GEORGIA TRAUMA CARE NETWORK COMMISSION

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA

AGREED UPON PROCEDURES

For the Year Ending December 31, 2011
GEORGIA TRAUMA CARE NETWORK COMMISSION

TABLE OF CONTENTS

For the Year Ending December 31, 2011

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Accountants’ Report</td>
<td>1</td>
</tr>
<tr>
<td>Attachment A – Validation of Uncompensated Care Claim Data: Procedures</td>
<td>2-4</td>
</tr>
<tr>
<td>Attachment A-1 – Additional Procedures Performed</td>
<td>5</td>
</tr>
<tr>
<td>Attachment B – Validation of Uncompensated Care Claim Data: Findings Summary</td>
<td>6-7</td>
</tr>
<tr>
<td>Attachment B-1 – Detail Findings by Location</td>
<td>8-16</td>
</tr>
<tr>
<td>Attachment B-2 – Summary Findings by Location</td>
<td>17-20</td>
</tr>
<tr>
<td>Conclusion</td>
<td>21</td>
</tr>
</tbody>
</table>
INDEPENDENT ACCOUNTANTS’ REPORT

To the Georgia Trauma
Care Network Commission

We have performed the procedures enumerated on Attachments A and A-1, which were agreed to by you, solely to assist you with respect to the validation of uncompensated care claim data for the year ending December 31, 2011. The Georgia Trauma Care Network Commission and the Georgia-designated Trauma Centers’ (as listed on Attachment A) management are responsible for the uncompensated care claim data submitted for these procedures. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the Georgia Trauma Care Network Commission. Consequently, we make no representation regarding the sufficiency of the procedures described on Attachments A and A-1, either for the purpose for which this report has been requested, or for any other purpose.

Our findings, documentation and recommendations for the procedures outlined in Attachments A and A-1 are outlined in Attachments B, B-1, and B-2, to this report.

We were not engaged to, and did not, conduct an audit or examination, the objective of which would be the expression of an opinion on the uncompensated care claim data. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Georgia Trauma Care Network Commission and the Georgia-designated Trauma Centers and is not intended to be and should not be used by anyone other than these specified parties.

WARREN AVERETT, LLC

May 14, 2013
Atlanta, Georgia
ATTACHMENT A

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA: PROCEDURES

Georgia-designated Trauma Centers:
- Atlanta Medical Center (AMC) – Atlanta
- Grady Memorial Hospital (Grady) – Atlanta
- Medical Center of Central Georgia, Inc. (MCCG) – Macon
- GA Health Sciences Medical Center (GHS) – Augusta
- Memorial Health University Medical Center (Memorial) – Savannah
- Athens Regional Medical Center (Athens) – Athens
- Floyd Medical Center (Floyd) – Rome
- Gwinnett Medical Center (Gwinnett) – Lawrenceville
- Hamilton Medical Center (Hamilton) – Dalton
- John D. Archbold Memorial Hospital (Archbold) – Thomasville
- Medical Center-Columbus (Columbus) – Columbus
- North Fulton Regional Hospital (North Fulton) – Roswell
- Clearview Regional Medical Center (Clearview) – Monroe
- Childrens Healthcare of Atlanta at Egleston (Egleston) – Atlanta
- Childrens Healthcare of Atlanta at Scottish Rite (Scottish Rite) – Atlanta
- Morgan Memorial Hospital (Morgan) – Madison
- Taylor Regional Hospital (Taylor) – Hawkinsville
- Lower Oconee Community Hospital (Oconee) – Glenwood
- Doctors Hospital (Doctors) – Augusta
- Wills Memorial Hospital (Wills) – Washington
- Wellstar Kennestone Hospital (Wellstar) – Marietta

Procedures:
The following are the agreed-upon procedures that Warren Averett, LLC (WA) was engaged to perform related to the Georgia-designated Trauma Centers (Trauma Centers) listed above.

1. WA will assist the Georgia Trauma Care Network Commission (GTCNC) in the development of the uncompensated care claims survey instrument for the year ending December 31, 2011 (CY2011). WA will deliver the survey instrument to all Trauma (Burn) Centers that were designated for all or part of CY2011 as listed above.

2. WA will collect the CY2011 uncompensated care claims survey instruments and detailed listings of uncompensated care claims submitted by each Trauma (Burn) Center during the period that Trauma (Burn) Center was designated in CY2011.

