	CONTRACTUAL ALLOW	2,622,568.16
NON-COVERD CHARGES	83,053.64	TOTAL MEDICAID LIAB	263,122.58
		LESS: COB	21,471.55
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	241,567.03

TOTAL NUMBER OF CLAIMS 56

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL  
 247 S MAIN ST  
 REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
 000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,009.58	2,504.40	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,417.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	144.95	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,197.90	7,200.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	426.55	1,953.39	FEE SCHEDULE LAB	1,929.97	212.85
EKG/ECG	0.00	172.45	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,001,416.40	66,865.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	461.36	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	500.00	4,000.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	329.95	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	818,438.78	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,466.10	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	2,097.08	0.00			
			TOTAL ANCILLARY	2,885,690.74	83,053.64
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,885,690.74	83,053.64



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

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS HOSPITAL OF TATTNALL  
247 S MAIN ST  
REIDSVILLE,GA 30453-4605

PROVIDER NUMBER  
000001878A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,357.86	ADJUSTMENTS	0.00
COVERED CHARGES	27,636.26	CONTRACTUAL ALLOW	13,957.33
NON-COVERD CHARGES	8,721.60	TOTAL MEDICAID LIAB	13,678.93
		LESS: COB	13,678.93
		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

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	511.46	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	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	26,164.80	8,721.60	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	960.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	27,636.26	8,721.60
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	27,636.26	8,721.60

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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 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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	26,256,380.25	ADJUSTMENTS	143,391.50
COVERED CHARGES	25,672,836.03	CONTRACTUAL ALLOW	18,701,323.85
NON-COVERD CHARGES	583,544.22	TOTAL MEDICAID LIAB	6,971,512.18
		LESS: COB	30,333.94
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,941,178.24

TOTAL NUMBER OF ADMISSIONS 912

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	3,161		0	2,003,120.00		262,970.00
ROUTINE NURSERY	224		0	127,440.00		6,760.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,385		0	2,130,560.00		269,730.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	993		0	1,528,760.00		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	993		0	1,528,760.00		0.00
TOTAL ACCOMODATIONS	4,378		0	3,659,320.00		269,730.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,581,535.67	1,844.72	OTHER LAB	158,870.50	0.00
MED/SURG SUPPLY	1,656,628.30	4,529.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,065,418.67	0.00	EDUCATION & TRAINING	390.00	0.00
RADIOLOGY-DIAGNOSTIC	622,509.75	0.00	OTHER THERAPEUTIC SVC	0.00	27,205.50
CT SCAN	1,021,915.25	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	182,971.06	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	472,067.20	0.00	MRI SERVICES	270,775.25	0.00
IV THERAPY	129,097.33	0.00	PROFESSIONAL FEES	0.00	360.25
OPERATING ROOM	1,653,062.50	7,386.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	122,632.25	0.00	REHAB THERAPY	2,187.00	0.00
RESPIRATORY SERVICES	1,340,765.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,172.55	0.00	AMBULANCE	0.00	0.00
GI SERVICES	175,623.25	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	641,397.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	172,001.41	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	114,767.75	0.00	INJECTABLE DRUGS	2,001,590.18	0.00
RADIOLOGY THERAPEUTIC	72,633.25	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	24,751.54	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	15,533.50	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	33,739.25	9,835.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	11,833.00	4,614.75	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	679,795.25	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	122,882.50	19,123.50			
BLOOD	23,515.00	0.00			
BLOOD STORAGE & PRO.	408,243.00	228,251.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	102,176.75	8,270.75			
AUDIOLOGY	22,891.50	0.00			
CARDIOLOGY	742,909.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	18,455.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	341,778.12	2,393.25			
			TOTAL ANCILLARY	22,013,516.03	313,814.22
			TOTAL ACCOMODATIONS	3,659,320.00	269,730.00
			TOTAL CHARGES	25,672,836.03	583,544.22

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	110,775.63	ADJUSTMENTS	0.00
COVERED CHARGES	105,852.63	CONTRACTUAL ALLOW	20,388.25
NON-COVERD CHARGES	4,923.00	TOTAL MEDICAID LIAB	85,464.38
		LESS: COB	85,464.38
		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	22		0	14,410.00		2,840.00
ROUTINE NURSERY	9		0	5,355.00		1,905.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	31		0	19,765.00		4,745.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	19,765.00		4,745.00

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,803.44	0.00	OTHER LAB	2,547.00	0.00
MED/SURG SUPPLY	8,889.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,487.25	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	965.50	0.00	OTHER THERAPEUTIC SVC	0.00	116.50
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	5,274.50	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,073.50	0.00	PROFESSIONAL FEES	0.00	61.50
OPERATING ROOM	13,084.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,969.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,126.75	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	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,380.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	463.75	0.00	INJECTABLE DRUGS	4,036.46	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	231.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	775.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,049.25	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	700.50	0.00			
CARDIOLOGY	3,211.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,018.73	0.00			
			TOTAL ANCILLARY	86,087.63	178.00
			TOTAL ACCOMODATIONS	19,765.00	4,745.00
			TOTAL CHARGES	105,852.63	4,923.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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TIFT REGIONAL MEDICAL CTR  
901 18TH ST E  
TIFTON,GA 31794-3648

PROVIDER NUMBER  
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,495,122.49	ADJUSTMENTS	277,489.88
COVERED CHARGES	20,250,098.43	CONTRACTUAL ALLOW	16,360,960.79
NON-COVERD CHARGES	3,245,024.06	TOTAL MEDICAID LIAB	3,889,137.64
		LESS: COB	1,442.84
		LESS: COPAYMENT	13,438.57
		REIMBURSEMENT	3,874,256.23
		ALL OTHER	3,048,266.32
		FEE SCHEDULE-LAB	381,717.49
		INJECTABLE DRUGS	444,272.42

TOTAL NUMBER OF CLAIMS 9,382

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,269,837.36	5,324.84	OTHER LAB	574,022.75	53,636.00
MED/SURG SUPPLY	537,860.55	138,981.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	16,529.75	EDUCATION & TRAINING	2,787.50	125.00
RADIOLOGY-DIAGNOSTIC	882,593.25	31,850.00	OTHER THERAPEUTIC SVC	0.00	95,237.75
CT SCAN	2,141,832.00	203,385.25	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,121.00	12,129.27	FEE SCHEDULE LAB	4,093,048.14	937,280.04
EKG/ECG	269,452.50	28,402.00	MRI SERVICES	605,276.75	33,438.75
IV THERAPY	557,109.75	55,133.25	PROFESSIONAL FEES	0.00	6,304.09
OPERATING ROOM	1,281,480.00	316,837.25	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,353.25	0.00	REHAB THERAPY	7,663.00	0.00
RESPIRATORY SERVICES	98,252.00	20,416.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	10,826.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	272,173.75	49,122.75	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,351,827.50	64,372.75	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	248,517.23	867.36	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,362,675.55	290,711.94
RADIOLOGY THERAPEUTIC	607,542.75	4,066.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	671.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,329.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	36,437.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	94,533.75	5,142.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,357.25	460,575.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,093.75
OTHER IMAGING SERVICE	622,617.00	59,735.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	140,498.75	60,532.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	392,514.50	53,529.25			
AUDIOLOGY	0.00	233.50			
CARDIOLOGY	434,690.00	157,245.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	14,685.00	1,420.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	323,619.55	38,157.27			
			TOTAL ANCILLARY	20,250,098.43	3,242,924.06
			TOTAL ACCOMODATIONS	0.00	2,100.00
			TOTAL CHARGES	20,250,098.43	3,245,024.06



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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TIFT REGIONAL MEDICAL CTR  
901 18TH ST E  
TIFTON,GA 31794-3648

PROVIDER NUMBER  
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
7063	5912363000955	11/05/12 - 11/05/12	12/31/12	0.00	5,093.75	0.00	0.00	0.00
TOTAL				0.00	5,093.75	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

TIFT REGIONAL MEDICAL CTR  
901 18TH ST E  
TIFTON,GA 31794-3648

PROVIDER NUMBER  
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	296,316.28	ADJUSTMENTS	0.00
COVERED CHARGES	213,582.16	CONTRACTUAL ALLOW	63,634.54
NON-COVERD CHARGES	82,734.12	TOTAL MEDICAID LIAB	149,947.62
		LESS: COB	149,766.88
		LESS: COPAYMENT	180.74
		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

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,112.32	304.00	OTHER LAB	990.50	683.75
MED/SURG SUPPLY	5,258.00	3,145.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	60.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,003.75	0.00	OTHER THERAPEUTIC SVC	0.00	1,571.50
CT SCAN	5,867.75	18,691.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	69,344.50	11,223.23
EKG/ECG	4,020.00	420.00	MRI SERVICES	6,522.00	0.00
IV THERAPY	4,560.50	498.00	PROFESSIONAL FEES	0.00	5,999.25
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,370.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	495.50	59.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,208.75	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	33,478.13	591.50	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	5,518.33	14,658.60
RADIOLOGY THERAPEUTIC	23,779.25	4,379.50	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,028.00	241.50	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,239.25	3,736.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,329.25	4,568.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	3,295.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,683.00	7,867.75			
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	7,773.38	739.79			
			TOTAL ANCILLARY	213,582.16	82,734.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	213,582.16	82,734.12

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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TIFT REGIONAL MEDICAL CTR  
901 18TH ST E  
TIFTON,GA 31794-3648

PROVIDER NUMBER  
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	881,820.56	ADJUSTMENTS	1,135.74
COVERED CHARGES	815,995.06	CONTRACTUAL ALLOW	774,040.06
NON-COVERD CHARGES	65,825.50	TOTAL MEDICAID LIAB	41,955.00
		LESS: COB	0.00
		LESS: COPAYMENT	1,350.02
		REIMBURSEMENT	40,604.98
		TOTAL NUMBER OF CLAIMS	750

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,451.14	0.00	OTHER LAB	4,751.00	0.00
MED/SURG SUPPLY	8,933.50	2,414.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,043.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,780.50	0.00	OTHER THERAPEUTIC SVC	0.00	535.50
CT SCAN	41,892.75	3,035.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	386.75	FEE SCHEDULE LAB	231,803.75	39,510.00
EKG/ECG	8,560.00	214.00	MRI SERVICES	0.00	0.00
IV THERAPY	17,695.00	2,000.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,759.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,237.25	118.50	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	353,996.75	2,469.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	32,416.22	0.00
RADIOLOGY THERAPEUTIC	464.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,941.50	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	219.50	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	16,026.25	12,157.75			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,124.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,883.20	0.00			
			TOTAL ANCILLARY	815,995.06	65,825.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	815,995.06	65,825.50

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

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	32,662.13	ADJUSTMENTS	0.00
COVERED CHARGES	30,468.13	CONTRACTUAL ALLOW	20,595.79
NON-COVERD CHARGES	2,194.00	TOTAL MEDICAID LIAB	9,872.34
		LESS: COB	9,851.34
		LESS: COPAYMENT	21.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	15

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,465.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	702.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,632.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,035.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,250.75	1,054.00
EKG/ECG	856.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	695.00	0.00	PROFESSIONAL FEES	0.00	1,140.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	110.75	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,722.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	175.03	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	747.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	76.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	30,468.13	2,194.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	30,468.13	2,194.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR  
901 18TH ST E  
TIFTON,GA 31794-3648

PROVIDER NUMBER  
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,137,854.24	ADJUSTMENTS	88,515.02
COVERED CHARGES	2,865,336.69	CONTRACTUAL ALLOW	2,503,587.20
NON-COVERD CHARGES	272,517.55	TOTAL MEDICAID LIAB	361,749.49
		LESS: COB	0.00
		LESS: COPAYMENT	723.00
		REIMBURSEMENT	361,026.49
		TOTAL NUMBER OF CLAIMS	72



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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	108,186.27	349.25	OTHER LAB	1,748.00	3,607.25
MED/SURG SUPPLY	99,084.75	62,154.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,298.75	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,570.75	2,571.75	OTHER THERAPEUTIC SVC	0.00	9,914.25
CT SCAN	27,264.75	1,517.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	773.50	FEE SCHEDULE LAB	38,616.75	24,787.75
EKG/ECG	1,498.00	1,038.00	MRI SERVICES	8,084.25	0.00
IV THERAPY	53,737.75	2,335.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	240,025.00	49,085.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	831.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,463.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,013.58	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,686,548.89	30,495.00
RADIOLOGY THERAPEUTIC	234,967.25	650.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	4,917.50	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,368.00	25.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	276,713.75	67,752.25
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,374.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,611.25	6,912.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,223.25	125.25			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	16,111.50	1,386.25			
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	9,293.45	820.80			
			TOTAL ANCILLARY	2,865,336.69	272,517.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,865,336.69	272,517.55

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: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

TIFT REGIONAL MEDICAL CTR  
901 18TH ST E  
TIFTON,GA 31794-3648

PROVIDER NUMBER  
000001922A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,320.57	ADJUSTMENTS	0.00
COVERED CHARGES	97,055.57	CONTRACTUAL ALLOW	35,710.14
NON-COVERD CHARGES	5,265.00	TOTAL MEDICAID LIAB	61,345.43
		LESS: COB	61,261.43
		LESS: COPAYMENT	84.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,263.57	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	851.25	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	673.00	673.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	214.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	21,297.75	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	0.00	0.00
RADIOLOGY THERAPEUTIC	62,924.50	4,378.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	483.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	9,562.50	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	97,055.57	5,265.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	97,055.57	5,265.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	127,360.29	ADJUSTMENTS	0.00
COVERED CHARGES	126,610.29	CONTRACTUAL ALLOW	67,133.44
NON-COVERD CHARGES	750.00	TOTAL MEDICAID LIAB	59,476.85
		LESS: COB	1,380.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	58,096.85

TOTAL NUMBER OF ADMISSIONS 10

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	26		0	18,750.00		750.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	26		0	18,750.00		750.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	26		0	18,750.00		750.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

CHATUGE REGIONAL HOSPITAL  
 PO BOX 509  
 HIWASSEE,GA 30546-0509

PROVIDER NUMBER  
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,302.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	6,136.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	19,853.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,840.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,350.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	140.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	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	4,665.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	7,477.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	15,870.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,567.29	0.00			
			TOTAL ANCILLARY	107,860.29	0.00
			TOTAL ACCOMODATIONS	18,750.00	750.00
			TOTAL CHARGES	126,610.29	750.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	05/01/12	THROUGH	04/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	446,837.49	ADJUSTMENTS	3,951.42
COVERED CHARGES	375,868.49	CONTRACTUAL ALLOW	271,420.35
NON-COVERD CHARGES	70,969.00	TOTAL MEDICAID LIAB	104,448.14
		LESS: COB	0.00
		LESS: COPAYMENT	714.00
		REIMBURSEMENT	103,734.14
		ALL OTHER	86,861.65
		FEE SCHEDULE-LAB	16,638.02
		INJECTABLE DRUGS	234.47

TOTAL NUMBER OF CLAIMS 526

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 11:56:38  
 Page: 5

CHATUGE REGIONAL HOSPITAL  
 PO BOX 509  
 HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
 000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,693.00	6,765.00	OTHER LAB	12,750.00	0.00
MED/SURG SUPPLY	8,125.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,370.00	550.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	44,275.00	19,475.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,560.00	390.00	FEE SCHEDULE LAB	124,550.10	31,612.00
EKG/ECG	9,106.00	165.00	MRI SERVICES	8,750.00	1,500.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,410.00	1,345.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	761.00	650.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	77,385.00	1,587.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,135.00	5,655.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,675.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,803.00	900.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,175.00	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	8,345.39	375.00			
			TOTAL ANCILLARY	375,868.49	70,969.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	375,868.49	70,969.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

CHATUGE REGIONAL HOSPITAL  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,615.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,097.00	CONTRACTUAL ALLOW	-292.92
NON-COVERD CHARGES	1,518.00	TOTAL MEDICAID LIAB	1,389.92
		LESS: COB	1,389.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5.00	10.00	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	1,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	145.00	8.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	72.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,097.00	1,518.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,097.00	1,518.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:56:52  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	21,143.00	ADJUSTMENTS	124.01
COVERED CHARGES	19,319.00	CONTRACTUAL ALLOW	17,118.95
NON-COVERD CHARGES	1,824.00	TOTAL MEDICAID LIAB	2,200.05
		LESS: COB	0.00
		LESS: COPAYMENT	78.00
		REIMBURSEMENT	2,122.05
		TOTAL NUMBER OF CLAIMS	46

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	889.00	382.00	OTHER LAB	600.00	0.00
MED/SURG SUPPLY	337.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	105.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,350.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	4,198.00	1,219.00
EKG/ECG	165.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,450.00	10.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	225.00	213.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,319.00	1,824.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,319.00	1,824.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHATUGE REGIONAL HOSPITAL  
PO BOX 509  
HIAWASSEE,GA 30546-0509

PROVIDER NUMBER  
000001933A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/12	THROUGH	04/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	05/01/12	THROUGH	04/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	05/01/12	THROUGH	04/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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 Page: 1

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	536,142.37	ADJUSTMENTS	6,804.57
COVERED CHARGES	520,804.37	CONTRACTUAL ALLOW	181,117.15
NON-COVERD CHARGES	15,338.00	TOTAL MEDICAID LIAB	339,687.22
		LESS: COB	8,594.48
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	331,092.74

TOTAL NUMBER OF ADMISSIONS 65

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	142		0	103,050.00		3,450.00
ROUTINE NURSERY	0		23	0.00		8,050.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	142		23	103,050.00		11,500.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	13		0	16,250.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	13		0	16,250.00		0.00
TOTAL ACCOMODATIONS	155		23	119,300.00		11,500.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNION COUNTY HOSPITAL AUTHORITY  
 35 HOSPITAL RD  
 BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER  
 000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	71,531.50	0.00	OTHER LAB	2,450.00	0.00
MED/SURG SUPPLY	28,597.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	69,565.45	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,090.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	25,500.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	985.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	3,795.00	0.00	MRI SERVICES	1,500.00	0.00
IV THERAPY	325.00	0.00	PROFESSIONAL FEES	0.00	2,100.00
OPERATING ROOM	3,582.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,390.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	20,305.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	1,050.00	450.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	36,815.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	70.00	60.00	INJECTABLE DRUGS	85,922.75	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	4,675.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,430.00	450.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	3,350.00	778.00			
AUDIOLOGY	520.00	0.00			
CARDIOLOGY	6,373.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,931.89	0.00			
			TOTAL ANCILLARY	401,504.37	3,838.00
			TOTAL ACCOMODATIONS	119,300.00	11,500.00
			TOTAL CHARGES	520,804.37	15,338.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:12:41  
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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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,039.80	ADJUSTMENTS	0.00
COVERED CHARGES	21,839.80	CONTRACTUAL ALLOW	5,037.80
NON-COVERD CHARGES	1,200.00	TOTAL MEDICAID LIAB	16,802.00
		LESS: COB	16,802.00
		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	3,750.00		700.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	5		0	3,750.00		700.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		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	2		0	2,500.00		0.00
TOTAL ACCOMODATIONS	7		0	6,250.00		700.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:12:41  
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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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,630.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	610.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,309.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	310.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,975.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	500.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	957.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	2,778.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	40.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,589.80	500.00
			TOTAL ACCOMODATIONS	6,250.00	700.00
			TOTAL CHARGES	21,839.80	1,200.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:12:42  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,908,328.33	ADJUSTMENTS	75,661.55
COVERED CHARGES	1,794,125.68	CONTRACTUAL ALLOW	1,324,369.15
NON-COVERD CHARGES	114,202.65	TOTAL MEDICAID LIAB	469,756.53
		LESS: COB	1,000.00
		LESS: COPAYMENT	1,800.00
		REIMBURSEMENT	466,956.53
		ALL OTHER	409,124.70
		FEE SCHEDULE-LAB	51,931.61
		INJECTABLE DRUGS	5,900.22
		TOTAL NUMBER OF CLAIMS	1,738

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	151,957.00	387.00	OTHER LAB	13,445.00	1,060.00
MED/SURG SUPPLY	88,615.49	71.85	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	142,150.00	3,040.00	OTHER THERAPEUTIC SVC	0.00	3,265.00
CT SCAN	265,900.00	7,250.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,160.00	122.00	FEE SCHEDULE LAB	313,978.00	55,102.80
EKG/ECG	29,865.00	990.00	MRI SERVICES	97,325.00	7,625.00
IV THERAPY	97,855.00	7,235.00	PROFESSIONAL FEES	0.00	550.00
OPERATING ROOM	54,372.00	2,214.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,670.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,610.00	80.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,150.00	1,050.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	240,918.00	1,170.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	17,200.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	87,228.00	3,461.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,760.00	240.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	300.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,952.00	106.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,500.00
OTHER IMAGING SERVICE	59,074.00	4,807.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,031.00	2,250.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	44,600.00	10,161.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	23,222.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36,088.19	165.00			
			TOTAL ANCILLARY	1,794,125.68	114,202.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,794,125.68	114,202.65

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:12:42  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012256037802	09/07/12 - 09/07/12	09/17/12	0.00	1,500.00	0.00	0.00	0.00
TOTAL				0.00	1,500.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 09:13:26  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNION COUNTY HOSPITAL AUTHORITY  
35 HOSPITAL RD  
BLAIRSVILLE,GA 30512-3139

PROVIDER NUMBER  
000001966A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,792.90	ADJUSTMENTS	0.00
COVERED CHARGES	15,585.90	CONTRACTUAL ALLOW	8,643.82
NON-COVERD CHARGES	1,207.00	TOTAL MEDICAID LIAB	6,942.08
		LESS: COB	6,936.08
		LESS: COPAYMENT	6.00
		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

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	920.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	231.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	675.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,100.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,020.00	357.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,350.00	0.00	PROFESSIONAL FEES	0.00	800.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	82.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,750.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	345.00	50.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,839.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	272.65	0.00			
			TOTAL ANCILLARY	15,585.90	1,207.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,585.90	1,207.00



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	84,114.80	ADJUSTMENTS	596.50
COVERED CHARGES	81,166.80	CONTRACTUAL ALLOW	73,530.38
NON-COVERD CHARGES	2,948.00	TOTAL MEDICAID LIAB	7,636.42
		LESS: COB	0.00
		LESS: COPAYMENT	267.01
		REIMBURSEMENT	7,369.41
		TOTAL NUMBER OF CLAIMS	143

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,281.00	0.00	OTHER LAB	1,100.00	0.00
MED/SURG SUPPLY	831.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,130.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,100.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,482.00	2,268.00
EKG/ECG	1,320.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,700.00	180.00	PROFESSIONAL FEES	0.00	200.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	280.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,845.00	250.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,094.00	50.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,003.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	81,166.80	2,948.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	81,166.80	2,948.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,350.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,965.00	CONTRACTUAL ALLOW	593.00
NON-COVERD CHARGES	385.00	TOTAL MEDICAID LIAB	1,372.00
		LESS: COB	1,369.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5

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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35.00	10.00	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	767.00	16.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	200.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,110.00	30.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	50.00	129.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,965.00	385.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,965.00	385.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	05/01/12	THROUGH	04/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 09:13:32  
Page: 15

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	05/01/12	THROUGH	04/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA, GA 30901-2612

PROVIDER NUMBER 000001977A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	40,504,827.53	ADJUSTMENTS	1,998,842.88
COVERED CHARGES	39,309,265.13	CONTRACTUAL ALLOW	27,853,989.13
NON-COVERD CHARGES	1,195,562.40	TOTAL MEDICAID LIAB	11,455,276.00
		LESS: COB	140,737.89
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	11,314,538.11

TOTAL NUMBER OF ADMISSIONS 1,173

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,961	0	1,645,140.00	72,240.00
ROUTINE NURSERY	320	223	377,304.00	124,838.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,281	223	2,022,444.00	197,078.00
SPECIAL CARE SERVICES				
CCU	164	0	264,875.00	1,625.00
ICU	3,800	0	3,954,488.00	68,053.00
NICU	187	0	303,875.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	4,151	0	4,523,238.00	69,678.00
TOTAL ACCOMODATIONS	7,432	223	6,545,682.00	266,756.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,635,312.18	200,750.52	OTHER LAB	200,718.00	4,743.00
MED/SURG SUPPLY	5,371,274.35	203,345.46	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,843,791.58	52,191.80	EDUCATION & TRAINING	9,417.00	98.00
RADIOLOGY-DIAGNOSTIC	894,618.00	9,985.00	OTHER THERAPEUTIC SVC	103,434.95	6,868.00
CT SCAN	1,544,348.00	21,300.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	201,259.00	17,003.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	248,829.00	1,048.00	MRI SERVICES	335,166.00	8,889.00
IV THERAPY	217,991.00	10,421.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,043,076.00	13,509.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	143,277.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,152,441.00	12,079.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	198,997.00	1,444.00	AMBULANCE	0.00	0.00
GI SERVICES	272,223.00	12,127.00	CAST ROOM	71.00	0.00
EMERGENCY ROOM	862,229.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	187,906.00	1,098.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	176,420.90	1,688.86	INJECTABLE DRUGS	204,400.29	4,480.36
RADIOLOGY THERAPEUTIC	7,132.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	72,468.00	2,801.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	82,377.00	1,967.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	278,472.00	54,336.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	36,337.13	4,488.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,220,482.25	9,167.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	5,226.00
OTHER IMAGING SERVICE	188,290.00	40,266.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	380,143.50	153,152.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	160,301.00	49,379.00			
AUDIOLOGY	7,548.00	12,220.00			
CARDIOLOGY	1,139,682.00	2,367.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	19,172.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	323,978.00	10,368.00			
			TOTAL ANCILLARY	32,763,583.13	928,806.40
			TOTAL ACCOMODATIONS	6,545,682.00	266,756.00
			TOTAL CHARGES	39,309,265.13	1,195,562.40



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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UNIVERSITY HOSPITAL  
1350 WALTON WAY  
AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013241026721	01/15/13 - 01/29/13	09/02/13	0.00	2,613.00	0.00	0.00	0.00
615	2014112029229	05/17/13 - 05/23/13	04/28/14	0.00	2,613.00	0.00	0.00	0.00
TOTAL				0.00	5,226.00	0.00	0.00	0.00

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	517,072.00	ADJUSTMENTS	0.00
COVERED CHARGES	511,055.00	CONTRACTUAL ALLOW	258,165.50
NON-COVERD CHARGES	6,017.00	TOTAL MEDICAID LIAB	252,889.50
		LESS: COB	252,889.50
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 24

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	77		0	43,680.00		980.00
ROUTINE NURSERY	15		7	17,970.00		3,087.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	92		7	61,650.00		4,067.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	25		0	27,330.00		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	25		0	27,330.00		0.00
TOTAL ACCOMODATIONS	117		7	88,980.00		4,067.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	89,835.98	0.00	OTHER LAB	2,364.00	0.00
MED/SURG SUPPLY	74,645.42	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	43,705.94	0.00	EDUCATION & TRAINING	20.00	0.00
RADIOLOGY-DIAGNOSTIC	5,070.00	0.00	OTHER THERAPEUTIC SVC	0.00	34.00
CT SCAN	15,601.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,732.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,572.00	0.00	MRI SERVICES	3,335.00	0.00
IV THERAPY	336.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	70,206.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	18,070.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,963.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,027.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,320.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,797.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	3,330.92	0.00	INJECTABLE DRUGS	88.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,355.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	447.24	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	53,478.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	441.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,256.00	1,176.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,730.00	480.00			
AUDIOLOGY	738.00	260.00			
CARDIOLOGY	9,721.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	889.00	0.00			
			TOTAL ANCILLARY	422,075.00	1,950.00
			TOTAL ACCOMODATIONS	88,980.00	4,067.00
			TOTAL CHARGES	511,055.00	6,017.00

Report : CLM-0804-0  
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Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

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UNIVERSITY HOSPITAL  
1350 WALTON WAY  
AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	17,120,869.28	ADJUSTMENTS	800,677.18
COVERED CHARGES	15,474,032.98	CONTRACTUAL ALLOW	12,079,781.62
NON-COVERD CHARGES	1,646,836.30	TOTAL MEDICAID LIAB	3,394,251.36
		LESS: COB	28,029.15
		LESS: COPAYMENT	10,312.46
		REIMBURSEMENT	3,355,909.75
		ALL OTHER	2,747,522.34
		FEE SCHEDULE-LAB	337,846.36
		INJECTABLE DRUGS	270,541.05

TOTAL NUMBER OF CLAIMS 10,288

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

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PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	767,300.58	18,012.01	OTHER LAB	191,726.00	491.00
MED/SURG SUPPLY	1,687,594.60	61,204.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	258.00	EDUCATION & TRAINING	332.00	3,177.00
RADIOLOGY-DIAGNOSTIC	803,122.00	3,956.00	OTHER THERAPEUTIC SVC	517.20	105.00
CT SCAN	1,498,603.00	138,215.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,253.00	8,866.00	FEE SCHEDULE LAB	2,005,114.45	424,726.81
EKG/ECG	276,350.00	13,624.00	MRI SERVICES	493,053.00	31,939.00
IV THERAPY	201,131.00	9,126.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	915,979.48	175,284.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	55,014.00	0.00	REHAB THERAPY	377.00	0.00
RESPIRATORY SERVICES	124,350.00	20,333.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	119,063.00	158.00	AMBULANCE	0.00	0.00
GI SERVICES	191,068.01	27,262.99	CAST ROOM	10,182.00	0.00
EMERGENCY ROOM	2,194,066.00	1,844.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	195,572.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	257.95
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,075,898.98	267,552.91
RADIOLOGY THERAPEUTIC	140,296.00	780.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	23,147.00	5,593.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,442.00	2,537.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	10,754.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	251,768.50	16,911.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	104,514.18	189,170.28
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	198.00
OTHER IMAGING SERVICE	329,968.00	25,723.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	121,341.00	7,290.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	383,823.00	49,313.00			
AUDIOLOGY	2,702.00	256.00			
CARDIOLOGY	546,137.00	89,532.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,436.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	732,791.00	42,386.00			
			TOTAL ANCILLARY	15,474,032.98	1,646,836.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	15,474,032.98	1,646,836.30

Report : CLM-0804-0  
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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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UNIVERSITY HOSPITAL  
1350 WALTON WAY  
AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013364009868	10/28/13 - 10/28/13	01/06/14	0.00	198.00	0.00	0.00	0.00
TOTAL				0.00	198.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

UNIVERSITY HOSPITAL  
1350 WALTON WAY  
AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	273,962.68	ADJUSTMENTS	0.00
COVERED CHARGES	216,515.88	CONTRACTUAL ALLOW	113,456.71
NON-COVERD CHARGES	57,446.80	TOTAL MEDICAID LIAB	103,059.17
		LESS: COB	102,983.58
		LESS: COPAYMENT	75.59
		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

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,906.09	400.18	OTHER LAB	291.00	0.00
MED/SURG SUPPLY	21,875.72	1,621.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	39.00
RADIOLOGY-DIAGNOSTIC	4,663.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,750.00	7,288.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,280.23	4,074.21
EKG/ECG	2,620.00	262.00	MRI SERVICES	0.00	2,722.00
IV THERAPY	3,268.00	324.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	29,046.00	1,846.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,147.00	924.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	271.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,299.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,242.00	4,203.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	30,714.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,738.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,734.84	10,513.41
RADIOLOGY THERAPEUTIC	735.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	354.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	19,767.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,095.00	1,186.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	7,251.00	1,670.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,169.00	233.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	15,066.00	374.00			
			TOTAL ANCILLARY	216,515.88	57,446.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	216,515.88	57,446.80



