LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON , SC 29405-7493

PROVIDER ID. 000058418 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 1

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
6070387	1435200276812300A				170.00	0.00	R	4780946627	D A REAFLER				
	01		120614	T1019	102.00	0.00	R			000		0.00	0.00
	02		121014	T1019	68.00	0.00	R			000		0.00	0.00
									EDITS: L01 712		L01 717		
									EDITS: L01 883		L02 712		
									EDITS: L02 717		L02 883		
6070388	1435200310812300A				459.00	204.00	P	5714231101	B S JAMERSON				
	01		120614	T1019	204.00	204.00	P			000		0.00	0.00
	02		120814	T1019	85.00	0.00	R			000		0.00	0.00
	03		121014	T1019	85.00	0.00	R			000		0.00	0.00
	04		121214	T1019	85.00	0.00	R			000		0.00	0.00
									EDITS: L02 852 12/26/14		L03 852 12/26/14		
									EDITS: L04 852 12/26/14				
0616493	1435400959877400A				52.70	52.70	P	1780374972	S G AXSON				
	01		121814	T1019	52.70	52.70	P			000		0.00	0.00
1035609	1435400960877400A				34.00	34.00	P	3106809101	P L SINGLETARY				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
1039718	1435400961877400A				46.90	46.90	P	4108888201	C MILLER				
	01		121814	S5130	12.90	12.90	P			000		0.00	0.00
	02		121814	T1019	34.00	34.00	P			000		0.00	0.00
1041158	1435400962877400A				46.90	46.90	P	1605964401	T JEFFERSON				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
	02		121814	S5130	12.90	12.90	P			000		0.00	0.00
1043080	1435400963877400A				59.80	59.80	P	7101399301	J SIMPSON				
	01		121814	S5130	25.80	25.80	P			000		0.00	0.00
	02		121814	T1019	34.00	34.00	P			000		0.00	0.00
1048200	1435400964877400A				42.21	42.21	P	2780432044	M T TURNER				
	01		121814	T1019	30.60	30.60	P			000		0.00	0.00
	02		121814	S5130	11.61	11.61	P			000		0.00	0.00
						$486.51							

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT	MEDICAID PG TOT
CERTIFIED AMT	MEDICAID TOTAL
	CHECK TOTAL

STATUS CODES:
P = PAYMENT MADE
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CHECK NUMBER

PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058419 | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

1063422988

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

REMITTANCE ADVICE

01/02/2015

2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
1048222	14354009658774 00A				29.90	29.90	P	4107048001	V MCFADDEN				
	01		121814	T1019	17.00	17.00	P			000		0.00	0.00
	02		121814	S5130	12.90	12.90	P			000		0.00	0.00
1048951	14354009668774 00A				46.90	46.90	P	2108057301	J BROOKS				
	01		121814	S5130	12.90	12.90	P			000		0.00	0.00
	02		121814	T1019	34.00	34.00	P			000		0.00	0.00
1050002	14354009678774 00A				29.90	29.90	P	3106156201	M L SINGLETON				
	01		121814	S5130	12.90	12.90	P			000		0.00	0.00
	02		121814	T1019	17.00	17.00	P			000		0.00	0.00
1052939	14354009688774 00A				34.00	34.00	P	0102002701	B PRIOLEAU				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
1053178	14354009698774 00A				44.20	0.00	R	0780818325	S M STANLEY				
	01		121814	T1019	44.20	0.00	R			000		0.00	0.00
									EDITS: L01 951				
1053430	14354009708774 00A				51.00	51.00	P	5607273201	L P OTT				
	01		121814	T1019	51.00	51.00	P			000		0.00	0.00
1053456	14354009718774 00A				52.70	52.70	P	5780843758	B R MORRILL				
	01		121814	T1019	52.70	52.70	P			000		0.00	0.00
1053931	14354009728774 00A				71.40	71.40	P	2780870723	C COOK				
	01		121814	T1019	71.40	71.40	P			000		0.00	0.00
1055390	14354009738774 00A				63.90	63.90	P	0715045901	D G BROWN				
	01		121814	S5130	12.90	12.90	P			000		0.00	0.00
	02		121814	T1019	51.00	51.00	P			000		0.00	0.00
1055416	14354009748774 00A				47.60	47.60	P	5101694402	J T WASHINGTON				
	01		121814	T1019	47.60	47.60	P			000		0.00	0.00
1055545	14354009758774 00A				46.90	46.90	P	9100493602	H W RANDOLPH				
						$474.20							

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CERT. PG TOT

MEDICAID PG TOT

CERTIFIED AMT

MEDICAID TOTAL

CHECK TOTAL

CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058420 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		121814	S5130	12.90	12.90	P			000		0.00	0.00
	02		121814	T1019	34.00	34.00	P			000		0.00	0.00
1055656	14354009768774 00A				163.20	163.20	P	8781045381	F S NEUNER				
	01		120914	T1019	37.40	37.40	P			000		0.00	0.00
	02		121114	T1019	37.40	37.40	P			000		0.00	0.00
	03		121214	T1019	39.10	39.10	P			000		0.00	0.00
	04		121314	T1019	49.30	49.30	P			000		0.00	0.00
1056019	14354009778774 00A				46.90	46.90	P	0780925395	S G BROOKS				
	01		121814	S5130	12.90	12.90	P			000		0.00	0.00
	02		121814	T1019	34.00	34.00	P			000		0.00	0.00
1056240	14354009788774 00A				156.40	156.40	P	5781085266	D O IWEGBUE				
	01		121714	T1019	81.60	81.60	P			000		0.00	0.00
	02		121814	T1019	74.80	74.80	P			000		0.00	0.00
1056439	14354009798774 00A				62.90	62.90	P	1630239869	M D SINGLETON				
	01		121814	T1019	17.00	17.00	P			000		0.00	0.00
	02		121814	T1019	45.90	45.90	P			000		0.00	0.00
1056598	14354009808774 00A				35.70	35.70	P	5182563502	S A MUCKELVANEY				
	01		121814	T1019	35.70	35.70	P			000		0.00	0.00
9600013	14354009818774 00A				35.70	35.70	P	3780727363	J C LECLAIR				
	01		121814	T1019	35.70	35.70	P			000		0.00	0.00
9601882	14354009828774 00A				61.32	61.32	P	1781134836	J SINGLETON JR				
	01		121814	S5130	10.32	10.32	P			000		0.00	0.00
	02		121814	T1019	39.10	39.10	P			000		0.00	0.00
	03		121814	T1019	11.90	11.90	P			000		0.00	0.00
9602100	14354009838774 00A				63.90	63.90	P	1107733501	L M PAGE				
	01		121814	S5130	12.90	12.90	P			000		0.00	0.00
	02		121814	T1019	51.00	51.00	P			000		0.00	0.00
9602136	14354009848774 00A				42.80	42.80	P	8726370301	M B SMITH				

$668.82

CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058421 | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

1063422988 | DEPT OF HEALTH AND HUMAN SERVICES | 01/02/2015 | 4

SOUTH CAROLINA MEDICAID PROGRAM | REMITTANCE ADVICE

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		121814	S5130	25.80	25.80	P			000		0.00	0.00
	02		121814	T1019	17.00	17.00	P			000		0.00	0.00
9604737	1435400985877400A				51.00	51.00	P	7729773201	S E ALSTON				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
	02		121814	T1019	17.00	17.00	P			000		0.00	0.00
9605752	1435400986877400A				34.94	34.94	P	4105281901	J WASHINGTON				
	01		121814	S5130	7.74	7.74	P			000		0.00	0.00
	02		121814	T1019	27.20	27.20	P			000		0.00	0.00
9613401	1435400987877400A				20.40	20.40	P	4780915876	C D SMITH				
	01		121814	T1019	20.40	20.40	P			000		0.00	0.00
9613479	1435400988877400A				35.70	35.70	P	8781273683	K P BOYD				
	01		121814	T1019	35.70	35.70	P			000		0.00	0.00
9616105	1435400989877400A				35.70	35.70	P	1781331779	K U BOYD				
	01		121814	T1019	35.70	35.70	P			000		0.00	0.00
9620895	1435400990877400A				20.40	20.40	P	4780705471	B C MAI				
	01		121814	T1019	20.40	20.40	P			000		0.00	0.00
9622104	1435400991877400A				35.70	35.70	P	5730567001	M D GIBSON				
	01		121814	T1019	35.70	35.70	P			000		0.00	0.00
9623713	1435400992877400A				34.00	34.00	P	1107209301	S BROWN				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
9637474	1435400993877400A				34.00	34.00	P	5780433859	J BROOKINS				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
9639410	1435400994877400A				68.00	68.00	P	1781301837	G L BRYANT				
	01		121814	T1019	68.00	68.00	P			000		0.00	0.00
9642075	1435400995877400A				46.90	46.90	P	0086572201	L JEFFERSON				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00

$416.74

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CERTIFIED AMT | MEDICAID TOTAL

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058422 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 5

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	MO D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	02		121814	S5130	12.90	12.90	P			000		0.00	0.00
9642179	1435400996877400A				153.00	153.00	P	0781568307	R J HUANG				
	01		121814	T1019	68.00	68.00	P			000		0.00	0.00
	02		121814	T1019	85.00	85.00	P			000		0.00	0.00
9646177	1435400997877400A				193.20	183.54	P	3781484082	S A BROWN				
	01		121814	T1003	193.20	183.54	P			000		0.00	0.00
9649580	1435400998877400A				34.00	34.00	P	9780580973	B HALL				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
9650393	1435400999877400A				28.50	28.50	P	1555072602	E HAYNES				
	01		121814	X0273	28.50	28.50	P			000		0.00	0.00
9650394	1435401000877400A				103.60	98.42	P	7781528787	M N BROWN				
	01		121814	T1003	103.60	98.42	P			000		0.00	0.00
9650999	1435400001877500A				62.50	62.50	P	8960252301	H RIGBY				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
	02		121814	X0273	28.50	28.50	P			000		0.00	0.00
9652816	1435400002877500A				44.20	44.20	P	0781657439	W POWELL				
	01		121814	T1019	44.20	44.20	P			000		0.00	0.00
9653656	1435400003877500A				46.90	46.90	P	4108310201	H B HARRELL				
	01		121814	S5130	12.90	12.90	P			000		0.00	0.00
	02		121814	T1019	34.00	34.00	P			000		0.00	0.00
9656068	1435400004877500A				63.90	63.90	P	1780548440	V L JOHNSON				
	01		121814	T1019	51.00	51.00	P			000		0.00	0.00
	02		121814	S5130	12.90	12.90	P			000		0.00	0.00
9661458	1435400005877500A				34.00	34.00	P	6721948901	M F DAVIS				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
9661760	1435400006877500A				34.00	34.00	P	4781947739	M JORDAN				

$782.96

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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058423 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 6

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
9663223	1435400007877500A				32.30	32.30	P	1781963077	Z SPANOS				
	01		121814	T1019	32.30	32.30	P			000		0.00	0.00
9663483	1435400008877500A				316.40	300.58	P	2781624221	S M SMILEY				
	01		121814	T1003	316.40	300.58	P			000		0.00	0.00
9667527	1435400009877500A				46.90	46.90	P	3102250401	M J MAZYCK				
	01		121814	S5130	12.90	12.90	P			000		0.00	0.00
	02		121814	T1019	34.00	34.00	P			000		0.00	0.00
1032058	1435400614888100A				28.67	28.67	P	9605922001	T R BLAYTON				
	01		121914	S5130	16.77	16.77	P			000		0.00	0.00
	02		121914	T1019	11.90	11.90	P			000		0.00	0.00
1035609	1435400615888100A				34.00	34.00	P	3106809101	P L SINGLETARY				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
1039718	1435400616888100A				46.90	46.90	P	4108888201	C MILLER				
	01		121914	S5130	12.90	12.90	P			000		0.00	0.00
	02		121914	T1019	34.00	34.00	P			000		0.00	0.00
1041158	1435400617888100A				34.00	34.00	P	1605964401	T JEFFERSON				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
1043080	1435400618888100A				34.00	34.00	P	7101399301	J SIMPSON				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
1044837	1435400619888100A				34.00	34.00	P	2100383303	J S TAYLOR				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
1048200	1435400620888100A				46.90	46.90	P	2780432044	M T TURNER				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
	02		121914	S5130	12.90	12.90	P			000		0.00	0.00
1048222	1435400621888100A				29.90	29.90	P	4107048001	V MCFADDEN				