3. WA will consider each Trauma (Burn) Center listed above and will recommend to the GTCNC sample sizes for detailed testing of the uncompensated care claims that were submitted. Factors that will be considered in determining the sample for detailed testing are listed below:
a. WA will evaluate the quantity and trending of the historical error rate for uncompensated care claims based on the test results of WA procedures in prior years.
b. WA will consider the consistency or variances noted in the number of claims that each Trauma (Burn) Center has submitted in the current year compared with prior years.
c. WA will consider the volume of claims submitted by each Trauma (Burn) Center.
d. WA will exclude only one or two Level I Trauma (Burn) Centers from our testing each year. WA will not exclude any Level I Trauma (Burn) Center from testing for more than one consecutive year.
e. For Level II, III and IV Trauma (Burn) Centers, WA may propose excluding a Trauma (Burn) Center from testing for two consecutive years, but in the third year WA will include the Trauma (Burn) Center in the sample for testing.
f. WA will structure the sample selection to achieve a testing average of 55%-65% of the physical locations and 70%-80% of the total claims population for the year.
g. WA will also exercise professional judgment in determining the proposed sample of Trauma (Burn) Center locations for testing in consultation with Jim Pettyjohn, Executive Director of GTCNC. Mr. Pettyjohn will approve the final sample selection.

4. For each Trauma (Burn) Center selected for testing as outlined in procedure #3 above, WA will select a sample of the uncompensated care claims for testing as follows:
   a. For Trauma Centers with less than 25 claims, WA will test 5 claims;
   b. For Trauma Centers with between 25 and 50 claims, WA will test 10 claims;
   c. For Trauma Centers with between 50 and 150 claims, WA will test 20 claims; and,
   d. For Trauma Centers with greater than 150 claims, WA will test 40 claims.

5. For each claim selected in procedure #4 above, WA will view (on site at the Trauma (Burn) Center location) the electronic billing record (EBR) or documents comparable to the EBR to determine that as of February 1, 2013 each claim selected in our sample met the criteria for consideration as an uncompensated care claim. The criteria for consideration as an uncompensated care claim are as follows:
   a. The EBR documents that the patient had no medical insurance, including Medicare Part B coverage;
   b. The EBR documents the patient was not eligible for medical assistance coverage;
   c. The EBR documents that the patient had no medical coverage for trauma care through workers’ compensation insurance, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage;
   d. The EBR documents that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments;
   e. The EBR documents that there were no third party payments received.
ATTACHMENT A
VALIDATION OF UNCOMPENSATED CARE CLAIM DATA: PROCEDURES

6. For each claim selected in our sample (as defined above), WA will determine that the Trauma (Burn) Center has documented attempts at collection using the documentation that is available at each Trauma (Burn) Center.

7. WA will verify that the Severity Score Category (SSC) assigned to each claim selected in our sample (as defined above) matches the SSC for that patient in NTRACS (trauma registry software) used by all Trauma Centers or the burn registry used by Burn Centers.

8. WA will consider the additional clarifications approved by the GTCNC listed below:

   A. Claims deemed qualified under the GTCNC uncompensated care definition:
      a. Cases where financial counselors at the Trauma Center determined that the patients qualified for a charity program offered by the hospital whereby the account was written off and further attempts to collect were not made.
      b. Cases where patients were victims of a crime and the Trauma Center received a small payment up to 10% of hospital charges from a third party charity.
      c. Cases where patients were undocumented aliens and the Trauma Center received a small payment up to 10% of hospital charges from a third party charity.
      d. Cases where insurance could not be verified.

   B. Claims deemed NOT qualified under the GTCNC uncompensated care definition:
      a. Cases where the patient expired and the Trauma Center did not attempt to collect.
      b. Cases where patients received settlements directly but did not pay the Trauma Center after repeated collection attempts.
      c. Cases where there was a reciprocal agreement with another party for exchange of services and the Trauma Center did not attempt further collection procedures.
      d. Cases where claims are sold to collections agency.
ATTACHMENT A-1

ADDITIONAL PROCEDURES PERFORMED

WA discussed the findings summarized in Attachment B and presented in detail in Attachment B-1 from the execution of our agreed-upon procedures as described in Attachment A with the Executive Director for the Georgia Trauma Care Network Commission. As a result of this discussion, WA was engaged to perform the following additional procedures:

1. Provide each Trauma (Burn) Center with the findings from our agreed-upon procedures as described in Attachment A. See the information that was provided to each Trauma (Burn) Center in Attachment B-1.

2. Request revised lists of uncompensated care claims from the following Trauma (Burn) Centers:
   - Grady
   - Memorial
   - Gwinnett
   - Archbold
   - Columbus
   - North Fulton
   - Taylor

   These revised lists should be duplicates of the original list provided to WA minus any claims that were identified in our agreed-upon procedures (AUP) to be in error (re: Attachment B Findings A through G in our report).

3. Compare the revised lists received above against the original lists received to ensure that errors WA noted in the AUP were eliminated (along with any other claims that the hospitals identified as erroneous) and that there are no new claims added to the list.

4. Revise WA AUP report to report the updated uncompensated care claims for each Trauma (Burn) Center. Results are presented in Attachment B-2.