Report : CLM-0808-0  
Process : CLMJ0800  
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GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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UNIVERSITY HOSPITAL  
1350 WALTON WAY  
AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	438,402.66	ADJUSTMENTS	1,061.77
COVERED CHARGES	422,390.57	CONTRACTUAL ALLOW	388,810.21
NON-COVERD CHARGES	16,012.09	TOTAL MEDICAID LIAB	33,580.36
		LESS: COB	352.00
		LESS: COPAYMENT	1,254.07
		REIMBURSEMENT	31,974.29
		TOTAL NUMBER OF CLAIMS	594

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

UNIVERSITY HOSPITAL  
 1350 WALTON WAY  
 AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
 000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,509.94	601.26	OTHER LAB	2,343.00	0.00
MED/SURG SUPPLY	23,073.57	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	29,111.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,243.00	1,776.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	56,152.65	10,858.00
EKG/ECG	4,716.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,471.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	260.00	299.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	224,695.00	132.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,214.41	833.83
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	302.00	378.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,372.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,709.00	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	25,218.00	1,134.00			
			TOTAL ANCILLARY	422,390.57	16,012.09
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	422,390.57	16,012.09

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,142.68	ADJUSTMENTS	0.00
COVERED CHARGES	4,303.34	CONTRACTUAL ALLOW	2,154.97
NON-COVERD CHARGES	839.34	TOTAL MEDICAID LIAB	2,148.37
		LESS: COB	2,142.37
		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: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23.21	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	332.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,070.52	148.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,401.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	98.61	98.34
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	0.00	593.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	378.00	0.00			
			TOTAL ANCILLARY	4,303.34	839.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,303.34	839.34

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL  
1350 WALTON WAY  
AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
000001977A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,355,425.45	ADJUSTMENTS	59,697.80
COVERED CHARGES	751,943.33	CONTRACTUAL ALLOW	577,314.80
NON-COVERD CHARGES	603,482.12	TOTAL MEDICAID LIAB	174,628.53
		LESS: COB	0.00
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	174,511.53
		TOTAL NUMBER OF CLAIMS	33

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	34,485.52	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	58,357.76	8,113.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	9,921.00	200.00	OTHER THERAPEUTIC SVC	3,150.00	0.00
CT SCAN	0.00	1,776.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	3,775.00	FEE SCHEDULE LAB	11,261.07	1,009.08
EKG/ECG	2,096.00	2,096.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,985.00	1,042.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	414,355.61	10,104.39	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	876.00	242.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,219.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,160.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,294.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	137,810.07	13,498.05
RADIOLOGY THERAPEUTIC	8,774.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	627.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	378.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,925.30	541,206.60
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	480.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,795.00	17,801.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,478.00	1,134.00			
			TOTAL ANCILLARY	751,943.33	603,482.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	751,943.33	603,482.12

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UNIVERSITY HOSPITAL  
1350 WALTON WAY  
AUGUSTA,GA 30901-2612

PROVIDER NUMBER  
000001977A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:27:07  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

UPSON REGIONAL MEDICAL CENTER  
 801 W GORDON ST  
 THOMASTON,GA 30286-3426

PROVIDER NUMBER 000001988A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,318,772.20	ADJUSTMENTS	586,665.89
COVERED CHARGES	8,247,521.79	CONTRACTUAL ALLOW	5,019,252.30
NON-COVERD CHARGES	71,250.41	TOTAL MEDICAID LIAB	3,228,269.49
		LESS: COB	33,040.87
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,195,228.62

TOTAL NUMBER OF ADMISSIONS 375

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	979		0	919,575.00		3,185.00
ROUTINE NURSERY	51		0	35,700.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,030		0	955,275.00		3,185.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	502		0	849,424.00		0.00
NICU	14		0	14,000.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	516		0	863,424.00		0.00
TOTAL ACCOMODATIONS	1,546		0	1,818,699.00		3,185.00



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:27:07  
 Page: 2

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	536,325.97	1,525.16	OTHER LAB	22,605.00	0.00
MED/SURG SUPPLY	467,360.60	16,671.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,064,000.00	3,301.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	187,426.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	500,633.00	2,867.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	188,088.03	652.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	73,718.00	0.00	MRI SERVICES	61,985.00	0.00
IV THERAPY	212,056.00	6,313.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	686,685.00	14,846.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	72,644.00	0.00	REHAB THERAPY	117.00	0.00
RESPIRATORY SERVICES	637,285.00	4,456.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,269.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	65,677.00	2,894.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	350,274.00	1,697.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	129,726.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	2,112.00
LABORATORY PATHOLOGIC	32,610.00	0.00	INJECTABLE DRUGS	721,235.19	671.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	19,212.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,829.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,064.00	2,688.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	110.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52,608.00	0.00
LITHOTRIPSY	15,882.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	40,007.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	68,906.00	661.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	19,140.00	4,896.00			
AUDIOLOGY	2,268.00	1,815.00			
CARDIOLOGY	118,721.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	842.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36,514.00	0.00			
			TOTAL ANCILLARY	6,428,822.79	68,065.41
			TOTAL ACCOMODATIONS	1,818,699.00	3,185.00
			TOTAL CHARGES	8,247,521.79	71,250.41

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 11:27:18  
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UPSON REGIONAL MEDICAL CENTER  
 801 W GORDON ST  
 THOMASTON,GA 30286-3426

PROVIDER NUMBER  
 000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,038.35	ADJUSTMENTS	0.00
COVERED CHARGES	70,970.35	CONTRACTUAL ALLOW	30,394.89
NON-COVERD CHARGES	68.00	TOTAL MEDICAID LIAB	40,575.46
		LESS: COB	40,575.46
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF ADMISSIONS	5

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	7		0	6,650.00		0.00
ROUTINE NURSERY	1		0	700.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	7,350.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	3		0	3,900.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	3		0	3,900.00		0.00
TOTAL ACCOMODATIONS	11		0	11,250.00		0.00

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,611.25	0.00	OTHER LAB	1,197.00	0.00
MED/SURG SUPPLY	1,498.00	68.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	7,193.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,274.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,424.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,329.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	840.00	0.00	MRI SERVICES	5,663.00	0.00
IV THERAPY	2,268.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,554.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	97.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,491.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	406.00	0.00	INJECTABLE DRUGS	4,450.10	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	6,786.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	842.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	797.00	0.00			
			TOTAL ANCILLARY	59,720.35	68.00
			TOTAL ACCOMODATIONS	11,250.00	0.00
			TOTAL CHARGES	70,970.35	68.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:27:20  
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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,778,671.98	ADJUSTMENTS	538,411.87
COVERED CHARGES	9,278,420.95	CONTRACTUAL ALLOW	7,446,746.92
NON-COVERD CHARGES	500,251.03	TOTAL MEDICAID LIAB	1,831,674.03
		LESS: COB	118.45
		LESS: COPAYMENT	2,799.00
		REIMBURSEMENT	1,828,756.58
		ALL OTHER	1,651,670.93
		FEE SCHEDULE-LAB	137,886.61
		INJECTABLE DRUGS	39,199.04

TOTAL NUMBER OF CLAIMS 4,343

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	167,399.53	3.50	OTHER LAB	74,566.00	1,836.00
MED/SURG SUPPLY	229,096.55	430.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,320.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	683,441.00	6,705.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,352,256.00	25,504.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	43,895.00	6,814.00	FEE SCHEDULE LAB	1,653,439.07	238,773.75
EKG/ECG	152,198.00	6,440.00	MRI SERVICES	210,547.00	7,011.00
IV THERAPY	539,775.00	78,172.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	579,675.34	51,950.66	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	33,136.00	0.00	REHAB THERAPY	1,287.00	460.00
RESPIRATORY SERVICES	23,728.00	5,349.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	33,048.00	324.00	AMBULANCE	0.00	0.00
GI SERVICES	80,215.00	5,787.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,131,564.00	5,894.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	150,857.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	209,730.46	44,521.12
RADIOLOGY THERAPEUTIC	2,279.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,028.00	349.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,604.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	5,940.00	110.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	57,790.00	0.00
LITHOTRIPSY	23,804.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	245,953.00	6,260.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	15,138.00	661.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	181,864.00	884.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	113,503.00	608.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	46,879.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	230,389.00	2,480.00			
			TOTAL ANCILLARY	9,278,420.95	500,251.03
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,278,420.95	500,251.03

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	180,936.63	ADJUSTMENTS	0.00
COVERED CHARGES	142,841.28	CONTRACTUAL ALLOW	65,322.24
NON-COVERD CHARGES	38,095.35	TOTAL MEDICAID LIAB	77,519.04
		LESS: COB	77,483.04
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 80

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,709.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,570.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,833.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,370.00	16,752.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	34,626.00	8,113.00
EKG/ECG	3,690.00	0.00	MRI SERVICES	3,848.00	0.00
IV THERAPY	8,521.00	945.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	18,363.00	163.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,464.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	100.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,053.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	9,676.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	31,376.00	1,020.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,358.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3,468.53	1,316.35
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	110.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,747.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,324.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	420.00	0.00			
			TOTAL ANCILLARY	142,841.28	38,095.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	142,841.28	38,095.35

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,041,666.91	ADJUSTMENTS	3,542.02
COVERED CHARGES	1,002,691.87	CONTRACTUAL ALLOW	957,212.66
NON-COVERD CHARGES	38,975.04	TOTAL MEDICAID LIAB	45,479.21
		LESS: COB	40.00
		LESS: COPAYMENT	1,689.04
		REIMBURSEMENT	43,750.17
		TOTAL NUMBER OF CLAIMS	813



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,007.88	0.00	OTHER LAB	5,792.00	0.00
MED/SURG SUPPLY	11,069.00	304.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,598.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	86,310.00	2,141.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	443.00	0.00	FEE SCHEDULE LAB	212,183.00	27,424.00
EKG/ECG	9,839.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	55,718.00	5,538.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,333.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	208.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	914.00	380.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	351.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	494,652.00	163.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	2,179.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,088.99	1,886.04
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	220.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	6.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	75.00
OTHER IMAGING SERVICE	30,672.00	1,064.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,108.00	0.00			
			TOTAL ANCILLARY	1,002,691.87	38,975.04
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,002,691.87	38,975.04

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213108018919	01/01/13 - 01/01/13	04/22/13	0.00	75.00	0.00	0.00	0.00
TOTAL				0.00	75.00	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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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	23,184.50	ADJUSTMENTS	0.00
COVERED CHARGES	19,308.50	CONTRACTUAL ALLOW	11,288.20
NON-COVERD CHARGES	3,876.00	TOTAL MEDICAID LIAB	8,020.30
		LESS: COB	7,996.30
		LESS: COPAYMENT	24.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	9

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	79.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	143.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,396.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	2,141.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,185.00	1,101.00
EKG/ECG	840.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	888.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	190.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,398.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	189.50	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	0.00	532.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	19,308.50	3,876.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,308.50	3,876.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CENTER  
801 W GORDON ST  
THOMASTON,GA 30286-3426

PROVIDER NUMBER  
000001988A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	416,271.45	ADJUSTMENTS	29,384.96
COVERED CHARGES	410,656.20	CONTRACTUAL ALLOW	345,028.99
NON-COVERD CHARGES	5,615.25	TOTAL MEDICAID LIAB	65,627.21
		LESS: COB	0.00
		LESS: COPAYMENT	81.00
		REIMBURSEMENT	65,546.21
		TOTAL NUMBER OF CLAIMS	13

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,023.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	57,869.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,258.00	2,242.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,665.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,842.00	771.00
EKG/ECG	1,120.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	6,518.00	1,899.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	185,393.00	6.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	734.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,910.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,328.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	21,790.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	38,789.60	692.25
RADIOLOGY THERAPEUTIC	1,353.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	60,250.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	871.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,262.00	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	1,680.00	5.00			
			TOTAL ANCILLARY	410,656.20	5,615.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	410,656.20	5,615.25

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

UPSON REGIONAL MEDICAL CENTER  
801 W GORDON ST  
THOMASTON,GA 30286-3426

PROVIDER NUMBER  
000001988A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR WINDY HILL HOSPITAL  
 2540 WINDY HILL RD SE  
 MARIETTA,GA 30067-8605

PROVIDER NUMBER 000001999A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,600,415.22	ADJUSTMENTS	903,754.30
COVERED CHARGES	5,931,383.80	CONTRACTUAL ALLOW	4,361,216.47
NON-COVERD CHARGES	669,031.42	TOTAL MEDICAID LIAB	1,570,167.33
		LESS: COB	15,182.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,554,985.13

TOTAL NUMBER OF ADMISSIONS 31

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	238		0	203,580.00		44,996.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	238		0	203,580.00		44,996.00
SPECIAL CARE SERVICES						
CCU	976		0	1,647,776.00		198,449.00
ICU	2		0	5,200.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	978		0	1,652,976.00		198,449.00
TOTAL ACCOMODATIONS	1,216		0	1,856,556.00		243,445.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WELLSTAR WINDY HILL HOSPITAL  
 2540 WINDY HILL RD SE  
 MARIETTA,GA 30067-8605

PROVIDER NUMBER  
 000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	876,349.00	76,193.50	OTHER LAB	12,107.00	1,084.00
MED/SURG SUPPLY	180,628.80	24,378.92	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	374,335.00	21,833.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	69,347.00	3,262.00	OTHER THERAPEUTIC SVC	0.00	1,608.00
CT SCAN	49,788.00	8,172.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	100,097.00	6,778.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,199.00	0.00	MRI SERVICES	9,078.00	3,763.00
IV THERAPY	9,778.00	7,066.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	65,964.00	4,457.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,116,357.00	254,715.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	7,493.00	1,763.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	868.00	2,064.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,693.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	34,902.00	2,682.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	51,148.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	42,039.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	35,254.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,058.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	7,176.00	4,630.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	14,995.00	1,137.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,672.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	502.00	0.00			
			TOTAL ANCILLARY	4,074,827.80	425,586.42
			TOTAL ACCOMODATIONS	1,856,556.00	243,445.00
			TOTAL CHARGES	5,931,383.80	669,031.42

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:10:59  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:10:59  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	845,632.76	ADJUSTMENTS	19,702.17
COVERED CHARGES	804,249.76	CONTRACTUAL ALLOW	533,180.10
NON-COVERD CHARGES	41,383.00	TOTAL MEDICAID LIAB	271,069.66
		LESS: COB	138.91
		LESS: COPAYMENT	576.00
		REIMBURSEMENT	270,354.75
		ALL OTHER	268,066.40
		FEE SCHEDULE-LAB	1,993.42
		INJECTABLE DRUGS	294.93

TOTAL NUMBER OF CLAIMS 253

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 12:10:59  
 Page: 5

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,769.75	0.00	OTHER LAB	4,159.00	0.00
MED/SURG SUPPLY	24,480.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	41,495.00	650.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,895.00	10,075.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	299.00	0.00	FEE SCHEDULE LAB	22,808.00	1,845.00
EKG/ECG	646.00	0.00	MRI SERVICES	62,996.00	9,884.00
IV THERAPY	5,073.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	111,589.00	17,805.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	200.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	60,429.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	34,398.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,614.25	224.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,082.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	900.00
OTHER IMAGING SERVICE	45,736.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,519.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	340,681.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,380.76	0.00			
			TOTAL ANCILLARY	804,249.76	41,383.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	804,249.76	41,383.00

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 12:10:59  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013098030399	03/19/13 - 03/19/13	04/15/13	0.00	200.00	0.00	0.00	0.00
948	2013098030399	03/21/13 - 03/21/13	04/15/13	0.00	200.00	0.00	0.00	0.00
948	2013098030399	03/27/13 - 03/27/13	04/15/13	0.00	200.00	0.00	0.00	0.00
948	5913169001730	04/25/13 - 04/25/13	06/24/13	0.00	200.00	0.00	0.00	0.00
948	5913169001730	04/30/13 - 04/30/13	06/24/13	0.00	100.00	0.00	0.00	0.00
TOTAL				0.00	900.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 12:11:01  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR WINDY HILL HOSPITAL  
2540 WINDY HILL RD SE  
MARIETTA,GA 30067-8605

PROVIDER NUMBER  
000001999A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,547.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,097.00	CONTRACTUAL ALLOW	3,160.56
NON-COVERD CHARGES	2,450.00	TOTAL MEDICAID LIAB	2,936.44
		LESS: COB	2,902.27
		LESS: COPAYMENT	34.17
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WELLSTAR 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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	153.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	288.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	200.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	2,250.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	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	6,097.00	2,450.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,097.00	2,450.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013254070980	09/05/12 - 09/05/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070980	09/06/12 - 09/06/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070980	09/10/12 - 09/10/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070980	09/12/12 - 09/12/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070980	09/13/12 - 09/13/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070980	09/27/12 - 09/27/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070980	09/25/12 - 09/25/12	09/16/13	0.00	75.00	0.00	0.00	0.00
948	2013254070980	09/20/12 - 09/20/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070980	09/19/12 - 09/19/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070980	09/17/12 - 09/17/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070983	08/20/12 - 08/20/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070983	08/30/12 - 08/30/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070983	08/28/12 - 08/28/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070983	08/27/12 - 08/27/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070983	08/23/12 - 08/23/12	09/16/13	0.00	150.00	0.00	0.00	0.00
948	2013254070983	08/22/12 - 08/22/12	09/16/13	0.00	75.00	0.00	0.00	0.00
TOTAL				0.00	2,250.00	0.00	0.00	0.00



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:11:01  
Page: 10

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:11:01  
Page: 11

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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Page: 12

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	305,866.50	ADJUSTMENTS	15,626.13
COVERED CHARGES	305,791.50	CONTRACTUAL ALLOW	253,664.40
NON-COVERD CHARGES	75.00	TOTAL MEDICAID LIAB	52,127.10
		LESS: COB	0.00
		LESS: COPAYMENT	36.00
		REIMBURSEMENT	52,091.10
		TOTAL NUMBER OF CLAIMS	10

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WELLSTAR WINDY HILL HOSPITAL PROVIDER NUMBER PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 2540 WINDY HILL RD SE 000001999A SERVICE DATES 07/01/12 THROUGH 06/30/13  
 MARIETTA,GA 30067-8605 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	910.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,112.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,663.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,573.00	0.00
EKG/ECG	323.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,783.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,527.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,209.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	345.00	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	284,346.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	305,791.50	75.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	305,791.50	75.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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Page: 14

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:02:42  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR  
 3131 THOMASVILLE HWY  
 MOULTRIE,GA 31776-6925

PROVIDER NUMBER 000002021A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,646,345.06	ADJUSTMENTS	430,475.55
COVERED CHARGES	9,128,215.22	CONTRACTUAL ALLOW	5,420,317.41
NON-COVERD CHARGES	518,129.84	TOTAL MEDICAID LIAB	3,707,897.81
		LESS: COB	16,255.96
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	3,691,641.85

TOTAL NUMBER OF ADMISSIONS 665

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,318		0	717,400.00		65,403.00
ROUTINE NURSERY	318		0	152,867.00		265.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,636		0	870,267.00		65,668.00
SPECIAL CARE SERVICES						
CCU	459		0	397,078.00		17,680.00
ICU	339		0	370,040.00		47,931.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	798		0	767,118.00		65,611.00
TOTAL ACCOMODATIONS	2,434		0	1,637,385.00		131,279.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR  
 3131 THOMASVILLE HWY  
 MOULTRIE,GA 31776-6925

PROVIDER NUMBER  
 000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,123,552.56	79,692.69	OTHER LAB	22,204.00	1,432.00
MED/SURG SUPPLY	636,818.54	31,218.04	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,193,848.00	39,184.00	EDUCATION & TRAINING	4,953.00	0.00
RADIOLOGY-DIAGNOSTIC	177,121.00	6,576.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	496,424.00	33,071.00	SPECIAL CHARGES	3,467.00	0.00
PHYSICAL THERAPY	48,736.00	1,919.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	74,337.00	1,010.00	MRI SERVICES	45,132.00	0.00
IV THERAPY	103,779.11	18,565.10	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	641,615.00	11,772.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	172,003.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	391,234.00	49,905.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	110,863.00	3,393.00	AMBULANCE	0.00	0.00
GI SERVICES	79,414.00	7,761.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	283,125.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	88,359.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	58,533.00	910.00	INJECTABLE DRUGS	961,178.81	59,395.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	956.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,908.00	1,164.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	16,707.00	6,303.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	210.00	16,757.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	379,703.20	78.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	38,674.00	439.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	76,410.00	7,785.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	61,081.00	8,521.00			
AUDIOLOGY	15,408.00	0.00			
CARDIOLOGY	126,057.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,202.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	48,817.00	0.00			
			TOTAL ANCILLARY	7,490,830.22	386,850.84
			TOTAL ACCOMODATIONS	1,637,385.00	131,279.00
			TOTAL CHARGES	9,128,215.22	518,129.84

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:02:55  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

COLQUITT REGIONAL MEDICAL CTR  
3131 THOMASVILLE HWY  
MOULTRIE,GA 31776-6925

PROVIDER NUMBER  
000002021A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:02:57  
Page: 4

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,194,455.17	ADJUSTMENTS	392,201.93
COVERED CHARGES	6,489,800.43	CONTRACTUAL ALLOW	4,798,837.37
NON-COVERD CHARGES	704,654.74	TOTAL MEDICAID LIAB	1,690,963.06
		LESS: COB	1,853.15
		LESS: COPAYMENT	7,868.35
		REIMBURSEMENT	1,681,241.56
		ALL OTHER	1,414,963.58
		FEE SCHEDULE-LAB	185,028.15
		INJECTABLE DRUGS	81,249.83

TOTAL NUMBER OF CLAIMS 5,742

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	205,578.59	3,482.44	OTHER LAB	49,394.00	0.00
MED/SURG SUPPLY	211,296.80	11,869.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	68.00	EDUCATION & TRAINING	0.00	1,094.00
RADIOLOGY-DIAGNOSTIC	332,384.00	16,307.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	901,146.00	23,598.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	34,251.00	3,942.00	FEE SCHEDULE LAB	846,964.80	222,426.40
EKG/ECG	71,074.00	8,788.00	MRI SERVICES	222,824.00	4,692.00
IV THERAPY	145,837.00	53,264.22	PROFESSIONAL FEES	0.00	2,542.00
OPERATING ROOM	540,001.09	36,611.91	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	63,138.00	18,272.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	99,097.00	3,900.00	AMBULANCE	0.00	0.00
GI SERVICES	153,521.00	11,498.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	753,340.00	10,326.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	67,365.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	450,401.15	159,354.32
RADIOLOGY THERAPEUTIC	32,803.00	166.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,877.00	2,029.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	798.00	719.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	573.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	261,892.00	21,596.35	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,386.00	43,702.00
LITHOTRIPSY	30,747.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	249,786.00	6,424.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	12,806.00	7,254.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	254,540.00	23,868.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	225,220.00	1,610.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	106,261.00	576.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	158,071.00	4,102.00			
			TOTAL ANCILLARY	6,489,800.43	704,654.74
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,489,800.43	704,654.74

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: 07/23/2014  
Run Time: 12:04:00  
Page: 6

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,377.85	ADJUSTMENTS	0.00
COVERED CHARGES	33,717.89	CONTRACTUAL ALLOW	13,137.75
NON-COVERD CHARGES	7,659.96	TOTAL MEDICAID LIAB	20,580.14
		LESS: COB	20,555.31
		LESS: COPAYMENT	24.83
		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

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,234.28	240.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,665.31	311.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	69.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,648.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,500.00	4,500.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,769.00	1,315.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	691.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,798.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	397.00	212.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,070.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	6,400.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,056.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	145.30	336.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,004.00	676.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,220.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	120.00	0.00			
			TOTAL ANCILLARY	33,717.89	7,659.96
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,717.89	7,659.96

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: 07/23/2014  
Run Time: 12:04:02  
Page: 8

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	291,163.41	ADJUSTMENTS	815.10
COVERED CHARGES	273,980.06	CONTRACTUAL ALLOW	251,395.29
NON-COVERD CHARGES	17,183.35	TOTAL MEDICAID LIAB	22,584.77
		LESS: COB	58.13
		LESS: COPAYMENT	648.06
		REIMBURSEMENT	21,878.58
		TOTAL NUMBER OF CLAIMS	405

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	5,847.62	0.00	OTHER LAB	1,582.00	0.00
MED/SURG SUPPLY	4,678.73	137.31	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	54.00	63.00
RADIOLOGY-DIAGNOSTIC	22,196.00	220.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	30,561.00	1,866.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	111.00	FEE SCHEDULE LAB	29,602.00	4,286.00
EKG/ECG	2,828.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	7,591.00	458.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	535.00	137.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	148,221.00	1,369.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,860.71	6,307.04
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	248.00	44.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	156.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,603.00	1,509.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	502.00	676.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,914.00	0.00			
			TOTAL ANCILLARY	273,980.06	17,183.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	273,980.06	17,183.35

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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Page: 10

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 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,829.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,666.00	CONTRACTUAL ALLOW	806.96
NON-COVERD CHARGES	163.00	TOTAL MEDICAID LIAB	1,859.04
		LESS: COB	1,859.04
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 4

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	30.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	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	608.00	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	1,812.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,666.00	163.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,666.00	163.00



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLQUITT REGIONAL MEDICAL CTR  
3131 THOMASVILLE HWY  
MOULTRIE,GA 31776-6925

PROVIDER NUMBER  
000002021A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,536,540.48	ADJUSTMENTS	85,877.32
COVERED CHARGES	1,448,308.17	CONTRACTUAL ALLOW	1,225,897.92
NON-COVERD CHARGES	88,232.31	TOTAL MEDICAID LIAB	222,410.25
		LESS: COB	536.08
		LESS: COPAYMENT	690.56
		REIMBURSEMENT	221,183.61

TOTAL NUMBER OF CLAIMS 44

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 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	44,397.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	27,516.00	1,150.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,708.00	1,942.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	28,372.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	374.00	FEE SCHEDULE LAB	16,569.00	2,191.00
EKG/ECG	202.00	0.00	MRI SERVICES	5,562.00	2,781.00
IV THERAPY	34,662.80	2,762.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,772.00	3,999.00	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	16,225.00	1,222.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,752.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,397.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,088,797.77	26,869.31
RADIOLOGY THERAPEUTIC	65,891.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	19,604.00	644.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	117.00	39,390.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	43,647.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,622.00	2,028.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,833.00	2,880.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,610.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,448,308.17	88,232.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,448,308.17	88,232.31

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	10/01/12	THROUGH	09/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:04:04  
 Page: 1

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,546,531.65	ADJUSTMENTS	251,267.18
COVERED CHARGES	13,735,120.77	CONTRACTUAL ALLOW	7,063,966.32
NON-COVERD CHARGES	811,410.88	TOTAL MEDICAID LIAB	6,671,154.45
		LESS: COB	15,220.20
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,655,934.25

TOTAL NUMBER OF ADMISSIONS 1,442

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8,654		9	7,641,401.00		706,342.00
ROUTINE NURSERY	72		0	40,890.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8,726		9	7,682,291.00		706,342.00
SPECIAL CARE SERVICES						
CCU	315		0	453,230.00		14,860.00
ICU	116		0	263,088.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	431		0	716,318.00		14,860.00
TOTAL ACCOMODATIONS	9,157		9	8,398,609.00		721,202.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,555,698.35	13,395.15	OTHER LAB	26,014.00	0.00
MED/SURG SUPPLY	235,847.42	5,776.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,434,541.00	29,743.00	EDUCATION & TRAINING	1,160.00	84.00
RADIOLOGY-DIAGNOSTIC	72,809.00	317.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	259,819.00	1,962.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	22,045.86	8,337.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	47,860.00	0.00	MRI SERVICES	62,438.00	0.00
IV THERAPY	71,675.00	1,631.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	151,538.00	2,219.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	100,957.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	207,029.00	16,632.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,414.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	44,064.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	293,012.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,614.25
LABORATORY PATHOLOGIC	24,082.00	0.00	INJECTABLE DRUGS	353,717.32	266.48
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	6,249.27	331.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	5,466.00	3,644.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	3,797.00	869.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,570.55	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	12,375.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	57,156.00	1,220.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	52,668.00	0.00			
AUDIOLOGY	2,550.00	0.00			
CARDIOLOGY	155,901.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,056.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	45,002.00	168.00			
			TOTAL ANCILLARY	5,336,511.77	90,208.88
			TOTAL ACCOMODATIONS	8,398,609.00	721,202.00
			TOTAL CHARGES	13,735,120.77	811,410.88

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:04:38  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

TANNER MEDICAL CENTER VILLA RICA  
 601 DALLAS HWY  
 VILLA RICA,GA 30180-1202

PROVIDER NUMBER  
 000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	101,656.39	ADJUSTMENTS	0.00
COVERED CHARGES	0.00	CONTRACTUAL ALLOW	-3,537.07
NON-COVERD CHARGES	101,656.39	TOTAL MEDICAID LIAB	3,537.07
		LESS: COB	3,537.07
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	32		0	0.00		30,821.00
ROUTINE NURSERY	0		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	0.00		30,821.00
SPECIAL CARE SERVICES						
CCU	3		0	0.00		4,458.00
ICU	2		0	0.00		4,536.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	0.00		8,994.00
TOTAL ACCOMODATIONS	37		0	0.00		39,815.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:04:38  
 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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	13,111.59	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	3,169.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	20,645.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	1,839.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	9,592.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	374.19	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	690.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	815.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	615.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	1,286.00	FREE STANDING CLINIC	0.00	0.00
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	5,572.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	50.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	886.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	1,615.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,581.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	0.00	61,841.39
			TOTAL ACCOMODATIONS	0.00	39,815.00
			TOTAL CHARGES	0.00	101,656.39

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:04:39  
Page: 5

TANNER MEDICAL CENTER VILLA RICA  
601 DALLAS HWY  
VILLA RICA,GA 30180-1202

PROVIDER NUMBER  
000002032A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,967,223.82	ADJUSTMENTS	503,488.91
COVERED CHARGES	8,531,581.23	CONTRACTUAL ALLOW	5,737,982.92
NON-COVERD CHARGES	435,642.59	TOTAL MEDICAID LIAB	2,793,598.31
		LESS: COB	4,050.53
		LESS: COPAYMENT	5,194.00
		REIMBURSEMENT	2,784,353.78
		ALL OTHER	2,055,904.22
		FEE SCHEDULE-LAB	85,401.49
		INJECTABLE DRUGS	643,048.07

TOTAL NUMBER OF CLAIMS 3,869



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	309,866.61	2,497.83	OTHER LAB	55,325.00	0.00
MED/SURG SUPPLY	232,614.38	1,580.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	3,323.00	EDUCATION & TRAINING	0.00	750.00
RADIOLOGY-DIAGNOSTIC	366,956.00	9,325.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,025,908.00	34,880.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,361.38	FEE SCHEDULE LAB	986,442.70	131,537.90
EKG/ECG	86,302.00	7,370.00	MRI SERVICES	299,564.00	6,192.00
IV THERAPY	371,926.00	45,939.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	467,661.54	61,564.46	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	8,956.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	43,776.00	5,586.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,146.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	160,288.00	19,836.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,066,687.49	2,983.51	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	235.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,060,941.51	62,995.40
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	365.11	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9,110.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	7,082.00	1,736.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,384,845.00	0.00	IMPL DEV CHARGE PATIENTS	10,135.00	1,185.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	192,719.00	18,594.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,822.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	92,651.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	111,185.00	6,620.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	80,212.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	73,334.00	311.00			
			TOTAL ANCILLARY	8,531,581.23	435,642.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	8,531,581.23	435,642.59

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 11:06:01  
Page: 7

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	49,396.34	ADJUSTMENTS	0.00
COVERED CHARGES	33,570.22	CONTRACTUAL ALLOW	16,052.55
NON-COVERD CHARGES	15,826.12	TOTAL MEDICAID LIAB	17,517.67
		LESS: COB	17,517.67
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 12