$668.15

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CERT. PG TOT | MEDICAID PG TOT

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CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058424 | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

1063422988 | DEPT OF HEALTH AND HUMAN SERVICES | 01/02/2015 | 7

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		121914	T1019	17.00	17.00	P			000		0.00	0.00
	02		121914	S5130	12.90	12.90	P			000		0.00	0.00
1048951	14354006228888100A				46.90	46.90	P	2108057301	J BROOKS				
	01		121914	S5130	12.90	12.90	P			000		0.00	0.00
	02		121914	T1019	34.00	34.00	P			000		0.00	0.00
1050002	14354006238888100A				59.80	59.80	P	3106156201	M L SINGLETON				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
	02		121914	S5130	25.80	25.80	P			000		0.00	0.00
1052939	14354006248888100A				34.00	34.00	P	0102002701	B PRIOLEAU				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
1053178	14354006258888100A				32.30	0.00	R	0780818325	S M STANLEY				
	01		121914	T1019	32.30	0.00	R			000		0.00	0.00
									EDITS: L01 951				
1053430	14354006268888100A				96.90	96.90	P	5607273201	L P OTT				
	01		120914	T1019	51.00	51.00	P			000		0.00	0.00
	02		121914	T1019	45.90	45.90	P			000		0.00	0.00
1053456	14354006278888100A				37.40	37.40	P	5780843758	B R MORRILL				
	01		121914	T1019	37.40	37.40	P			000		0.00	0.00
1053931	14354006288888100A				88.40	88.40	P	2780870723	C COOK				
	01		121914	T1019	88.40	88.40	P			000		0.00	0.00
1055390	14354006298888100A				34.00	34.00	P	0715045901	D G BROWN				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
1055545	14354006308888100A				46.90	46.90	P	9100493602	H W RANDOLPH				
	01		121914	S5130	12.90	12.90	P			000		0.00	0.00
	02		121914	T1019	34.00	34.00	P			000		0.00	0.00
1056019	14354006318888100A				46.90	46.90	P	0780925395	S G BROOKS				
	01		121914	S5130	12.90	12.90	P			000		0.00	0.00

$491.20

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IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058425 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 8

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	02		121914	T1019	34.00	34.00	P			000		0.00	0.00
1056240	1435400632888100A				68.00	68.00	P	5781085266	D O IWEGBUE				
	01		120914	T1019	68.00	68.00	P			000		0.00	0.00
1056439	1435400633888100A				49.30	49.30	P	1630239869	M D SINGLETON				
	01		121914	T1019	15.30	15.30	P			000		0.00	0.00
	02		121914	T1019	34.00	34.00	P			000		0.00	0.00
1056598	1435400634888100A				30.60	30.60	P	5182563502	S A MUCKELVANEY				
	01		121914	T1019	30.60	30.60	P			000		0.00	0.00
9600013	1435400635888100A				35.70	35.70	P	3780727363	J C LECLAIR				
	01		121914	T1019	35.70	35.70	P			000		0.00	0.00
9601882	1435400636888100A				63.90	63.90	P	1781134836	J SINGLETON JR				
	01		121914	S5130	10.32	10.32	P			000		0.00	0.00
	02		121914	T1019	39.10	39.10	P			000		0.00	0.00
	03		121914	S5130	2.58	2.58	P			000		0.00	0.00
	04		121914	T1019	11.90	11.90	P			000		0.00	0.00
9602100	1435400637888100A				63.90	63.90	P	1107733501	L M PAGE				
	01		121914	S5130	12.90	12.90	P			000		0.00	0.00
	02		121914	T1019	51.00	51.00	P			000		0.00	0.00
9602136	1435400638888100A				42.80	42.80	P	8726370301	M B SMITH				
	01		121914	S5130	25.80	25.80	P			000		0.00	0.00
	02		121914	T1019	17.00	17.00	P			000		0.00	0.00
9603628	1435400639888100A				81.60	81.60	P	6558889001	L M HARRIS				
	01		121914	T1019	81.60	81.60	P			000		0.00	0.00
9604737	1435400640888100A				34.00	34.00	P	7729773201	S E ALSTON				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
9605190	1435400641888100A				66.30	66.30	P	9781024819	E S THEOBALD				
	01		121914	T1019	66.30	66.30	P			000		0.00	0.00

$536.10

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CERTIFIED AMT | MEDICAID TOTAL

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058426 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 9

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
9605752	14354006428888100A				55.81	55.81	P	4105281901	J WASHINGTON				
	01		121914	S5130	11.61	11.61	P			000		0.00	0.00
	02		121914	T1019	44.20	44.20	P			000		0.00	0.00
9613479	14354006438888100A				30.60	30.60	P	8781273683	K P BOYD				
	01		121914	T1019	30.60	30.60	P			000		0.00	0.00
9616105	14354006448888100A				30.60	30.60	P	1781331779	K U BOYD				
	01		121914	T1019	30.60	30.60	P			000		0.00	0.00
9622104	14354006458888100A				28.90	28.90	P	5730567001	M D GIBSON				
	01		121914	T1019	28.90	28.90	P			000		0.00	0.00
9623565	14354006468888100A				56.69	56.69	P	6781410284	R S SANDERS				
	01		120814	T1019	42.50	42.50	P			000		0.00	0.00
	02		120814	S5130	14.19	14.19	P			000		0.00	0.00
9623713	14354006478888100A				34.00	34.00	P	1107209301	S BROWN				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
9637474	14354006488888100A				34.00	34.00	P	5780433859	J BROOKINS				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
9639410	14354006498888100A				62.90	62.90	P	1781301837	G L BRYANT				
	01		121914	T1019	62.90	62.90	P			000		0.00	0.00
9642075	14354006508888100A				46.90	46.90	P	0086572201	L JEFFERSON				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
	02		121914	S5130	12.90	12.90	P			000		0.00	0.00
9642179	14354006518888100A				88.40	88.40	P	0781568307	R J HUANG				
	01		121914	T1019	88.40	88.40	P			000		0.00	0.00
9646177	14354006528888100A				75.60	71.82	P	3781484082	S A BROWN				
	01		121914	T1003	75.60	71.82	P			000		0.00	0.00

$540.62

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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CERTIFIED AMT | MEDICAID TOTAL | CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058427 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 10

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
9649580	1435400653888100A				34.00	34.00	P	9780580973	B HALL				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
9650394	1435400654888100A				302.40	287.28	P	7781528787	M N BROWN				
	01		121214	T1003	128.80	122.36	P			000		0.00	0.00
	02		121914	T1003	173.60	164.92	P			000		0.00	0.00
9650999	1435400655888100A				62.50	62.50	P	8960252301	H RIGBY				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
	02		121914	X0273	28.50	28.50	P			000		0.00	0.00
9652816	1435400656888100A				44.20	44.20	P	0781657439	W POWELL				
	01		121914	T1019	44.20	44.20	P			000		0.00	0.00
9653656	1435400657888100A				23.45	23.45	P	4108310201	H B HARRELL				
	01		121914	S5130	6.45	6.45	P			000		0.00	0.00
	02		121914	T1019	17.00	17.00	P			000		0.00	0.00
9656068	1435400658888100A				63.90	63.90	P	1780548440	V L JOHNSON				
	01		121914	T1019	51.00	51.00	P			000		0.00	0.00
	02		121914	S5130	12.90	12.90	P			000		0.00	0.00
9661458	1435400659888100A				34.00	34.00	P	6721948901	M F DAVIS				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
9661760	1435400660888100A				34.00	34.00	P	4781947739	M JORDAN				
	01		121914	T1019	34.00	34.00	P			000		0.00	0.00
9663483	1435400661888100A				316.40	300.58	P	2781624221	S M SMILEY				
	01		121914	T1003	316.40	300.58	P			000		0.00	0.00
1035609	1435500445810200A				34.00	34.00	P	3106809101	P L SINGLETARY				
	01		122014	T1019	34.00	34.00	P			000		0.00	0.00
1039718	1435500446810200A				46.90	46.90	P	4108888201	C MILLER				
	01		122014	S5130	12.90	12.90	P			000		0.00	0.00
	02		122014	T1019	34.00	34.00	P			000		0.00	0.00

$964.81

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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL | CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058428 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 11

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
1048200	1435500447810200A				42.21	42.21	P	2780432044	M T TURNER				
	01		122014	T1019	30.60	30.60	P			000		0.00	0.00
	02		122014	S5130	11.61	11.61	P			000		0.00	0.00
1048951	1435500448810200A				34.00	34.00	P	2108057301	J BROOKS				
	01		122014	T1019	34.00	34.00	P			000		0.00	0.00
1050002	1435500449810200A				29.90	29.90	P	3106156201	M L SINGLETON				
	01		122014	S5130	12.90	12.90	P			000		0.00	0.00
	02		122014	T1019	17.00	17.00	P			000		0.00	0.00
1052939	1435500450810200A				34.00	34.00	P	0102002701	B PRIOLEAU				
	01		122014	T1019	34.00	34.00	P			000		0.00	0.00
1053931	1435500451810200A				257.80	248.14	P	2780870723	C COOK				
	01		122014	T1003	193.20	183.54	P			000		0.00	0.00
	02		122014	T1019	64.60	64.60	P			000		0.00	0.00
1056019	1435500452810200A				34.00	34.00	P	0780925395	S G BROOKS				
	01		122014	T1019	34.00	34.00	P			000		0.00	0.00
9601882	1435500453810200A				63.90	63.90	P	1781134836	J SINGLETON JR				
	01		122014	S5130	10.32	10.32	P			000		0.00	0.00
	02		122014	T1019	39.10	39.10	P			000		0.00	0.00
	03		122014	S5130	2.58	2.58	P			000		0.00	0.00
	04		122014	T1019	11.90	11.90	P			000		0.00	0.00
9602100	1435500454810200A				34.00	34.00	P	1107733501	L M PAGE				
	01		122014	T1019	34.00	34.00	P			000		0.00	0.00
9602136	1435500455810200A				83.30	83.30	P	8726370301	M B SMITH				
	01		122014	T1019	83.30	83.30	P			000		0.00	0.00
9603628	1435500456810200A				119.00	119.00	P	6558889001	L M HARRIS				
	01		122014	T1019	119.00	119.00	P			000		0.00	0.00
						$722.45							

CERT. PG TOT — MEDICAID PG TOT

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CHECK TOTAL — CHECK NUMBER

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LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058429 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 12