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	608.22	171.12	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	514.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,605.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,488.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,944.00	733.00
EKG/ECG	460.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,137.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	272.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	1,944.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,420.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	33.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	19,965.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	9,490.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	612.00	0.00			
			TOTAL ANCILLARY	33,570.22	15,826.12
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,570.22	15,826.12

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213282009778	03/14/13 - 03/14/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/15/13 - 03/15/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/18/13 - 03/18/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/19/13 - 03/19/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/20/13 - 03/20/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/21/13 - 03/21/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/22/13 - 03/22/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/25/13 - 03/25/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/26/13 - 03/26/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/27/13 - 03/27/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/28/13 - 03/28/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	03/29/13 - 03/29/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2213282009778	04/01/13 - 04/01/13	10/14/13	0.00	365.00	0.00	6,684.13	0.00
905	2013311004569	07/03/13 - 07/03/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/05/13 - 07/05/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/15/13 - 07/15/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/16/13 - 07/16/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/17/13 - 07/17/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/18/13 - 07/18/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/19/13 - 07/19/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/22/13 - 07/22/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/23/13 - 07/23/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/24/13 - 07/24/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/25/13 - 07/25/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/26/13 - 07/26/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
905	2013311004569	07/29/13 - 07/29/13	11/11/13	0.00	365.00	0.00	5,711.20	0.00
TOTAL				0.00	9,490.00	0.00	161,139.29	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:06:03  
Page: 10

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	519,201.27	ADJUSTMENTS	538.40
COVERED CHARGES	503,480.00	CONTRACTUAL ALLOW	468,965.02
NON-COVERD CHARGES	15,721.27	TOTAL MEDICAID LIAB	34,514.98
		LESS: COB	40.75
		LESS: COPAYMENT	1,089.03
		REIMBURSEMENT	33,385.20
		TOTAL NUMBER OF CLAIMS	617

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,576.23	0.00	OTHER LAB	2,028.00	0.00
MED/SURG SUPPLY	9,031.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	40,088.00	273.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	49,595.00	1,744.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	100,462.00	7,322.00
EKG/ECG	10,065.00	230.00	MRI SERVICES	6,192.00	0.00
IV THERAPY	21,893.00	3,154.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,984.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,999.00	798.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	230,103.00	450.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,525.77	54.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	48.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	8,729.00	1,648.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	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	503,480.00	15,721.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	503,480.00	15,721.27

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 11:06:13  
Page: 12

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,719.00	ADJUSTMENTS	0.00
COVERED CHARGES	1,719.00	CONTRACTUAL ALLOW	1,346.36
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	372.64
		LESS: COB	369.64
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:06:13  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	76.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	273.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	204.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,166.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,719.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,719.00	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

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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,158,557.84	ADJUSTMENTS	28,579.60
COVERED CHARGES	1,137,055.82	CONTRACTUAL ALLOW	833,889.46
NON-COVERD CHARGES	21,502.02	TOTAL MEDICAID LIAB	303,166.36
		LESS: COB	0.00
		LESS: COPAYMENT	528.00
		REIMBURSEMENT	302,638.36
		TOTAL NUMBER OF CLAIMS	53

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,407.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	50,462.35	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,786.00	4,270.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,540.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	18,849.00	1,313.00
EKG/ECG	1,390.00	230.00	MRI SERVICES	0.00	0.00
IV THERAPY	4,407.00	1,421.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	147,533.25	14,213.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,140.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,704.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,647.70	54.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	820,380.00	0.00	IMPL DEV CHARGE PATIENTS	29,039.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	382.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,578.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,361.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,448.00	0.00			
			TOTAL ANCILLARY	1,137,055.82	21,502.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,137,055.82	21,502.02

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
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SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,442,075.82	ADJUSTMENTS	5,258.28
COVERED CHARGES	1,437,428.06	CONTRACTUAL ALLOW	809,935.68
NON-COVERD CHARGES	4,647.76	TOTAL MEDICAID LIAB	627,492.38
		LESS: COB	2,995.41
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	624,496.97

TOTAL NUMBER OF ADMISSIONS 87

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	246		0	70,879.60		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	246		0	70,879.60		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	83		0	83,033.20		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	83,033.20		0.00
TOTAL ACCOMODATIONS	329		0	153,912.80		0.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	449,589.11	0.00	OTHER LAB	7,657.30	0.00
MED/SURG SUPPLY	111,936.23	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	179,059.33	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	28,160.05	0.00	OTHER THERAPEUTIC SVC	0.00	95.00
CT SCAN	37,244.91	3,194.76	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	4,043.45	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	23,946.00	0.00	MRI SERVICES	1,896.30	0.00
IV THERAPY	59,372.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	85,143.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	66,492.05	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	31,907.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	66,454.61	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	19,650.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	14,255.55	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,531.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	995.60	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	98.80	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	64,383.96	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,507.25	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,997.80	1,358.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,390.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,775.21	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	5,028.50	0.00			
			TOTAL ANCILLARY	1,283,515.26	4,647.76
			TOTAL ACCOMODATIONS	153,912.80	0.00
			TOTAL CHARGES	1,437,428.06	4,647.76

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:35:15  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,409,038.98	ADJUSTMENTS	12,549.37
COVERED CHARGES	2,232,189.51	CONTRACTUAL ALLOW	1,752,029.02
NON-COVERD CHARGES	176,849.47	TOTAL MEDICAID LIAB	480,160.49
		LESS: COB	3,291.76
		LESS: COPAYMENT	2,163.00
		REIMBURSEMENT	474,705.73
		ALL OTHER	427,641.38
		FEE SCHEDULE-LAB	46,715.62
		INJECTABLE DRUGS	348.73
		TOTAL NUMBER OF CLAIMS	1,857

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	142,524.89	319.70	OTHER LAB	17,289.10	3,678.60
MED/SURG SUPPLY	144,390.70	1,987.96	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	138.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	135,221.10	5,642.40	OTHER THERAPEUTIC SVC	0.00	1,235.00
CT SCAN	108,124.89	9,055.01	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	389,657.14	78,195.59
EKG/ECG	49,565.80	13,327.00	MRI SERVICES	34,262.46	862.64
IV THERAPY	109,057.90	30,210.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	243,097.15	13,765.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	11,880.10	1,169.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	90,372.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	494,243.82	79.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	101,850.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,997.18	4,071.19
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	497.80	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	16,792.02	400.80	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	8,008.80	7,899.75
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	27,621.20	310.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,486.00	638.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	30,641.20	2,637.55			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	32,911.70	350.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,265.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	36,928.86	378.18			
			TOTAL ANCILLARY	2,232,189.51	176,849.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,232,189.51	176,849.47



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

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,871.52	ADJUSTMENTS	0.00
COVERED CHARGES	9,816.91	CONTRACTUAL ALLOW	6,529.08
NON-COVERD CHARGES	1,054.61	TOTAL MEDICAID LIAB	3,287.83
		LESS: COB	3,272.83
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	311.03	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	233.40	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	725.25	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	3,110.93	1,054.61
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,085.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,106.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	3.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	242.30	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	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	9,816.91	1,054.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,816.91	1,054.61

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY,GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	708,290.83	ADJUSTMENTS	323.64
COVERED CHARGES	702,381.24	CONTRACTUAL ALLOW	689,347.22
NON-COVERD CHARGES	5,909.59	TOTAL MEDICAID LIAB	13,034.02
		LESS: COB	0.00
		LESS: COPAYMENT	330.00
		REIMBURSEMENT	12,704.02
		TOTAL NUMBER OF CLAIMS	233

Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH GEORGIA MEDICAL CENTER  
 1362 S MAIN ST  
 ELLIJAY, GA 30540-5410

PROVIDER NUMBER  
 000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	16,067.58	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,154.35	51.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,601.95	0.00	OTHER THERAPEUTIC SVC	0.00	95.00
CT SCAN	4,737.12	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	29,585.79	3,068.39
EKG/ECG	2,795.00	585.00	MRI SERVICES	0.00	0.00
IV THERAPY	8,847.00	2,110.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	622,473.15	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,072.80	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	2,346.50	0.00			
			TOTAL ANCILLARY	702,381.24	5,909.59
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	702,381.24	5,909.59

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY,GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,565.98	ADJUSTMENTS	0.00
COVERED CHARGES	2,702.58	CONTRACTUAL ALLOW	1,778.41
NON-COVERD CHARGES	863.40	TOTAL MEDICAID LIAB	924.17
		LESS: COB	918.17
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	115.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	512.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	852.50	350.50
EKG/ECG	377.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	2,702.58	863.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,702.58	863.40

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH GEORGIA MEDICAL CENTER  
1362 S MAIN ST  
ELLIJAY,GA 30540-5410

PROVIDER NUMBER  
000002043A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	146,647.60	ADJUSTMENTS	15,121.98
COVERED CHARGES	134,604.71	CONTRACTUAL ALLOW	109,386.41
NON-COVERD CHARGES	12,042.89	TOTAL MEDICAID LIAB	25,218.30
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	25,206.30

TOTAL NUMBER OF CLAIMS 5

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	9,749.54	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	33,573.27	92.61	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	476.15	OTHER THERAPEUTIC SVC	0.00	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	182.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	50,950.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,827.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	685.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	13,500.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,004.40	10,607.13
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	134,604.71	12,042.89
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	134,604.71	12,042.89



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 11:20:50  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,163,728.70	ADJUSTMENTS	80,162.08
COVERED CHARGES	4,141,656.70	CONTRACTUAL ALLOW	2,505,590.35
NON-COVERD CHARGES	22,072.00	TOTAL MEDICAID LIAB	1,636,066.35
		LESS: COB	11,449.62
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,624,616.73

TOTAL NUMBER OF ADMISSIONS 274

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	966		0	463,220.00		4,865.00
ROUTINE NURSERY	82		0	23,452.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,048		0	486,672.00		4,865.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	170		0	192,100.00		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	170		0	192,100.00		0.00
TOTAL ACCOMODATIONS	1,218		0	678,772.00		4,865.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WAYNE MEMORIAL HOSPITAL  
 865 S 1ST ST  
 JESUP,GA 31545-0210

PROVIDER NUMBER  
 000002054A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,061,969.05	0.00	OTHER LAB	11,027.00	0.00
MED/SURG SUPPLY	680,485.00	428.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	572,255.00	533.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	80,136.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	184,503.00	1,900.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	35,032.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	24,174.00	0.00	MRI SERVICES	51,879.00	0.00
IV THERAPY	79,715.00	423.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	187,392.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	30,505.67	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	86,748.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	27,601.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,905.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	16,900.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	426.00	0.00	INJECTABLE DRUGS	7,666.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,915.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,841.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	4,160.00	1,040.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	7,920.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	29,113.20	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,395.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,108.00	2,830.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,725.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	64,243.00	0.00			
AMBULATORY SURGERY	2,625.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	91,440.78	2,133.00			
			TOTAL ANCILLARY	3,462,884.70	17,207.00
			TOTAL ACCOMODATIONS	678,772.00	4,865.00
			TOTAL CHARGES	4,141,656.70	22,072.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	79,162.41	ADJUSTMENTS	0.00
COVERED CHARGES	79,062.41	CONTRACTUAL ALLOW	25,116.82
NON-COVERD CHARGES	100.00	TOTAL MEDICAID LIAB	53,945.59
		LESS: COB	53,945.59
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 7

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	20		0	9,600.00		100.00
ROUTINE NURSERY	4		0	1,144.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	24		0	10,744.00		100.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	24		0	10,744.00		100.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,827.25	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	16,042.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	9,087.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,397.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,521.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	9,600.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,000.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	192.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,400.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	611.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,090.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	488.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	70.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	625.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,368.16	0.00			
			TOTAL ANCILLARY	68,318.41	0.00
			TOTAL ACCOMODATIONS	10,744.00	100.00
			TOTAL CHARGES	79,062.41	100.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:20:57  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,964,680.86	ADJUSTMENTS	499,661.75
COVERED CHARGES	4,600,814.35	CONTRACTUAL ALLOW	3,459,914.99
NON-COVERD CHARGES	363,866.51	TOTAL MEDICAID LIAB	1,140,899.36
		LESS: COB	729.67
		LESS: COPAYMENT	2,804.22
		REIMBURSEMENT	1,137,365.47
		ALL OTHER	1,041,084.36
		FEE SCHEDULE-LAB	89,298.25
		INJECTABLE DRUGS	6,982.86
		TOTAL NUMBER OF CLAIMS	3,103

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	390,919.47	4,844.00	OTHER LAB	23,912.00	0.00
MED/SURG SUPPLY	660,229.40	457.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	189,247.00	6,534.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	661,093.00	21,107.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	6,782.00	10,290.00	FEE SCHEDULE LAB	688,280.10	169,012.40
EKG/ECG	54,540.00	4,185.00	MRI SERVICES	140,849.00	2,855.00
IV THERAPY	138,350.00	39,081.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	413,532.00	15,008.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	17,804.00	512.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	25,351.00	1,088.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	63,927.00	238.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	562,798.00	12,280.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	42,180.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	107,947.00	36,901.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	894.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	352.00	954.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	10,320.00	120.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	55,804.00	9,398.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	109,986.00	9,921.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,362.00	545.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	47,348.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	50,543.00	634.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	133,358.38	17,008.11			
			TOTAL ANCILLARY	4,600,814.35	363,866.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,600,814.35	363,866.51

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 11:21:43  
Page: 7

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	74,705.40	ADJUSTMENTS	0.00
COVERED CHARGES	66,278.40	CONTRACTUAL ALLOW	23,278.62
NON-COVERD CHARGES	8,427.00	TOTAL MEDICAID LIAB	42,999.78
		LESS: COB	42,972.78
		LESS: COPAYMENT	27.00
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,230.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,934.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,359.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	9,201.00	4,052.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,963.00	1,224.00
EKG/ECG	135.00	0.00	MRI SERVICES	2,531.00	0.00
IV THERAPY	1,790.00	559.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	4,624.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	480.00	240.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	839.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	399.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,981.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	840.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,461.00	2,064.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,292.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,247.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	510.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,462.40	288.00			
			TOTAL ANCILLARY	66,278.40	8,427.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	66,278.40	8,427.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:21:44  
Page: 9

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	383,048.44	ADJUSTMENTS	1,820.96
COVERED CHARGES	365,309.42	CONTRACTUAL ALLOW	329,004.36
NON-COVERD CHARGES	17,739.02	TOTAL MEDICAID LIAB	36,305.06
		LESS: COB	18.99
		LESS: COPAYMENT	1,197.00
		REIMBURSEMENT	35,089.07
		TOTAL NUMBER OF CLAIMS	649

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,596.25	0.00	OTHER LAB	4,594.00	0.00
MED/SURG SUPPLY	13,614.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	21,135.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,540.00	2,447.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	328.00	0.00	FEE SCHEDULE LAB	61,958.00	10,196.00
EKG/ECG	3,915.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	14,775.00	3,960.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	364.00	20.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	175,058.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,892.25	718.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	120.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,806.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	613.92	398.02			
			TOTAL ANCILLARY	365,309.42	17,739.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	365,309.42	17,739.02

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,430.00	ADJUSTMENTS	0.00
COVERED CHARGES	4,421.00	CONTRACTUAL ALLOW	2,204.08
NON-COVERD CHARGES	9.00	TOTAL MEDICAID LIAB	2,216.92
		LESS: COB	2,213.92
		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: 07/23/2014  
 Run Time: 11:21:52  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	42.00	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	694.00	9.00
EKG/ECG	0.00	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	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,254.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	276.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	625.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	4,421.00	9.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	4,421.00	9.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	406,584.41	ADJUSTMENTS	35,562.98
COVERED CHARGES	401,316.85	CONTRACTUAL ALLOW	314,920.47
NON-COVERD CHARGES	5,267.56	TOTAL MEDICAID LIAB	86,396.38
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	86,345.38
		TOTAL NUMBER OF CLAIMS	17

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	23,656.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	141,359.85	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,073.00	1,012.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,900.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	328.00	FEE SCHEDULE LAB	6,667.00	1,297.00
EKG/ECG	1,890.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	3,756.00	526.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	154,073.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	646.00	84.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	13,489.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	706.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,220.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,206.00	1,602.00
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	36,504.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	171.00	418.56			
			TOTAL ANCILLARY	401,316.85	5,267.56
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	401,316.85	5,267.56

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: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WAYNE MEMORIAL HOSPITAL  
865 S 1ST ST  
JESUP,GA 31545-0210

PROVIDER NUMBER  
000002054A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER 000002065A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,284,815.20	ADJUSTMENTS	898,956.26
COVERED CHARGES	15,253,416.54	CONTRACTUAL ALLOW	10,232,314.52
NON-COVERD CHARGES	31,398.66	TOTAL MEDICAID LIAB	5,021,102.02
		LESS: COB	59,485.60
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,961,616.42

TOTAL NUMBER OF ADMISSIONS 759

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,018		4	876,805.00		7,315.00
ROUTINE NURSERY	187		0	90,610.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,205		4	967,415.00		7,315.00
SPECIAL CARE SERVICES						
CCU	1,369		0	2,057,160.00		0.00
ICU	408		0	783,395.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	1,777		0	2,840,555.00		0.00
TOTAL ACCOMODATIONS	2,982		4	3,807,970.00		7,315.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,734,828.57	0.00	OTHER LAB	60,775.60	0.00
MED/SURG SUPPLY	729,372.38	1,406.65	RECREATIONAL THERAPY	401.85	0.00
LABORATORY-GENERAL	1,790,150.10	0.00	EDUCATION & TRAINING	2,720.40	0.00
RADIOLOGY-DIAGNOSTIC	253,133.55	0.00	OTHER THERAPEUTIC SVC	2,930.20	164.30
CT SCAN	698,443.40	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	126,654.90	0.03	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	103,671.05	0.00	MRI SERVICES	69,473.55	0.00
IV THERAPY	9,112.80	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,528,776.68	16,726.80	DURABLE MED. EQUIP.	0.00	20.58
LABOR/DELIVERY ROOM	253,273.05	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	534,416.55	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	347,909.80	0.00	AMBULANCE	0.00	0.00
GI SERVICES	146,055.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	851,279.10	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	117,286.95	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	65,010.24	0.00	INJECTABLE DRUGS	157.50	0.00
RADIOLOGY THERAPEUTIC	42,388.70	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	355.45	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	5,940.20	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	68,751.90	2,343.90	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	326.10	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	117.75	1,019.30	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	380,470.57	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	77,017.50	445.65			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	281,218.30	1,802.60			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	97,340.95	153.85			
AUDIOLOGY	15,327.10	0.00			
CARDIOLOGY	1,034,503.35	0.00			
AMBULATORY SURGERY	643.90	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,777.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,434.05	0.00			
			TOTAL ANCILLARY	11,445,446.54	24,083.66
			TOTAL ACCOMODATIONS	3,807,970.00	7,315.00
			TOTAL CHARGES	15,253,416.54	31,398.66

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 12:08:54  
 Page: 3

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	255,271.26	ADJUSTMENTS	0.00
COVERED CHARGES	254,491.11	CONTRACTUAL ALLOW	125,780.93
NON-COVERD CHARGES	780.15	TOTAL MEDICAID LIAB	128,710.18
		LESS: COB	128,710.18
		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	33		0	28,425.00		120.00
ROUTINE NURSERY	9		0	4,185.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	42		0	32,610.00		120.00
SPECIAL CARE SERVICES						
CCU	13		0	19,760.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	19,760.00		0.00
TOTAL ACCOMODATIONS	55		0	52,370.00		120.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	19,055.05	0.00	OTHER LAB	486.90	0.00
MED/SURG SUPPLY	7,885.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	18,023.55	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	835.00	0.00	OTHER THERAPEUTIC SVC	0.00	341.80
CT SCAN	12,463.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	500.85	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,447.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	52,535.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	27,340.25	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,359.40	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	16,638.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,752.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	5,313.45	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,054.85	0.00	INJECTABLE DRUGS	2,572.16	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	264.85	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,996.35	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,218.30	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,842.65	318.35			
AUDIOLOGY	785.40	0.00			
CARDIOLOGY	15,058.10	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	691.75	0.00			
			TOTAL ANCILLARY	202,121.11	660.15
			TOTAL ACCOMODATIONS	52,370.00	120.00
			TOTAL CHARGES	254,491.11	780.15

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:08:56  
Page: 5

WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,185,704.64	ADJUSTMENTS	779,176.01
COVERED CHARGES	13,217,699.54	CONTRACTUAL ALLOW	10,455,367.22
NON-COVERD CHARGES	968,005.10	TOTAL MEDICAID LIAB	2,762,332.32
		LESS: COB	31,090.65
		LESS: COPAYMENT	5,176.26
		REIMBURSEMENT	2,726,065.41
		ALL OTHER	2,423,028.78
		FEE SCHEDULE-LAB	261,742.01
		INJECTABLE DRUGS	41,294.62

TOTAL NUMBER OF CLAIMS 7,100

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	379,817.61	2,081.81	OTHER LAB	287,875.85	0.00
MED/SURG SUPPLY	413,162.21	63,563.85	RECREATIONAL THERAPY	80.60	0.00
LABORATORY-GENERAL	0.00	207.35	EDUCATION & TRAINING	0.00	443.60
RADIOLOGY-DIAGNOSTIC	420,354.05	25,845.60	OTHER THERAPEUTIC SVC	241.80	55.45
CT SCAN	1,240,168.25	70,715.35	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,690.90	5,423.10	FEE SCHEDULE LAB	1,912,002.15	224,588.06
EKG/ECG	109,819.30	13,686.40	MRI SERVICES	116,882.60	0.00
IV THERAPY	199,772.15	35,933.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,924,371.38	176,776.82	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37,723.40	803.80	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	44,117.40	16,864.45	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	723,409.10	0.00	AMBULANCE	0.00	0.00
GI SERVICES	289,675.74	17,039.76	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,909,975.27	93,001.55	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	304,247.55	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	513,054.91	60,977.10
RADIOLOGY THERAPEUTIC	281,896.35	2,669.30	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	5,348.75	2,774.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,815.80	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	5,141.20	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	30,367.10	4,677.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	3,392.10	17,521.65
LITHOTRIPSY	15,057.00	0.00	NO CC/INVALID REV CODE	0.00	17.50
OTHER IMAGING SERVICE	300,974.45	48,568.55			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,744.40	1,577.30			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	117,323.45	5,179.40			
AUDIOLOGY	332.65	300.05			
CARDIOLOGY	371,745.25	69,617.15			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,382.50	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	214,693.32	138.60			
			TOTAL ANCILLARY	13,217,699.54	968,005.10
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,217,699.54	968,005.10

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: 07/23/2014  
Run Time: 12:08:56  
Page: 7

WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
836	1013116003904	03/29/13 - 03/29/13	05/13/13	0.00	17.50	0.00	0.00	0.00
TOTAL				0.00	17.50	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	319,999.20	ADJUSTMENTS	0.00
COVERED CHARGES	240,121.70	CONTRACTUAL ALLOW	67,689.80
NON-COVERD CHARGES	79,877.50	TOTAL MEDICAID LIAB	172,431.90
		LESS: COB	172,371.51
		LESS: COPAYMENT	60.39
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 134



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	7,662.04	0.00	OTHER LAB	4,528.60	0.00
MED/SURG SUPPLY	10,115.85	4,250.20	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	51.90	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,972.00	2,581.65	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,815.45	8,399.10	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	50,120.30	4,233.30
EKG/ECG	921.20	0.00	MRI SERVICES	2,215.50	2,367.30
IV THERAPY	980.10	581.70	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	30,111.95	32,300.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,582.60	401.90	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	188.60	137.65	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	22,160.60	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,247.00	5,617.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	52,151.65	206.25	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,726.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	6,527.06	796.85
RADIOLOGY THERAPEUTIC	1,370.80	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	216.60	615.60
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	6,890.30	8,141.25			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,581.70	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,480.20	9,194.60			
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	2,555.55	0.00			
			TOTAL ANCILLARY	240,121.70	79,877.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	240,121.70	79,877.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	941,933.05	ADJUSTMENTS	2,115.66
COVERED CHARGES	923,500.00	CONTRACTUAL ALLOW	855,718.31
NON-COVERD CHARGES	18,433.05	TOTAL MEDICAID LIAB	67,781.69
		LESS: COB	682.81
		LESS: COPAYMENT	2,127.07
		REIMBURSEMENT	64,971.81
		TOTAL NUMBER OF CLAIMS	1,204

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	15,650.83	0.00	OTHER LAB	1,947.60	0.00
MED/SURG SUPPLY	6,972.65	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	178.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	34,708.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	46,860.80	1,195.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	159,022.60	10,006.45
EKG/ECG	6,580.00	131.60	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	13,900.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	1,488.90	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,242.00	1,222.45	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,915.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	603,105.10	4,444.90	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	853.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,272.47	279.80
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	9.40	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	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,058.45	337.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,842.65	627.45			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,998.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,081.45	0.00			
			TOTAL ANCILLARY	923,500.00	18,433.05
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	923,500.00	18,433.05

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: 07/23/2014  
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WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	22,157.50	ADJUSTMENTS	0.00
COVERED CHARGES	18,343.10	CONTRACTUAL ALLOW	8,509.23
NON-COVERD CHARGES	3,814.40	TOTAL MEDICAID LIAB	9,833.87
		LESS: COB	9,830.87
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	21

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	322.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	217.15	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	639.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,602.05	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,639.45	134.95
EKG/ECG	131.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,469.95	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	172.50	77.40
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	750.15	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	18,343.10	3,814.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	18,343.10	3,814.40

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,210,787.45	ADJUSTMENTS	118,142.60
COVERED CHARGES	1,089,622.58	CONTRACTUAL ALLOW	906,475.03
NON-COVERD CHARGES	121,164.87	TOTAL MEDICAID LIAB	183,147.55
		LESS: COB	0.00
		LESS: COPAYMENT	498.00
		REIMBURSEMENT	182,649.55
		TOTAL NUMBER OF CLAIMS	37

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,857.84	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	86,809.70	37,430.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	55.45
RADIOLOGY-DIAGNOSTIC	8,009.25	13,443.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,351.20	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	28,119.28	2,548.37
EKG/ECG	921.20	1,316.00	MRI SERVICES	0.00	0.00
IV THERAPY	100,900.25	1,834.95	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	225,403.75	25,523.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,074.90	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	93,190.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,775.95	3,094.40	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	14,223.05	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	190,903.91	5,731.45
RADIOLOGY THERAPEUTIC	232,223.35	394.75	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,308.45	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	13,177.60	10,698.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,161.35	970.90			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,020.90	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	946.25	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	33,346.95	18,123.50			
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	8,897.30	0.00			
			TOTAL ANCILLARY	1,089,622.58	121,164.87
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,089,622.58	121,164.87

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: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.  
1514 VERNON RD  
LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 10/01/12 THROUGH 09/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	29,738.55	ADJUSTMENTS	0.00
COVERED CHARGES	28,534.40	CONTRACTUAL ALLOW	6,914.31
NON-COVERD CHARGES	1,204.15	TOTAL MEDICAID LIAB	21,620.09
		LESS: COB	21,605.09
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1



Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WEST GEORGIA MEDICAL CENTER, INC.  
 1514 VERNON RD  
 LAGRANGE,GA 30240-4131

PROVIDER NUMBER  
 000002065A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 10/01/12 THROUGH 09/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	376.00	0.00	OTHER LAB	645.85	0.00
MED/SURG SUPPLY	190.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	690.65	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	5,975.45	767.65	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	20,316.75	436.50
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	339.40	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	28,534.40	1,204.15
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	28,534.40	1,204.15

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:50:48  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER 000002076A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,200,637.89	ADJUSTMENTS	30,266.73
COVERED CHARGES	1,190,365.14	CONTRACTUAL ALLOW	698,144.81
NON-COVERD CHARGES	10,272.75	TOTAL MEDICAID LIAB	492,220.33
		LESS: COB	10,584.22
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	481,636.11

TOTAL NUMBER OF ADMISSIONS 80

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	324		0	178,200.00		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	324		0	178,200.00		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	324		0	178,200.00		0.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	349,202.68	0.00	OTHER LAB	6,423.40	0.00
MED/SURG SUPPLY	199,387.30	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	153,738.35	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,263.55	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	92,320.15	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,835.90	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,245.30	0.00	MRI SERVICES	2,228.60	0.00
IV THERAPY	4,129.16	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	43,951.15	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	76,211.95	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	1,473.45	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	515.95	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	309.40	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,904.70	0.00			
BLOOD	3,559.20	0.00			
BLOOD STORAGE & PRO.	35,612.50	10,272.75			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,850.15	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	9,216.90	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	785.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,012,165.14	10,272.75
			TOTAL ACCOMODATIONS	178,200.00	0.00
			TOTAL CHARGES	1,190,365.14	10,272.75

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:50:51  
Page: 4

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,206,512.74	ADJUSTMENTS	64.52
COVERED CHARGES	2,032,128.95	CONTRACTUAL ALLOW	1,651,479.73
NON-COVERD CHARGES	174,383.79	TOTAL MEDICAID LIAB	380,649.22
		LESS: COB	175.00
		LESS: COPAYMENT	1,359.83
		REIMBURSEMENT	379,114.39
		ALL OTHER	344,726.32
		FEE SCHEDULE-LAB	32,666.02
		INJECTABLE DRUGS	1,722.05
		TOTAL NUMBER OF CLAIMS	1,228

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	156,238.79	1,686.64	OTHER LAB	23,756.80	0.00
MED/SURG SUPPLY	164,952.37	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	360.31	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,377.60	1,770.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	80,162.85	4,208.90	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,595.00	1,829.65	FEE SCHEDULE LAB	295,331.71	64,901.54
EKG/ECG	16,954.00	3,164.40	MRI SERVICES	26,743.20	0.00
IV THERAPY	716.20	34,914.75	PROFESSIONAL FEES	0.00	278.65
OPERATING ROOM	916,019.50	40,930.35	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,233.80	1,099.05	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	142,455.01	7,443.30	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	109,971.40	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,614.40	20.10
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	657.80	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	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	1,295.05
OTHER IMAGING SERVICE	4,087.10	599.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,384.80	1,794.65			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,224.35	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,950.10	3,950.10			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,359.97	3,478.30			
			TOTAL ANCILLARY	2,032,128.95	174,383.79
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,032,128.95	174,383.79

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8010	2213053001921	02/16/13 - 02/17/13	02/25/13	0.00	80.00	0.00	0.00	0.00
30	2213053001921	02/16/13 - 02/17/13	02/25/13	0.00	96.00	0.00	0.00	0.00
2701	2213059015024	02/26/13 - 02/26/13	03/04/13	0.00	454.65	0.00	0.00	0.00
30	2213233013653	08/20/13 - 08/20/13	08/26/13	0.00	57.20	0.00	0.00	0.00
3210	2213351009072	12/04/13 - 12/04/13	12/23/13	0.00	303.60	0.00	0.00	0.00
30	2213365009187	12/24/13 - 12/25/13	01/06/14	0.00	303.60	0.00	0.00	0.00
TOTAL				0.00	1,295.05	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

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,580.60	ADJUSTMENTS	0.00
COVERED CHARGES	2,116.10	CONTRACTUAL ALLOW	1,446.37
NON-COVERD CHARGES	3,464.50	TOTAL MEDICAID LIAB	669.73
		LESS: COB	658.41
		LESS: COPAYMENT	11.32
		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

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	137.25	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	466.95	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	3,421.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	796.00	43.50
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	715.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,116.10	3,464.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,116.10	3,464.50

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,741.90	ADJUSTMENTS	0.00
COVERED CHARGES	46,621.25	CONTRACTUAL ALLOW	43,821.25
NON-COVERD CHARGES	2,120.65	TOTAL MEDICAID LIAB	2,800.00
		LESS: COB	0.00
		LESS: COPAYMENT	93.00
		REIMBURSEMENT	2,707.00
		TOTAL NUMBER OF CLAIMS	56

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,182.40	120.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	366.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	3,451.65	172.15	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,356.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,545.45	1,828.50
EKG/ECG	495.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,913.60	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	309.65	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	46,621.25	2,120.65
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	46,621.25	2,120.65

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: 07/23/2014  
Run Time: 12:51:13  
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LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:51:13  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	483,376.85	ADJUSTMENTS	0.00
COVERED CHARGES	479,795.85	CONTRACTUAL ALLOW	384,827.65
NON-COVERD CHARGES	3,581.00	TOTAL MEDICAID LIAB	94,968.20
		LESS: COB	0.00
		LESS: COPAYMENT	51.00
		REIMBURSEMENT	94,917.20
		TOTAL NUMBER OF CLAIMS	20

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONCEE COMMUNITY HOSPITAL IN  
 111 N 3RD ST  
 GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
 000002076A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,138.90	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	130,965.60	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	295.35	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	3,581.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	320,000.00	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	11,396.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	479,795.85	3,581.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	479,795.85	3,581.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

LOWER OCONCEE COMMUNITY HOSPITAL IN  
111 N 3RD ST  
GLENWOOD,GA 30428-9004

PROVIDER NUMBER  
000002076A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:08:09  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WILLS MEMORIAL HOSPITAL  
 120 GORDON ST  
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER 000002087A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	389,302.00	ADJUSTMENTS	0.00
COVERED CHARGES	386,567.00	CONTRACTUAL ALLOW	197,481.52
NON-COVERD CHARGES	2,735.00	TOTAL MEDICAID LIAB	189,085.48
		LESS: COB	6,763.01
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	182,322.47

TOTAL NUMBER OF ADMISSIONS 37

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	114		0	55,470.00		390.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	114		0	55,470.00		390.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	51		0	75,990.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	75,990.00		0.00
TOTAL ACCOMODATIONS	165		0	131,460.00		390.00



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WILLS MEMORIAL HOSPITAL  
 120 GORDON ST  
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	83,287.00	0.00	OTHER LAB	415.00	0.00
MED/SURG SUPPLY	26,205.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	34,536.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,747.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	24,441.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,420.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	440.00	440.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,912.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,445.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	129.00	0.00	INJECTABLE DRUGS	2,275.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	8,255.00	1,905.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,146.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,374.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,024.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,056.00	0.00			
			TOTAL ANCILLARY	255,107.00	2,345.00
			TOTAL ACCOMODATIONS	131,460.00	390.00
			TOTAL CHARGES	386,567.00	2,735.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	500,901.80	ADJUSTMENTS	26,472.22
COVERED CHARGES	446,051.00	CONTRACTUAL ALLOW	226,125.76
NON-COVERD CHARGES	54,850.80	TOTAL MEDICAID LIAB	219,925.24
		LESS: COB	499.54
		LESS: COPAYMENT	1,818.00
		REIMBURSEMENT	217,607.70
		ALL OTHER	193,637.83
		FEE SCHEDULE-LAB	22,485.30
		INJECTABLE DRUGS	1,484.57
		TOTAL NUMBER OF CLAIMS	1,090

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 12:08:11  
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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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,786.00	0.00	OTHER LAB	3,984.00	0.00
MED/SURG SUPPLY	26,681.00	242.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	222.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,309.00	291.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	33,751.00	2,560.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	10,730.00	2,035.00	FEE SCHEDULE LAB	113,158.00	26,804.80
EKG/ECG	7,865.00	85.00	MRI SERVICES	26,800.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	36,918.00	10,930.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,042.00	1,075.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	450.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	71,433.00	6,178.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,860.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,535.00	51.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,783.00	2,476.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	615.00	50.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,575.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	60.00
OTHER IMAGING SERVICE	6,610.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	356.00	60.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,255.00	1,476.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	16,000.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	6,555.00	255.00			
			TOTAL ANCILLARY	446,051.00	54,850.80
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	446,051.00	54,850.80

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: 07/23/2014  
Run Time: 12:08:11  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2213123017088	02/04/13 - 02/04/13	05/06/13	0.00	60.00	0.00	0.00	0.00
TOTAL				0.00	60.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 12:08:31  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,361.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,292.00	CONTRACTUAL ALLOW	-93.48
NON-COVERD CHARGES	4,069.00	TOTAL MEDICAID LIAB	6,385.48
		LESS: COB	6,379.52
		LESS: COPAYMENT	5.96
		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 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	424.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	238.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	297.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,930.00	3,397.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,502.00	337.00
EKG/ECG	210.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	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	1,401.00	335.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	18.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	160.00	0.00			
			TOTAL ANCILLARY	6,292.00	4,069.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,292.00	4,069.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:08:31  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,442.00	ADJUSTMENTS	47.00
COVERED CHARGES	14,834.00	CONTRACTUAL ALLOW	11,934.00
NON-COVERD CHARGES	1,608.00	TOTAL MEDICAID LIAB	2,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	102.00
		REIMBURSEMENT	2,798.00
		TOTAL NUMBER OF CLAIMS	59



Report : CLM-0808-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

WILLS MEMORIAL HOSPITAL  
 120 GORDON ST  
 WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
 000002087A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 05/01/12 THROUGH 04/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	975.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	541.00	8.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	404.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	1,280.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,943.00	80.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	429.00	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	10,080.00	165.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	194.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	268.00	0.00			
			TOTAL ANCILLARY	14,834.00	1,608.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,834.00	1,608.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 05/01/12 THROUGH 04/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WILLS MEMORIAL HOSPITAL  
120 GORDON ST  
WASHINGTON,GA 30673-1602

PROVIDER NUMBER  
000002087A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	05/01/12	THROUGH	04/30/13
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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,080,041.13	ADJUSTMENTS	96,319.71
COVERED CHARGES	9,696,812.42	CONTRACTUAL ALLOW	7,313,770.68
NON-COVERD CHARGES	383,228.71	TOTAL MEDICAID LIAB	2,383,041.74
		LESS: COB	21,492.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,361,549.37

TOTAL NUMBER OF ADMISSIONS 326

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	422		346	180,215.75		279,212.62
ROUTINE NURSERY	33		0	10,482.66		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	455		346	190,698.41		279,212.62
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	244		0	270,533.92		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	244		0	270,533.92		0.00
TOTAL ACCOMODATIONS	699		346	461,232.33		279,212.62

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,548,774.63	0.00	OTHER LAB	64,506.65	0.00
MED/SURG SUPPLY	697,978.86	3.87	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,358,916.17	0.00	EDUCATION & TRAINING	262.00	0.00
RADIOLOGY-DIAGNOSTIC	288,217.47	26,475.51	OTHER THERAPEUTIC SVC	0.00	38,783.93
CT SCAN	1,083,998.73	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	137,089.85	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	118,283.44	0.00	MRI SERVICES	62,691.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	938,531.27	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	98,574.56	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	578,159.21	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	384,522.43	0.00	AMBULANCE	0.00	0.00
GI SERVICES	74,719.73	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	592,862.68	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	85,624.38	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	277.47	0.00	INJECTABLE DRUGS	117.48	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,626.79	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	94.20	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	842,883.66	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	13,085.80
OTHER IMAGING SERVICE	84,309.86	5,539.52			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	33,361.16	16,867.04			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	24,996.29	3,260.42			
AUDIOLOGY	351.43	0.00			
CARDIOLOGY	112,335.80	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,282.33	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,230.56	0.00			
			TOTAL ANCILLARY	9,235,580.09	104,016.09
			TOTAL ACCOMODATIONS	461,232.33	279,212.62
			TOTAL CHARGES	9,696,812.42	383,228.71

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
Run Time: 12:46:41  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013079036463	03/12/13 - 03/15/13	03/25/13	0.00	8,652.80	0.00	0.00	0.00
615	2013190030003	06/27/13 - 06/30/13	07/15/13	0.00	4,433.00	0.00	0.00	0.00
TOTAL				0.00	13,085.80	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: 07/23/2014  
 Run Time: 12:46:52  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	11,504.07	ADJUSTMENTS	0.00
COVERED CHARGES	10,289.12	CONTRACTUAL ALLOW	6,737.72
NON-COVERD CHARGES	1,214.95	TOTAL MEDICAID LIAB	3,551.40
		LESS: COB	3,551.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 1

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2		0	792.00		119.68
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	2		0	792.00		119.68
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	2		0	792.00		119.68



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,322.02	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	675.48	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,266.43	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	1,095.27
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	5,187.26	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	45.93	0.00			
			TOTAL ANCILLARY	9,497.12	1,095.27
			TOTAL ACCOMODATIONS	792.00	119.68
			TOTAL CHARGES	10,289.12	1,214.95

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: 07/23/2014  
Run Time: 12:46:53  
Page: 6

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	14,407,327.45	ADJUSTMENTS	884,949.12
COVERED CHARGES	13,022,348.45	CONTRACTUAL ALLOW	10,389,088.82
NON-COVERD CHARGES	1,384,979.00	TOTAL MEDICAID LIAB	2,633,259.63
		LESS: COB	8,053.66
		LESS: COPAYMENT	4,915.81
		REIMBURSEMENT	2,620,290.16
		ALL OTHER	2,532,106.15
		FEE SCHEDULE-LAB	79,875.32
		INJECTABLE DRUGS	8,308.69

TOTAL NUMBER OF CLAIMS 3,804

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,045.21	200,321.42	OTHER LAB	118,389.41	695.93
MED/SURG SUPPLY	288,973.32	18,073.03	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	181.07	EDUCATION & TRAINING	0.00	104.80
RADIOLOGY-DIAGNOSTIC	1,044,572.18	14,565.88	OTHER THERAPEUTIC SVC	0.00	6,039.13
CT SCAN	2,413,718.88	280,933.49	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	50,074.00	8,288.70	FEE SCHEDULE LAB	1,267,435.37	295,561.87
EKG/ECG	119,213.18	6,574.26	MRI SERVICES	497,062.10	28,747.53
IV THERAPY	41,851.11	1,449.91	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	731,138.59	170,742.89	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	157,959.26	26,935.03	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	626,249.96	27,223.18	AMBULANCE	0.00	0.00
GI SERVICES	806,219.43	83,533.80	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,579,527.80	23,459.27	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	220,406.34	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	334,673.97	118,289.77
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,320.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,161.12	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	0.00	2,701.57	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	22,224.29	24,117.62
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	272,111.46	8,488.68			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,944.93	2,327.77			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	171,983.91	17,088.15			
AUDIOLOGY	48.40	0.00			
CARDIOLOGY	28,770.89	12,672.48			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	221,434.46	4,700.65			
			TOTAL ANCILLARY	13,022,348.45	1,384,979.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,022,348.45	1,384,979.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 12:47:52  
Page: 8

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	78,945.09	ADJUSTMENTS	0.00
COVERED CHARGES	63,709.58	CONTRACTUAL ALLOW	38,583.36
NON-COVERD CHARGES	15,235.51	TOTAL MEDICAID LIAB	25,126.22
		LESS: COB	25,115.10
		LESS: COPAYMENT	11.12
		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

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	989.68	OTHER LAB	1,567.88	0.00
MED/SURG SUPPLY	3,911.59	1.41	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,744.51	0.00	OTHER THERAPEUTIC SVC	0.00	730.18
CT SCAN	3,643.14	11,298.56	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	318.00	254.00	FEE SCHEDULE LAB	9,555.84	557.24
EKG/ECG	727.07	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	773.19	335.82	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	28,932.41	86.52	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	2,873.11	31.67
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,019.65	950.43			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,643.19	0.00			
			TOTAL ANCILLARY	63,709.58	15,235.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	63,709.58	15,235.51

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:47:54  
Page: 10

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,319,988.00	ADJUSTMENTS	1,718.06
COVERED CHARGES	1,259,332.17	CONTRACTUAL ALLOW	1,225,991.37
NON-COVERD CHARGES	60,655.83	TOTAL MEDICAID LIAB	33,340.80
		LESS: COB	1,510.94
		LESS: COPAYMENT	1,011.02
		REIMBURSEMENT	30,818.84
		TOTAL NUMBER OF CLAIMS	569

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	12,395.23	OTHER LAB	2,934.05	0.00
MED/SURG SUPPLY	27,302.78	5.49	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	75,419.89	0.00	OTHER THERAPEUTIC SVC	0.00	93.72
CT SCAN	142,979.94	19,226.55	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	113,318.52	22,644.73
EKG/ECG	13,146.90	0.00	MRI SERVICES	4,326.40	0.00
IV THERAPY	357.87	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,941.09	1,199.16	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	842,529.03	1,057.36	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	20,324.55	3,930.17
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1.26	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	13,257.23	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,492.66	103.42			
			TOTAL ANCILLARY	1,259,332.17	60,655.83
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,259,332.17	60,655.83

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: 07/23/2014  
Run Time: 12:48:04  
Page: 12

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A  
PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,946.84	ADJUSTMENTS	0.00
COVERED CHARGES	37,345.03	CONTRACTUAL ALLOW	28,341.09
NON-COVERD CHARGES	6,601.81	TOTAL MEDICAID LIAB	9,003.94
		LESS: COB	8,988.94
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	11



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	686.65	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,565.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	668.07	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,568.45	3,889.97	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,796.25	836.94
EKG/ECG	367.06	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,955.27	88.78	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,424.68	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,099.47			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	37,345.03	6,601.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	37,345.03	6,601.81

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 12:48:06  
Page: 14

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,106,003.76	ADJUSTMENTS	102,204.60
COVERED CHARGES	934,119.36	CONTRACTUAL ALLOW	790,363.19
NON-COVERD CHARGES	171,884.40	TOTAL MEDICAID LIAB	143,756.17
		LESS: COB	0.00
		LESS: COPAYMENT	182.58
		REIMBURSEMENT	143,573.59
		TOTAL NUMBER OF CLAIMS	28

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	170.00	22,808.61	OTHER LAB	3,050.00	3,050.00
MED/SURG SUPPLY	20,533.59	3,759.64	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	10,133.90	1,198.30	OTHER THERAPEUTIC SVC	0.00	377.56
CT SCAN	0.00	16,212.21	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,045.18	FEE SCHEDULE LAB	26,263.03	2,976.85
EKG/ECG	5,131.79	1,094.13	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	433,702.37	43,368.24	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,046.86	562.26	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	202,666.36	40,698.77	AMBULANCE	0.00	0.00
GI SERVICES	5,501.26	5,501.26	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,140.47	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	61,504.89	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35,664.66	16,871.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	115,145.90	9,615.07
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,497.54	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,875.75	1,744.50			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,090.99	0.00			
			TOTAL ANCILLARY	934,119.36	171,884.40
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	934,119.36	171,884.40

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 12:48:09  
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BARROW REGIONAL MEDICAL CENTER  
316 N BROAD ST  
WINDER,GA 30680-2150

PROVIDER NUMBER  
000002098A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 10:53:07  
 Page: 1

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	238,420.00	ADJUSTMENTS	0.00
COVERED CHARGES	236,255.00	CONTRACTUAL ALLOW	96,961.66
NON-COVERD CHARGES	2,165.00	TOTAL MEDICAID LIAB	139,293.34
		LESS: COB	3,503.28
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	135,790.06
		TOTAL NUMBER OF ADMISSIONS	31

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	91		0	46,902.00		1,396.00
ROUTINE NURSERY	0		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	46,902.00		1,396.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	46,902.00		1,396.00

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	43,949.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	52,530.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	37,920.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	7,839.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	10,961.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,882.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,973.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,160.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	11,805.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	10,376.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	312.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,939.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,170.00	769.00			
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	189,353.00	769.00
			TOTAL ACCOMODATIONS	46,902.00	1,396.00
			TOTAL CHARGES	236,255.00	2,165.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	08/01/12	THROUGH	07/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:53:08  
Page: 4

PHOEBE WORTH MEDICAL CENTER  
807 S ISABELLA ST  
SYLVESTER,GA 31791-7554

PROVIDER NUMBER  
000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	899,996.23	ADJUSTMENTS	14,495.79
COVERED CHARGES	799,526.21	CONTRACTUAL ALLOW	558,663.11
NON-COVERD CHARGES	100,470.02	TOTAL MEDICAID LIAB	240,863.10
		LESS: COB	60.35
		LESS: COPAYMENT	897.00
		REIMBURSEMENT	239,905.75
		ALL OTHER	219,460.86
		FEE SCHEDULE-LAB	18,773.17
		INJECTABLE DRUGS	1,671.72
		TOTAL NUMBER OF CLAIMS	1,067



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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	18,362.69	214.00	OTHER LAB	4,896.00	2,160.00
MED/SURG SUPPLY	44,999.00	156.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	71,952.00	802.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	117,972.00	28,925.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,290.00	11,209.02	FEE SCHEDULE LAB	207,195.00	44,259.00
EKG/ECG	8,489.00	660.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,994.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	512.00	182.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,380.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	246,974.00	9,109.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,297.00	113.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	444.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,386.52	1,548.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,080.00	689.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,074.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	20,619.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,054.00	0.00			
			TOTAL ANCILLARY	799,526.21	100,470.02
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	799,526.21	100,470.02

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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,561.00	ADJUSTMENTS	0.00
COVERED CHARGES	14,016.00	CONTRACTUAL ALLOW	4,858.75
NON-COVERD CHARGES	2,545.00	TOTAL MEDICAID LIAB	9,157.25
		LESS: COB	9,154.25
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 14

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PHOEBE WORTH MEDICAL CENTER  
 807 S ISABELLA ST  
 SYLVESTER,GA 31791-7554

PROVIDER NUMBER  
 000002109A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	179.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	268.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,892.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,712.00	1,442.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,440.00	1,071.00
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	3,445.00	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	45.00	32.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	595.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	14,016.00	2,545.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	14,016.00	2,545.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	90,817.16	ADJUSTMENTS	97.00
COVERED CHARGES	85,022.16	CONTRACTUAL ALLOW	77,122.16
NON-COVERD CHARGES	5,795.00	TOTAL MEDICAID LIAB	7,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	273.00
		REIMBURSEMENT	7,627.00
		TOTAL NUMBER OF CLAIMS	158

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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,110.16	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,434.00	175.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,520.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,667.00	3,368.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	12,854.00	1,759.00
EKG/ECG	1,306.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	30.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	53,609.00	463.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	776.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,690.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	85,022.16	5,795.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	85,022.16	5,795.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	531.00	ADJUSTMENTS	0.00
COVERED CHARGES	531.00	CONTRACTUAL ALLOW	210.18
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	320.82
		LESS: COB	317.82
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 08/01/12 THROUGH 07/31/13  
 ADMISSION DATES 00/00/00 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	175.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	356.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	531.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	531.00	0.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	08/01/12	THROUGH	07/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VIII

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PHOEBE WORTH MEDICAL CENTER  
807 S ISABELLA ST  
SYLVESTER,GA 31791-7554

PROVIDER NUMBER  
000002109A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	08/01/12	THROUGH	07/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 11:25:26  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,472,745.75	ADJUSTMENTS	30,935.95
COVERED CHARGES	8,348,158.28	CONTRACTUAL ALLOW	6,033,061.78
NON-COVERD CHARGES	124,587.47	TOTAL MEDICAID LIAB	2,315,096.50
		LESS: COB	20,037.95
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,295,058.55
		TOTAL NUMBER OF ADMISSIONS	298

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	435		0	235,079.14		5,556.38
ROUTINE NURSERY	57		0	15,145.68		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	492		0	250,224.82		5,556.38
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	585		0	607,969.29		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	585		0	607,969.29		0.00
TOTAL ACCOMODATIONS	1,077		0	858,194.11		5,556.38

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,284,701.23	0.00	OTHER LAB	116,319.85	0.00
MED/SURG SUPPLY	202,811.89	136.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,429,546.84	0.00	EDUCATION & TRAINING	562.15	0.00
RADIOLOGY-DIAGNOSTIC	268,450.73	4,813.64	OTHER THERAPEUTIC SVC	0.00	11,390.23
CT SCAN	656,748.98	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,408.90	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	129,170.16	0.00	MRI SERVICES	104,853.19	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	640,589.96	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	34,901.08	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	336,109.25	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	534,894.57	0.00	AMBULANCE	0.00	0.00
GI SERVICES	75,601.28	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	710,668.76	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	203,659.96	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	16,270.66	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	27,612.65	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	30,686.38	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	6,364.47	2,921.40	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	52,786.14	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	68,721.39
OTHER IMAGING SERVICE	65,214.87	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	34,771.57	25,297.38			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	56,567.35	5,750.55			
AUDIOLOGY	4,233.36	0.00			
CARDIOLOGY	409,580.71	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	7,924.51	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	11,952.72	0.00			
			TOTAL ANCILLARY	7,489,964.17	119,031.09
			TOTAL ACCOMODATIONS	858,194.11	5,556.38
			TOTAL CHARGES	8,348,158.28	124,587.47

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MONROE HMA INC  
 2151 W SPRING ST  
 MONROE,GA 30655-3115

PROVIDER NUMBER  
 000020677A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013124003210	04/28/13 - 05/01/13	05/13/13	0.00	8,586.26	0.00	0.00	0.00
615	2213150002609	01/20/13 - 01/29/13	06/03/13	0.00	4,706.60	0.00	0.00	0.00
615	9113122004306	02/21/13 - 02/21/13	06/10/13	0.00	4,706.60	0.00	3,519.36	0.00
615	2013175012882	06/18/13 - 06/21/13	07/01/13	0.00	3,879.66	0.00	0.00	0.00
618	2013191056915	07/01/13 - 07/03/13	07/15/13	0.00	3,897.01	0.00	0.00	0.00
615	2013200028446	07/11/13 - 07/16/13	07/22/13	0.00	4,706.60	0.00	0.00	0.00
618	2013266018013	06/07/13 - 06/11/13	09/30/13	0.00	3,897.01	0.00	0.00	0.00
616	2213275001072	01/29/13 - 02/09/13	10/07/13	0.00	4,265.41	0.00	0.00	0.00
618	2213275001072	01/29/13 - 02/09/13	10/07/13	0.00	7,794.02	0.00	0.00	0.00
615	2013289019284	10/05/13 - 10/13/13	10/21/13	0.00	4,706.60	0.00	0.00	0.00
615	2013313023413	11/03/13 - 11/05/13	11/18/13	0.00	4,706.60	0.00	0.00	0.00
616	2013324042077	03/29/13 - 04/05/13	11/25/13	0.00	4,265.41	0.00	0.00	0.00
618	2013324042077	03/29/13 - 04/05/13	11/25/13	0.00	3,897.01	0.00	0.00	0.00
615	9114022004333	08/16/13 - 08/18/13	03/10/14	0.00	4,706.60	0.00	1,324.79	0.00
TOTAL				0.00	68,721.39	0.00	4,844.15	0.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

MONROE HMA INC  
2151 W SPRING ST  
MONROE,GA 30655-3115

PROVIDER NUMBER  
000020677A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,760,713.45	ADJUSTMENTS	376,180.86
COVERED CHARGES	10,682,784.84	CONTRACTUAL ALLOW	8,541,340.15
NON-COVERD CHARGES	2,077,928.61	TOTAL MEDICAID LIAB	2,141,444.69
		LESS: COB	5,813.79
		LESS: COPAYMENT	3,313.11
		REIMBURSEMENT	2,132,317.79
		ALL OTHER	2,022,261.42
		FEE SCHEDULE-LAB	99,170.80
		INJECTABLE DRUGS	10,885.57

TOTAL NUMBER OF CLAIMS 3,752

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	429.80	246,788.98	OTHER LAB	215,322.86	2,498.23
MED/SURG SUPPLY	120,536.21	15,001.57	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	262.05	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	509,284.23	13,351.80	OTHER THERAPEUTIC SVC	0.00	92,985.06
CT SCAN	923,811.34	947,459.94	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	5,942.00	3,962.76	FEE SCHEDULE LAB	1,357,450.24	333,411.55
EKG/ECG	197,934.17	6,974.81	MRI SERVICES	390,842.10	11,285.73
IV THERAPY	16,628.59	1,476.47	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	435,454.05	133,880.87	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	31,910.91	13,662.81	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	454,535.65	0.00	AMBULANCE	0.00	0.00
GI SERVICES	254,347.37	34,645.93	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,176,871.62	42,003.67	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	351,135.87	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	245,408.74	103,221.08
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	1,487.16	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	1,835.58	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,493.96	38,464.83
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	421,215.90	6,595.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,285.08	1,762.47			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	160,850.33	21,960.98			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	204,069.60	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	2,328.90	1,397.34			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	201,695.32	1,551.24			
			TOTAL ANCILLARY	10,682,784.84	2,077,928.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,682,784.84	2,077,928.61

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,503.25	ADJUSTMENTS	0.00
COVERED CHARGES	24,428.03	CONTRACTUAL ALLOW	7,275.55
NON-COVERD CHARGES	24,075.22	TOTAL MEDICAID LIAB	17,152.48
		LESS: COB	17,141.44
		LESS: COPAYMENT	11.04
		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

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	1,387.12	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	22.52	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	801.67	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	22,523.85	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,342.27	22.12
EKG/ECG	472.67	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	18,951.61	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	899.53	119.61
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	1,960.28	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	24,428.03	24,075.22
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	24,428.03	24,075.22

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,002,056.76	ADJUSTMENTS	1,976.76
COVERED CHARGES	905,633.26	CONTRACTUAL ALLOW	867,705.97
NON-COVERD CHARGES	96,423.50	TOTAL MEDICAID LIAB	37,927.29
		LESS: COB	0.00
		LESS: COPAYMENT	1,176.06
		REIMBURSEMENT	36,751.23
		TOTAL NUMBER OF CLAIMS	678

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	99.93	13,889.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	349.34	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,706.67	0.00	OTHER THERAPEUTIC SVC	0.00	461.42
CT SCAN	18,493.69	51,332.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	94,791.26	24,855.13
EKG/ECG	17,056.64	472.67	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,211.56	1,344.71	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	681,543.99	760.46	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	24,136.97	3,308.03
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	20,151.97	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	91.24	0.00			
			TOTAL ANCILLARY	905,633.26	96,423.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	905,633.26	96,423.50

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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Page: 11

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,067.70	ADJUSTMENTS	0.00
COVERED CHARGES	913.57	CONTRACTUAL ALLOW	3.02
NON-COVERD CHARGES	154.13	TOTAL MEDICAID LIAB	910.55
		LESS: COB	907.55
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	1

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:26:56  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	154.13	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	255.21	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	658.36	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	913.57	154.13
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	913.57	154.13

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,238,415.02	ADJUSTMENTS	63,917.76
COVERED CHARGES	1,101,284.32	CONTRACTUAL ALLOW	948,779.20
NON-COVERD CHARGES	137,130.70	TOTAL MEDICAID LIAB	152,505.12
		LESS: COB	0.00
		LESS: COPAYMENT	117.00
		REIMBURSEMENT	152,388.12

TOTAL NUMBER OF CLAIMS 31

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	15,965.85	OTHER LAB	859.05	0.00
MED/SURG SUPPLY	73,992.50	739.36	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,020.06	0.00	OTHER THERAPEUTIC SVC	0.00	1,614.87
CT SCAN	2,905.54	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	344.52	FEE SCHEDULE LAB	19,311.70	2,487.37
EKG/ECG	1,833.06	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	412,992.16	82,606.06	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,260.30	503.71	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	251,243.66	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,532.36	4,587.67	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,996.98	678.83	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	113,206.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	24,040.04	11,727.41
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	26,583.58	15,875.05
LITHOTRIPSY	141,725.75	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	173.02	0.00			
CARDIOLOGY	5,603.39	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,005.17	0.00			
			TOTAL ANCILLARY	1,101,284.32	137,130.70
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,101,284.32	137,130.70

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:55:57  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,806,583.70	ADJUSTMENTS	46,746.57
COVERED CHARGES	1,786,265.70	CONTRACTUAL ALLOW	1,068,823.65
NON-COVERD CHARGES	20,318.00	TOTAL MEDICAID LIAB	717,442.05
		LESS: COB	2,519.72
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	714,922.33

TOTAL NUMBER OF ADMISSIONS 81

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	198		5	129,942.79		17,431.00
ROUTINE NURSERY	10		0	6,650.00		174.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	208		5	136,592.79		17,605.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	68		0	80,180.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	68		0	80,180.00		0.00
TOTAL ACCOMODATIONS	276		5	216,772.79		17,605.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	399,093.35	0.00	OTHER LAB	12,528.49	0.00
MED/SURG SUPPLY	112,719.76	264.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	235,402.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,125.00	0.00	OTHER THERAPEUTIC SVC	0.00	424.00
CT SCAN	77,292.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,999.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	9,504.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	211.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	87,672.00	1,006.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	16,096.95	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	101,755.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	48,016.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	75,269.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,096.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	133,109.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	159,402.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,429.00	0.00			
BLOOD	4,648.00	0.00			
BLOOD STORAGE & PRO.	10,410.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,384.00	1,019.00			
AUDIOLOGY	1,507.86	0.00			
CARDIOLOGY	13,322.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,773.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	728.00	0.00			
			TOTAL ANCILLARY	1,569,492.91	2,713.00
			TOTAL ACCOMODATIONS	216,772.79	17,605.00
			TOTAL CHARGES	1,786,265.70	20,318.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:56:00  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,341,383.37	ADJUSTMENTS	129,757.23
COVERED CHARGES	2,048,727.12	CONTRACTUAL ALLOW	1,650,661.19
NON-COVERD CHARGES	292,656.25	TOTAL MEDICAID LIAB	398,065.93
		LESS: COB	4,115.83
		LESS: COPAYMENT	1,788.00
		REIMBURSEMENT	392,162.10
		ALL OTHER	361,007.08
		FEE SCHEDULE-LAB	29,906.01
		INJECTABLE DRUGS	1,249.01
		TOTAL NUMBER OF CLAIMS	1,291

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	88,508.03	49,241.00	OTHER LAB	12,030.44	1,659.22
MED/SURG SUPPLY	120,676.14	2,056.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	129.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	113,091.00	3,398.00	OTHER THERAPEUTIC SVC	0.00	5,746.00
CT SCAN	241,981.00	30,364.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	335.00	0.00	FEE SCHEDULE LAB	392,539.20	105,690.60
EKG/ECG	17,759.00	1,386.00	MRI SERVICES	8,630.00	0.00
IV THERAPY	6,258.00	402.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	143,772.01	14,798.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	21,067.00	2,684.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	120,300.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	472,832.08	20,138.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	12,880.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	22,758.00	33,332.43
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	10,147.00	2,784.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	64,129.00	2,965.00	IMPL DEV CHARGE PATIENTS	4,227.22	3,586.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	96,386.00	6,108.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	28,083.00	5,420.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	15,837.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,633.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	30,868.00	104.00			
			TOTAL ANCILLARY	2,048,727.12	291,991.25
			TOTAL ACCOMODATIONS	0.00	665.00
			TOTAL CHARGES	2,048,727.12	292,656.25

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	31,257.22	ADJUSTMENTS	0.00
COVERED CHARGES	23,751.61	CONTRACTUAL ALLOW	10,517.09
NON-COVERD CHARGES	7,505.61	TOTAL MEDICAID LIAB	13,234.52
		LESS: COB	13,231.52
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 17

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,465.00	0.00	OTHER LAB	398.61	398.61
MED/SURG SUPPLY	279.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	263.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,601.00	0.00	OTHER THERAPEUTIC SVC	0.00	212.00
CT SCAN	0.00	6,041.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	6,249.00	393.00
EKG/ECG	0.00	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	152.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,278.00	70.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	473.00	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	2,005.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,640.00	26.00			
			TOTAL ANCILLARY	23,751.61	7,505.61
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	23,751.61	7,505.61