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
9604737	1435500457810200A				51.00	51.00	P	7729773201	S E ALSTON				
	01		122014	T1019	51.00	51.00	P			000		0.00	0.00
9637474	1435500458810200A				34.00	34.00	P	5780433859	J BROOKINS				
	01		122014	T1019	34.00	34.00	P			000		0.00	0.00
9650394	1435500459810200A				168.00	159.60	P	7781528787	M N BROWN				
	01		122014	T1003	168.00	159.60	P			000		0.00	0.00
9652816	1435500460810200A				44.20	44.20	P	0781657439	W POWELL				
	01		122014	T1019	44.20	44.20	P			000		0.00	0.00
9661458	1435500461810200A				17.00	17.00	P	6721948901	M F DAVIS				
	01		122014	T1019	17.00	17.00	P			000		0.00	0.00
1035609	1435700906810800A				68.00	68.00	P	3106809101	P L SINGLETARY				
	01		122114	T1019	34.00	34.00	P			000		0.00	0.00
	02		122214	T1019	34.00	34.00	P			000		0.00	0.00
1039718	1435700907810800A				79.20	79.20	P	4108888201	C MILLER				
	01		122114	T1019	34.00	34.00	P			000		0.00	0.00
	02		122214	S5130	12.90	12.90	P			000		0.00	0.00
	03		122214	T1019	32.30	32.30	P			000		0.00	0.00
1041158	1435700908810800A				46.90	46.90	P	1605964401	T JEFFERSON				
	01		122214	T1019	34.00	34.00	P			000		0.00	0.00
	02		122214	S5130	12.90	12.90	P			000		0.00	0.00
1042533	1435700909810800A				170.00	170.00	P	2100383302	J P NEWMAN				
	01		122114	T1019	91.80	91.80	P			000		0.00	0.00
	02		122214	T1019	78.20	78.20	P			000		0.00	0.00
1043080	1435700910810800A				59.80	59.80	P	7101399301	J SIMPSON				
	01		122214	S5130	25.80	25.80	P			000		0.00	0.00
	02		122214	T1019	34.00	34.00	P			000		0.00	0.00
1044837	1435700911810800A				105.40	105.40	P	2100383303	J S TAYLOR				

$835.10

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058430 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 13

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		122214	T1019	105.40	105.40	P			000		0.00	0.00
1048200	1435700912810800A				76.80	76.80	P	2780432044	M T TURNER				
	01		122114	T1019	17.00	17.00	P			000		0.00	0.00
	02		122114	S5130	12.90	12.90	P			000		0.00	0.00
	03		122214	T1019	34.00	34.00	P			000		0.00	0.00
	04		122214	S5130	12.90	12.90	P			000		0.00	0.00
1048222	1435700913810800A				32.89	32.89	P	4107048001	V MCFADDEN				
	01		122214	T1019	18.70	18.70	P			000		0.00	0.00
	02		122214	S5130	14.19	14.19	P			000		0.00	0.00
1048951	1435700914810800A				80.90	80.90	P	2108057301	J BROOKS				
	01		122114	T1019	34.00	34.00	P			000		0.00	0.00
	02		122214	S5130	12.90	12.90	P			000		0.00	0.00
	03		122214	T1019	34.00	34.00	P			000		0.00	0.00
1050002	1435700915810800A				59.80	59.80	P	3106156201	M L SINGLETON				
	01		122214	T1019	34.00	34.00	P			000		0.00	0.00
	02		122214	S5130	25.80	25.80	P			000		0.00	0.00
1052939	1435700916810800A				34.00	34.00	P	0102002701	B PRIOLEAU				
	01		122214	T1019	34.00	34.00	P			000		0.00	0.00
1053456	1435700917810800A				52.70	52.70	P	5780843758	B R MORRILL				
	01		122214	T1019	52.70	52.70	P			000		0.00	0.00
1053931	1435700918810800A				281.00	271.20	P	2780870723	C COOK				
	01		122114	T1003	196.00	186.20	P			000		0.00	0.00
	02		122114	T1019	85.00	85.00	P			000		0.00	0.00
1055390	1435700919810800A				59.80	59.80	P	0715045901	D G BROWN				
	01		120814	S5130	25.80	25.80	P			000		0.00	0.00
	02		122214	T1019	34.00	34.00	P			000		0.00	0.00
1055545	1435700920810800A				46.90	46.90	P	9100493602	H W RANDOLPH				
	01		122214	S5130	12.90	12.90	P			000		0.00	0.00

$714.99

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
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S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058431 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 14

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	02		122214	T1019	34.00	34.00	P			000		0.00	0.00
1056019	1435700921810800A				80.90	80.90	P	0780925395	S G BROOKS				
	01		122114	T1019	34.00	34.00	P			000		0.00	0.00
	02		122214	S5130	12.90	12.90	P			000		0.00	0.00
	03		122214	T1019	34.00	34.00	P			000		0.00	0.00
1056439	1435700922810800A				51.00	51.00	P	1630239869	M D SINGLETON				
	01		122214	T1019	51.00	51.00	P			000		0.00	0.00
1056598	1435700923810800A				34.00	34.00	P	5182563502	S A MUCKELVANEY				
	01		122214	T1019	34.00	34.00	P			000		0.00	0.00
9601882	1435700924810800A				64.02	64.02	P	1781134836	J SINGLETON JR				
	01		122114	S5130	12.90	12.90	P			000		0.00	0.00
	02		122214	S5130	10.32	10.32	P			000		0.00	0.00
	03		122214	T1019	40.80	40.80	P			000		0.00	0.00
9602100	1435700925810800A				35.82	35.82	P	1107733501	L M PAGE				
	01		122114	T1019	25.50	25.50	P			000		0.00	0.00
	02		122214	S5130	10.32	10.32	P			000		0.00	0.00
9602136	1435700926810800A				42.80	42.80	P	8726370301	M B SMITH				
	01		122214	S5130	25.80	25.80	P			000		0.00	0.00
	02		122214	T1019	17.00	17.00	P			000		0.00	0.00
9603628	1435700927810800A				51.00	51.00	P	6558889001	L M HARRIS				
	01		121014	T1019	51.00	51.00	P			000		0.00	0.00
9604737	1435700928810800A				51.00	51.00	P	7729773201	S E ALSTON				
	01		122214	T1019	51.00	51.00	P			000		0.00	0.00
9605190	1435700929810800A				64.60	64.60	P	9781024819	E S THEOBALD				
	01		122214	T1019	64.60	64.60	P			000		0.00	0.00
9605752	1435700930810800A				49.42	49.42	P	4105281901	J WASHINGTON				
	01		122214	S5130	10.32	10.32	P			000		0.00	0.00

$524.56

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058432 | DEPT OF HEALTH AND HUMAN SERVICES | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

1063422988 | SOUTH CAROLINA MEDICAID PROGRAM | REMITTANCE ADVICE | 01/02/2015 | 15

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	MOD	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	02		122214	T1019	39.10	39.10	P			000		0.00	0.00
9613401	1435700931810800A				47.60	47.60	P	4780915876	C D SMITH				
	01		122114	T1019	28.90	28.90	P			000		0.00	0.00
	02		122214	T1019	18.70	18.70	P			000		0.00	0.00
9613479	1435700932810800A				62.90	62.90	P	8781273683	K P BOYD				
	01		121014	T1019	28.90	28.90	P			000		0.00	0.00
	02		122214	T1019	34.00	34.00	P			000		0.00	0.00
9616105	1435700933810800A				34.00	34.00	P	1781331779	K U BOYD				
	01		122214	T1019	34.00	34.00	P			000		0.00	0.00
9620895	1435700934810800A				47.60	47.60	P	4780705471	B C MAI				
	01		122114	T1019	28.90	28.90	P			000		0.00	0.00
	02		122214	T1019	18.70	18.70	P			000		0.00	0.00
9622104	1435700935810800A				35.70	35.70	P	5730567001	M D GIBSON				
	01		122214	T1019	35.70	35.70	P			000		0.00	0.00
9623565	1435700936810800A				78.85	78.85	P	6781410284	R S SANDERS				
	01		122214	T1019	59.50	59.50	P			000		0.00	0.00
	02		122214	S5130	19.35	19.35	P			000		0.00	0.00
9623713	1435700937810800A				34.00	34.00	P	1107209301	S BROWN				
	01		121014	T1019	34.00	34.00	P			000		0.00	0.00
9637474	1435700938810800A				68.00	68.00	P	5780433859	J BROOKINS				
	01		122114	T1019	34.00	34.00	P			000		0.00	0.00
	02		122214	T1019	34.00	34.00	P			000		0.00	0.00
9639410	1435700939810800A				137.70	137.70	P	1781301837	G L BRYANT				
	01		122114	T1019	73.10	73.10	P			000		0.00	0.00
	02		122214	T1019	64.60	64.60	P			000		0.00	0.00
9642075	1435700940810800A				46.90	46.90	P	0086572201	L JEFFERSON				
	01		122214	T1019	34.00	34.00	P			000		0.00	0.00

$593.25

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058433 | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

1063422988 | DEPT OF HEALTH AND HUMAN SERVICES | 01/02/2015 | 16

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	02		122214	S5130	12.90	12.90	P			000		0.00	0.00
9642179	1435700941810800A				154.70	154.70	P	0781568307	R J HUANG				
	01		122214	T1019	69.70	69.70	P			000		0.00	0.00
	02		122214	T1019	85.00	85.00	P			000		0.00	0.00
9643386	1435700942810800A				34.00	34.00	P	8730335701	M NARODNITSKAYA				
	01		122214	T1019	34.00	34.00	P			000		0.00	0.00
9646177	1435700943810800A				204.40	194.18	P	3781484082	S A BROWN				
	01		122214	T1003	204.40	194.18	P			000		0.00	0.00
9649580	1435700944810800A				68.00	68.00	P	9780580973	B HALL				
	01		122114	T1019	34.00	34.00	P			000		0.00	0.00
	02		122214	T1019	34.00	34.00	P			000		0.00	0.00
9650393	1435700945810800A				39.40	39.40	P	1555072602	E HAYNES				
	01		122214	S5130	12.90	12.90	P			000		0.00	0.00
	02		122214	T1019	17.00	17.00	P			000		0.00	0.00
	03		122214	X0273	9.50	9.50	P			000		0.00	0.00
9650394	1435700946810800A				173.60	164.92	P	7781528787	M N BROWN				
	01		122214	T1003	173.60	164.92	P			000		0.00	0.00
9650999	1435700947810800A				34.00	34.00	P	8960252301	H RIGBY				
	01		122214	T1019	34.00	34.00	P			000		0.00	0.00
9652816	1435700948810800A				85.00	85.00	P	0781657439	W POWELL				
	01		122114	T1019	34.00	34.00	P			000		0.00	0.00
	02		122214	T1019	51.00	51.00	P			000		0.00	0.00
9653656	1435700949810800A				46.90	46.90	P	4108310201	H B HARRELL				
	01		122214	S5130	12.90	12.90	P			000		0.00	0.00
	02		122214	T1019	34.00	34.00	P			000		0.00	0.00
9656068	1435700950810800A				63.90	63.90	P	1780548440	V L JOHNSON				
	01		122214	T1019	51.00	51.00	P			000		0.00	0.00

$885.00

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058434 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 17

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	02		122214	S5130	12.90	12.90	P			000		0.00	0.00
9661458	1435700951810800A				102.00	102.00	P	6721948901	M F DAVIS				
	01		122114	T1019	68.00	68.00	P			000		0.00	0.00
	02		122214	T1019	34.00	34.00	P			000		0.00	0.00
9661760	1435700952810800A				34.00	34.00	P	4781947739	M JORDAN				
	01		122214	T1019	34.00	34.00	P			000		0.00	0.00
9663483	1435700953810800A				319.20	303.24	P	2781624221	S M SMILEY				
	01		122214	T1003	319.20	303.24	P			000		0.00	0.00
9665495	1435700954810800A				39.10	39.10	P	5781243820	A E OUZTS				
	01		122214	T1019	39.10	39.10	P			000		0.00	0.00
9667527	1435700955810800A				46.90	46.90	P	3102250401	M J MAZYCK				
	01		122214	S5130	12.90	12.90	P			000		0.00	0.00
	02		122214	T1019	34.00	34.00	P			000		0.00	0.00
1035609	1435800848810800A				34.00	34.00	P	3106809101	P L SINGLETARY				
	01		122314	T1019	34.00	34.00	P			000		0.00	0.00
1039718	1435800849810800A				46.90	46.90	P	4108888201	C MILLER				
	01		122314	S5130	12.90	12.90	P			000		0.00	0.00
	02		122314	T1019	34.00	34.00	P			000		0.00	0.00
1041158	1435800850810800A				46.90	46.90	P	1605964401	T JEFFERSON				
	01		122314	T1019	34.00	34.00	P			000		0.00	0.00
	02		122314	S5130	12.90	12.90	P			000		0.00	0.00
1043080	1435800851810800A				59.80	59.80	P	7101399301	J SIMPSON				
	01		122314	S5130	25.80	25.80	P			000		0.00	0.00
	02		122314	T1019	34.00	34.00	P			000		0.00	0.00
1044837	1435800852810800A				85.00	85.00	P	2100383303	J S TAYLOR				
	01		122314	T1019	85.00	85.00	P			000		0.00	0.00
						$797.84							