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:56:26  
Page: 8

CHESTATEE REGIONAL HOSPITAL  
227 MOUNTAIN DR  
DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	106,244.99	ADJUSTMENTS	923.98
COVERED CHARGES	98,912.00	CONTRACTUAL ALLOW	91,779.26
NON-COVERD CHARGES	7,332.99	TOTAL MEDICAID LIAB	7,132.74
		LESS: COB	0.00
		LESS: COPAYMENT	195.00
		REIMBURSEMENT	6,937.74
		TOTAL NUMBER OF CLAIMS	134



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,425.00	1,873.00	OTHER LAB	0.00	431.00
MED/SURG SUPPLY	2,109.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	5,403.00	0.00	OTHER THERAPEUTIC SVC	0.00	954.00
CT SCAN	3,482.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	26,456.00	2,359.00
EKG/ECG	594.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	720.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	54,850.00	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	500.00	1,365.99
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,749.00	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	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	624.00	0.00			
			TOTAL ANCILLARY	98,912.00	7,332.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	98,912.00	7,332.99

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,250.00	ADJUSTMENTS	0.00
COVERED CHARGES	3,838.00	CONTRACTUAL ALLOW	2,969.58
NON-COVERD CHARGES	412.00	TOTAL MEDICAID LIAB	868.42
		LESS: COB	868.42
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

CHESTATEE REGIONAL HOSPITAL  
 227 MOUNTAIN DR  
 DAHLONEGA,GA 30533-1606

PROVIDER NUMBER  
 000081232A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	254.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,587.00	158.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,242.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,838.00	412.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,838.00	412.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:56:30  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:50:54  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

FANNIN REGIONAL HOSP  
 2855 OLD HIGHWAY 5  
 BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER 000134406A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,062,011.51	ADJUSTMENTS	45,420.47
COVERED CHARGES	3,965,985.64	CONTRACTUAL ALLOW	3,273,875.84
NON-COVERD CHARGES	96,025.87	TOTAL MEDICAID LIAB	692,109.80
		LESS: COB	200.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	691,909.80

TOTAL NUMBER OF ADMISSIONS 214

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	194		89	149,570.19		87,031.59
ROUTINE NURSERY	188		0	113,389.27		3,800.76
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	382		89	262,959.46		90,832.35
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	57		0	65,839.70		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		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	57		0	65,839.70		0.00
TOTAL ACCOMODATIONS	439		89	328,799.16		90,832.35

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	478,061.86	0.00	OTHER LAB	3,468.98	0.00
MED/SURG SUPPLY	67,154.98	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	581,433.18	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	22,594.61	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	77,136.48	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	12,448.73	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	19,320.60	0.00	MRI SERVICES	4,069.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	732,672.42	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	404,334.46	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	75,485.94	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	119,207.52	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	101,432.55	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	52,338.48	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	17,156.50	0.00	INJECTABLE DRUGS	685,109.92	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,290.23	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	2,311.63	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	116,421.26	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,466.45
OTHER IMAGING SERVICE	6,535.47	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,639.09	2,473.67			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	6,317.82	253.40			
AUDIOLOGY	11,757.82	0.00			
CARDIOLOGY	8,925.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	9,561.95	0.00			
			TOTAL ANCILLARY	3,637,186.48	5,193.52
			TOTAL ACCOMODATIONS	328,799.16	90,832.35
			TOTAL CHARGES	3,965,985.64	96,025.87

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: 07/23/2014  
Run Time: 09:50:54  
Page: 3

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013211039299	07/11/13 - 07/13/13	08/05/13	0.00	2,466.45	0.00	0.00	0.00
TOTAL				0.00	2,466.45	0.00	0.00	0.00



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	116,132.17	ADJUSTMENTS	0.00
COVERED CHARGES	114,762.12	CONTRACTUAL ALLOW	76,455.30
NON-COVERD CHARGES	1,370.05	TOTAL MEDICAID LIAB	38,306.82
		LESS: COB	38,306.82
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	10		0	7,488.81		679.79
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	10		0	7,488.81		679.79
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	2		0	2,773.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	2		0	2,773.00		0.00
TOTAL ACCOMODATIONS	12		0	10,261.81		679.79

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	26,943.28	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,370.52	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	10,975.15	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	238.06	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	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	27,117.63	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	15,684.46	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,652.34	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,649.33	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,442.56	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	9,814.32	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,612.66	690.26			
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	104,500.31	690.26
			TOTAL ACCOMODATIONS	10,261.81	679.79
			TOTAL CHARGES	114,762.12	1,370.05

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:50:59  
Page: 6

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,034,579.89	ADJUSTMENTS	176,647.08
COVERED CHARGES	3,584,443.44	CONTRACTUAL ALLOW	3,013,765.69
NON-COVERD CHARGES	450,136.45	TOTAL MEDICAID LIAB	570,677.75
		LESS: COB	542.85
		LESS: COPAYMENT	1,407.00
		REIMBURSEMENT	568,727.90
		ALL OTHER	521,215.71
		FEE SCHEDULE-LAB	34,936.07
		INJECTABLE DRUGS	12,576.12
		TOTAL NUMBER OF CLAIMS	1,272

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 09:50:59  
 Page: 7

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	167,782.51	15,807.02	OTHER LAB	118,994.06	1,346.14
MED/SURG SUPPLY	11,553.65	2,410.88	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	498.20	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	131,201.40	6,057.16	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	395,424.57	15,916.26	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	44,472.46	13,248.25	FEE SCHEDULE LAB	970,412.94	186,886.50
EKG/ECG	52,655.03	640.58	MRI SERVICES	90,541.60	0.00
IV THERAPY	9,434.01	301.13	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	250,167.94	28,413.36	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	4,678.86	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,919.62	1,930.70	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	74,793.84	0.00	AMBULANCE	0.00	0.00
GI SERVICES	67,631.86	2,446.80	CAST ROOM	0.00	0.00
EMERGENCY ROOM	611,949.10	27,523.96	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	63,663.81	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	272,468.46	119,119.38
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	11,381.33	6,962.38	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	728.73	3,091.20	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	5,759.17	559.25	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	5,649.24
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	4,452.00
OTHER IMAGING SERVICE	72,646.46	1,090.88			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,028.40	690.26			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	51,188.39	4,312.29			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	39,315.77	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	6,994.38	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	31,655.09	782.63			
			TOTAL ANCILLARY	3,584,443.44	450,136.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,584,443.44	450,136.45

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:50:59  
Page: 8

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013042028035	02/01/13 - 02/01/13	02/18/13	0.00	2,226.00	0.00	0.00	0.00
614	2013318055826	11/08/13 - 11/08/13	11/18/13	0.00	2,226.00	0.00	0.00	0.00
TOTAL				0.00	4,452.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 09:51:20  
Page: 9

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	93,972.58	ADJUSTMENTS	0.00
COVERED CHARGES	73,965.61	CONTRACTUAL ALLOW	44,664.66
NON-COVERD CHARGES	20,006.97	TOTAL MEDICAID LIAB	29,300.95
		LESS: COB	29,285.95
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 21

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,686.91	4,283.05	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	35.58	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	271.87	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,143.87	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,352.68	5,424.93	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	20,136.95	4,316.91
EKG/ECG	1,259.50	309.46	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	10,030.43	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,074.46	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	15,567.58	2,534.64	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,956.46	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	368.12	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	171.31	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,283.17
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,181.76	1,582.94			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	73,965.61	20,006.97
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	73,965.61	20,006.97

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:51:21  
Page: 11

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	263,855.35	ADJUSTMENTS	1,067.79
COVERED CHARGES	241,407.10	CONTRACTUAL ALLOW	231,785.42
NON-COVERD CHARGES	22,448.25	TOTAL MEDICAID LIAB	9,621.68
		LESS: COB	0.00
		LESS: COPAYMENT	303.01
		REIMBURSEMENT	9,318.67
		TOTAL NUMBER OF CLAIMS	172



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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,748.34	1,503.88	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	11,583.73	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	19,703.30	6,174.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	62,343.82	12,973.99
EKG/ECG	2,893.44	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	116,664.18	971.88	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	13,299.66	823.82
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,181.76	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,988.87	0.00			
			TOTAL ANCILLARY	241,407.10	22,448.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	241,407.10	22,448.25

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:51:24  
Page: 13

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	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 09:51:24  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,222,167.32	ADJUSTMENTS	102,281.95
COVERED CHARGES	1,116,893.93	CONTRACTUAL ALLOW	965,812.33
NON-COVERD CHARGES	105,273.39	TOTAL MEDICAID LIAB	151,081.60
		LESS: COB	2,178.26
		LESS: COPAYMENT	90.65
		REIMBURSEMENT	148,812.69
		TOTAL NUMBER OF CLAIMS	31

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	73,579.75	16,373.48	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	30,268.33	366.38	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,332.84	1,546.37	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,904.46	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,882.90	1,415.42
EKG/ECG	331.12	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	705,609.43	35,314.06	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,782.74	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	133,075.45	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,000.39	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	67,761.71	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	45,595.80	25,947.32
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	22,075.53
LITHOTRIPSY	17,855.19	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,090.88	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,785.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,037.94	2,234.83			
			TOTAL ANCILLARY	1,116,893.93	105,273.39
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,116,893.93	105,273.39

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 09:51:25  
Page: 16

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

FANNIN REGIONAL HOSP  
2855 OLD HIGHWAY 5  
BLUE RIDGE,GA 30513-6248

PROVIDER NUMBER  
000134406A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	53,542.68	ADJUSTMENTS	0.00
COVERED CHARGES	52,169.69	CONTRACTUAL ALLOW	30,785.95
NON-COVERD CHARGES	1,372.99	TOTAL MEDICAID LIAB	21,383.74
		LESS: COB	21,377.74
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0814-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:51:25  
 Page: 17

SUMMARY TYPE VIII

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,560.21	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	76.14	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,570.66	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	81.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	16,547.04	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,659.15	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,820.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,372.99
LITHOTRIPSY	17,855.19	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	52,169.69	1,372.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	52,169.69	1,372.99

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DOCTORS SPECIALTY HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER 000148233A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	6,197,069.05	ADJUSTMENTS	159,432.75
COVERED CHARGES	6,115,244.95	CONTRACTUAL ALLOW	4,517,880.53
NON-COVERD CHARGES	81,824.10	TOTAL MEDICAID LIAB	1,597,364.42
		LESS: COB	9,842.53
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,587,521.89

TOTAL NUMBER OF ADMISSIONS 239

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	919		0	460,358.00		11,893.00
ROUTINE NURSERY	58		0	24,489.00		150.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	977		0	484,847.00		12,043.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	283		0	251,940.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	283		0	251,940.00		0.00
TOTAL ACCOMODATIONS	1,260		0	736,787.00		12,043.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DOCTORS SPECIALTY HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	770,096.50	18,762.00	OTHER LAB	19,131.00	0.00
MED/SURG SUPPLY	473,189.71	10,050.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	820,608.15	3,185.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	63,582.00	0.00	OTHER THERAPEUTIC SVC	0.00	62.00
CT SCAN	156,323.00	361.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	42,055.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,580.00	0.00	MRI SERVICES	92,063.71	0.00
IV THERAPY	542.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	645,704.65	9,232.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	56,848.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	203,893.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	121,765.00	881.00	AMBULANCE	0.00	0.00
GI SERVICES	21,568.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	62,559.00	1,591.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,558,058.63	16,902.00
RADIOLOGY THERAPEUTIC	23,238.70	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	13,213.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,552.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,176.00	4,352.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,491.00	957.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	27,033.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	26,547.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	28,988.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	21,979.00	3,446.00			
AUDIOLOGY	6,766.00	0.00			
CARDIOLOGY	90,048.50	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	8,716.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	4,142.00	0.00			
			TOTAL ANCILLARY	5,378,457.95	69,781.10
			TOTAL ACCOMODATIONS	736,787.00	12,043.00
			TOTAL CHARGES	6,115,244.95	81,824.10



Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:37:23  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DOCTORS SPECIALTY HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,248.45	ADJUSTMENTS	0.00
COVERED CHARGES	43,248.45	CONTRACTUAL ALLOW	24,419.70
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	18,828.75
		LESS: COB	18,828.75
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	4,305.00		0.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9		0	4,305.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	9		0	4,305.00		0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DOCTORS SPECIALTY HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,564.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	4,677.45	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,216.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,838.00	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	7,316.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,465.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,083.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	8,742.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,042.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	38,943.45	0.00
			TOTAL ACCOMODATIONS	4,305.00	0.00
			TOTAL CHARGES	43,248.45	0.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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DOCTORS SPECIALTY HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,954,162.70	ADJUSTMENTS	19,813.87
COVERED CHARGES	1,703,959.40	CONTRACTUAL ALLOW	1,338,487.68
NON-COVERD CHARGES	250,203.30	TOTAL MEDICAID LIAB	365,471.72
		LESS: COB	149.14
		LESS: COPAYMENT	951.00
		REIMBURSEMENT	364,371.58
		ALL OTHER	334,784.19
		FEE SCHEDULE-LAB	8,523.30
		INJECTABLE DRUGS	21,064.09

TOTAL NUMBER OF CLAIMS 390

DOCTORS SPECIALTY HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	52,482.60	386.00	OTHER LAB	9,888.00	0.00
MED/SURG SUPPLY	105,885.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	16,712.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	52,306.00	11,173.45	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	1,144.00	FEE SCHEDULE LAB	104,890.00	14,086.00
EKG/ECG	8,255.00	386.00	MRI SERVICES	0.00	0.00
IV THERAPY	13,948.00	72.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	644,529.00	189,436.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	7,314.00	6,124.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	86,298.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	143,355.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,931.00	2,669.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	728.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	89,574.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	96,853.55	11,828.00
RADIOLOGY THERAPEUTIC	3,693.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	17,213.00	1,291.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,137.40	8,079.85
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,413.00	1,384.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,820.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	5,157.00	1,488.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,299.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	177,737.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,540.75	656.00			
			TOTAL ANCILLARY	1,703,959.40	250,203.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,703,959.40	250,203.30

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

DOCTORS SPECIALTY HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,067.75	ADJUSTMENTS	0.00
COVERED CHARGES	1,339.75	CONTRACTUAL ALLOW	47.51
NON-COVERD CHARGES	728.00	TOTAL MEDICAID LIAB	1,292.24
		LESS: COB	1,289.24
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DOCTORS SPECIALTY HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	0.00	0.00
MED/SURG SUPPLY	434.75	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	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	473.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	728.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	311.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,339.75	728.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,339.75	728.00

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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DOCTORS SPECIALTY HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
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

DOCTORS SPECIALTY HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
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

DOCTORS SPECIALTY HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	852,070.10	ADJUSTMENTS	15,002.61
COVERED CHARGES	807,614.60	CONTRACTUAL ALLOW	682,221.32
NON-COVERD CHARGES	44,455.50	TOTAL MEDICAID LIAB	125,393.28
		LESS: COB	2,376.94
		LESS: COPAYMENT	110.32
		REIMBURSEMENT	122,906.02
		TOTAL NUMBER OF CLAIMS	25

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS SPECIALTY HOSPITAL  
 616 19TH ST  
 COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
 000148233A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	21,096.15	40.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	166,300.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	35.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,122.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,902.00	1,787.00
EKG/ECG	2,119.00	197.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	381,524.50	34,801.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	725.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	76,960.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	38,685.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,117.20	940.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	46.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	39,668.00	6,609.00
LITHOTRIPSY	57,431.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,964.00	0.00			
			TOTAL ANCILLARY	807,614.60	44,455.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	807,614.60	44,455.50

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DOCTORS SPECIALTY HOSPITAL  
616 19TH ST  
COLUMBUS,GA 31901-1528

PROVIDER NUMBER  
000148233A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER 000149487A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,389,360.90	ADJUSTMENTS	0.00
COVERED CHARGES	2,188,309.40	CONTRACTUAL ALLOW	986,962.66
NON-COVERD CHARGES	201,051.50	TOTAL MEDICAID LIAB	1,201,346.74
		LESS: COB	2,391.43
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,198,955.31

TOTAL NUMBER OF ADMISSIONS 331

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,727		85	949,800.00		192,365.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,727		85	949,800.00		192,365.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,727		85	949,800.00		192,365.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	630,810.37	91.28	OTHER LAB	1,751.23	0.00
MED/SURG SUPPLY	58,279.67	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	274,498.00	967.51	EDUCATION & TRAINING	65.00	0.00
RADIOLOGY-DIAGNOSTIC	19,717.37	160.24	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	55,707.67	938.08	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,243.19	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,463.27	224.77	MRI SERVICES	0.00	0.00
IV THERAPY	16,651.44	0.00	PROFESSIONAL FEES	0.00	372.66
OPERATING ROOM	5,200.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	23,808.55	172.14	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,559.92	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	82,441.75	2,251.47	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	12,032.28	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	79.11	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,233.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	31,005.65	3,508.35			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	6,605.05	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	356.48	0.00			
			TOTAL ANCILLARY	1,238,509.40	8,686.50
			TOTAL ACCOMODATIONS	949,800.00	192,365.00
			TOTAL CHARGES	2,188,309.40	201,051.50

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:50:30  
Page: 4

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,113,666.18	ADJUSTMENTS	323.67
COVERED CHARGES	1,007,711.77	CONTRACTUAL ALLOW	800,699.21
NON-COVERD CHARGES	105,954.41	TOTAL MEDICAID LIAB	207,012.56
		LESS: COB	6.01
		LESS: COPAYMENT	999.00
		REIMBURSEMENT	206,007.55
		ALL OTHER	177,093.13
		FEE SCHEDULE-LAB	28,748.57
		INJECTABLE DRUGS	165.85
		TOTAL NUMBER OF CLAIMS	1,207

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	49,485.08	640.61	OTHER LAB	61,062.69	0.00
MED/SURG SUPPLY	21,695.46	972.31	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	60,960.66	395.22	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	67,254.85	3,963.16	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,925.85	0.00	FEE SCHEDULE LAB	207,214.40	57,031.02
EKG/ECG	14,134.11	449.54	MRI SERVICES	0.00	0.00
IV THERAPY	1,610.19	2,460.47	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	180,831.17	26,995.89	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,413.70	1,631.19	FREE STANDING CLINIC	7.70	0.00
ANESTHESIA	33,988.76	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	264,990.41	417.98	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	823.64	5,164.44
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	395.55	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	587.35	1,540.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	15,292.43	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	5,382.95	2,105.01			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,284.04	1,321.01			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,766.33	471.01			
			TOTAL ANCILLARY	1,007,711.77	105,954.41
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,007,711.77	105,954.41



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: 07/23/2014  
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Page: 6

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,767.54	ADJUSTMENTS	0.00
COVERED CHARGES	7,519.96	CONTRACTUAL ALLOW	2,094.18
NON-COVERD CHARGES	247.58	TOTAL MEDICAID LIAB	5,425.78
		LESS: COB	5,419.78
		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

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	667.18	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1.84	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,336.67	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	938.08	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	714.94	247.58
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,856.05	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	5.20	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	7,519.96	247.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,519.96	247.58

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:50:46  
Page: 8

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	68,086.63	ADJUSTMENTS	55.94
COVERED CHARGES	65,034.94	CONTRACTUAL ALLOW	61,119.14
NON-COVERD CHARGES	3,051.69	TOTAL MEDICAID LIAB	3,915.80
		LESS: COB	0.00
		LESS: COPAYMENT	138.00
		REIMBURSEMENT	3,777.80
		TOTAL NUMBER OF CLAIMS	70

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,367.76	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	91.07	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,840.01	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,431.29	1,462.49	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,205.59	1,255.93
EKG/ECG	674.31	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	315.37	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,955.08	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	154.46	333.27
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	65,034.94	3,051.69
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	65,034.94	3,051.69

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:50:47  
Page: 10

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,023.92	ADJUSTMENTS	0.00
COVERED CHARGES	2,763.48	CONTRACTUAL ALLOW	2,305.48
NON-COVERD CHARGES	260.44	TOTAL MEDICAID LIAB	458.00
		LESS: COB	455.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

BACCHUS OPERATIONS GROUP INC  
 509 SUMTER ST  
 MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
 000149487A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	215.94	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	160.24	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	747.36	260.44
EKG/ECG	224.77	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,408.02	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7.15	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,763.48	260.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,763.48	260.44

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 09:50:48  
Page: 13

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

BACCHUS OPERATIONS GROUP INC  
509 SUMTER ST  
MONTEZUMA,GA 31063-1733

PROVIDER NUMBER  
000149487A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	33,258,832.98	ADJUSTMENTS	2,054,673.61
COVERED CHARGES	31,438,076.72	CONTRACTUAL ALLOW	23,458,573.31
NON-COVERD CHARGES	1,820,756.26	TOTAL MEDICAID LIAB	7,979,503.41
		LESS: COB	82,607.12
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	7,896,896.29

TOTAL NUMBER OF ADMISSIONS 825

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	2,913	10	1,866,318.82	47,966.07
ROUTINE NURSERY	463	4	231,558.43	11,816.54
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,376	14	2,097,877.25	59,782.61
SPECIAL CARE SERVICES				
CCU	799	0	1,587,034.00	0.00
ICU	0	0	0.00	0.00
NICU	751	0	969,107.54	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,550	0	2,556,141.54	0.00
TOTAL ACCOMODATIONS	4,926	14	4,654,018.79	59,782.61

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,793,803.85	10,071.31	OTHER LAB	121,105.61	0.00
MED/SURG SUPPLY	900,030.65	9,190.16	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,189,209.36	43,747.65	EDUCATION & TRAINING	10,446.50	117.12
RADIOLOGY-DIAGNOSTIC	757,119.33	1,389.69	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	821,615.90	101,151.24	SPECIAL CHARGES	1,254.08	0.00
PHYSICAL THERAPY	104,700.56	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	131,031.30	0.00	MRI SERVICES	287,622.38	0.00
IV THERAPY	3,047,859.51	1,029,620.41	PROFESSIONAL FEES	0.00	4,516.16
OPERATING ROOM	2,253,591.19	60,463.06	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	75,944.88	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,471,777.73	29,578.62	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	296,696.02	0.00	AMBULANCE	0.00	0.00
GI SERVICES	36,070.66	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	275,168.30	243.79	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	143,111.12	0.00	DRUG-SPECIFIC/HOME IV	0.00	128,918.42
LABORATORY PATHOLOGIC	121,931.12	0.00	INJECTABLE DRUGS	2,063,587.34	6,005.49
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	25,827.02	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	28,285.71	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	21,868.77	5,301.52	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	117.82	106,269.59	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,382,160.48	48,414.28
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	34,909.76
OTHER IMAGING SERVICE	290,657.66	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	195,128.09	77,804.85			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	204,010.60	56,182.25			
AUDIOLOGY	811.80	0.00			
CARDIOLOGY	559,292.84	1,062.72			
AMBULATORY SURGERY	1,675.30	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	31,511.20	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	139,033.25	6,015.56			
			TOTAL ANCILLARY	26,784,057.93	1,760,973.65
			TOTAL ACCOMODATIONS	4,654,018.79	59,782.61
			TOTAL CHARGES	31,438,076.72	1,820,756.26

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012205037739	07/03/12 - 07/16/12	07/30/12	0.00	2,408.42	0.00	0.00	0.00
12	2212286013743	09/30/12 - 10/02/12	10/15/12	0.00	301.48	0.00	0.00	0.00
615	2012289031800	10/04/12 - 10/09/12	10/22/12	0.00	2,408.42	0.00	0.00	0.00
618	2012319043594	10/26/12 - 11/04/12	11/19/12	0.00	890.40	0.00	0.00	0.00
615	2012335074841	10/16/12 - 10/28/12	12/10/12	0.00	2,408.42	0.00	0.00	0.00
615	2012355062468	12/09/12 - 12/14/12	12/24/12	0.00	2,408.42	0.00	0.00	0.00
615	2013014024411	09/03/12 - 09/06/12	01/21/13	0.00	2,408.42	0.00	0.00	0.00
615	2013016050613	01/06/13 - 01/09/13	01/21/13	0.00	2,408.42	0.00	0.00	0.00
615	2013071054832	12/12/12 - 12/19/12	03/18/13	0.00	2,408.42	0.00	0.00	0.00
615	2213081017347	03/09/13 - 03/12/13	03/25/13	0.00	2,408.42	0.00	0.00	0.00
615	5213177029915	09/01/12 - 09/15/12	07/01/13	0.00	2,408.42	0.00	0.00	0.00
615	2213242012764	06/17/13 - 06/22/13	09/02/13	0.00	2,408.42	0.00	0.00	0.00
615	2213242017785	02/07/13 - 02/10/13	09/02/13	0.00	2,408.42	0.00	0.00	0.00
615	2013287026020	02/19/13 - 02/22/13	10/21/13	0.00	2,408.42	0.00	0.00	0.00
615	2014063036997	06/14/13 - 06/20/13	03/10/14	0.00	2,408.42	0.00	0.00	0.00
615	2014139031755	06/09/13 - 06/17/13	05/26/14	0.00	2,408.42	0.00	0.00	0.00
TOTAL				0.00	34,909.76	0.00	0.00	0.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:58:43  
 Page: 4

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	67,279.37	ADJUSTMENTS	0.00
COVERED CHARGES	66,050.86	CONTRACTUAL ALLOW	15,423.05
NON-COVERD CHARGES	1,228.51	TOTAL MEDICAID LIAB	50,627.81
		LESS: COB	50,627.81
		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	2		0	1,315.30		292.99
ROUTINE NURSERY	34		0	21,786.70		935.52
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	36		0	23,102.00		1,228.51
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	7		0	7,630.50		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	7		0	7,630.50		0.00
TOTAL ACCOMODATIONS	43		0	30,732.50		1,228.51

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

PIEDMONT HENRY HOSPITAL, INC.  
 1133 EAGLES LANDING PKWY  
 STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
 000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,318.08	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,276.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	6,927.92	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	327.22	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	12,513.03	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,565.85	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	456.18	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	3,249.50	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	89.60	0.00			
CARDIOLOGY	1,594.08	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	35,318.36	0.00
			TOTAL ACCOMODATIONS	30,732.50	1,228.51
			TOTAL CHARGES	66,050.86	1,228.51

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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PIEDMONT HENRY HOSPITAL, INC.  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	15,450,582.92	ADJUSTMENTS	575,163.63
COVERED CHARGES	13,844,117.62	CONTRACTUAL ALLOW	11,433,366.90
NON-COVERD CHARGES	1,606,465.30	TOTAL MEDICAID LIAB	2,410,750.72
		LESS: COB	3,059.43
		LESS: COPAYMENT	4,238.73
		REIMBURSEMENT	2,403,452.56
		ALL OTHER	2,160,668.68
		FEE SCHEDULE-LAB	215,914.43
		INJECTABLE DRUGS	26,869.45

TOTAL NUMBER OF CLAIMS 6,219

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	436,035.66	1,245.55	OTHER LAB	59,052.73	2,286.00
MED/SURG SUPPLY	173,879.81	97.34	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,137.46	EDUCATION & TRAINING	117.12	0.00
RADIOLOGY-DIAGNOSTIC	989,304.30	36,791.06	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,135,093.26	241,035.51	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	17,062.63	6,025.76	FEE SCHEDULE LAB	3,106,213.39	403,991.85
EKG/ECG	214,535.69	6,176.29	MRI SERVICES	197,294.05	36,382.58
IV THERAPY	441,772.78	68,970.67	PROFESSIONAL FEES	0.00	100.18
OPERATING ROOM	2,146,263.66	351,875.01	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	75,798.01	1,824.72	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	56,010.70	5,052.21	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	387,856.54	834.28	AMBULANCE	0.00	0.00
GI SERVICES	37,000.65	5,468.14	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,034,176.02	8,940.89	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	219,055.48	0.00	DRUG-SPECIFIC/HOME IV	0.00	12,884.86
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,050,220.98	162,492.26
RADIOLOGY THERAPEUTIC	566.09	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,825.35	834.23	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	939.34	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	182,915.21	11,719.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	136,434.06	19,747.88
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,019.28
OTHER IMAGING SERVICE	692,026.26	81,693.12			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	19,360.42	17,672.01			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	410,639.17	106,312.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	367,647.97	5,914.82			
AMBULATORY SURGERY	837.65	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	149,982.48	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	104,139.50	0.00			
			TOTAL ANCILLARY	13,844,117.62	1,606,465.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	13,844,117.62	1,606,465.30

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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PIEDMONT HENRY HOSPITAL, INC.  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE, GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5912271002200	07/08/12 - 07/08/12	10/01/12	0.00	2,408.42	0.00	0.00	0.00
618	2012306067460	10/24/12 - 10/24/12	11/05/12	0.00	794.02	0.00	0.00	0.00
615	2012345037680	09/24/12 - 09/24/12	12/17/12	0.00	2,408.42	0.00	0.00	0.00
615	2013119030796	03/28/13 - 03/28/13	05/06/13	0.00	2,408.42	0.00	0.00	0.00
TOTAL				0.00	8,019.28	0.00	0.00	0.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT HENRY HOSPITAL, INC.  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,578.59	ADJUSTMENTS	0.00
COVERED CHARGES	64,920.61	CONTRACTUAL ALLOW	34,290.19
NON-COVERD CHARGES	37,657.98	TOTAL MEDICAID LIAB	30,630.42
		LESS: COB	30,595.54
		LESS: COPAYMENT	34.88
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,672.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	656.78	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,577.16	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	2,196.14	4,834.68	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	17,988.81	593.77
EKG/ECG	627.58	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	872.70	451.59	PROFESSIONAL FEES	0.00	210.79
OPERATING ROOM	11,097.08	16,811.56	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,226.62	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,016.03	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,751.65	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	4,167.11	4,054.94
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	1,109.24	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	326.34
OTHER IMAGING SERVICE	7,541.17	3,208.80			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	2,077.06	5,511.53			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	1,653.98			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	342.98	0.00			
			TOTAL ANCILLARY	64,920.61	37,657.98
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	64,920.61	37,657.98

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
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SUMMARY TYPE IV

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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

PIEDMONT 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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR INVALID REVENUE CODE FOR PAID CLAIMS

REV. CD	CLAIM ICN	FROM-TO SVC DATES	PAYMENT DATE	COVERED CHARGES	NON-COVERED CHARGES	COPAY	COB	PAYMENT
8005	2213005000302	07/11/12 - 07/11/12	01/14/13	0.00	326.34	0.00	331.75	0.00
TOTAL				0.00	326.34	0.00	331.75	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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PIEDMONT HENRY HOSPITAL, INC.  
1133 EAGLES LANDING PKWY  
STOCKBRIDGE,GA 30281-5085

PROVIDER NUMBER  
000182388A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	780,879.24	ADJUSTMENTS	2,321.39
COVERED CHARGES	733,193.69	CONTRACTUAL ALLOW	690,287.74
NON-COVERD CHARGES	47,685.55	TOTAL MEDICAID LIAB	42,905.95
		LESS: COB	0.00
		LESS: COPAYMENT	1,356.22
		REIMBURSEMENT	41,549.73
		TOTAL NUMBER OF CLAIMS	767

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	24,916.42	0.00	OTHER LAB	3,429.00	0.00
MED/SURG SUPPLY	6,832.01	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	119.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	55,301.35	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	37,625.52	9,951.04	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	244,199.62	12,805.62
EKG/ECG	16,776.16	313.79	MRI SERVICES	0.00	0.00
IV THERAPY	41,105.34	9,206.95	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,567.01	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,123.47	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,353.39	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	144,152.56	266.65	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	781.89	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	101,875.91	4,906.81
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	325.82	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	36,693.01	9,789.87			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,461.03	0.00			
			TOTAL ANCILLARY	733,193.69	47,685.55
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	733,193.69	47,685.55

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,489.06	ADJUSTMENTS	0.00
COVERED CHARGES	5,278.63	CONTRACTUAL ALLOW	4,958.30
NON-COVERD CHARGES	2,210.43	TOTAL MEDICAID LIAB	320.33
		LESS: COB	317.33
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:00:01  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	573.77	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,728.44	1,728.44	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,550.85	25.07
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	922.86	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	428.91	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	73.80	456.92
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
LITHOTRIPTY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	5,278.63	2,210.43
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	5,278.63	2,210.43

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: 07/23/2014  
Run Time: 10:00:03  
Page: 16

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,393,094.53	ADJUSTMENTS	147,361.02
COVERED CHARGES	2,287,374.67	CONTRACTUAL ALLOW	2,074,346.53
NON-COVERD CHARGES	105,719.86	TOTAL MEDICAID LIAB	213,028.14
		LESS: COB	0.00
		LESS: COPAYMENT	171.00
		REIMBURSEMENT	212,857.14

TOTAL NUMBER OF CLAIMS 39



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	35,345.74	0.00	OTHER LAB	1,755.55	0.00
MED/SURG SUPPLY	88,654.18	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	11,162.93	1,326.25	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,479.62	4,158.11	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	525.38	FEE SCHEDULE LAB	64,849.80	10,053.47
EKG/ECG	4,393.06	3,765.48	MRI SERVICES	0.00	0.00
IV THERAPY	2,395.94	4,521.26	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	596,161.46	23,933.53	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	226.11	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	70,980.85	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,959.19	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	27,313.84	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	671.27	INJECTABLE DRUGS	60,577.86	28,348.40
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	662.69	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,141,814.13	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,984.77	884.39			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,743.00	2,070.16			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	8,365.15	3,408.60			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	134,634.55	19,275.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	21,576.94	2,115.87			
			TOTAL ANCILLARY	2,287,374.67	105,719.86
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,287,374.67	105,719.86

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:00:05  
Page: 18

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER 000190088A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	41,722,839.12	ADJUSTMENTS	1,295,912.84
COVERED CHARGES	35,146,663.83	CONTRACTUAL ALLOW	28,212,141.58
NON-COVERD CHARGES	6,576,175.29	TOTAL MEDICAID LIAB	6,934,522.25
		LESS: COB	129,837.83
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,804,684.42

TOTAL NUMBER OF ADMISSIONS 913

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	4,342	31	4,489,576.00	4,146,180.00
ROUTINE NURSERY	335	10	388,883.00	7,692.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	4,677	41	4,878,459.00	4,153,872.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	1,135	2	2,119,254.00	385,381.00
NICU	226	0	522,512.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	1,361	2	2,641,766.00	385,381.00
TOTAL ACCOMODATIONS	6,038	43	7,520,225.00	4,539,253.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,361,072.58	161,433.05	OTHER LAB	253,571.72	6,621.12
MED/SURG SUPPLY	2,539,805.76	265,701.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	5,983,467.96	289,239.93	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	667,825.35	35,141.60	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,607,327.55	70,187.28	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	198,177.10	17,822.25	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	297,673.46	1,631.73	MRI SERVICES	271,043.86	8,466.03
IV THERAPY	3,310.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	1,186,105.13	57,538.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	362,827.47	7,747.72	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,508,964.19	565,523.91	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	445,783.32	14,220.14	AMBULANCE	0.00	0.00
GI SERVICES	133,646.37	2,820.92	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,070,282.16	7,476.86	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	406,351.20	13,429.89	DRUG-SPECIFIC/HOME IV	0.00	2,166.92
LABORATORY PATHOLOGIC	221,662.49	16,761.22	INJECTABLE DRUGS	4,177,526.69	235,501.89
RADIOLOGY THERAPEUTIC	2,439.42	13,349.23	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	42,625.15	8,633.91	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	122,882.21	11,743.66	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	129,491.56	36,684.94	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	12,666.43	4,738.38	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	1,176,919.75	5,827.25
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	222,138.82	3,990.49			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	105,745.52	126,964.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	336,487.99	20,990.26			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	610,107.31	22,885.37			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	51,958.54	1,681.87			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	116,551.77	0.00			
			TOTAL ANCILLARY	27,626,438.83	2,036,922.29
			TOTAL ACCOMODATIONS	7,520,225.00	4,539,253.00
			TOTAL CHARGES	35,146,663.83	6,576,175.29

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER 000190088A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	649,700.06	ADJUSTMENTS	0.00
COVERED CHARGES	610,248.06	CONTRACTUAL ALLOW	349,351.44
NON-COVERD CHARGES	39,452.00	TOTAL MEDICAID LIAB	260,896.62
		LESS: COB	260,896.62
		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	35		3	36,008.00		34,218.00
ROUTINE NURSERY	46		3	64,452.00		4,482.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	81		6	100,460.00		38,700.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	11		0	24,561.00		0.00
NICU	9		0	20,617.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	20		0	45,178.00		0.00
TOTAL ACCOMODATIONS	101		6	145,638.00		38,700.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	96,272.53	0.00	OTHER LAB	4,076.60	0.00
MED/SURG SUPPLY	33,526.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	108,452.85	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	12,390.99	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	12,626.56	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,297.32	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,351.28	0.00	MRI SERVICES	2,823.10	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	3,871.68	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	41,130.37	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	42,539.30	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,633.94	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	8,261.11	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	8,180.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	850.20	0.00	INJECTABLE DRUGS	64,438.79	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	499.22	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	1,408.28	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	190.80	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,795.12	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	275.00	752.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,717.37	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	464,610.06	752.00
			TOTAL ACCOMODATIONS	145,638.00	38,700.00
			TOTAL CHARGES	610,248.06	39,452.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:47:43  
Page: 5

EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	13,380,532.12	ADJUSTMENTS	152,155.31
COVERED CHARGES	12,317,586.80	CONTRACTUAL ALLOW	10,019,774.58
NON-COVERD CHARGES	1,062,945.32	TOTAL MEDICAID LIAB	2,297,812.22
		LESS: COB	14,420.89
		LESS: COPAYMENT	3,086.77
		REIMBURSEMENT	2,280,304.56
		ALL OTHER	2,152,721.49
		FEE SCHEDULE-LAB	97,324.81
		INJECTABLE DRUGS	30,258.26

TOTAL NUMBER OF CLAIMS 4,019

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	298,054.56	1,074.74	OTHER LAB	241,275.59	5,188.48
MED/SURG SUPPLY	202,512.75	238.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,044.74	EDUCATION & TRAINING	184.21	0.00
RADIOLOGY-DIAGNOSTIC	773,044.30	12,941.20	OTHER THERAPEUTIC SVC	0.00	5,240.72
CT SCAN	1,614,880.19	105,347.41	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,347.39	11,885.98	FEE SCHEDULE LAB	2,302,263.35	265,404.22
EKG/ECG	220,612.89	7,614.74	MRI SERVICES	199,131.01	23,751.10
IV THERAPY	397,220.19	79,973.58	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	521,829.32	120,845.67	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	42,375.34	29,528.10	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	63,022.56	2,293.36	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	231,213.56	0.00	AMBULANCE	0.00	0.00
GI SERVICES	12,102.27	7,318.26	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,916,140.74	11,313.54	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	484,343.61	0.00	DRUG-SPECIFIC/HOME IV	0.00	7,584.22
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	293,652.61	120,631.50
RADIOLOGY THERAPEUTIC	106.82	213.64	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,717.37	8,360.54	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	13,815.90	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	147,327.13	12,548.03	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	64,870.75	1,479.50
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	476,367.07	72,137.53			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	10,820.20	3,760.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	294,778.22	26,613.36			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	101,586.28	55,605.26			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	53,397.83	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	348,408.69	48,674.84			
			TOTAL ANCILLARY	12,317,586.80	1,062,428.66
			TOTAL ACCOMODATIONS	0.00	516.66
			TOTAL CHARGES	12,317,586.80	1,062,945.32



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: 07/23/2014  
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Page: 7

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	340,809.82	ADJUSTMENTS	0.00
COVERED CHARGES	267,003.15	CONTRACTUAL ALLOW	168,803.54
NON-COVERD CHARGES	73,806.67	TOTAL MEDICAID LIAB	98,199.61
		LESS: COB	98,154.61
		LESS: COPAYMENT	45.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 94

SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,881.30	768.45	OTHER LAB	3,093.42	0.00
MED/SURG SUPPLY	3,840.50	498.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	19,233.23	511.21	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,156.64	31,699.38	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	62,799.39	10,325.34
EKG/ECG	5,439.10	0.00	MRI SERVICES	9,327.13	6,657.72
IV THERAPY	12,026.43	1,590.32	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	15,300.86	12,645.58	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	518.84	846.93	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,495.48	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,506.36	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	74,275.87	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,967.11	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	5,276.04	5,586.28
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,345.73	478.51	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	7,321.53	2,198.20			
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	12,198.19	0.00			
			TOTAL ANCILLARY	267,003.15	73,806.67
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	267,003.15	73,806.67

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: 07/23/2014  
Run Time: 09:48:28  
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EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	980,925.83	ADJUSTMENTS	538.40
COVERED CHARGES	910,567.52	CONTRACTUAL ALLOW	884,611.36
NON-COVERD CHARGES	70,358.31	TOTAL MEDICAID LIAB	25,956.16
		LESS: COB	0.00
		LESS: COPAYMENT	705.04
		REIMBURSEMENT	25,251.12
		TOTAL NUMBER OF CLAIMS	464

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	10,761.04	25.07	OTHER LAB	10,254.72	0.00
MED/SURG SUPPLY	3,253.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	47,608.32	1,723.29	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	60,041.39	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	225,396.83	48,222.84
EKG/ECG	13,962.02	543.91	MRI SERVICES	5,131.72	0.00
IV THERAPY	35,337.72	3,365.94	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,991.58	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	449,754.22	1,701.49	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,753.67	6,565.06
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	806.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	22,084.66	4,783.75			
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	9,236.38	2,620.36			
			TOTAL ANCILLARY	910,567.52	70,358.31
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	910,567.52	70,358.31

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:48:33  
Page: 11

EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,836.53	ADJUSTMENTS	0.00
COVERED CHARGES	22,158.72	CONTRACTUAL ALLOW	18,684.58
NON-COVERD CHARGES	5,677.81	TOTAL MEDICAID LIAB	3,474.14
		LESS: COB	3,465.14
		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: 07/23/2014  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	381.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	79.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,700.74	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	5,650.96	37.06
EKG/ECG	1,087.82	0.00	MRI SERVICES	4,477.72	3,857.51
IV THERAPY	372.78	112.27	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	258.33	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	6,041.81	211.46	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	183.12	682.34
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	1,924.94	777.17			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	22,158.72	5,677.81
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	22,158.72	5,677.81

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,787,537.19	ADJUSTMENTS	36,449.82
COVERED CHARGES	1,694,410.96	CONTRACTUAL ALLOW	1,459,419.45
NON-COVERD CHARGES	93,126.23	TOTAL MEDICAID LIAB	234,991.51
		LESS: COB	0.00
		LESS: COPAYMENT	165.00
		REIMBURSEMENT	234,826.51

TOTAL NUMBER OF CLAIMS 45

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY EASTSIDE MEDICAL CENTER  
 1700 MEDICAL WAY  
 SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
 000190088A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	74,900.55	275.77	OTHER LAB	4,537.67	0.00
MED/SURG SUPPLY	169,589.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	42,613.65	720.53	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	59,457.32	18,032.96	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	2,560.43	FEE SCHEDULE LAB	108,156.89	12,059.09
EKG/ECG	8,158.65	2,175.64	MRI SERVICES	2,823.10	0.00
IV THERAPY	14,976.30	3,903.29	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	217,270.67	14,074.03	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,755.67	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	88,087.26	0.00	AMBULANCE	0.00	0.00
GI SERVICES	7,322.62	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	34,614.04	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	120,604.14	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	112,897.87	9,501.75
RADIOLOGY THERAPEUTIC	0.00	2,864.86	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	499.22	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	130.80	988.63	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	392,182.75	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	4,098.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	550.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	134,394.82	9,112.40			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	25,405.72	16,357.63			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	66,882.32	0.00			
			TOTAL ANCILLARY	1,694,410.96	93,126.23
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,694,410.96	93,126.23



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 09:48:36  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY EASTSIDE MEDICAL CENTER  
1700 MEDICAL WAY  
SNELLVILLE,GA 30078-2195

PROVIDER NUMBER  
000190088A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

DONALSONVILLE HOSPITAL INC  
 102 HOSPITAL CIR  
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER 000206181A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,143,405.08	ADJUSTMENTS	5,827.50
COVERED CHARGES	2,095,113.08	CONTRACTUAL ALLOW	948,718.49
NON-COVERD CHARGES	48,292.00	TOTAL MEDICAID LIAB	1,146,394.59
		LESS: COB	5,644.37
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,140,750.22
		TOTAL NUMBER OF ADMISSIONS	238

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	674		0	414,510.00		44,790.00
ROUTINE NURSERY	52		0	30,220.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	726		0	444,730.00		44,790.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	726		0	444,730.00		44,790.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC  
 102 HOSPITAL CIR  
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
 000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	736,143.08	0.00	OTHER LAB	2,800.00	0.00
MED/SURG SUPPLY	243,095.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	253,564.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,884.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	58,854.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,718.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	8,540.00	0.00	MRI SERVICES	2,207.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	122,719.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	24,777.00	1,387.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	60,393.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	27,025.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	25,750.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	249.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	876.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	9,777.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,894.00	2,115.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	848.00	0.00			
CARDIOLOGY	5,784.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,486.00	0.00			
			TOTAL ANCILLARY	1,650,383.08	3,502.00
			TOTAL ACCOMODATIONS	444,730.00	44,790.00
			TOTAL CHARGES	2,095,113.08	48,292.00

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:35:19  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,217.00	ADJUSTMENTS	0.00
COVERED CHARGES	38,952.00	CONTRACTUAL ALLOW	12,607.36
NON-COVERD CHARGES	4,265.00	TOTAL MEDICAID LIAB	26,344.64
		LESS: COB	26,344.64
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 4

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	9		0	5,535.00		4,265.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	9		0	5,535.00		4,265.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	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	5,535.00		4,265.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

DONALSONVILLE HOSPITAL INC  
 102 HOSPITAL CIR  
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
 000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,878.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	3,675.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	1,482.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	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	3,091.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	5,270.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	77.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	4,944.00	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	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,417.00	0.00
			TOTAL ACCOMODATIONS	5,535.00	4,265.00
			TOTAL CHARGES	38,952.00	4,265.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,619,598.50	ADJUSTMENTS	232.43
COVERED CHARGES	1,453,310.20	CONTRACTUAL ALLOW	1,139,684.21
NON-COVERD CHARGES	166,288.30	TOTAL MEDICAID LIAB	313,625.99
		LESS: COB	0.00
		LESS: COPAYMENT	1,332.00
		REIMBURSEMENT	312,293.99
		ALL OTHER	273,956.68
		FEE SCHEDULE-LAB	38,297.37
		INJECTABLE DRUGS	39.94
		TOTAL NUMBER OF CLAIMS	1,253

DONALSONVILLE HOSPITAL INC  
 102 HOSPITAL CIR  
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
 000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	176,643.00	0.00	OTHER LAB	5,889.00	0.00
MED/SURG SUPPLY	126,116.00	591.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	278.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	92,914.00	1,157.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	68,449.00	1,821.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	33,520.20	15,750.30	FEE SCHEDULE LAB	450,540.00	105,980.00
EKG/ECG	9,240.00	630.00	MRI SERVICES	9,448.00	2,622.00
IV THERAPY	70,754.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	135,824.00	32,814.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	692.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	8,101.00	1,948.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	98,267.00	654.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	63,860.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	820.00	410.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	242.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	4,421.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	62,805.00	721.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	1,844.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	2,685.00	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	30,478.00	670.00			
			TOTAL ANCILLARY	1,453,310.20	166,288.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,453,310.20	166,288.30

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,669.00	ADJUSTMENTS	0.00
COVERED CHARGES	19,817.00	CONTRACTUAL ALLOW	6,159.53
NON-COVERD CHARGES	7,852.00	TOTAL MEDICAID LIAB	13,657.47
		LESS: COB	13,644.47
		LESS: COPAYMENT	13.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 27



SUMMARY TYPE IV  
 ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

DONALSONVILLE HOSPITAL INC  
 102 HOSPITAL CIR  
 DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
 000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 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	377.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	666.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	221.00	364.00	FEE SCHEDULE LAB	12,572.00	4,988.00
EKG/ECG	70.00	0.00	MRI SERVICES	3,100.00	2,500.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	37.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	806.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	831.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	350.00	0.00			
			TOTAL ANCILLARY	19,817.00	7,852.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	19,817.00	7,852.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	94,357.00	ADJUSTMENTS	0.00
COVERED CHARGES	88,613.00	CONTRACTUAL ALLOW	81,284.86
NON-COVERD CHARGES	5,744.00	TOTAL MEDICAID LIAB	7,328.14
		LESS: COB	0.00
		LESS: COPAYMENT	252.00
		REIMBURSEMENT	7,076.14
		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: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,241.00	0.00	OTHER LAB	0.00	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	8,132.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,171.00	707.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	22,048.00	2,677.00
EKG/ECG	700.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	309.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	45,919.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	78.00	2,360.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	88,613.00	5,744.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	88,613.00	5,744.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 09:35:52  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSPITAL INC  
102 HOSPITAL CIR  
DONALSONVILLE,GA 39845-1100

PROVIDER NUMBER  
000206181A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	102,043.00	ADJUSTMENTS	0.00
COVERED CHARGES	102,020.00	CONTRACTUAL ALLOW	87,117.35
NON-COVERD CHARGES	23.00	TOTAL MEDICAID LIAB	14,902.65
		LESS: COB	0.00
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	14,890.65

TOTAL NUMBER OF CLAIMS 3

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

DONALSONVILLE HOSPITAL INC	PROVIDER NUMBER	PAYMENT DATES	00/00/00	THROUGH	00/00/00
102 HOSPITAL CIR	000206181A	SERVICE DATES	07/01/12	THROUGH	06/30/13
DONALSONVILLE,GA 39845-1100		ADMISSION DATES	00/00/00	THROUGH	00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	17,445.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	60,840.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	300.00	23.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	11,115.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,451.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,090.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	7,779.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	102,020.00	23.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	102,020.00	23.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 10:59:40  
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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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	20,389,338.02	ADJUSTMENTS	7,269,857.69
COVERED CHARGES	18,902,942.64	CONTRACTUAL ALLOW	9,966,447.44
NON-COVERD CHARGES	1,486,395.38	TOTAL MEDICAID LIAB	8,936,495.20
		LESS: COB	1,000.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	8,935,495.20

TOTAL NUMBER OF ADMISSIONS 104

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	4,506		0	5,594,362.35		91,948.65
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	4,506		0	5,594,362.35		91,948.65
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	103		0	259,492.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	103		0	259,492.00		0.00
TOTAL ACCOMODATIONS	4,609		0	5,853,854.35		91,948.65



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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,926,082.88	10,625.65	OTHER LAB	143,457.00	0.00
MED/SURG SUPPLY	1,990,488.70	550,698.48	RECREATIONAL THERAPY	104,359.00	190,117.00
LABORATORY-GENERAL	468,620.80	25,551.00	EDUCATION & TRAINING	124,193.40	88,288.60
RADIOLOGY-DIAGNOSTIC	213,423.50	0.00	OTHER THERAPEUTIC SVC	0.00	15,647.00
CT SCAN	170,515.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	1,255,912.00	92,507.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	11,324.00	0.00	MRI SERVICES	26,542.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	828,028.41	15,161.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	3,013,762.00	175,984.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	10,012.50	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,635.10	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,161,422.00	101,468.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	467,277.00	52,946.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	3,578.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	787.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	55,800.00
OTHER IMAGING SERVICE	14,748.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	13,134.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,440.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	12,858.00	0.00			
AMBULATORY SURGERY	23,937.00	15,288.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	4,339.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	10,577.00	0.00			
			TOTAL ANCILLARY	13,049,088.29	1,394,446.73
			TOTAL ACCOMODATIONS	5,853,854.35	91,948.65
			TOTAL CHARGES	18,902,942.64	1,486,395.38

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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012191018222	05/04/12 - 06/22/12	07/16/12	0.00	1,709.00	0.00	0.00	0.00
952	5212215000091	04/18/12 - 05/22/12	08/06/12	0.00	1,317.00	0.00	0.00	0.00
952	2012237043874	06/05/12 - 07/13/12	08/27/12	0.00	392.00	0.00	0.00	0.00
952	5212241000184	04/04/12 - 05/31/12	09/03/12	0.00	1,989.00	0.00	0.00	0.00
952	5212243000104	04/06/12 - 06/07/12	09/03/12	0.00	560.00	0.00	0.00	0.00
952	2012244039564	07/11/12 - 08/22/12	09/03/12	0.00	406.00	0.00	0.00	0.00
952	5212311000102	05/04/12 - 06/19/12	11/12/12	0.00	666.00	0.00	0.00	0.00
952	5212318000109	06/19/12 - 08/07/12	11/19/12	0.00	1,410.00	0.00	0.00	0.00
952	2012320066506	09/10/12 - 11/01/12	11/19/12	0.00	3,356.00	0.00	0.00	0.00
952	5212321027567	05/16/12 - 07/31/12	11/26/12	0.00	70.00	0.00	0.00	0.00
952	2012335076132	09/27/12 - 11/08/12	12/10/12	0.00	1,262.00	0.00	0.00	0.00
952	5212338000113	05/02/12 - 05/29/12	12/10/12	0.00	504.00	0.00	0.00	0.00
952	2012355067887	11/20/12 - 12/11/12	12/24/12	0.00	224.00	0.00	0.00	0.00
952	5213002000104	07/31/12 - 10/12/12	01/07/13	0.00	224.00	0.00	0.00	0.00
952	5213002000109	07/27/12 - 10/08/12	01/07/13	0.00	2,661.00	0.00	0.00	0.00
952	5213004000085	06/13/12 - 09/06/12	01/14/13	0.00	1,361.00	0.00	0.00	0.00
952	5213009000099	08/01/12 - 11/01/12	01/14/13	0.00	260.00	0.00	0.00	0.00
952	2013028034335	11/15/12 - 01/14/13	02/04/13	0.00	3,252.00	0.00	0.00	0.00
952	5213030000182	08/15/12 - 11/08/12	02/04/13	0.00	2,606.00	0.00	0.00	0.00
952	2013042037528	01/04/13 - 01/31/13	02/18/13	0.00	1,010.00	0.00	0.00	0.00
952	5213045000137	05/25/12 - 07/11/12	02/18/13	0.00	1,338.00	0.00	0.00	0.00
952	2213052015549	12/14/12 - 02/07/13	02/25/13	0.00	1,983.00	0.00	0.00	0.00
952	5213081000144	11/29/12 - 01/05/13	04/01/13	0.00	2,930.00	0.00	0.00	0.00
952	5213081000145	10/01/12 - 12/14/12	04/01/13	0.00	995.00	0.00	0.00	0.00
952	2013102068566	02/14/13 - 04/04/13	04/22/13	0.00	1,458.00	0.00	0.00	0.00
952	5213106001588	11/19/12 - 01/29/13	04/22/13	0.00	2,534.00	0.00	0.00	0.00
952	5213119000079	01/04/13 - 02/14/13	05/06/13	0.00	1,709.00	0.00	0.00	0.00
952	2013126059393	03/07/13 - 04/26/13	05/13/13	0.00	2,326.00	0.00	0.00	0.00
952	5213151000193	12/07/12 - 02/20/13	06/10/13	0.00	3,544.00	0.00	0.00	0.00
952	2013156068131	03/08/13 - 04/09/13	06/10/13	0.00	1,522.00	0.00	0.00	0.00
952	2013162042995	03/27/13 - 05/31/13	06/17/13	0.00	296.00	0.00	0.00	0.00
952	5213169000116	03/04/13 - 04/09/13	06/24/13	0.00	1,362.00	0.00	0.00	0.00
952	5213170000096	03/26/13 - 05/03/13	06/24/13	0.00	797.00	0.00	0.00	0.00
952	5213179000068	08/08/12 - 11/07/12	07/08/13	0.00	2,348.00	0.00	0.00	0.00
952	5213193000222	03/05/13 - 04/10/13	07/22/13	0.00	1,361.00	0.00	0.00	0.00
952	2013206074732	01/01/13 - 02/01/13	07/29/13	0.00	168.00	0.00	0.00	0.00
952	5213214000116	11/09/12 - 01/24/13	08/12/13	0.00	2,686.00	0.00	0.00	0.00
952	2213225007839	03/01/13 - 05/08/13	08/19/13	0.00	1,204.00	0.00	0.00	0.00
TOTAL				0.00	55,800.00	0.00	0.00	0.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SHEPHERD CENTER  
 2020 PEACHTREE RD NW  
 ATLANTA,GA 30309-1426

PROVIDER NUMBER 000248069A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	677,922.95	ADJUSTMENTS	0.00
COVERED CHARGES	589,631.95	CONTRACTUAL ALLOW	149,252.29
NON-COVERD CHARGES	88,291.00	TOTAL MEDICAID LIAB	440,379.66
		LESS: COB	440,379.66
		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	73		0	91,688.00		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	73		0	91,688.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	10		0	25,120.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		70	0.00		87,920.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	10		70	25,120.00		87,920.00
TOTAL ACCOMODATIONS	83		70	116,808.00		87,920.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

SHEPHERD CENTER  
 2020 PEACHTREE RD NW  
 ATLANTA,GA 30309-1426

PROVIDER NUMBER  
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110,652.45	0.00	OTHER LAB	4,625.00	0.00
MED/SURG SUPPLY	81,693.00	0.00	RECREATIONAL THERAPY	10,403.00	0.00
LABORATORY-GENERAL	16,536.00	0.00	EDUCATION & TRAINING	6,789.00	0.00
RADIOLOGY-DIAGNOSTIC	7,083.00	0.00	OTHER THERAPEUTIC SVC	0.00	264.00
CT SCAN	3,115.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	39,950.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	269.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	32,657.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	87,706.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	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	48.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	38,656.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	32,641.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	107.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	472,823.95	371.00
			TOTAL ACCOMODATIONS	116,808.00	87,920.00
			TOTAL CHARGES	589,631.95	88,291.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:59:44  
Page: 6

SHEPHERD CENTER  
2020 PEACHTREE RD NW  
ATLANTA,GA 30309-1426

PROVIDER NUMBER  
000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,629,227.15	ADJUSTMENTS	117,628.13
COVERED CHARGES	2,568,489.70	CONTRACTUAL ALLOW	1,557,235.37
NON-COVERD CHARGES	1,060,737.45	TOTAL MEDICAID LIAB	1,011,254.33
		LESS: COB	0.00
		LESS: COPAYMENT	5,526.00
		REIMBURSEMENT	1,005,728.33
		ALL OTHER	621,254.05
		FEE SCHEDULE-LAB	17,617.95
		INJECTABLE DRUGS	366,856.33

TOTAL NUMBER OF CLAIMS 1,687

SHEPHERD CENTER  
 2020 PEACHTREE RD NW  
 ATLANTA, GA 30309-1426

PROVIDER NUMBER  
 000248069A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	29,190.60	0.00	OTHER LAB	45,221.00	847.00
MED/SURG SUPPLY	36,111.20	2.00	RECREATIONAL THERAPY	107,690.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	20,751.00	2,462.00
RADIOLOGY-DIAGNOSTIC	40,474.00	664.00	OTHER THERAPEUTIC SVC	0.00	1,496.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	192,343.00	242,130.00	FEE SCHEDULE LAB	166,357.50	4,582.00
EKG/ECG	1,345.00	0.00	MRI SERVICES	317,471.00	25,011.00
IV THERAPY	11,220.00	1,484.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,136.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	354.00	AMBULANCE	0.00	0.00
GI SERVICES	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	978,002.40	392,801.45
RADIOLOGY THERAPEUTIC	63,784.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	118,677.00	233,918.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	88,465.00	52,308.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	234.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	222,816.00	7,295.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	12,561.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	53,203.00
OTHER IMAGING SERVICE	18,019.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	8,399.00	2,276.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	100,017.00	27,109.00			
			TOTAL ANCILLARY	2,568,489.70	1,060,737.45
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,568,489.70	1,060,737.45

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:59:44  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2012347085173	11/01/12 - 11/01/12	12/17/12	0.00	672.00	0.00	0.00	0.00
671	2013136074903	12/18/12 - 12/18/12	06/10/13	0.00	26,466.00	0.00	0.00	0.00
671	2014048033774	12/19/12 - 12/19/12	02/24/14	0.00	26,065.00	0.00	0.00	0.00
TOTAL				0.00	53,203.00	0.00	0.00	0.00

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:00:17  
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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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 11:00:18  
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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 04/01/12 THROUGH 03/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,468.00	ADJUSTMENTS	0.00
COVERED CHARGES	33,256.00	CONTRACTUAL ALLOW	19,420.83
NON-COVERD CHARGES	3,212.00	TOTAL MEDICAID LIAB	13,835.17
		LESS: COB	0.00
		LESS: COPAYMENT	135.00
		REIMBURSEMENT	13,700.17
		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 04/01/12 THROUGH 03/31/13  
 ADMISSION DATES 00/00/00 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	6,779.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	108.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	8,063.00	1,748.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	7,652.00	1,464.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	10,654.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	33,256.00	3,212.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	33,256.00	3,212.00

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:00:18  
Page: 14

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	04/01/12	THROUGH	03/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 08:37:31  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BOULEVARD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER 000275976A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	36,605,372.12	ADJUSTMENTS	3,035,792.77
COVERED CHARGES	35,511,202.25	CONTRACTUAL ALLOW	29,390,571.65
NON-COVERD CHARGES	1,094,169.87	TOTAL MEDICAID LIAB	6,120,630.60
		LESS: COB	39,655.78
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	6,080,974.82

TOTAL NUMBER OF ADMISSIONS 1,233

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	2,039		0	2,287,810.50		303,946.50
ROUTINE NURSERY	1,877		4	2,833,623.00		35,829.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	3,916		4	5,121,433.50		339,775.50
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	619		0	2,170,677.00		0.00
NICU	81		0	374,845.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	700		0	2,545,522.00		0.00
TOTAL ACCOMODATIONS	4,616		4	7,666,955.50		339,775.50

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BOULEVARD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,261,131.60	289,502.30	OTHER LAB	48,163.80	3,624.80
MED/SURG SUPPLY	4,317,301.09	120,597.30	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	3,541,437.50	68,964.97	EDUCATION & TRAINING	146.60	0.00
RADIOLOGY-DIAGNOSTIC	254,627.40	3,418.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	796,474.90	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	171,137.44	8,603.50	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	101,335.00	627.70	MRI SERVICES	152,724.30	18,645.60
IV THERAPY	28,311.70	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	2,110,197.60	42,621.20	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,138,023.50	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,101,875.90	21,886.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	579,711.70	0.00	AMBULANCE	0.00	1,179.50
GI SERVICES	133,341.60	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	579,434.90	33,932.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	749,352.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	162,960.50	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	49,822.70	4,038.30	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	126,368.62	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	43,381.50	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	59,626.00	634.10	TRAUMA RESPONSE	0.00	23,972.70
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	442,408.40	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	180,201.20	580.70			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	66,002.00	107,626.80			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	55,413.60	0.00			
AUDIOLOGY	191,408.40	0.00			
CARDIOLOGY	342,866.90	3,737.50			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	15,806.40	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	43,251.10	199.20			
			TOTAL ANCILLARY	27,844,246.75	754,394.37
			TOTAL ACCOMODATIONS	7,666,955.50	339,775.50
			TOTAL CHARGES	35,511,202.25	1,094,169.87