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058435 | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

1063422988 | DEPT OF HEALTH AND HUMAN SERVICES | 01/02/2015 | 18

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
1048200	1435800853810800A				46.90	46.90	P	2780432044	M T TURNER				
	01		122314	T1019	34.00	34.00	P			000		0.00	0.00
	02		122314	S5130	12.90	12.90	P			000		0.00	0.00
1048222	1435800854810800A				29.90	29.90	P	4107048001	V MCFADDEN				
	01		122314	T1019	17.00	17.00	P			000		0.00	0.00
	02		122314	S5130	12.90	12.90	P			000		0.00	0.00
1048951	1435800855810800A				46.90	46.90	P	2108057301	J BROOKS				
	01		122314	S5130	12.90	12.90	P			000		0.00	0.00
	02		122314	T1019	34.00	34.00	P			000		0.00	0.00
1050002	1435800856810800A				29.90	29.90	P	3106156201	M L SINGLETON				
	01		122314	S5130	12.90	12.90	P			000		0.00	0.00
	02		122314	T1019	17.00	17.00	P			000		0.00	0.00
1052939	1435800857810800A				34.00	34.00	P	0102002701	B PRIOLEAU				
	01		122314	T1019	34.00	34.00	P			000		0.00	0.00
1053456	1435800858810800A				52.70	52.70	P	5780843758	B R MORRILL				
	01		122314	T1019	52.70	52.70	P			000		0.00	0.00
1053931	1435800859810800A				86.70	86.70	P	2780870723	C COOK				
	01		122314	T1019	86.70	86.70	P			000		0.00	0.00
1055390	1435800860810800A				63.90	63.90	P	0715045901	D G BROWN				
	01		122314	S5130	12.90	12.90	P			000		0.00	0.00
	02		122314	T1019	51.00	51.00	P			000		0.00	0.00
1055416	1435800861810800A				44.20	44.20	P	5101694402	J T WASHINGTON				
	01		122314	T1019	44.20	44.20	P			000		0.00	0.00
1056019	1435800862810800A				46.90	46.90	P	0780925395	S G BROOKS				
	01		122314	S5130	12.90	12.90	P			000		0.00	0.00
	02		122314	T1019	34.00	34.00	P			000		0.00	0.00
1056240	1435800863810800A				74.80	74.80	P	5781085266	D O IWEGBUE				

$556.80

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CERT. PG TOT | MEDICAID PG TOT

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CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058436 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 19

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		122314	T1019	74.80	74.80	P			000		0.00	0.00
1056439	14358008648108 00A				90.10	90.10	P	1630239869	M D SINGLETON				
	01		122314	T1019	90.10	90.10	P			000		0.00	0.00
1056598	14358008658108 00A				32.30	32.30	P	5182563502	S A MUCKELVANEY				
	01		122314	T1019	32.30	32.30	P			000		0.00	0.00
9601882	14358008668108 00A				63.90	63.90	P	1781134836	J SINGLETON JR				
	01		122314	S5130	10.32	10.32	P			000		0.00	0.00
	02		122314	T1019	39.10	39.10	P			000		0.00	0.00
	03		122314	S5130	2.58	2.58	P			000		0.00	0.00
	04		122314	T1019	11.90	11.90	P			000		0.00	0.00
9602100	14358008678108 00A				62.20	62.20	P	1107733501	L M PAGE				
	01		122314	S5130	12.90	12.90	P			000		0.00	0.00
	02		122314	T1019	49.30	49.30	P			000		0.00	0.00
9604737	14358008688108 00A				51.00	51.00	P	7729773201	S E ALSTON				
	01		122314	T1019	35.70	35.70	P			000		0.00	0.00
	02		122314	T1019	15.30	15.30	P			000		0.00	0.00
9605190	14358008698108 00A				32.30	32.30	P	9781024819	E S THEOBALD				
	01		122314	T1019	32.30	32.30	P			000		0.00	0.00
9605752	14358008708108 00A				49.42	49.42	P	4105281901	J WASHINGTON				
	01		122314	S5130	10.32	10.32	P			000		0.00	0.00
	02		122314	T1019	39.10	39.10	P			000		0.00	0.00
9613401	14358008718108 00A				18.70	18.70	P	4780915876	C D SMITH				
	01		122314	T1019	18.70	18.70	P			000		0.00	0.00
9613479	14358008728108 00A				35.70	35.70	P	8781273683	K P BOYD				
	01		122314	T1019	35.70	35.70	P			000		0.00	0.00
9616105	14358008738108 00A				35.70	35.70	P	1781331779	K U BOYD				
	01		122314	T1019	35.70	35.70	P			000		0.00	0.00
						$471.32							

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058437 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 20

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
9620895	1435800874810800A				18.70	18.70	P	4780705471	B C MAI				
	01		122314	T1019	18.70	18.70	P			000		0.00	0.00
9622104	1435800875810800A				35.70	35.70	P	5730567001	M D GIBSON				
	01		122314	T1019	35.70	35.70	P			000		0.00	0.00
9623713	1435800876810800A				34.00	34.00	P	1107209301	S BROWN				
	01		122314	T1019	34.00	34.00	P			000		0.00	0.00
9637474	1435800877810800A				34.00	34.00	P	5780433859	J BROOKINS				
	01		122314	T1019	34.00	34.00	P			000		0.00	0.00
9639410	1435800878810800A				68.00	68.00	P	1781301837	G L BRYANT				
	01		122314	T1019	68.00	68.00	P			000		0.00	0.00
9642075	1435800879810800A				46.90	46.90	P	0086572201	L JEFFERSON				
	01		122314	T1019	34.00	34.00	P			000		0.00	0.00
	02		122314	S5130	12.90	12.90	P			000		0.00	0.00
9642179	1435800880810800A				86.70	86.70	P	0781568307	R J HUANG				
	01		122314	T1019	86.70	86.70	P			000		0.00	0.00
9646177	1435800881810800A				224.00	212.80	P	3781484082	S A BROWN				
	01		122314	T1003	224.00	212.80	P			000		0.00	0.00
9649580	1435800882810800A				32.30	32.30	P	9780580973	B HALL				
	01		122314	T1019	32.30	32.30	P			000		0.00	0.00
9650393	1435800883810800A				39.40	39.40	P	1555072602	E HAYNES				
	01		122314	S5130	12.90	12.90	P			000		0.00	0.00
	02		122314	T1019	17.00	17.00	P			000		0.00	0.00
	03		122314	X0273	9.50	9.50	P			000		0.00	0.00
9650999	1435800884810800A				34.00	34.00	P	8960252301	H RIGBY				
	01		122314	T1019	34.00	34.00	P			000		0.00	0.00

$642.50

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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL | CHECK TOTAL | CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058438 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 21

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
9652816	1435800885810800A				51.00	51.00	P	0781657439	W POWELL				
	01		122314	T1019	51.00	51.00	P			000		0.00	0.00
9653656	1435800886810800A				31.13	31.13	P	4108310201	H B HARRELL				
	01		122314	S5130	9.03	9.03	P			000		0.00	0.00
	02		122314	T1019	22.10	22.10	P			000		0.00	0.00
9656068	1435800887810800A				63.90	63.90	P	1780548440	V L JOHNSON				
	01		122314	T1019	51.00	51.00	P			000		0.00	0.00
	02		122314	S5130	12.90	12.90	P			000		0.00	0.00
9661458	1435800888810800A				34.00	34.00	P	6721948901	M F DAVIS				
	01		122314	T1019	34.00	34.00	P			000		0.00	0.00
9661760	1435800889810800A				34.00	34.00	P	4781947739	M JORDAN				
	01		122314	T1019	34.00	34.00	P			000		0.00	0.00
9663483	1435800890810800A				313.60	297.92	P	2781624221	S M SMILEY				
	01		122314	T1003	313.60	297.92	P			000		0.00	0.00
9665495	1435800891810800A				37.40	37.40	P	5781243820	A E OUZTS				
	01		122314	T1019	37.40	37.40	P			000		0.00	0.00
9667527	1435800892810800A				45.20	45.20	P	3102250401	M J MAZYCK				
	01		122314	S5130	12.90	12.90	P			000		0.00	0.00
	02		122314	T1019	32.30	32.30	P			000		0.00	0.00
1035609	1435900708810500A				34.00	34.00	P	3106809101	P L SINGLETARY				
	01		122414	T1019	34.00	34.00	P			000		0.00	0.00
1041158	1435900709810500A				46.90	46.90	P	1605964401	T JEFFERSON				
	01		122414	T1019	34.00	34.00	P			000		0.00	0.00
	02		122414	S5130	12.90	12.90	P			000		0.00	0.00
1043080	1435900710810500A				59.80	59.80	P	7101399301	J SIMPSON				
	01		122414	S5130	25.80	25.80	P			000		0.00	0.00
	02		122414	T1019	34.00	34.00	P			000		0.00	0.00
						$735.25							

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
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S = IN PROCESS
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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058439 | DEPT OF HEALTH AND HUMAN SERVICES | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

1063422988 | SOUTH CAROLINA MEDICAID PROGRAM | REMITTANCE ADVICE | 01/02/2015 | 22

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
1044837	1435900711810500A				30.60	30.60	P	2100383303	J S TAYLOR				
	01		122414	T1019	30.60	30.60	P			000		0.00	0.00
1048200	1435900712810500A				46.90	46.90	P	2780432044	M T TURNER				
	01		122414	T1019	34.00	34.00	P			000		0.00	0.00
	02		122414	S5130	12.90	12.90	P			000		0.00	0.00
1048222	1435900713810500A				32.89	32.89	P	4107048001	V MCFADDEN				
	01		122414	T1019	18.70	18.70	P			000		0.00	0.00
	02		122414	S5130	14.19	14.19	P			000		0.00	0.00
1048951	1435900714810500A				46.90	46.90	P	2108057301	J BROOKS				
	01		122414	S5130	12.90	12.90	P			000		0.00	0.00
	02		122414	T1019	34.00	34.00	P			000		0.00	0.00
1050002	1435900715810500A				34.00	34.00	P	3106156201	M L SINGLETON				
	01		122414	T1019	34.00	34.00	P			000		0.00	0.00
1052939	1435900716810500A				34.00	34.00	P	0102002701	B PRIOLEAU				
	01		122414	T1019	34.00	34.00	P			000		0.00	0.00
1053178	1435900717810500A				47.60	0.00	R	0780818325	S M STANLEY				
	01		122414	T1019	47.60	0.00	R			000		0.00	0.00
									EDITS: L01 951				
1053931	1435900718810500A				81.60	81.60	P	2780870723	C COOK				
	01		122414	T1019	81.60	81.60	P			000		0.00	0.00
1055416	1435900719810500A				35.70	35.70	P	5101694402	J T WASHINGTON				
	01		122414	T1019	35.70	35.70	P			000		0.00	0.00
1055545	1435900720810500A				46.90	46.90	P	9100493602	H W RANDOLPH				
	01		122414	S5130	12.90	12.90	P			000		0.00	0.00
	02		122414	T1019	34.00	34.00	P			000		0.00	0.00
1056019	1435900721810500A				46.90	46.90	P	0780925395	S G BROOKS				

$436.39

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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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E = ENCOUNTER

PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058440 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 23