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 08:38:53  
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SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BOULEVARD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	211,336.40	ADJUSTMENTS	0.00
COVERED CHARGES	207,038.00	CONTRACTUAL ALLOW	151,382.82
NON-COVERD CHARGES	4,298.40	TOTAL MEDICAID LIAB	55,655.18
		LESS: COB	55,655.18
		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	16		0	19,412.00		1,063.00
ROUTINE NURSERY	7		0	19,841.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	23		0	39,253.00		1,063.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	23		0	39,253.00		1,063.00



SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BOULEVARD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	46,891.50	0.00	OTHER LAB	1,516.20	0.00
MED/SURG SUPPLY	24,122.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	28,006.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	550.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	8,189.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	6,148.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	26,347.70	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,656.70	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	9,479.20	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	6,958.20	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,049.60	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	917.30	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	3,235.40			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	379.10	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,573.10	0.00			
			TOTAL ANCILLARY	167,785.00	3,235.40
			TOTAL ACCOMODATIONS	39,253.00	1,063.00
			TOTAL CHARGES	207,038.00	4,298.40

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: 07/23/2014  
Run Time: 08:38:54  
Page: 5

NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BOULEVARD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	8,369,814.26	ADJUSTMENTS	458,380.20
COVERED CHARGES	7,478,129.68	CONTRACTUAL ALLOW	6,196,301.85
NON-COVERD CHARGES	891,684.58	TOTAL MEDICAID LIAB	1,281,827.83
		LESS: COB	14,966.81
		LESS: COPAYMENT	1,230.00
		REIMBURSEMENT	1,265,631.02
		ALL OTHER	1,195,342.36
		FEE SCHEDULE-LAB	64,233.04
		INJECTABLE DRUGS	6,055.62
		TOTAL NUMBER OF CLAIMS	2,140

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 08:38:54  
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NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BOULEVARD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	308,896.40	3,688.20	OTHER LAB	51,882.20	0.00
MED/SURG SUPPLY	434,522.90	16,569.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	30.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	398,770.40	602.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	931,384.50	61,753.80	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	377.10	2,894.20	FEE SCHEDULE LAB	1,517,835.58	433,884.48
EKG/ECG	138,847.90	3,138.50	MRI SERVICES	92,198.70	6,304.80
IV THERAPY	585,645.20	88,129.10	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	261,367.12	16,143.48	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	18,379.90	3,645.90	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	55,844.20	0.00	AMBULANCE	0.00	0.00
GI SERVICES	23,258.80	6,241.20	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,545,043.70	12,796.80	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	71,710.90	0.00	DRUG-SPECIFIC/HOME IV	0.00	1,300.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	516,093.30	118,556.80
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	13,163.60	1,891.30	TRAUMA RESPONSE	0.00	7,159.40
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	1,285.40
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	201,409.30	34,491.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,079.30	4,474.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	46,066.40	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	35,224.30	27,201.60			
AMBULATORY SURGERY	94,828.98	24,740.32			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	43,198.30	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	91,100.70	14,761.90			
			TOTAL ANCILLARY	7,478,129.68	891,684.58
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,478,129.68	891,684.58

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE IV

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BOULEVARD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	145,208.00	ADJUSTMENTS	0.00
COVERED CHARGES	131,286.07	CONTRACTUAL ALLOW	67,858.47
NON-COVERD CHARGES	13,921.93	TOTAL MEDICAID LIAB	63,427.60
		LESS: COB	63,415.60
		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

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BOULEVARD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,641.70	164.70	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,393.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,001.90	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,053.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	31,781.70	3,020.20
EKG/ECG	3,797.60	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,632.10	4,005.60	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	723.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	40,208.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	7,279.60	2,219.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	187.80	99.60	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,086.40	1,716.40			
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	3,382.47	1,691.23			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,116.90	1,005.20			
			TOTAL ANCILLARY	131,286.07	13,921.93
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	131,286.07	13,921.93

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BOULEVARD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	514,803.20	ADJUSTMENTS	961.91
COVERED CHARGES	472,166.00	CONTRACTUAL ALLOW	459,579.52
NON-COVERD CHARGES	42,637.20	TOTAL MEDICAID LIAB	12,586.48
		LESS: COB	0.00
		LESS: COPAYMENT	408.01
		REIMBURSEMENT	12,178.47
		TOTAL NUMBER OF CLAIMS	225

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BOULEVARD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,609.90	795.80	OTHER LAB	4,921.00	0.00
MED/SURG SUPPLY	13,508.20	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	32,650.60	467.70	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,241.60	22,351.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	97,877.20	8,730.20
EKG/ECG	5,053.00	0.00	MRI SERVICES	5,612.30	0.00
IV THERAPY	40,833.30	1,041.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	431.90	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	217,862.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	30,556.10	4,332.60
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	4,600.40	4,074.80			
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	3,407.60	843.60			
			TOTAL ANCILLARY	472,166.00	42,637.20
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	472,166.00	42,637.20

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BOULEVARD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	35,000.40	ADJUSTMENTS	0.00
COVERED CHARGES	32,642.40	CONTRACTUAL ALLOW	28,215.09
NON-COVERD CHARGES	2,358.00	TOTAL MEDICAID LIAB	4,427.31
		LESS: COB	4,415.30
		LESS: COPAYMENT	12.01
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	5



Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI

ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BOULEVARD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,163.60	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,506.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,492.30	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	7,799.70	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	7,078.70	1,170.40
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	2,172.00	639.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	5,896.70	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,373.60	548.60
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	1,159.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	32,642.40	2,358.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	32,642.40	2,358.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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Page: 13

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BOULEVARD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,115,629.18	ADJUSTMENTS	46,193.70
COVERED CHARGES	990,902.66	CONTRACTUAL ALLOW	856,797.03
NON-COVERD CHARGES	124,726.52	TOTAL MEDICAID LIAB	134,105.63
		LESS: COB	7,354.78
		LESS: COPAYMENT	54.00
		REIMBURSEMENT	126,696.85

TOTAL NUMBER OF CLAIMS 26

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP  
 3000 HOSPITAL BOULEVARD  
 ROSWELL,GA 30076-4915

PROVIDER NUMBER  
 000275976A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	85,897.50	2,260.40	OTHER LAB	0.00	1,932.70
MED/SURG SUPPLY	239,823.08	2,474.40	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	920.50	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,641.60	1,643.50	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	36,122.20	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	377.10	FEE SCHEDULE LAB	58,482.70	6,704.10
EKG/ECG	5,178.60	627.70	MRI SERVICES	0.00	0.00
IV THERAPY	16,735.60	11,694.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	245,166.78	31,608.32	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	55,799.30	0.00	AMBULANCE	0.00	0.00
GI SERVICES	14,224.70	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	12,628.60	3,459.20	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	40,102.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	49,345.00	15,846.10
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	1,160.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	89.30	TRAUMA RESPONSE	0.00	2,354.60
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	34,597.80	30,197.90
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,149.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	10,063.20	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	20,727.70	7,848.80			
AMBULATORY SURGERY	42,553.70	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	1,125.50			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	13,663.10	2,402.40			
			TOTAL ANCILLARY	990,902.66	124,726.52
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	990,902.66	124,726.52

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 08:40:15  
Page: 15

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

NORTH FULTON REGIONAL HOSP  
3000 HOSPITAL BOULEVARD  
ROSWELL,GA 30076-4915

PROVIDER NUMBER  
000275976A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 09:22:13  
 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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,141,340.65	ADJUSTMENTS	133,361.27
COVERED CHARGES	3,932,121.90	CONTRACTUAL ALLOW	2,732,985.94
NON-COVERD CHARGES	209,218.75	TOTAL MEDICAID LIAB	1,199,135.96
		LESS: COB	13,207.40
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,185,928.56

TOTAL NUMBER OF ADMISSIONS 123

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	452		0	370,077.00		118,804.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	452		0	370,077.00		118,804.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	131		0	343,845.00		7,792.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	343,845.00		7,792.00
TOTAL ACCOMODATIONS	583		0	713,922.00		126,596.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	354,056.75	7,569.00	OTHER LAB	7,063.00	0.00
MED/SURG SUPPLY	155,342.75	1,882.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	575,303.50	9,426.25	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	115,694.00	2,503.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	105,510.25	25,297.75	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	36,118.25	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	26,660.75	0.00	MRI SERVICES	37,917.25	0.00
IV THERAPY	23,202.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	300,319.75	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	234,991.50	6,875.25	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	124,953.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	6,371.75	3,253.50	CAST ROOM	0.00	0.00
EMERGENCY ROOM	105,071.75	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	44,482.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	3,913.50
LABORATORY PATHOLOGIC	2,166.00	0.00	INJECTABLE DRUGS	625,091.65	18,415.25
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	28,283.75	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	3,260.75	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	13,500.00	977.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	228.75	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	184,984.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	19,502.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	30,621.75	654.25			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	4,947.75	1,855.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	51,148.75	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,405.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,218,199.90	82,622.75
			TOTAL ACCOMODATIONS	713,922.00	126,596.00
			TOTAL CHARGES	3,932,121.90	209,218.75

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 09:22:18  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 09:22:19  
Page: 4

COLISEUM NORTHSIDE HOSPITAL  
400 CHARTER BLVD  
MACON,GA 31210-4831

PROVIDER NUMBER  
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,892,845.39	ADJUSTMENTS	34,179.18
COVERED CHARGES	3,650,495.07	CONTRACTUAL ALLOW	2,960,911.87
NON-COVERD CHARGES	242,350.32	TOTAL MEDICAID LIAB	689,583.20
		LESS: COB	378.64
		LESS: COPAYMENT	861.00
		REIMBURSEMENT	688,343.56
		ALL OTHER	640,169.81
		FEE SCHEDULE-LAB	41,566.64
		INJECTABLE DRUGS	6,607.11
		TOTAL NUMBER OF CLAIMS	1,590



COLISEUM NORTHSIDE HOSPITAL  
 400 CHARTER BLVD  
 MACON,GA 31210-4831

PROVIDER NUMBER  
 000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	81,465.75	0.00	OTHER LAB	51,077.50	0.00
MED/SURG SUPPLY	34,142.40	85.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	360,157.50	4,776.75	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	699,158.75	51,502.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	40,947.50	11,941.50	FEE SCHEDULE LAB	716,163.25	84,067.00
EKG/ECG	51,780.00	2,770.00	MRI SERVICES	25,984.25	0.00
IV THERAPY	86,007.75	12,443.50	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	196,632.92	22,639.57	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	12,675.50	4,200.75	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	68,260.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	980,288.50	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	46,193.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	66,270.50	34,702.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	6,231.50	803.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	819.75	901.75	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	4,957.00	995.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	5,265.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	74,243.00	5,535.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,308.50	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,658.75	4,044.75			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	13,897.00	941.25			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	1,277.75	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	8,631.50	0.00			
			TOTAL ANCILLARY	3,650,495.07	242,350.32
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,650,495.07	242,350.32

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: 07/23/2014  
Run Time: 09:23:05  
Page: 6

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	71,435.50	ADJUSTMENTS	0.00
COVERED CHARGES	63,335.75	CONTRACTUAL ALLOW	39,206.68
NON-COVERD CHARGES	8,099.75	TOTAL MEDICAID LIAB	24,129.07
		LESS: COB	24,120.07
		LESS: COPAYMENT	9.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 24

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,340.50	0.00	OTHER LAB	10,526.00	0.00
MED/SURG SUPPLY	1,191.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	4,204.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	4,799.50	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	11,224.75	22.25
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	1,232.75	424.75	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	8,313.25	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,962.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,036.25	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	2,593.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	13,856.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,707.75	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	578.75	260.25
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	3,162.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	63,335.75	8,099.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	63,335.75	8,099.75

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 09:23:06  
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COLISEUM NORTHSIDE HOSPITAL  
400 CHARTER BLVD  
MACON,GA 31210-4831

PROVIDER NUMBER  
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	492,089.25	ADJUSTMENTS	706.22
COVERED CHARGES	471,830.25	CONTRACTUAL ALLOW	449,006.73
NON-COVERD CHARGES	20,259.00	TOTAL MEDICAID LIAB	22,823.52
		LESS: COB	0.00
		LESS: COPAYMENT	720.00
		REIMBURSEMENT	22,103.52
		TOTAL NUMBER OF CLAIMS	408

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,948.25	0.00	OTHER LAB	7,031.25	0.00
MED/SURG SUPPLY	871.75	66.25	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	46,917.50	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	43,550.25	9,599.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	83,641.50	3,736.00
EKG/ECG	3,431.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	10,722.25	1,455.50	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	900.75	667.50	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	258,856.75	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	8,157.25	3,531.25
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	3,801.75	1,203.50			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	471,830.25	20,259.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	471,830.25	20,259.00

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 09:23:17  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	10,116.50	ADJUSTMENTS	0.00
COVERED CHARGES	9,965.75	CONTRACTUAL ALLOW	7,401.34
NON-COVERD CHARGES	150.75	TOTAL MEDICAID LIAB	2,564.41
		LESS: COB	2,552.41
		LESS: COPAYMENT	12.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 5

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	310.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	25.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	538.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,551.50	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,691.75	150.75
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	405.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	3,391.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	53.25	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	9,965.75	150.75
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	9,965.75	150.75

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

COLISEUM NORTHSIDE HOSPITAL  
400 CHARTER BLVD  
MACON,GA 31210-4831

PROVIDER NUMBER  
000295358A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	164,963.75	ADJUSTMENTS	0.00
COVERED CHARGES	152,757.91	CONTRACTUAL ALLOW	130,835.67
NON-COVERD CHARGES	12,205.84	TOTAL MEDICAID LIAB	21,922.24
		LESS: COB	0.00
		LESS: COPAYMENT	15.30
		REIMBURSEMENT	21,906.94
		TOTAL NUMBER OF CLAIMS	4



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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	8,951.50	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	8,396.25	12.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	877.50	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	1,397.25	FEE SCHEDULE LAB	611.50	104.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,822.41	8,724.59	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	73.50	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	25,580.50	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,585.25	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	794.50	178.75
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	1,789.25	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	42,065.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	152,757.91	12,205.84
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	152,757.91	12,205.84

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: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:05:30  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER 000315642A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,077,998.88	ADJUSTMENTS	0.00
COVERED CHARGES	1,077,998.88	CONTRACTUAL ALLOW	820,847.11
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	257,151.77
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	257,151.77

TOTAL NUMBER OF ADMISSIONS 17

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	53		0	47,700.00		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	53		0	47,700.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	6		0	10,086.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	10,086.00		0.00
TOTAL ACCOMODATIONS	59		0	57,786.00		0.00

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:05:30  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

NORTHSIDE MEDICAL CENTER  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	40,938.75	0.00	OTHER LAB	1,336.25	0.00
MED/SURG SUPPLY	76,418.50	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	31,010.71	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	6,263.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	13,587.53	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,297.68	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	248,682.72	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,560.38	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	48,630.63	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	33,703.15	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	60,547.50	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	2,450.77	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	663.42	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	86.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	446,188.50	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	902.75	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,944.64	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,020,212.88	0.00
			TOTAL ACCOMODATIONS	57,786.00	0.00
			TOTAL CHARGES	1,077,998.88	0.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 10:05:31  
Page: 3

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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:05:31  
Page: 4

NORTHSIDE MEDICAL CENTER  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	189,679.44	ADJUSTMENTS	89.20
COVERED CHARGES	180,272.18	CONTRACTUAL ALLOW	141,112.64
NON-COVERD CHARGES	9,407.26	TOTAL MEDICAID LIAB	39,159.54
		LESS: COB	0.00
		LESS: COPAYMENT	90.00
		REIMBURSEMENT	39,069.54
		ALL OTHER	38,602.11
		FEE SCHEDULE-LAB	416.05
		INJECTABLE DRUGS	51.38

TOTAL NUMBER OF CLAIMS 33

NORTHSIDE MEDICAL CENTER  
 100 FRIST CT  
 COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
 000315642A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	6,395.25	0.00	OTHER LAB	1,336.25	0.00
MED/SURG SUPPLY	14,131.25	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,006.25	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	433.75	625.94	FEE SCHEDULE LAB	5,373.14	253.00
EKG/ECG	1,093.68	204.00	MRI SERVICES	50,575.50	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	55,953.58	7,324.72	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	17,110.98	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	9,677.30	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,101.75	999.60
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	15,083.50	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	180,272.18	9,407.26
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	180,272.18	9,407.26

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

NORTHSIDE MEDICAL CENTER  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

NORTHSIDE MEDICAL CENTER  
100 FRIST CT  
COLUMBUS,GA 31909-3578

PROVIDER NUMBER  
000315642A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	82,943.75	ADJUSTMENTS	0.00
COVERED CHARGES	79,042.50	CONTRACTUAL ALLOW	63,078.39
NON-COVERD CHARGES	3,901.25	TOTAL MEDICAID LIAB	15,964.11
		LESS: COB	0.00
		LESS: COPAYMENT	15.00
		REIMBURSEMENT	15,949.11

TOTAL NUMBER OF CLAIMS 3

Report : CLM-0812-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	2,143.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	10,963.25	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	710.00	FEE SCHEDULE LAB	1,300.75	0.00
EKG/ECG	408.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	28,101.25	2,774.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	6,639.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	4,767.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	289.75	416.50
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	22,625.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,805.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	79,042.50	3,901.25
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	79,042.50	3,901.25

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP  
 1821 CLIFTON RD NE  
 ATLANTA,GA 30329-4021

PROVIDER NUMBER 000339831A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,105,412.66	ADJUSTMENTS	1,059,129.90
COVERED CHARGES	5,637,293.53	CONTRACTUAL ALLOW	3,083,714.72
NON-COVERD CHARGES	1,468,119.13	TOTAL MEDICAID LIAB	2,553,578.81
		LESS: COB	55,618.34
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,497,960.47

TOTAL NUMBER OF ADMISSIONS 71

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,557		0	1,789,840.00		1,270,820.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,557		0	1,789,840.00		1,270,820.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,557		0	1,789,840.00		1,270,820.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP  
 1821 CLIFTON RD NE  
 ATLANTA,GA 30329-4021

PROVIDER NUMBER  
 000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	241,084.70	9,569.28	OTHER LAB	24,598.00	0.00
MED/SURG SUPPLY	307,930.50	64,960.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	523,752.00	54,636.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	65,764.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	178,680.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	246,713.00	323.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	12,276.00	0.00	MRI SERVICES	17,392.00	0.00
IV THERAPY	2,791.25	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	27,292.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,003,864.00	32,799.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	1,168.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	980.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	1,564.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	7,556.00	0.00	INJECTABLE DRUGS	653,716.08	24,645.85
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	304,557.00	1,512.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	122,090.00	167.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	29,880.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	29,117.00	0.00	IMPL DEV CHARGE PATIENTS	8,050.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	8,687.00
OTHER IMAGING SERVICE	5,680.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	17,405.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	3,124.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,429.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,847,453.53	197,299.13
			TOTAL ACCOMODATIONS	1,789,840.00	1,270,820.00
			TOTAL CHARGES	5,637,293.53	1,468,119.13

Report : CLM-0800-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE I  
INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
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WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	5214008027688	09/20/12 - 12/31/12	01/13/14	0.00	2,705.00	0.00	0.00	0.00
614	9114014003262	05/10/13 - 06/06/13	03/17/14	0.00	5,982.00	0.00	4,148.05	0.00
TOTAL				0.00	8,687.00	0.00	4,148.05	0.00



Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	690,444.19	ADJUSTMENTS	5,027.53
COVERED CHARGES	635,252.51	CONTRACTUAL ALLOW	383,620.99
NON-COVERD CHARGES	55,191.68	TOTAL MEDICAID LIAB	251,631.52
		LESS: COB	0.00
		LESS: COPAYMENT	1,212.00
		REIMBURSEMENT	250,419.52
		ALL OTHER	249,045.09
		FEE SCHEDULE-LAB	712.28
		INJECTABLE DRUGS	662.15

TOTAL NUMBER OF CLAIMS 452

Report : CLM-0804-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
 Run Time: 12:10:47  
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WESLEY WOODS GERIATRIC HOSP  
 1821 CLIFTON RD NE  
 ATLANTA,GA 30329-4021

PROVIDER NUMBER  
 000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,690.30	207.10	OTHER LAB	2,242.00	0.00
MED/SURG SUPPLY	12,484.00	11,653.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	38,323.00	491.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	6,440.00	7,040.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	5,746.00	716.00
EKG/ECG	124.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	130,262.00	29,444.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	3,153.21	2,516.58
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	3,009.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	115.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	60,983.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	49,989.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	844.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	304,378.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	16,594.00	0.00			
			TOTAL ANCILLARY	635,252.51	55,191.68
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	635,252.51	55,191.68

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,976.08	ADJUSTMENTS	0.00
COVERED CHARGES	3,353.00	CONTRACTUAL ALLOW	1,728.60
NON-COVERD CHARGES	623.08	TOTAL MEDICAID LIAB	1,624.40
		LESS: COB	1,617.81
		LESS: COPAYMENT	6.59
		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

WESLEY WOODS GERIATRIC HOSP  
 1821 CLIFTON RD NE  
 ATLANTA,GA 30329-4021

PROVIDER NUMBER  
 000339831A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	6.08	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	301.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	617.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	35.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	3,017.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	3,353.00	623.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,353.00	623.08

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

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WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

WESLEY WOODS GERIATRIC HOSP  
1821 CLIFTON RD NE  
ATLANTA,GA 30329-4021

PROVIDER NUMBER  
000339831A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
 1355 INDEPENDENCE DR  
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
 000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 04/25/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	584,627.24	ADJUSTMENTS	0.00
COVERED CHARGES	550,061.24	CONTRACTUAL ALLOW	209,377.72
NON-COVERD CHARGES	34,566.00	TOTAL MEDICAID LIAB	340,683.52
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	340,683.52

TOTAL NUMBER OF ADMISSIONS 30

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	229		30	201,978.00		34,566.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	229		30	201,978.00		34,566.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	229		30	201,978.00		34,566.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HEALTHSOUTH WALTON REHABILITATION HOSPITAL, LLC  
 1355 INDEPENDENCE DR  
 AUGUSTA,GA 30901-1037

PROVIDER NUMBER  
 000368387A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 04/25/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	110,857.24	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	41,000.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	12,945.00	0.00	EDUCATION & TRAINING	90.00	0.00
RADIOLOGY-DIAGNOSTIC	9,267.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	60,696.00	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	5,631.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	64,741.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	40,678.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	2,178.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	348,083.24	0.00
			TOTAL ACCOMODATIONS	201,978.00	34,566.00
			TOTAL CHARGES	550,061.24	34,566.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 04/25/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 04/25/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	88,504.00	ADJUSTMENTS	343.75
COVERED CHARGES	67,753.00	CONTRACTUAL ALLOW	37,821.81
NON-COVERD CHARGES	20,751.00	TOTAL MEDICAID LIAB	29,931.19
		LESS: COB	0.00
		LESS: COPAYMENT	519.00
		REIMBURSEMENT	29,412.19
		ALL OTHER	22,674.07
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	6,738.12

TOTAL NUMBER OF CLAIMS 153

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 07/01/12 THROUGH 04/25/13  
 ADMISSION DATES 00/00/00 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	25,364.00	4,307.00	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	13.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	13,200.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	3,577.00	1,606.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	4,482.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	20,059.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	1,740.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,800.00	10,356.00			
			TOTAL ANCILLARY	67,753.00	20,751.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	67,753.00	20,751.00

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

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 07/01/12 THROUGH 04/25/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,030.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,030.00	CONTRACTUAL ALLOW	1,527.20
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	502.80
		LESS: COB	499.80
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 2

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 07/01/12 THROUGH 04/25/13  
 ADMISSION DATES 00/00/00 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	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,030.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,030.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,030.00	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

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	04/25/13
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	07/01/12	THROUGH	04/25/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 11:25:20  
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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	07/01/12	THROUGH	04/25/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:25:20  
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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	07/01/12	THROUGH	04/25/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:07:51  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

KINDRED HOSPITAL ATLANTA  
 705 JUNIPER ST NE  
 ATLANTA,GA 30308-1307

PROVIDER NUMBER 000472513A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	27,407,843.69	ADJUSTMENTS	401,491.90
COVERED CHARGES	21,337,842.49	CONTRACTUAL ALLOW	15,939,473.47
NON-COVERD CHARGES	6,070,001.20	TOTAL MEDICAID LIAB	5,398,369.02
		LESS: COB	66,403.92
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	5,331,965.10

TOTAL NUMBER OF ADMISSIONS 135

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	DAYS		CHARGES	
	COVERED	NONCOVERED	COVERED	NONCOVERED
ROUTINE SERVICES				
ROUTINE CARE	3,413	1,254	3,435,966.00	4,462,592.00
ROUTINE NURSERY	0	0	0.00	0.00
SWING BED	0	0	0.00	0.00
LEAVE OF ABSENCE	0	0	0.00	0.00
TOTAL ROUTINE	3,413	1,254	3,435,966.00	4,462,592.00
SPECIAL CARE SERVICES				
CCU	0	0	0.00	0.00
ICU	608	0	1,302,762.00	0.00
NICU	0	0	0.00	0.00
PED ICU	0	0	0.00	0.00
NEURO ICU	0	0	0.00	0.00
SHOCK TRAUMA	0	0	0.00	0.00
BURN UNIT	0	0	0.00	0.00
HOSPICE	0	0	0.00	0.00
REHAB	0	0	0.00	0.00
PRTF	0	0	0.00	0.00
TOTAL SPEC CARE	608	0	1,302,762.00	0.00
TOTAL ACCOMODATIONS	4,021	1,254	4,738,728.00	4,462,592.00

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 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	4,939,977.90	449.50	OTHER LAB	24,742.00	0.00
MED/SURG SUPPLY	2,629,802.30	1,677.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,108,579.50	29,393.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	311,284.14	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	63,271.00	9,603.20	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	204,422.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	36,015.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	408,640.65	1,098.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,825,042.00	1,507,636.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	77,527.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	51,896.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	217,296.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	235,257.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	272,616.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	10,714.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	127,151.00	57,552.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	28,140.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	12,166.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	14,575.00	0.00			
			TOTAL ANCILLARY	16,599,114.49	1,607,409.20
			TOTAL ACCOMODATIONS	4,738,728.00	4,462,592.00
			TOTAL CHARGES	21,337,842.49	6,070,001.20

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
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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	09/01/12	THROUGH	08/31/13
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: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

KINDRED HOSPITAL ATLANTA  
705 JUNIPER ST NE  
ATLANTA,GA 30308-1307

PROVIDER NUMBER  
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

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KINDRED HOSPITAL ATLANTA  
705 JUNIPER ST NE  
ATLANTA,GA 30308-1307

PROVIDER NUMBER  
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

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SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

KINDRED HOSPITAL ATLANTA  
705 JUNIPER ST NE  
ATLANTA,GA 30308-1307

PROVIDER NUMBER  
000472513A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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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	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 11:50:14  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	9,100,789.28	ADJUSTMENTS	302,736.38
COVERED CHARGES	8,797,885.18	CONTRACTUAL ALLOW	6,646,533.40
NON-COVERD CHARGES	302,904.10	TOTAL MEDICAID LIAB	2,151,351.78
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	2,151,351.78

TOTAL NUMBER OF ADMISSIONS 364

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,181		0	1,229,322.00		273,998.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	1,181		0	1,229,322.00		273,998.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	1,181		0	1,229,322.00		273,998.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP  
 35 JESSE HILL JR DR SE  
 ATLANTA,GA 30303-3032

PROVIDER NUMBER  
 000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	815,988.39	0.00	OTHER LAB	4,820.90	0.00
MED/SURG SUPPLY	265,375.20	3,752.90	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	458,714.00	1,212.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	114,675.80	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	5,778.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,880.50	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	4,435.90	0.00	MRI SERVICES	9,885.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	612.30
OPERATING ROOM	140,697.50	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	4,763,467.70	5,982.40	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	823,404.60	2,244.50	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	4,492.00	0.00	INJECTABLE DRUGS	28,242.09	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	602.30	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	15,102.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	41,283.50	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	68,629.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	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	13,405.80	0.00			
			TOTAL ANCILLARY	7,568,563.18	28,906.10
			TOTAL ACCOMODATIONS	1,229,322.00	273,998.00
			TOTAL CHARGES	8,797,885.18	302,904.10

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 11:50:24  
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SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

HUGHES SPALDING CHILDRENS HOSP  
35 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3032

PROVIDER NUMBER  
000679808A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*



Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 11:50:27  
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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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	16,661,755.22	ADJUSTMENTS	715,663.57
COVERED CHARGES	16,112,444.11	CONTRACTUAL ALLOW	11,365,336.74
NON-COVERD CHARGES	549,311.11	TOTAL MEDICAID LIAB	4,747,107.37
		LESS: COB	1,429.32
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,745,678.05
		ALL OTHER	4,265,461.78
		FEE SCHEDULE-LAB	228,888.71
		INJECTABLE DRUGS	251,327.56

TOTAL NUMBER OF CLAIMS 12,371

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	377,108.07	867.15	OTHER LAB	268,964.10	0.00
MED/SURG SUPPLY	528,934.79	506.10	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	1,726.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	382,039.60	7,915.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	31,809.00	7,308.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	2,168,277.01	192,548.25
EKG/ECG	33,320.10	2,496.40	MRI SERVICES	0.00	0.00
IV THERAPY	4,054.50	0.00	PROFESSIONAL FEES	0.00	328.90
OPERATING ROOM	182,097.10	1,668.50	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,568,241.80	61,599.20	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	6,200,047.15	76,605.70	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	634,926.99	177,044.41
RADIOLOGY THERAPEUTIC	12,981.20	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	350.20
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	2,389,281.50	7,356.90	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	92,951.20	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	1,056,179.40	7,681.20			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	3,629.20	0.00			
CARDIOLOGY	5,964.00	2,829.40			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	171,637.40	479.70			
			TOTAL ANCILLARY	16,112,444.11	549,311.11
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	16,112,444.11	549,311.11

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 11:52:06  
Page: 6

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,557.45	ADJUSTMENTS	0.00
COVERED CHARGES	7,008.45	CONTRACTUAL ALLOW	6,156.45
NON-COVERD CHARGES	549.00	TOTAL MEDICAID LIAB	852.00
		LESS: COB	852.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 5

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	153.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	160.80	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	0.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,362.60	549.00
EKG/ECG	328.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	175.10	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,428.20	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,751.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	649.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	7,008.45	549.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	7,008.45	549.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 11:52:08  
Page: 8

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	1,793,439.58	ADJUSTMENTS	1,398.50
COVERED CHARGES	1,753,985.11	CONTRACTUAL ALLOW	1,652,397.07
NON-COVERD CHARGES	39,454.47	TOTAL MEDICAID LIAB	101,588.04
		LESS: COB	0.00
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	101,585.04
		TOTAL NUMBER OF CLAIMS	1,817

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,247.71	140.17	OTHER LAB	1,465.00	0.00
MED/SURG SUPPLY	26,240.90	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	24,974.50	739.10	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	4,872.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	119,123.60	32,495.00
EKG/ECG	1,412.20	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	97.50
OPERATING ROOM	3,707.40	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	46,976.20	1,177.50	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	1,486,806.60	4,423.60	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,008.50	206.50
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	175.10
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	1,287.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	5,292.40	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,571.10	0.00			
			TOTAL ANCILLARY	1,753,985.11	39,454.47
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,753,985.11	39,454.47

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: 07/23/2014  
Run Time: 11:52:19  
Page: 10

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 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	4,208.09	ADJUSTMENTS	0.00
COVERED CHARGES	3,996.09	CONTRACTUAL ALLOW	3,996.09
NON-COVERD CHARGES	212.00	TOTAL MEDICAID LIAB	0.00
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF CLAIMS 2

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 11:52:19  
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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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	12.49	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	0.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	524.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	352.00	212.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	435.60	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	2,672.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	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	3,996.09	212.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	3,996.09	212.00



Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

Run Date: 07/23/2014  
Run Time: 11:52:21  
Page: 12

OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP  
35 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3032

PROVIDER NUMBER  
000679808A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	48,709.50	ADJUSTMENTS	0.00
COVERED CHARGES	48,531.00	CONTRACTUAL ALLOW	35,608.94
NON-COVERD CHARGES	178.50	TOTAL MEDICAID LIAB	12,922.06
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,922.06

TOTAL NUMBER OF CLAIMS 2

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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	889.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,064.10	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,310.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	3,048.60	77.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	350.20	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	35,192.30	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	4,018.90	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	35.50	101.50
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.	64.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	2,558.40	0.00			
			TOTAL ANCILLARY	48,531.00	178.50
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	48,531.00	178.50

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 11:52:24  
Page: 14

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

HUGHES SPALDING CHILDRENS HOSP  
35 JESSE HILL JR DR SE  
ATLANTA,GA 30303-3032

PROVIDER NUMBER  
000679808A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
 SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

Run Date: 07/23/2014  
 Run Time: 10:24:40  
 Page: 1

MORGAN MEMORIAL HOSPITAL  
 1077 S MAIN ST  
 MADISON,GA 30650-2073

PROVIDER NUMBER 000694229A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	19,793.47	ADJUSTMENTS	0.00
COVERED CHARGES	19,613.47	CONTRACTUAL ALLOW	7,214.66
NON-COVERD CHARGES	180.00	TOTAL MEDICAID LIAB	12,398.81
		LESS: COB	0.00
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	12,398.81

TOTAL NUMBER OF ADMISSIONS 3

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	8		0	4,248.00		180.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	8		0	4,248.00		180.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	8		0	4,248.00		180.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

MORGAN MEMORIAL HOSPITAL  
 1077 S MAIN ST  
 MADISON,GA 30650-2073

PROVIDER NUMBER  
 000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,072.83	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	1,555.64	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	4,540.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	466.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,607.00	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	679.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,150.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	2,295.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	15,365.47	0.00
			TOTAL ACCOMODATIONS	4,248.00	180.00
			TOTAL CHARGES	19,613.47	180.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:24:41  
Page: 4

MORGAN MEMORIAL HOSPITAL  
1077 S MAIN ST  
MADISON,GA 30650-2073

PROVIDER NUMBER  
000694229A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	651,112.22	ADJUSTMENTS	118,164.70
COVERED CHARGES	589,760.95	CONTRACTUAL ALLOW	317,304.96
NON-COVERD CHARGES	61,351.27	TOTAL MEDICAID LIAB	272,455.99
		LESS: COB	1,053.17
		LESS: COPAYMENT	483.00
		REIMBURSEMENT	270,919.82
		ALL OTHER	251,174.95
		FEE SCHEDULE-LAB	16,940.69
		INJECTABLE DRUGS	2,804.18

TOTAL NUMBER OF CLAIMS 716

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	27,644.88	7,573.63	OTHER LAB	13,669.00	0.00
MED/SURG SUPPLY	7,637.27	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	51,262.00	428.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	110,070.00	10,629.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	2,780.00	2,430.00	FEE SCHEDULE LAB	142,380.00	27,128.92
EKG/ECG	7,424.00	0.00	MRI SERVICES	6,200.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	240.00
OPERATING ROOM	14,573.40	2,873.68	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,159.00	164.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	12,353.00	1,083.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	157,333.12	4,723.60	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	9,363.28	1,443.44
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,170.00	1,785.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	110.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	2,214.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	14,710.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	4,414.00	849.00			
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	2,240.00	0.00			
			TOTAL ANCILLARY	589,760.95	61,351.27
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	589,760.95	61,351.27



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	3,113.25	ADJUSTMENTS	0.00
COVERED CHARGES	2,784.74	CONTRACTUAL ALLOW	1,153.47
NON-COVERD CHARGES	328.51	TOTAL MEDICAID LIAB	1,631.27
		LESS: COB	1,631.27
		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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	178.34	127.76	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	57.05	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	437.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,055.75	50.75
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	1,056.60	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	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,784.74	328.51
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,784.74	328.51

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	43,340.91	ADJUSTMENTS	919.95
COVERED CHARGES	40,889.47	CONTRACTUAL ALLOW	35,989.47
NON-COVERD CHARGES	2,451.44	TOTAL MEDICAID LIAB	4,900.00
		LESS: COB	0.00
		LESS: COPAYMENT	132.09
		REIMBURSEMENT	4,767.91
		TOTAL NUMBER OF CLAIMS	98

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	1,814.80	1,191.59	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	418.94	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,410.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,343.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	10,035.00	720.00
EKG/ECG	384.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	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	44.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	22,931.08	447.84	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	502.65	48.01
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	40,889.47	2,451.44
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	40,889.47	2,451.44

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,053.51	ADJUSTMENTS	0.00
COVERED CHARGES	1,763.52	CONTRACTUAL ALLOW	1,212.51
NON-COVERD CHARGES	289.99	TOTAL MEDICAID LIAB	551.01
		LESS: COB	545.01
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	0.00	213.99	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	555.00	76.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	1,208.52	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	1,763.52	289.99
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,763.52	289.99

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 10:24:58  
Page: 13

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	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 10:51:24  
 Page: 1

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

PIEDMONT FAYETTE HOSPITAL  
 1255 HIGHWAY 54 W  
 FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER  
 000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	18,722,158.73	ADJUSTMENTS	740,417.92
COVERED CHARGES	18,550,860.07	CONTRACTUAL ALLOW	13,964,110.36
NON-COVERD CHARGES	171,298.66	TOTAL MEDICAID LIAB	4,586,749.71
		LESS: COB	39,282.81
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	4,547,466.90

TOTAL NUMBER OF ADMISSIONS 529

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	1,790		5	1,646,800.00		5,740.00
ROUTINE NURSERY	505		0	549,178.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	2,295		5	2,195,978.00		5,740.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	458		0	1,106,640.00		0.00
NICU	434		0	935,270.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	892		0	2,041,910.00		0.00
TOTAL ACCOMODATIONS	3,187		5	4,237,888.00		5,740.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	3,615,639.98	20.91	OTHER LAB	96,028.00	0.00
MED/SURG SUPPLY	449,722.54	7,313.75	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	2,290,232.82	19,000.00	EDUCATION & TRAINING	6,096.00	0.00
RADIOLOGY-DIAGNOSTIC	647,732.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,243,629.00	2,810.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	153,375.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	121,851.00	0.00	MRI SERVICES	209,529.00	0.00
IV THERAPY	37,442.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	730,763.00	40,754.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	218,540.00	4,893.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	1,326,001.00	15.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	135,307.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	257,359.00	38,900.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	916,488.00	10,456.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	213,907.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	145,464.00	0.00	INJECTABLE DRUGS	17,325.00	0.00
RADIOLOGY THERAPEUTIC	47,996.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	82,394.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	26,015.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	59,540.00	16,030.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	4,895.84	900.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	192,249.43	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	248,044.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	282,994.00	15,286.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	88,792.00	9,180.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	390,944.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	10,586.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	46,090.46	0.00			
			TOTAL ANCILLARY	14,312,972.07	165,558.66
			TOTAL ACCOMODATIONS	4,237,888.00	5,740.00
			TOTAL CHARGES	18,550,860.07	171,298.66

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	311,486.01	ADJUSTMENTS	0.00
COVERED CHARGES	305,690.01	CONTRACTUAL ALLOW	120,546.61
NON-COVERD CHARGES	5,796.00	TOTAL MEDICAID LIAB	185,143.40
		LESS: COB	185,143.40
		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	50		0	46,000.00		0.00
ROUTINE NURSERY	5		0	3,250.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	55		0	49,250.00		0.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	10		0	22,295.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
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	22,295.00		0.00
TOTAL ACCOMODATIONS	65		0	71,545.00		0.00

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	57,469.30	0.00	OTHER LAB	1,132.00	0.00
MED/SURG SUPPLY	9,698.75	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	29,644.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,410.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	14,381.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	1,050.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	7,865.00	4,664.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	21,683.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	2,627.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	5,515.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	16,207.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,844.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	422.00	0.00	INJECTABLE DRUGS	432.96	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	8,201.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	3,560.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	6,221.00	1,132.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	27,782.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	234,145.01	5,796.00
			TOTAL ACCOMODATIONS	71,545.00	0.00
			TOTAL CHARGES	305,690.01	5,796.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 10:51:44  
Page: 5

PIEDMONT FAYETTE HOSPITAL  
1255 HIGHWAY 54 W  
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER  
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	12,610,947.79	ADJUSTMENTS	282,776.66
COVERED CHARGES	10,886,878.49	CONTRACTUAL ALLOW	8,666,463.93
NON-COVERD CHARGES	1,724,069.30	TOTAL MEDICAID LIAB	2,220,414.56
		LESS: COB	23,282.35
		LESS: COPAYMENT	3,255.00
		REIMBURSEMENT	2,193,877.21
		ALL OTHER	2,018,888.54
		FEE SCHEDULE-LAB	123,843.47
		INJECTABLE DRUGS	51,145.20

TOTAL NUMBER OF CLAIMS 3,879

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	423,334.10	9,938.82	OTHER LAB	88,845.00	1,132.00
MED/SURG SUPPLY	337,249.21	13,587.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	24.00	EDUCATION & TRAINING	2,794.00	127.00
RADIOLOGY-DIAGNOSTIC	730,686.00	13,883.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	1,524,959.00	550,115.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	23,590.00	6,000.00	FEE SCHEDULE LAB	1,448,832.93	171,673.20
EKG/ECG	192,587.00	4,202.00	MRI SERVICES	192,076.00	9,587.00
IV THERAPY	63,812.00	5,272.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	800,785.25	102,503.75	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	89,370.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	48,571.00	27,417.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	128,083.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	421,464.00	52,565.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,383,741.00	135,893.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	217,079.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	310,872.26	314,247.03
RADIOLOGY THERAPEUTIC	93,236.00	617.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	17,179.00	5,728.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	4,313.00	746.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	71,125.00	2,314.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	55,588.88	38,022.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	383,780.00	158,126.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	78,359.00	20,319.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	119,802.00	14,502.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	316,445.00	40,103.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	67,681.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	250,638.86	25,425.00			
			TOTAL ANCILLARY	10,886,878.49	1,724,069.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	10,886,878.49	1,724,069.30

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 10:52:45  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	525,549.07	ADJUSTMENTS	0.00
COVERED CHARGES	321,400.77	CONTRACTUAL ALLOW	115,242.55
NON-COVERD CHARGES	204,148.30	TOTAL MEDICAID LIAB	206,158.22
		LESS: COB	206,095.22
		LESS: COPAYMENT	63.00
		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

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	13,978.76	374.00	OTHER LAB	4,640.00	0.00
MED/SURG SUPPLY	15,109.25	78.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	48.00	EDUCATION & TRAINING	195.00	0.00
RADIOLOGY-DIAGNOSTIC	27,347.00	6,797.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	13,543.00	23,611.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	42,458.00	5,247.00
EKG/ECG	4,900.00	350.00	MRI SERVICES	0.00	4,556.00
IV THERAPY	5,082.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	37,080.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	13,761.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	674.00	2,139.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	3,680.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	14,270.00	3,151.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	74,142.00	2,622.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	7,248.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	259.00	863.30
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	322.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	102.00	119,190.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	11,606.00	16,085.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	14,530.00	7,230.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	4,465.00	8,947.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	12,008.76	2,860.00			
			TOTAL ANCILLARY	321,400.77	204,148.30
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	321,400.77	204,148.30



Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 10:52:48  
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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	503,631.94	ADJUSTMENTS	476.45
COVERED CHARGES	464,703.60	CONTRACTUAL ALLOW	443,670.16
NON-COVERD CHARGES	38,928.34	TOTAL MEDICAID LIAB	21,033.44
		LESS: COB	0.00
		LESS: COPAYMENT	573.03
		REIMBURSEMENT	20,460.41
		TOTAL NUMBER OF CLAIMS	376

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	14,811.04	0.00	OTHER LAB	6,855.00	0.00
MED/SURG SUPPLY	2,390.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	44,048.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	62,073.00	22,332.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	59,860.00	4,120.00
EKG/ECG	11,904.00	0.00	MRI SERVICES	4,556.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	3,602.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	885.00	354.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	236,209.00	2,986.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	96.00	1,055.34
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	16,135.00	8,081.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	1,278.86	0.00			
			TOTAL ANCILLARY	464,703.60	38,928.34
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	464,703.60	38,928.34

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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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 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	7,567.00	ADJUSTMENTS	0.00
COVERED CHARGES	6,068.00	CONTRACTUAL ALLOW	3,035.59
NON-COVERD CHARGES	1,499.00	TOTAL MEDICAID LIAB	3,032.41
		LESS: COB	3,026.41
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	4

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	394.00	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	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	1,787.00	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	3,887.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	1,334.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	6,068.00	1,499.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	6,068.00	1,499.00

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VII

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OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT FAYETTE HOSPITAL  
1255 HIGHWAY 54 W  
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER  
000755323A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 07/01/12 THROUGH 06/30/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,742,627.05	ADJUSTMENTS	68,769.88
COVERED CHARGES	2,617,707.14	CONTRACTUAL ALLOW	2,278,591.02
NON-COVERD CHARGES	124,919.91	TOTAL MEDICAID LIAB	339,116.12
		LESS: COB	0.00
		LESS: COPAYMENT	657.00
		REIMBURSEMENT	338,459.12

TOTAL NUMBER OF CLAIMS 64

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 07/01/12 THROUGH 06/30/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	231,408.78	959.00	OTHER LAB	2,939.00	0.00
MED/SURG SUPPLY	36,372.70	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,784.00	1,310.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	40,195.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	24,736.00	7,222.00
EKG/ECG	4,900.00	1,050.00	MRI SERVICES	3,008.00	0.00
IV THERAPY	91,842.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	56,007.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	139.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	8,875.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	4,834.00	1,766.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	11,668.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	1,529,360.93	26,937.91
RADIOLOGY THERAPEUTIC	307,684.00	1,079.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	30,787.00	44,088.00
LITHOTRIpsy	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	53,334.00	14,465.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	16,308.00	1,428.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	134,637.00	22,157.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	26,887.73	2,458.00			
			TOTAL ANCILLARY	2,617,707.14	124,919.91
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,617,707.14	124,919.91

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

PIEDMONT FAYETTE HOSPITAL  
1255 HIGHWAY 54 W  
FAYETTEVILLE,GA 30214-4526

PROVIDER NUMBER  
000755323A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	07/01/12	THROUGH	06/30/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*

Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:08:02  
 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 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,204,488.22	ADJUSTMENTS	384,174.94
COVERED CHARGES	3,364,696.22	CONTRACTUAL ALLOW	2,467,943.17
NON-COVERD CHARGES	1,839,792.00	TOTAL MEDICAID LIAB	896,753.05
		LESS: COB	9,367.68
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	887,385.37

TOTAL NUMBER OF ADMISSIONS 28

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	988		33	663,894.00		1,736,950.00
ROUTINE NURSERY	0		0	0.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	988		33	663,894.00		1,736,950.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	0		0	0.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	0		0	0.00		0.00
TOTAL ACCOMODATIONS	988		33	663,894.00		1,736,950.00



Report : CLM-0800-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:08:02  
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SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL  
 320 TURNER MCCALL BLVD SW  
 ROME,GA 30165-5621

PROVIDER NUMBER  
 000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 01/01/13 THROUGH 12/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	871,108.24	2,385.50	OTHER LAB	13,891.00	0.00
MED/SURG SUPPLY	459,381.50	24,159.50	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	377,201.00	55,043.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	39,582.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	17,695.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	117,120.00	1,593.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	2,100.00	0.00	MRI SERVICES	11,982.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	39,234.48	1,008.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	532,131.00	14,231.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	8,844.00	4,422.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	0.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	79,180.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	57,145.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	55,055.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,788.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	11,415.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	5,949.00	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	0.00	0.00			
			TOTAL ANCILLARY	2,700,802.22	102,842.00
			TOTAL ACCOMODATIONS	663,894.00	1,736,950.00
			TOTAL CHARGES	3,364,696.22	1,839,792.00

Report : CLM-0802-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:08:02  
Page: 3

SUMMARY TYPE II  
ZERO PAID INPATIENT PAID CLAIMS

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:08:02  
Page: 4

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 01/01/13 THROUGH 12/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

\*\* NO DATA \*\*

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:08:02  
Page: 5

SUMMARY TYPE IV  
ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:08:02  
Page: 6

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
Run Time: 12:08:02  
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SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0812-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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Page: 8

SUMMARY TYPE VII  
OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
Run Time: 12:08:03  
Page: 9

ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

THE SPECIALTY HOSPITAL  
320 TURNER MCCALL BLVD SW  
ROME,GA 30165-5621

PROVIDER NUMBER  
000886179A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	01/01/13	THROUGH	12/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*



SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER 344886600A  
 PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	5,180,941.38	ADJUSTMENTS	343,444.66
COVERED CHARGES	5,046,749.30	CONTRACTUAL ALLOW	3,258,242.67
NON-COVERD CHARGES	134,192.08	TOTAL MEDICAID LIAB	1,788,506.63
		LESS: COB	74,009.47
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	1,714,497.16

TOTAL NUMBER OF ADMISSIONS 197

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	720		0	845,220.00		36,780.00
ROUTINE NURSERY	87		1	89,035.00		1,175.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	807		1	934,255.00		37,955.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	100		0	414,850.00		0.00
NICU	120		0	324,600.00		0.00
PED ICU	0		0	0.00		0.00
NEURO ICU	0		0	0.00		0.00
SHOCK TRAUMA	0		0	0.00		0.00
BURN UNIT	0		0	0.00		0.00
HOSPICE	0		0	0.00		0.00
REHAB	0		0	0.00		0.00
PRTF	0		0	0.00		0.00
TOTAL SPEC CARE	220		0	739,450.00		0.00
TOTAL ACCOMODATIONS	1,027		1	1,673,705.00		37,955.00

SUMMARY TYPE I  
 INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	217,811.65	0.00	OTHER LAB	23,555.00	0.00
MED/SURG SUPPLY	435,333.00	423.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	401,655.10	678.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	102,366.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	176,340.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	64,812.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	14,019.00	0.00	MRI SERVICES	35,204.00	0.00
IV THERAPY	9,602.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	387,819.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	186,628.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	104,727.00	285.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	58,496.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	25,438.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	146,740.00	542.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	43,417.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	4,784.12
LABORATORY PATHOLOGIC	10,799.00	0.00	INJECTABLE DRUGS	421,687.05	78,558.96
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	33,420.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	14,876.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	70,203.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	68,191.00	1,316.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	16,562.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	26,477.00	6,312.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	20,861.00	3,338.00			
AUDIOLOGY	118.00	0.00			
CARDIOLOGY	247,206.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	5,060.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	3,621.00	0.00			
			TOTAL ANCILLARY	3,373,044.30	96,237.08
			TOTAL ACCOMODATIONS	1,673,705.00	37,955.00
			TOTAL CHARGES	5,046,749.30	134,192.08

Report : CLM-0802-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
 Run Time: 12:07:29  
 Page: 3

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	203,757.03	ADJUSTMENTS	0.00
COVERED CHARGES	202,977.03	CONTRACTUAL ALLOW	102,792.74
NON-COVERD CHARGES	780.00	TOTAL MEDICAID LIAB	100,184.29
		LESS: COB	100,184.29
		LESS: COPAYMENT	0.00
		REIMBURSEMENT	0.00

TOTAL NUMBER OF ADMISSIONS 6

PART I - ACCOMODATIONS  
 MEDICAID DAYS AND CHARGES

	COVERED	DAYS	NONCOVERED	COVERED	CHARGES	NONCOVERED
ROUTINE SERVICES						
ROUTINE CARE	18		0	21,270.00		780.00
ROUTINE NURSERY	28		0	35,700.00		0.00
SWING BED	0		0	0.00		0.00
LEAVE OF ABSENCE	0		0	0.00		0.00
TOTAL ROUTINE	46		0	56,970.00		780.00
SPECIAL CARE SERVICES						
CCU	0		0	0.00		0.00
ICU	0		0	0.00		0.00
NICU	24		0	64,920.00		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	24		0	64,920.00		0.00
TOTAL ACCOMODATIONS	70		0	121,890.00		780.00

SUMMARY TYPE II  
 ZERO PAID INPATIENT PAID CLAIMS

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	25,567.75	0.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	680.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	11,701.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,584.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	3,102.00	0.00	FEE SCHEDULE LAB	0.00	0.00
EKG/ECG	0.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	262.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	319.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	25,056.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	38.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	780.00	0.00	INJECTABLE DRUGS	4,541.28	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	4,524.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	119.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	1,758.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	1,055.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	81,087.03	0.00
			TOTAL ACCOMODATIONS	121,890.00	780.00
			TOTAL CHARGES	202,977.03	780.00

Report : CLM-0804-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE III  
OUTPATIENT PAID CLAIMS - % OF CHARGES

Run Date: 07/23/2014  
Run Time: 12:07:30  
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EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,057,823.65	ADJUSTMENTS	65,265.43
COVERED CHARGES	1,650,380.57	CONTRACTUAL ALLOW	1,224,485.60
NON-COVERD CHARGES	407,443.08	TOTAL MEDICAID LIAB	425,894.97
		LESS: COB	2,255.53
		LESS: COPAYMENT	1,347.54
		REIMBURSEMENT	422,291.90
		ALL OTHER	399,794.46
		FEE SCHEDULE-LAB	18,587.00
		INJECTABLE DRUGS	3,910.44

TOTAL NUMBER OF CLAIMS 809

SUMMARY TYPE III  
 OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	11,980.07	29,314.22	OTHER LAB	25,889.00	0.00
MED/SURG SUPPLY	138,984.00	7,214.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	38.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	101,560.00	20,488.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	189,684.00	45,704.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	14,065.00	8,700.00	FEE SCHEDULE LAB	146,926.80	24,715.60
EKG/ECG	10,540.00	744.00	MRI SERVICES	117,676.00	33,913.00
IV THERAPY	20,347.50	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	178,602.00	103,407.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	2,752.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	5,006.00	1,100.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	42,496.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	25,054.00	5,547.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	246,238.00	11,219.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	39,309.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	26,820.20	34,314.26
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	1,104.00	4,816.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	254.00	2,241.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	21,340.00	38.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	16,261.00	4,471.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	87,410.00	12,765.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	963.00	658.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	29,581.00	10,886.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	111,966.00	45,150.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	9,108.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	28,464.00	0.00			
			TOTAL ANCILLARY	1,650,380.57	407,443.08
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	1,650,380.57	407,443.08

Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	76,658.13	ADJUSTMENTS	0.00
COVERED CHARGES	59,678.13	CONTRACTUAL ALLOW	16,119.63
NON-COVERD CHARGES	16,980.00	TOTAL MEDICAID LIAB	43,558.50
		LESS: COB	43,510.50
		LESS: COPAYMENT	48.00
		REIMBURSEMENT	0.00
		ALL OTHER	0.00
		FEE SCHEDULE-LAB	0.00
		INJECTABLE DRUGS	0.00

TOTAL NUMBER OF CLAIMS 50

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	166.67	358.20	OTHER LAB	2,256.00	0.00
MED/SURG SUPPLY	3,215.00	570.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	2,026.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	7,204.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,466.00	754.00
EKG/ECG	372.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	5,917.00	3,935.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	834.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	95.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	2,448.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	2,263.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	20,548.00	103.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	3,451.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	2,010.46	719.80
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	46.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	2,705.00
OTHER IMAGING SERVICE	571.00	223.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	3,743.00	408.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	250.00	0.00			
			TOTAL ANCILLARY	59,678.13	16,980.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	59,678.13	16,980.00



Report : CLM-0806-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE IV

Run Date: 07/23/2014  
Run Time: 12:07:35  
Page: 9

ZERO PAID OUTPATIENT PAID CLAIMS - % OF CHARGES

EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART III NO COST CENTER OR 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	2013238013257	08/07/13 - 08/07/13	09/02/13	0.00	2,705.00	0.00	1,983.80	0.00
TOTAL				0.00	2,705.00	0.00	1,983.80	0.00

Report : CLM-0808-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE V  
OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
Run Time: 12:07:36  
Page: 10

EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	56,827.62	ADJUSTMENTS	0.00
COVERED CHARGES	54,652.29	CONTRACTUAL ALLOW	51,298.81
NON-COVERD CHARGES	2,175.33	TOTAL MEDICAID LIAB	3,353.48
		LESS: COB	0.00
		LESS: COPAYMENT	114.01
		REIMBURSEMENT	3,239.47
		TOTAL NUMBER OF CLAIMS	60

SUMMARY TYPE V  
 OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	109.62	71.82	OTHER LAB	1,121.00	0.00
MED/SURG SUPPLY	33.00	0.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	1,440.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	3,688.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	9,020.00	1,005.00
EKG/ECG	620.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	428.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	35,232.00	206.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	469.67	564.51
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	2,491.00	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	0.00	0.00			
			TOTAL ANCILLARY	54,652.29	2,175.33
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	54,652.29	2,175.33

Report : CLM-0810-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VI  
ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

Run Date: 07/23/2014  
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EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	2,291.00	ADJUSTMENTS	0.00
COVERED CHARGES	2,291.00	CONTRACTUAL ALLOW	1,134.30
NON-COVERD CHARGES	0.00	TOTAL MEDICAID LIAB	1,156.70
		LESS: COB	1,153.70
		LESS: COPAYMENT	3.00
		REIMBURSEMENT	0.00
		TOTAL NUMBER OF CLAIMS	3

Report : CLM-0810-0  
 Process : CLMJ0800  
 Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT

Run Date: 07/23/2014  
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SUMMARY TYPE VI  
 ZERO PAID OUTPATIENT PAID CLAIMS - FIXED FEE

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 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	124.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	0.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	0.00	0.00	FREE STANDING CLINIC	0.00	0.00
ANESTHESIA	0.00	0.00	AMBULANCE	0.00	0.00
GI SERVICES	0.00	0.00	CAST ROOM	0.00	0.00
EMERGENCY ROOM	2,167.00	0.00	SPECIAL SERVICES	0.00	0.00
RECOVERY ROOM	0.00	0.00	DRUG-SPECIFIC/HOME IV	0.00	0.00
LABORATORY PATHOLOGIC	0.00	0.00	INJECTABLE DRUGS	0.00	0.00
RADIOLOGY THERAPEUTIC	0.00	0.00	HOME HEALTH SERVICES	0.00	0.00
OCCUPATIONAL THERAPY	0.00	0.00	HOSPICE SERVICES	0.00	0.00
SPEECH PATHOLOGY	0.00	0.00	ACTIVITIES OF DAILY LIFE	0.00	0.00
RENAL DIALYSIS	0.00	0.00	PATIENT CONVENIENCE	0.00	0.00
OUTPATIENT SERVICES	0.00	0.00	O/P SPECIAL RESIDENCE	0.00	0.00
CLINIC SERVICES	0.00	0.00	TRAUMA RESPONSE	0.00	0.00
PSYCHIATRIC SERVICES	0.00	0.00	IMPL DEV CHARGE PATIENTS	0.00	0.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	0.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	0.00	0.00			
			TOTAL ANCILLARY	2,291.00	0.00
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	2,291.00	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

EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
SERVICE DATES 09/01/12 THROUGH 08/31/13  
ADMISSION DATES 00/00/00 THROUGH 00/00/00

-----CHARGES-----		-----PAYMENTS-----	
TOTAL CHARGES	99,751.60	ADJUSTMENTS	5,163.26
COVERED CHARGES	58,014.25	CONTRACTUAL ALLOW	47,687.73
NON-COVERD CHARGES	41,737.35	TOTAL MEDICAID LIAB	10,326.52
		LESS: COB	0.00
		LESS: COPAYMENT	6.00
		REIMBURSEMENT	10,320.52
		TOTAL NUMBER OF CLAIMS	2

SUMMARY TYPE VII  
 OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL  
 5707 PEACHTREE PKWY  
 NORCROSS,GA 30092-2804

PROVIDER NUMBER  
 344886600A

PAYMENT DATES 00/00/00 THROUGH 00/00/00  
 SERVICE DATES 09/01/12 THROUGH 08/31/13  
 ADMISSION DATES 00/00/00 THROUGH 00/00/00

PART II ANCILLARY SERVICES

COST CENTER	COVERED CHARGES	NONCOVERED CHARGES	COST CENTER	COVERED CHARGES	NONCOVERED CHARGES
PHARMACY-GENERAL	86.10	3,500.00	OTHER LAB	0.00	0.00
MED/SURG SUPPLY	45,653.00	1,558.00	RECREATIONAL THERAPY	0.00	0.00
LABORATORY-GENERAL	0.00	0.00	EDUCATION & TRAINING	0.00	0.00
RADIOLOGY-DIAGNOSTIC	8,880.00	0.00	OTHER THERAPEUTIC SVC	0.00	0.00
CT SCAN	0.00	0.00	SPECIAL CHARGES	0.00	0.00
PHYSICAL THERAPY	0.00	0.00	FEE SCHEDULE LAB	1,366.00	1,071.40
EKG/ECG	124.00	0.00	MRI SERVICES	0.00	0.00
IV THERAPY	0.00	0.00	PROFESSIONAL FEES	0.00	0.00
OPERATING ROOM	0.00	34,628.00	DURABLE MED. EQUIP.	0.00	0.00
LABOR/DELIVERY ROOM	0.00	0.00	REHAB THERAPY	0.00	0.00
RESPIRATORY SERVICES	76.00	0.00	FREE STANDING CLINIC	0.00	0.00
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	694.15	259.95
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	720.00
LITHOTRIPSY	0.00	0.00	NO CC/INVALID REV CODE	0.00	0.00
OTHER IMAGING SERVICE	166.00	0.00			
BLOOD	0.00	0.00			
BLOOD STORAGE & PRO.	0.00	0.00			
ONCOLOGY	0.00	0.00			
NUCLEAR MEDICINE	0.00	0.00			
AUDIOLOGY	0.00	0.00			
CARDIOLOGY	0.00	0.00			
AMBULATORY SURGERY	0.00	0.00			
OSTEOPATHIC SERVICES	0.00	0.00			
E E G	0.00	0.00			
ORGAN ACQUISITION	0.00	0.00			
TREATMENT/OBSERV. RM	969.00	0.00			
			TOTAL ANCILLARY	58,014.25	41,737.35
			TOTAL ACCOMODATIONS	0.00	0.00
			TOTAL CHARGES	58,014.25	41,737.35

Report : CLM-0814-0  
Process : CLMJ0800  
Location: CLMP8000

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
HOSPITAL STATISTICAL AND REIMBURSEMENT REPORT  
SUMMARY TYPE VIII

Run Date: 07/23/2014  
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ZERO PAID OUTPATIENT PAID CLAIMS - LIMITED TO PER CASE RATE

EMORY JOHNS CREEK HOSPITAL  
5707 PEACHTREE PKWY  
NORCROSS,GA 30092-2804

PROVIDER NUMBER  
344886600A

PAYMENT DATES	00/00/00	THROUGH	00/00/00
SERVICE DATES	09/01/12	THROUGH	08/31/13
ADMISSION DATES	00/00/00	THROUGH	00/00/00

\*\* NO DATA \*\*

\*\* END OF REPORT \*\*