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	S T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		122414	S5130	12.90	12.90	P			000		0.00	0.00
	02		122414	T1019	34.00	34.00	P			000		0.00	0.00
1056439	1435900722810500A				51.00	51.00	P	1630239869	M D SINGLETON				
	01		122414	T1019	51.00	51.00	P			000		0.00	0.00
9601882	1435900723810500A				54.11	54.11	P	1781134836	J SINGLETON JR				
	01		122414	S5130	7.74	7.74	P			000		0.00	0.00
	02		122414	T1019	27.20	27.20	P			000		0.00	0.00
	03		122414	S5130	3.87	3.87	P			000		0.00	0.00
	04		122414	T1019	15.30	15.30	P			000		0.00	0.00
9602100	1435900724810500A				62.20	62.20	P	1107733501	L M PAGE				
	01		122414	T1019	49.30	49.30	P			000		0.00	0.00
	02		122414	S5130	12.90	12.90	P			000		0.00	0.00
9602136	1435900725810500A				42.80	42.80	P	8726370301	M B SMITH				
	01		122414	S5130	25.80	25.80	P			000		0.00	0.00
	02		122414	T1019	17.00	17.00	P			000		0.00	0.00
9604737	1435900726810500A				51.00	51.00	P	7729773201	S E ALSTON				
	01		122414	T1019	37.40	37.40	P			000		0.00	0.00
	02		122414	T1019	13.60	13.60	P			000		0.00	0.00
9605190	1435900727810500A				49.30	49.30	P	9781024819	E S THEOBALD				
	01		122414	T1019	49.30	49.30	P			000		0.00	0.00
9613401	1435900728810500A				18.70	18.70	P	4780915876	C D SMITH				
	01		122414	T1019	18.70	18.70	P			000		0.00	0.00
9613479	1435900729810500A				35.70	35.70	P	8781273683	K P BOYD				
	01		122414	T1019	35.70	35.70	P			000		0.00	0.00
9616105	1435900730810500A				35.70	35.70	P	1781331779	K U BOYD				
	01		122414	T1019	35.70	35.70	P			000		0.00	0.00
9620895	1435900731810500A				18.70	18.70	P	4780705471	B C MAI				

$419.21

CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058441 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES — REMITTANCE ADVICE — 01/02/2015 — 24

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		122414	T1019	18.70	18.70	P			000		0.00	0.00
9622104	1435900732810500A				35.70	35.70	P	5730567001	M D GIBSON				
	01		122414	T1019	35.70	35.70	P			000		0.00	0.00
9623713	1435900733810500A				34.00	34.00	P	1107209301	S BROWN				
	01		122414	T1019	34.00	34.00	P			000		0.00	0.00
9637474	1435900734810500A				34.00	34.00	P	5780433859	J BROOKINS				
	01		122414	T1019	34.00	34.00	P			000		0.00	0.00
9639410	1435900735810500A				59.50	59.50	P	1781301837	G L BRYANT				
	01		122414	T1019	59.50	59.50	P			000		0.00	0.00
9642075	1435900736810500A				46.90	46.90	P	0086572201	L JEFFERSON				
	01		122414	T1019	34.00	34.00	P			000		0.00	0.00
	02		122414	S5130	12.90	12.90	P			000		0.00	0.00
9642179	1435900737810500A				56.10	56.10	P	0781568307	R J HUANG				
	01		122414	T1019	56.10	56.10	P			000		0.00	0.00
9646177	1435900738810500A				207.20	196.84	P	3781484082	S A BROWN				
	01		122414	T1003	207.20	196.84	P			000		0.00	0.00
9649580	1435900739810500A				34.00	34.00	P	9780580973	B HALL				
	01		122414	T1019	34.00	34.00	P			000		0.00	0.00
9650999	1435900740810500A				49.05	49.05	P	8960252301	H RIGBY				
	01		122414	T1019	27.20	27.20	P			000		0.00	0.00
	02		122414	X0273	21.85	21.85	P			000		0.00	0.00
9652816	1435900741810500A				51.00	51.00	P	0781657439	W POWELL				
	01		122414	T1019	51.00	51.00	P			000		0.00	0.00
9653656	1435900742810500A				46.90	46.90	P	4108310201	H B HARRELL				
	01		122414	S5130	12.90	12.90	P			000		0.00	0.00
	02		122414	T1019	34.00	34.00	P			000		0.00	0.00

$643.99

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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058442 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 25

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
9656068	1435900743810500A				60.50	60.50	P	1780548440	V L JOHNSON				
	01		122414	T1019	47.60	47.60	P			000		0.00	0.00
	02		122414	S5130	12.90	12.90	P			000		0.00	0.00
9661458	1435900744810500A				34.00	34.00	P	6721948901	M F DAVIS				
	01		122414	T1019	34.00	34.00	P			000		0.00	0.00
9667527	1435900745810500A				45.20	45.20	P	3102250401	M J MAZYCK				
	01		122414	S5130	12.90	12.90	P			000		0.00	0.00
	02		122414	T1019	32.30	32.30	P			000		0.00	0.00
1043080	1436000647810200A				29.90	29.90	P	7101399301	J SIMPSON				
	01		122514	S5130	12.90	12.90	P			000		0.00	0.00
	02		122514	T1019	17.00	17.00	P			000		0.00	0.00
1048200	1436000648810200A				46.90	46.90	P	2780432044	M T TURNER				
	01		122514	T1019	34.00	34.00	P			000		0.00	0.00
	02		122514	S5130	12.90	12.90	P			000		0.00	0.00
1052939	1436000649810200A				34.00	34.00	P	0102002701	B PRIOLEAU				
	01		122514	T1019	34.00	34.00	P			000		0.00	0.00
1053456	1436000650810200A				52.70	52.70	P	5780843758	B R MORRILL				
	01		122514	T1019	52.70	52.70	P			000		0.00	0.00
1053931	1436000651810200A				85.00	85.00	P	2780870723	C COOK				
	01		122514	T1019	85.00	85.00	P			000		0.00	0.00
1056439	1436000652810200A				107.10	107.10	P	1630239869	M D SINGLETON				
	01		122514	T1019	107.10	107.10	P			000		0.00	0.00
1056598	1436000653810200A				34.00	34.00	P	5182563502	S A MUCKELVANEY				
	01		122514	T1019	34.00	34.00	P			000		0.00	0.00
9601882	1436000654810200A				23.86	23.86	P	1781134836	J SINGLETON JR				
	01		122514	S5130	5.16	5.16	P			000		0.00	0.00
						$553.16							

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
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E = ENCOUNTER

PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058443 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 26

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	02		122514	T1019	18.70	18.70	P			000		0.00	0.00
9602100	1436000655810200A				42.50	42.50	P	1107733501	L M PAGE				
	01		122514	T1019	42.50	42.50	P			000		0.00	0.00
9602136	1436000656810200A				42.80	42.80	P	8726370301	M B SMITH				
	01		122514	S5130	25.80	25.80	P			000		0.00	0.00
	02		122514	T1019	17.00	17.00	P			000		0.00	0.00
9604737	1436000657810200A				51.00	51.00	P	7729773201	S E ALSTON				
	01		122514	T1019	51.00	51.00	P			000		0.00	0.00
9605752	1436000658810200A				51.12	51.12	P	4105281901	J WASHINGTON				
	01		122514	S5130	10.32	10.32	P			000		0.00	0.00
	02		122514	T1019	40.80	40.80	P			000		0.00	0.00
9613401	1436000659810200A				20.40	20.40	P	4780915876	C D SMITH				
	01		122514	T1019	20.40	20.40	P			000		0.00	0.00
9620895	1436000660810200A				20.40	20.40	P	4780705471	B C MAI				
	01		122514	T1019	20.40	20.40	P			000		0.00	0.00
9622104	1436000661810200A				35.70	35.70	P	5730567001	M D GIBSON				
	01		122514	T1019	35.70	35.70	P			000		0.00	0.00
9623565	1436000662810200A				51.00	51.00	P	6781410284	R S SANDERS				
	01		122514	T1019	51.00	51.00	P			000		0.00	0.00
9623713	1436000663810200A				34.00	34.00	P	1107209301	S BROWN				
	01		122514	T1019	34.00	34.00	P			000		0.00	0.00
9637474	1436000664810200A				34.00	34.00	P	5780433859	J BROOKINS				
	01		122514	T1019	34.00	34.00	P			000		0.00	0.00
9642075	1436000665810200A				46.90	46.90	P	0086572201	L JEFFERSON				
	01		122514	T1019	34.00	34.00	P			000		0.00	0.00
	02		122514	S5130	12.90	12.90	P			000		0.00	0.00
						$429.82							

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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
9653656	1436000666810200A				46.90	46.90	P	4108310201	H B HARRELL				
	01		122514	S5130	12.90	12.90	P			000		0.00	0.00
	02		122514	T1019	34.00	34.00	P			000		0.00	0.00
9656068	1436000667810200A				51.00	51.00	P	1780548440	V L JOHNSON				
	01		122514	T1019	51.00	51.00	P			000		0.00	0.00
6086367	1436000385810700A				476.00	476.00	P	0182796901	W SHARTS				
	01		121514	T1019	93.50	93.50	P			000		0.00	0.00
	02		121614	T1019	93.50	93.50	P			000		0.00	0.00
	03		121714	T1019	93.50	93.50	P			000		0.00	0.00
	04		121814	T1019	93.50	93.50	P			000		0.00	0.00
	05		121914	T1019	102.00	102.00	P			000		0.00	0.00
6086355	1436000386810700A				238.00	238.00	P	1082756101	T L PERRY				
	01		121314	T1019	34.00	34.00	P			000		0.00	0.00
	02		121414	T1019	34.00	34.00	P			000		0.00	0.00
	03		121514	T1019	34.00	34.00	P			000		0.00	0.00
	04		121614	T1019	34.00	34.00	P			000		0.00	0.00
	05		121714	T1019	34.00	34.00	P			000		0.00	0.00
	06		121814	T1019	34.00	34.00	P			000		0.00	0.00
	07		121914	T1019	34.00	34.00	P			000		0.00	0.00
6086378	1436000387810700A				833.00	833.00	P	2780930711	S O ARCHIE				
	01		121314	X0241	102.00	102.00	P			000		0.00	0.00
	02		121414	X0241	102.00	102.00	P			000		0.00	0.00
	03		121514	X0241	102.00	102.00	P			000		0.00	0.00
	04		121614	X0241	102.00	102.00	P			000		0.00	0.00
	05		121714	X0241	161.50	161.50	P			000		0.00	0.00
	06		121814	X0241	161.50	161.50	P			000		0.00	0.00
	07		121914	X0241	102.00	102.00	P			000		0.00	0.00
6086468	1436000388810700A				357.00	357.00	P	8699818201	I ROBINSON JR				
	01		121314	X0241	51.00	51.00	P			000		0.00	0.00
	02		121414	X0241	51.00	51.00	P			000		0.00	0.00
	03		121514	X0241	51.00	51.00	P			000		0.00	0.00

$2,001.90

CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL | CHECK TOTAL | CHECK NUMBER

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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PROVIDER NAME AND ADDRESS
LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058445 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 28

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	04		121614	X0241	51.00	51.00	P			000		0.00	0.00
	05		121714	X0241	51.00	51.00	P			000		0.00	0.00
	06		121814	X0241	51.00	51.00	P			000		0.00	0.00
	07		121914	X0241	51.00	51.00	P			000		0.00	0.00
6086348	14360003898107O0A				518.50	518.50	P	9534675301	Z R LITCHFIELD				
	01		121314	T1019	68.00	68.00	P			000		0.00	0.00
	02		121414	T1019	76.50	76.50	P			000		0.00	0.00
	03		121514	T1019	68.00	68.00	P			000		0.00	0.00
	04		121614	T1019	68.00	68.00	P			000		0.00	0.00
	05		121714	T1019	68.00	68.00	P			000		0.00	0.00
	06		121814	T1019	76.50	76.50	P			000		0.00	0.00
	07		121914	T1019	93.50	93.50	P			000		0.00	0.00
6086408	14360003908107O0A				357.00	357.00	P	1780171768	M A BARBOT				
	01		121314	T1019	204.00	204.00	P			000		0.00	0.00
	02		121414	T1019	153.00	153.00	P			000		0.00	0.00
6086375	14360003918107O0A				510.00	510.00	P	6780175418	B N YOUNG				
	01		121514	T1019	102.00	102.00	P			000		0.00	0.00
	02		121614	T1019	102.00	102.00	P			000		0.00	0.00
	03		121714	T1019	102.00	102.00	P			000		0.00	0.00
	04		121814	T1019	102.00	102.00	P			000		0.00	0.00
	05		121914	T1019	102.00	102.00	P			000		0.00	0.00
6086342	14360003928107O0A				272.00	272.00	P	9102517201	J L JOYNER				
	01		113014	T1019	170.00	170.00	P			000		0.00	0.00
	02		121814	T1019	34.00	34.00	P			000		0.00	0.00
	03		121914	T1019	34.00	34.00	P			000		0.00	0.00
	04		121414	T1019	34.00	34.00	P			000		0.00	0.00
60866469	14360003938107O0A				833.00	833.00	P	1534471201	T J NEUROTH				
	01		121314	X0241	76.50	76.50	P			000		0.00	0.00
	02		121414	X0241	76.50	76.50	P			000		0.00	0.00
	03		121514	X0241	136.00	136.00	P			000		0.00	0.00
	04		121614	X0241	136.00	136.00	P			000		0.00	0.00
	05		121714	X0241	136.00	136.00	P			000		0.00	0.00
						$2,490.50							

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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058446 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 29

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	06		121814	X0241	136.00	136.00	P			000		0.00	0.00
	07		121914	X0241	136.00	136.00	P			000		0.00	0.00
6086356	1436000394810700A				238.00	238.00	P	1780171771	A K HERRICK				
	01		121314	T1019	34.00	34.00	P			000		0.00	0.00
	02		121414	T1019	34.00	34.00	P			000		0.00	0.00
	03		121514	T1019	34.00	34.00	P			000		0.00	0.00
	04		121614	T1019	34.00	34.00	P			000		0.00	0.00
	05		121714	T1019	34.00	34.00	P			000		0.00	0.00
	06		121814	T1019	34.00	34.00	P			000		0.00	0.00
	07		121914	T1019	34.00	34.00	P			000		0.00	0.00
6086442	1436000395810700A				238.00	238.00	P	3271770901	W J KIRKLAND				
	01		121314	X0241	34.00	34.00	P			000		0.00	0.00
	02		121414	X0241	34.00	34.00	P			000		0.00	0.00
	03		121514	X0241	34.00	34.00	P			000		0.00	0.00
	04		121614	X0241	34.00	34.00	P			000		0.00	0.00
	05		121714	X0241	34.00	34.00	P			000		0.00	0.00
	06		121814	X0241	34.00	34.00	P			000		0.00	0.00
	07		121914	X0241	34.00	34.00	P			000		0.00	0.00
6086376	1436000396810700A				340.00	340.00	P	5080409101	C A LOFTON				
	01		121514	T1019	68.00	68.00	P			000		0.00	0.00
	02		121614	T1019	68.00	68.00	P			000		0.00	0.00
	03		121714	T1019	68.00	68.00	P			000		0.00	0.00
	04		121814	T1019	68.00	68.00	P			000		0.00	0.00
	05		121914	T1019	68.00	68.00	P			000		0.00	0.00
6086350	1436000397810700A				560.00	532.00	P	9086510102	A L CAUSEY				
	01		121314	T1003	112.00	106.40	P			000		0.00	0.00
	02		121514	T1003	112.00	106.40	P			000		0.00	0.00
	03		121614	T1003	112.00	106.40	P			000		0.00	0.00
	04		121714	T1003	112.00	106.40	P			000		0.00	0.00
	05		121814	T1003	112.00	106.40	P			000		0.00	0.00
6086466	1436000398810700A				255.00	255.00	P	7718185201	D L GOLLATTSCHECK				
	01		121514	T1019	51.00	51.00	P			000		0.00	0.00
						$1,603.00							

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058447 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 30

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	02		121614	T1019	51.00	51.00	P			000		0.00	0.00
	03		121714	T1019	51.00	51.00	P			000		0.00	0.00
	04		121814	T1019	51.00	51.00	P			000		0.00	0.00
	05		121914	T1019	51.00	51.00	P			000		0.00	0.00
6086353	14360003998107 00A				297.50	0.00	R	4780946627	D A REAFLER				
	01		121314	T1019	102.00	0.00	R			000		0.00	0.00
	02		121514	T1019	127.50	0.00	R			000		0.00	0.00
	03		121714	T1019	68.00	0.00	R			000		0.00	0.00
									EDITS: L01 712		L01 717		
									EDITS: L01 883		L02 712		
									EDITS: L02 717		L02 883		
									EDITS: L03 712		L03 717		
									EDITS: L03 883				
6086346	14360004008107 00A				476.00	476.00	P	0605646801	B L LEWIS				
	01		121314	T1019	68.00	68.00	P			000		0.00	0.00
	02		121414	T1019	68.00	68.00	P			000		0.00	0.00
	03		121514	T1019	68.00	68.00	P			000		0.00	0.00
	04		121614	T1019	68.00	68.00	P			000		0.00	0.00
	05		121714	T1019	68.00	68.00	P			000		0.00	0.00
	06		121814	T1019	68.00	68.00	P			000		0.00	0.00
	07		121914	T1019	68.00	68.00	P			000		0.00	0.00
6086345	14360004018107 00A				1631.00	1549.45	P	1780171768	M A BARBOT				
	01		121514	T1003	315.00	299.25	P			000		0.00	0.00
	02		121614	T1003	280.00	266.00	P			000		0.00	0.00
	03		121714	T1003	322.00	305.90	P			000		0.00	0.00
	04		121814	T1003	266.00	252.70	P			000		0.00	0.00
	05		121914	T1003	448.00	425.60	P			000		0.00	0.00
6086440	14360004028107 00A				170.00	170.00	P	0726891601	V E DUDLEY				
	01		121814	T1019	34.00	34.00	P			000		0.00	0.00
	02		121914	T1019	34.00	34.00	P			000		0.00	0.00
	03		121514	T1019	34.00	34.00	P			000		0.00	0.00
	04		121614	T1019	34.00	34.00	P			000		0.00	0.00
	05		121714	T1019	34.00	34.00	P			000		0.00	0.00

$2,195.45

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058448 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 31

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
6086444	1436000403810700A				170.00	170.00	P	1078011802	H W MISHLER				
	01		121514	T1019	34.00	34.00	P			000		0.00	0.00
	02		121614	T1019	34.00	34.00	P			000		0.00	0.00
	03		121714	T1019	34.00	34.00	P			000		0.00	0.00
	04		121814	T1019	34.00	34.00	P			000		0.00	0.00
	05		121914	T1019	34.00	34.00	P			000		0.00	0.00
6086366	1436000404810700A				1008.00	957.60	P	5107425901	C BUNTING				
	01		121514	T1003	280.00	266.00	P			000		0.00	0.00
	02		121614	T1003	280.00	266.00	P			000		0.00	0.00
	03		121714	T1003	168.00	159.60	P			000		0.00	0.00
	04		121814	T1003	280.00	266.00	P			000		0.00	0.00
6086464	1436000405810700A				476.00	476.00	P	1106084301	T C BADGER				
	01		121314	T1019	68.00	68.00	P			000		0.00	0.00
	02		121414	T1019	68.00	68.00	P			000		0.00	0.00
	03		121514	T1019	68.00	68.00	P			000		0.00	0.00
	04		121614	T1019	68.00	68.00	P			000		0.00	0.00
	05		121714	T1019	68.00	68.00	P			000		0.00	0.00
	06		121814	T1019	68.00	68.00	P			000		0.00	0.00
	07		121914	T1019	68.00	68.00	P			000		0.00	0.00
6086439	1436000406810700A				170.00	170.00	P	5714231101	B S JAMERSON				
	01		121514	T1019	34.00	34.00	P			000		0.00	0.00
	02		121614	T1019	34.00	34.00	P			000		0.00	0.00
	03		121714	T1019	34.00	34.00	P			000		0.00	0.00
	04		121814	T1019	34.00	34.00	P			000		0.00	0.00
	05		121914	T1019	34.00	34.00	P			000		0.00	0.00
6086361	1436000407810700A				896.00	851.20	P	1107790804	O WIETERS				
	01		121414	T1003	56.00	53.20	P			000		0.00	0.00
	02		121514	T1003	224.00	212.80	P			000		0.00	0.00
	03		121614	T1003	224.00	212.80	P			000		0.00	0.00
	04		121714	T1003	224.00	212.80	P			000		0.00	0.00
	05		121814	T1003	168.00	159.60	P			000		0.00	0.00
						$2,624.80							

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
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S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058449 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 32

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
6086379	1436000408810700A				841.50	841.50	P	5780412868	D JAMISON				
	01		121314	X0241	76.50	76.50	P			000		0.00	0.00
	02		121414	X0241	85.00	85.00	P			000		0.00	0.00
	03		121514	X0241	136.00	136.00	P			000		0.00	0.00
	04		121614	X0241	136.00	136.00	P			000		0.00	0.00
	05		121714	X0241	136.00	136.00	P			000		0.00	0.00
	06		121814	X0241	136.00	136.00	P			000		0.00	0.00
	07		121914	X0241	136.00	136.00	P			000		0.00	0.00
6086438	1436000409810700A				1080.00	1064.00	P	0724134401	T FORD				
	01		121514	T1003	216.00	212.80	P			000		0.00	0.00
	02		121614	T1003	216.00	212.80	P			000		0.00	0.00
	03		121714	T1003	216.00	212.80	P			000		0.00	0.00
	04		121814	T1003	216.00	212.80	P			000		0.00	0.00
	05		121914	T1003	216.00	212.80	P			000		0.00	0.00
6086467	1436000410810700A				255.00	255.00	P	4630172653	J DELANEY				
	01		121514	T1019	51.00	51.00	P			000		0.00	0.00
	02		121614	T1019	51.00	51.00	P			000		0.00	0.00
	03		121714	T1019	51.00	51.00	P			000		0.00	0.00
	04		121814	T1019	51.00	51.00	P			000		0.00	0.00
	05		121914	T1019	51.00	51.00	P			000		0.00	0.00
6086465	1436000411810700A				425.00	425.00	P	2727849501	D J GOINS				
	01		121514	T1019	85.00	85.00	P			000		0.00	0.00
	02		121614	T1019	85.00	85.00	P			000		0.00	0.00
	03		121714	T1019	85.00	85.00	P			000		0.00	0.00
	04		121814	T1019	85.00	85.00	P			000		0.00	0.00
	05		121914	T1019	85.00	85.00	P			000		0.00	0.00
6086363	1436000412810700A				476.00	476.00	P	1730633601	L S WILSON				
	01		121514	T1019	76.50	76.50	P			000		0.00	0.00
	02		121614	T1019	127.50	127.50	P			000		0.00	0.00
	03		121714	T1019	76.50	76.50	P			000		0.00	0.00
	04		121814	T1019	119.00	119.00	P			000		0.00	0.00
	05		121914	T1019	76.50	76.50	P			000		0.00	0.00
						$3,061.50							

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IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:

P = PAYMENT MADE
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S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058450 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 33

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
6086410	1436000413810700A				340.00	340.00	P	1107790804	O WIETERS				
	01		121414	T1019	85.00	85.00	P			000		0.00	0.00
	02		121514	T1019	85.00	85.00	P			000		0.00	0.00
	03		121714	T1019	85.00	85.00	P			000		0.00	0.00
	04		121914	T1019	85.00	85.00	P			000		0.00	0.00
6086360	1436000414810700A				1904.00	1808.80	P	1107999601	K L LASBY				
	01		121414	T1003	168.00	159.60	P			000		0.00	0.00
	02		121514	T1003	280.00	266.00	P			000		0.00	0.00
	03		121614	T1003	280.00	266.00	P			000		0.00	0.00
	04		121714	T1003	280.00	266.00	P			000		0.00	0.00
	05		121814	T1003	280.00	266.00	P			000		0.00	0.00
	06		121914	T1003	280.00	266.00	P			000		0.00	0.00
	07		120514	T1003	336.00	319.20	P			000		0.00	0.00
6086364	1436000415810700A				476.00	476.00	P	0100517201	J H GALL				
	01		121514	T1019	68.00	68.00	P			000		0.00	0.00
	02		121614	T1019	102.00	102.00	P			000		0.00	0.00
	03		121714	T1019	102.00	102.00	P			000		0.00	0.00
	04		121814	T1019	102.00	102.00	P			000		0.00	0.00
	05		121914	T1019	102.00	102.00	P			000		0.00	0.00
6086357	1436000416810700A				357.00	357.00	P	1780171775	M A HERRICK				
	01		121314	T1019	51.00	51.00	P			000		0.00	0.00
	02		121414	T1019	51.00	51.00	P			000		0.00	0.00
	03		121514	T1019	51.00	51.00	P			000		0.00	0.00
	04		121614	T1019	51.00	51.00	P			000		0.00	0.00
	05		121714	T1019	51.00	51.00	P			000		0.00	0.00
	06		121814	T1019	51.00	51.00	P			000		0.00	0.00
	07		121914	T1019	51.00	51.00	P			000		0.00	0.00
6086349	1436000417810700A				476.00	476.00	P	7727270301	V S HEYWARD				
	01		121314	T1019	68.00	68.00	P			000		0.00	0.00
	02		121414	T1019	68.00	68.00	P			000		0.00	0.00
	03		121514	T1019	68.00	68.00	P			000		0.00	0.00
	04		121614	T1019	68.00	68.00	P			000		0.00	0.00
	05		121714	T1019	68.00	68.00	P			000		0.00	0.00
						$3,457.80							

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IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

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CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058451 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 34

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	06		121814	T1019	68.00	68.00	P			000		0.00	0.00
	07		121914	T1019	68.00	68.00	P			000		0.00	0.00
6070413	1436000418810700A				833.00	0.00	R	5780668697	E A KAPPERMAN				
	01		121314	X0241	119.00	0.00	R			000		0.00	0.00
	02		121414	X0241	119.00	0.00	R			000		0.00	0.00
	03		121514	X0241	119.00	0.00	R			000		0.00	0.00
	04		121614	X0241	119.00	0.00	R			000		0.00	0.00
	05		121714	X0241	119.00	0.00	R			000		0.00	0.00
	06		121814	X0241	119.00	0.00	R			000		0.00	0.00
	07		121914	X0241	119.00	0.00	R			000		0.00	0.00
									EDITS: L01 853		L02 853		
6086372	1436000419810700A				425.00	425.00	P	7107983301	A C SIMONS				
	01		121514	T1019	85.00	85.00	P			000		0.00	0.00
	02		121614	T1019	85.00	85.00	P			000		0.00	0.00
	03		121714	T1019	85.00	85.00	P			000		0.00	0.00
	04		121814	T1019	85.00	85.00	P			000		0.00	0.00
	05		121914	T1019	85.00	85.00	P			000		0.00	0.00
6086399	1436000420810700A				102.00	102.00	P	0103250304	J O MCMICHAEL				
	01		121714	T1019	51.00	51.00	P			000		0.00	0.00
	02		121914	T1019	51.00	51.00	P			000		0.00	0.00
6086351	1436000421810700A				212.50	212.50	P	2106953901	P SEABROOK				
	01		121314	T1019	34.00	34.00	P			000		0.00	0.00
	02		121414	T1019	34.00	34.00	P			000		0.00	0.00
	03		121514	T1019	34.00	34.00	P			000		0.00	0.00
	04		121614	T1019	34.00	34.00	P			000		0.00	0.00
	05		121714	T1019	25.50	25.50	P			000		0.00	0.00
	06		121814	T1019	25.50	25.50	P			000		0.00	0.00
	07		121914	T1019	25.50	25.50	P			000		0.00	0.00
6086370	1436000422810700A				960.00	950.00	P	1884450902	J C BROWN				
	01		121514	S9124	192.00	190.00	P			000		0.00	0.00
	02		121614	S9124	192.00	190.00	P			000		0.00	0.00
	03		121714	S9124	192.00	190.00	P			000		0.00	0.00

$1,689.50

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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E = ENCOUNTER

PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058452 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 | DEPT OF HEALTH AND HUMAN SERVICES | REMITTANCE ADVICE | 01/02/2015 | 35

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	04		121814	S9124	192.00	190.00	P			000		0.00	0.00
	05		121914	S9124	192.00	190.00	P			000		0.00	0.00
6086380	1436000423810700A				510.00	510.00	P	8607301401	T ELLIOTT				
	01		121514	X0241	102.00	102.00	P			000		0.00	0.00
	02		121614	X0241	102.00	102.00	P			000		0.00	0.00
	03		121714	X0241	102.00	102.00	P			000		0.00	0.00
	04		121814	X0241	102.00	102.00	P			000		0.00	0.00
	05		121914	X0241	102.00	102.00	P			000		0.00	0.00
6070413	1436000424810700A				523.60	522.50	P	5780668697	E A KAPPERMAN				
	01		121314	S9124	71.40	71.25	P			000		0.00	0.00
	02		121414	S9124	95.20	95.00	P			000		0.00	0.00
	03		121514	S9124	71.40	71.25	P			000		0.00	0.00
	04		121614	S9124	71.40	71.25	P			000		0.00	0.00
	05		121714	S9124	71.40	71.25	P			000		0.00	0.00
	06		121814	S9124	71.40	71.25	P			000		0.00	0.00
	07		121914	S9124	71.40	71.25	P			000		0.00	0.00
6086362	1436000425810700A				2744.00	2606.80	P	1103495901	H DOLLASON				
	01		121414	T1003	56.00	53.20	P			000		0.00	0.00
	02		121514	T1003	560.00	532.00	P			000		0.00	0.00
	03		121614	T1003	616.00	585.20	P			000		0.00	0.00
	04		121714	T1003	560.00	532.00	P			000		0.00	0.00
	05		121814	T1003	560.00	532.00	P			000		0.00	0.00
	06		121914	T1003	392.00	372.40	P			000		0.00	0.00
6086377	1436000426810700A				1282.80	1282.50	P	3100557301	S B EDWARDS				
	01		121314	S9124	190.00	190.00	P			000		0.00	0.00
	02		121414	S9124	142.80	142.50	P			000		0.00	0.00
	03		121514	S9124	190.00	190.00	P			000		0.00	0.00
	04		121614	S9124	190.00	190.00	P			000		0.00	0.00
	05		121714	S9124	190.00	190.00	P			000		0.00	0.00
	06		121814	S9124	190.00	190.00	P			000		0.00	0.00
	07		121914	S9124	190.00	190.00	P			000		0.00	0.00
6086371	1436000427810700A				1127.00	1070.65	P	0699021201	A M HAMMOND				

$5,992.45

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CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058453 | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

1063422988 | DEPT OF HEALTH AND HUMAN SERVICES | 01/02/2015 | 36

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		121514	T1003	231.00	219.45	P			000		0.00	0.00
	02		121614	T1003	224.00	212.80	P			000		0.00	0.00
	03		121714	T1003	224.00	212.80	P			000		0.00	0.00
	04		121814	T1003	224.00	212.80	P			000		0.00	0.00
	05		121914	T1003	224.00	212.80	P			000		0.00	0.00
6086369	1436000428810700A				720.00	712.50	P	8725173101	K Z WILLIAMS				
	01		121514	S9124	144.00	142.50	P			000		0.00	0.00
	02		121614	S9124	144.00	142.50	P			000		0.00	0.00
	03		121714	S9124	144.00	142.50	P			000		0.00	0.00
	04		121814	S9124	144.00	142.50	P			000		0.00	0.00
	05		121914	S9124	144.00	142.50	P			000		0.00	0.00
6086354	1436000429810700A				1596.00	1579.36	P	4182456001	E PRINGLE				
	01		121314	S9124	192.00	190.00	P			000		0.00	0.00
	02		121414	S9124	192.00	190.00	P			000		0.00	0.00
	03		121514	S9124	192.00	190.00	P			000		0.00	0.00
	04		121614	S9124	192.00	190.00	P			000		0.00	0.00
	05		121714	S9124	318.00	314.68	P			000		0.00	0.00
	06		121814	S9124	192.00	190.00	P			000		0.00	0.00
	07		121914	S9124	318.00	314.68	P			000		0.00	0.00
6086347	1436000430810700A				1344.00	1330.00	P	7181072801	M PRINGLE				
	01		121314	S9124	192.00	190.00	P			000		0.00	0.00
	02		121414	S9124	192.00	190.00	P			000		0.00	0.00
	03		121514	S9124	192.00	190.00	P			000		0.00	0.00
	04		121614	S9124	192.00	190.00	P			000		0.00	0.00
	05		121714	S9124	192.00	190.00	P			000		0.00	0.00
	06		121814	S9124	192.00	190.00	P			000		0.00	0.00
	07		121914	S9124	192.00	190.00	P			000		0.00	0.00
6086373	1436000431810700A				255.00	255.00	P	2780233994	N M WALKER				
	01		121514	T1019	85.00	85.00	P			000		0.00	0.00
	02		121614	T1019	85.00	85.00	P			000		0.00	0.00
	03		121714	T1019	85.00	85.00	P			000		0.00	0.00
6086368	1436000432810700A				255.00	0.00	R	5714231101	B S JAMERSON				
						$3,876.86							

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
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E = ENCOUNTER

PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058454 | PROFESSIONAL SERVICES | PAYMENT DATE | PAGE

1063422988 | DEPT OF HEALTH AND HUMAN SERVICES | 01/02/2015 | 37

SOUTH CAROLINA MEDICAID PROGRAM | REMITTANCE ADVICE

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		121514	T1019	85.00	0.00	R			000		0.00	0.00
	02		121714	T1019	85.00	0.00	R			000		0.00	0.00
	03		121914	T1019	85.00	0.00	R			000		0.00	0.00
									EDITS: L01 852 01/02/15 L02 852 01/02/15				
									EDITS: L03 852 01/02/15				
6086365	1436000433810700A				170.00	170.00	P	3780343401	T K SEAY				
	01		121514	T1019	85.00	85.00	P			000		0.00	0.00
	02		121814	T1019	85.00	85.00	P			000		0.00	0.00
6086352	1436000434810700A				561.00	561.00	P	1714333901	N E GIBSON				
	01		121314	T1019	51.00	51.00	P			000		0.00	0.00
	02		121414	T1019	85.00	85.00	P			000		0.00	0.00
	03		121514	T1019	85.00	85.00	P			000		0.00	0.00
	04		121614	T1019	85.00	85.00	P			000		0.00	0.00
	05		121714	T1019	85.00	85.00	P			000		0.00	0.00
	06		121814	T1019	85.00	85.00	P			000		0.00	0.00
	07		121914	T1019	85.00	85.00	P			000		0.00	0.00
6086374	1436000435810700A				340.00	340.00	P	7103293301	W SCHRECKER				
	01		121514	T1019	68.00	68.00	P			000		0.00	0.00
	02		121614	T1019	68.00	68.00	P			000		0.00	0.00
	03		121714	T1019	68.00	68.00	P			000		0.00	0.00
	04		121814	T1019	68.00	68.00	P			000		0.00	0.00
	05		121914	T1019	68.00	68.00	P			000		0.00	0.00
6086344	1436000436810710A				544.00	544.00	P	4100880501	W J CASON				
	01		120814	T1019	68.00	68.00	P			000		0.00	0.00
	02		120914	T1019	68.00	68.00	P			000		0.00	0.00
	03		121014	T1019	68.00	68.00	P			000		0.00	0.00
	04		121114	T1019	68.00	68.00	P			000		0.00	0.00
	05		121214	T1019	68.00	68.00	P			000		0.00	0.00
	06		121314	T1019	68.00	68.00	P			000		0.00	0.00
	07		121414	T1019	68.00	68.00	P			000		0.00	0.00
	08		121514	T1019	68.00	68.00	P			000		0.00	0.00
6086344	1436000436810720A				272.00	272.00	P	4100880501	W J CASON				
						$1,887.00							

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IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

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CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058455 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 38

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	MOD	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
	01		121614	T1019	68.00	68.00	P			000		0.00	0.00
	02		121714	T1019	68.00	68.00	P			000		0.00	0.00
	03		121814	T1019	68.00	68.00	P			000		0.00	0.00
	04		121914	T1019	68.00	68.00	P			000		0.00	0.00
1035609	1436100923810800A				34.00	34.00	P	3106809101	P L SINGLETARY				
	01		122614	T1019	34.00	34.00	P			000		0.00	0.00
1039718	1436100924810800A				46.90	46.90	P	4108888201	C MILLER				
	01		122614	S5130	12.90	12.90	P			000		0.00	0.00
	02		122614	T1019	34.00	34.00	P			000		0.00	0.00
1041158	1436100925810800A				46.90	46.90	P	1605964401	T JEFFERSON				
	01		122614	T1019	34.00	34.00	P			000		0.00	0.00
	02		122614	S5130	12.90	12.90	P			000		0.00	0.00
1043080	1436100926810800A				59.80	59.80	P	7101399301	J SIMPSON				
	01		122614	S5130	25.80	25.80	P			000		0.00	0.00
	02		122614	T1019	34.00	34.00	P			000		0.00	0.00
1048200	1436100927810800A				46.90	46.90	P	2780432044	M T TURNER				
	01		122614	T1019	34.00	34.00	P			000		0.00	0.00
	02		122614	S5130	12.90	12.90	P			000		0.00	0.00
1048222	1436100928810800A				29.90	29.90	P	4107048001	V MCFADDEN				
	01		122614	T1019	17.00	17.00	P			000		0.00	0.00
	02		122614	S5130	12.90	12.90	P			000		0.00	0.00
1048951	1436100929810800A				37.52	37.52	P	2108057301	J BROOKS				
	01		122614	S5130	10.32	10.32	P			000		0.00	0.00
	02		122614	T1019	27.20	27.20	P			000		0.00	0.00
1052939	1436100930810800A				34.00	34.00	P	0102002701	B PRIOLEAU				
	01		122614	T1019	34.00	34.00	P			000		0.00	0.00
1053178	1436100931810800A				42.50	0.00	R	0780818325	S M STANLEY				
	01		122614	T1019	42.50	0.00	R			000		0.00	0.00

$335.92

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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CERTIFIED AMT | MEDICAID TOTAL

CHECK TOTAL | CHECK NUMBER

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058456 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 39

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
									EDITS: L01 951				
1053456	1436100932810800A				52.70	52.70	P	5780843758	B R MORRILL				
	01		122614	T1019	52.70	52.70	P			000		0.00	0.00
1053931	1436100933810800A				85.00	85.00	P	2780870723	C COOK				
	01		122614	T1019	85.00	85.00	P			000		0.00	0.00
1055545	1436100934810800A				46.90	46.90	P	9100493602	H W RANDOLPH				
	01		122614	S5130	12.90	12.90	P			000		0.00	0.00
	02		122614	T1019	34.00	34.00	P			000		0.00	0.00
1056019	1436100935810800A				37.52	37.52	P	0780925395	S G BROOKS				
	01		122614	S5130	10.32	10.32	P			000		0.00	0.00
	02		122614	T1019	27.20	27.20	P			000		0.00	0.00
1056439	1436100936810800A				56.10	56.10	P	1630239869	M D SINGLETON				
	01		122614	T1019	56.10	56.10	P			000		0.00	0.00
1056598	1436100937810800A				35.70	35.70	P	5182563502	S A MUCKELVANEY				
	01		122614	T1019	35.70	35.70	P			000		0.00	0.00
9601882	1436100938810800A				63.90	63.90	P	1781134836	J SINGLETON JR				
	01		122614	S5130	10.32	10.32	P			000		0.00	0.00
	02		122614	T1019	39.10	39.10	P			000		0.00	0.00
	03		122614	S5130	2.58	2.58	P			000		0.00	0.00
	04		122614	T1019	11.90	11.90	P			000		0.00	0.00
9602100	1436100939810800A				51.00	51.00	P	1107733501	L M PAGE				
	01		122614	T1019	51.00	51.00	P			000		0.00	0.00
9602136	1436100940810800A				42.80	42.80	P	8726370301	M B SMITH				
	01		122614	S5130	25.80	25.80	P			000		0.00	0.00
	02		122614	T1019	17.00	17.00	P			000		0.00	0.00
9604737	1436100941810800A				51.00	51.00	P	7729773201	S E ALSTON				
	01		122614	T1019	51.00	51.00	P			000		0.00	0.00

$522.62

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

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CERT. PG TOT | MEDICAID PG TOT

CERTIFIED AMT | MEDICAID TOTAL | CHECK TOTAL | CHECK NUMBER

STATUS CODES:
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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058457 PROFESSIONAL SERVICES PAYMENT DATE PAGE

1063422988 DEPT OF HEALTH AND HUMAN SERVICES 01/02/2015 40

SOUTH CAROLINA MEDICAID PROGRAM REMITTANCE ADVICE

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
9605752	1436100942810800A				51.12	51.12	P	4105281901	J WASHINGTON				
	01		122614	S5130	10.32	10.32	P			000		0.00	0.00
	02		122614	T1019	40.80	40.80	P			000		0.00	0.00
9613401	1436100943810800A				20.40	20.40	P	4780915876	C D SMITH				
	01		122614	T1019	20.40	20.40	P			000		0.00	0.00
9620895	1436100944810800A				20.40	20.40	P	4780705471	B C MAI				
	01		122614	T1019	20.40	20.40	P			000		0.00	0.00
9623713	1436100945810800A				34.00	34.00	P	1107209301	S BROWN				
	01		122614	T1019	34.00	34.00	P			000		0.00	0.00
9637474	1436100946810800A				34.00	34.00	P	5780433859	J BROOKINS				
	01		122614	T1019	34.00	34.00	P			000		0.00	0.00
9642075	1436100947810800A				46.90	46.90	P	0086572201	L JEFFERSON				
	01		122614	T1019	34.00	34.00	P			000		0.00	0.00
	02		122614	S5130	12.90	12.90	P			000		0.00	0.00
9646177	1436100948810800A				176.40	167.58	P	3781484082	S A BROWN				
	01		122614	T1003	176.40	167.58	P			000		0.00	0.00
9649580	1436100949810800A				34.00	34.00	P	9780580973	B HALL				
	01		122614	T1019	34.00	34.00	P			000		0.00	0.00
9650394	1436100950810800A				218.40	207.48	P	7781528787	M N BROWN				
	01		122614	T1003	218.40	207.48	P			000		0.00	0.00
9652816	1436100951810800A				51.00	51.00	P	0781657439	W POWELL				
	01		122614	T1019	51.00	51.00	P			000		0.00	0.00
9656068	1436100952810800A				63.90	63.90	P	1780548440	V L JOHNSON				
	01		122614	T1019	51.00	51.00	P			000		0.00	0.00
	02		122614	S5130	12.90	12.90	P			000		0.00	0.00
						$730.78							

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058458 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 — DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE — 01/02/2015 — 41

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	MOD	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
9661458	1436100953810800A				34.00	34.00	P	6721948901	M F DAVIS				
	01		122614	T1019	34.00	34.00	P			000		0.00	0.00
9663483	1436100954810800A				221.20	210.14	P	2781624221	S M SMILEY				
	01		122614	T1003	221.20	210.14	P			000		0.00	0.00
1035609	1436200952810100A				34.00	34.00	P	3106809101	P L SINGLETARY				
	01		122714	T1019	34.00	34.00	P			000		0.00	0.00
1039718	1436200953810100A				46.90	46.90	P	4108888201	C MILLER				
	01		122714	S5130	12.90	12.90	P			000		0.00	0.00
	02		122714	T1019	34.00	34.00	P			000		0.00	0.00
1048951	1436200954810100A				34.00	34.00	P	2108057301	J BROOKS				
	01		122714	T1019	34.00	34.00	P			000		0.00	0.00
1050002	1436200955810100A				29.90	29.90	P	3106156201	M L SINGLETON				
	01		122714	S5130	12.90	12.90	P			000		0.00	0.00
	02		122714	T1019	17.00	17.00	P			000		0.00	0.00
1052939	1436200956810100A				34.00	34.00	P	0102002701	B PRIOLEAU				
	01		122714	T1019	34.00	34.00	P			000		0.00	0.00
1053931	1436200957810100A				282.70	272.90	P	2780870723	C COOK				
	01		122714	T1003	196.00	186.20	P			000		0.00	0.00
	02		122714	T1019	86.70	86.70	P			000		0.00	0.00
1056019	1436200958810100A				34.00	34.00	P	0780925395	S G BROOKS				
	01		122714	T1019	34.00	34.00	P			000		0.00	0.00
1056439	1436200959810100A				88.40	88.40	P	1630239869	M D SINGLETON				
	01		122714	T1019	88.40	88.40	P			000		0.00	0.00
9601882	1436200960810100A				26.50	26.50	P	1781134836	J SINGLETON JR				
	01		122714	S5130	12.90	12.90	P			000		0.00	0.00
	02		122714	T1019	13.60	13.60	P			000		0.00	0.00
						$844.74							

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PROVIDER NAME AND ADDRESS

LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

PROVIDER ID. 000058459 — PROFESSIONAL SERVICES — PAYMENT DATE — PAGE

1063422988 | DEPT OF HEALTH AND HUMAN SERVICES | 01/02/2015 | 42

SOUTH CAROLINA MEDICAID PROGRAM — REMITTANCE ADVICE

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	STS	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	MOD	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
9602100	1436200961810100A				34.00	34.00	P	1107733501	L M PAGE				
	01		122714	T1019	34.00	34.00	P			000		0.00	0.00
9602136	1436200962810100A				85.00	85.00	P	8726370301	M B SMITH				
	01		122714	T1019	85.00	85.00	P			000		0.00	0.00
9604737	1436200963810100A				51.00	51.00	P	7729773201	S E ALSTON				
	01		122714	T1019	51.00	51.00	P			000		0.00	0.00
9637474	1436200964810100A				34.00	34.00	P	5780433859	J BROOKINS				
	01		122714	T1019	34.00	34.00	P			000		0.00	0.00
9649580	1436200965810100A				34.00	34.00	P	9780580973	B HALL				
	01		122714	T1019	34.00	34.00	P			000		0.00	0.00
9652816	1436200966810100A				51.00	51.00	P	0781657439	W POWELL				
	01		122714	T1019	51.00	51.00	P			000		0.00	0.00
9661458	1436200967810100A				17.00	17.00	P	6721948901	M F DAVIS				
	01		122714	T1019	17.00	17.00	P			000		0.00	0.00
	TOTALS	373			52354.64	49612.56						0.00	0.00

$306.00

CERT. PG TOT	MEDICAID PG TOT
$0.00	$49,612.56

CERTIFIED AMT	MEDICAID TOTAL
$0.00	$49,612.56

* CHECK TOTAL

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

7669839
CHECK NUMBER

PROVIDER NAME AND ADDRESS
LOWCOUNTRY NURSING GROUP L
INTERIM HEALTHCARE
3870 LEEDS AVE STE 104
NORTH CHARLESTON SC 29405

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

* FUNDS AUTOMATICALLY DEPOSITED TO:
BANK NAME: COMMUNITY FIRSTBANK ACCOUNT #: XXXXXX2723
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.