5. Present our final report to the executive director of the Georgia Trauma Care Network Commission.

WA performed only the procedures outlined in Attachments A and A-1 and did not perform any additional procedures. We did not perform any procedures to evaluate if there were trauma patient claims that should have been reported by the Trauma (Burn) Centers as uncompensated care claims and were not.
ATTACHMENT B

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA

FINDINGS SUMMARY:
We have accumulated our findings from our agreed-upon procedures that are outlined in Attachment A. They are outlined below along with our recommendations which have been considered and acted upon as deemed appropriate (See Attachment A-1). Additional information for each finding can be found in the detailed reports by location. (See Attachment B-1)

1. Finding: We noted claims at the following Trauma (Burn) Centers where we concluded that the documentation did not meet the criteria for an uncompensated care claim due to:

   A. Patient had insurance including Medicare Part B coverage
      • Gwinnett
      • Archbold
      • North Fulton

   Recommendation: We recommend the GTCNC consider requesting that these Trauma (Burn) Centers revise their CY2011 uncompensated care claim list to exclude all claims where patients had insurance including Medicare Part B coverage.

   B. Patient was eligible for medical assistance coverage
      • Athens
      • Gwinnett
      • Columbus

   Recommendation: We recommend the GTCNC consider requesting that these Trauma (Burn) Centers revise their CY2011 uncompensated care claim list to exclude all claims where patients were eligible for medical assistance coverage.

   C. Patient had medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
      • AMC
      • Grady
      • Memorial
      • Athens
      • Gwinnett
      • Archbold
      • Columbus
      • Taylor
Recommendation: We recommend the GTCNC consider requesting that these Trauma (Burn) Centers revise their CY2011 uncompensated care claim list to exclude all claims where patients had medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.

D. Payment by patient greater than 10%

There were no trauma centers with exceptions to this criteria

E. Receipt of a third party payment
   - AMC
   - Grady
   - Memorial
   - Gwinnett
   - Columbus
   - North Fulton

Recommendation: We recommend that the GTCNC consider requesting these Trauma (Burn) Centers revise their CY2011 uncompensated care claim list to exclude all claims where third party payments were received.

F. No collection attempts were made by the Trauma Center.
   - Grady
   - Gwinnett

Recommendation: We recommend the GTCNC consider requesting that these Trauma (Burn) Centers revise their CY2011 uncompensated care claim list to exclude all claims where there were no collection attempts made.

G. The SSC provided in the detail list of uncompensated care claims did not match the SSC for that patient in the NTRACS or burn registry.
   - Grady
   - Taylor

Recommendation: We recommend the GTCNC consider requesting that these Trauma (Burn) Centers revise their CY2011 uncompensated care claim list to reflect the ISS listed in NTRACS.
HOSPITAL: AMC

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with greater than 150 claims, we will test 40.

AMC reported 379 claims, therefore we selected a sample of 40.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a) The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
b) The EBR shows the patient was not eligible for medical assistance coverage.
c) The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
d) The EBR shows that there were no third party payments received.
e) The hospital has documented attempts at collection via documentation available at the hospital.
f) The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each claim selected we determined the following:
1) We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Medical Record No</th>
<th>Trauma Number</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>g</th>
<th>h</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5215384</td>
<td>11503</td>
<td>2011/04/25</td>
<td>13</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Claim pending litigation, settlement reached and payment of settlement was received on 2/22/13.</td>
</tr>
</tbody>
</table>

Tickmark Explanations:
P  Step performed without exception
X  Issue noted, see explanation to the right of claim.
ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: GRADY

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with greater than 150 claims, we will test 40.

Grady reported 784 claims, therefore we selected a sample of 40 for testing.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a. The EBR shows the patient had no medical insurance, including Medicare Part B coverage.

b. The EBR shows the patient was not eligible for medical assistance coverage.

c. The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.

d. The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.

e. The EBR shows that there were no third party payments received.

f. The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each claim selected we determined the following:

1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Acct No</th>
<th>Medical Record No</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>l</th>
<th>Comments</th>
</tr>
</thead>
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<td>1000457373</td>
<td>100029381</td>
<td>7/3/2011</td>
<td>4</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>Prisoner of Atlanta write off</td>
</tr>
<tr>
<td>2</td>
<td>5000225564</td>
<td>100044718</td>
<td>11/2/2011</td>
<td>4</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>Prisoner of Atlanta write off</td>
</tr>
<tr>
<td>3</td>
<td>1000257763</td>
<td>100016298</td>
<td>3/18/2011</td>
<td>5</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Auto insurance payment</td>
</tr>
<tr>
<td>4</td>
<td>1000454856</td>
<td>11541614</td>
<td>6/30/2011</td>
<td>14</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Prisoner of Atlanta write off</td>
</tr>
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<td>5</td>
<td>1000395558</td>
<td>100025048</td>
<td>5/31/2011</td>
<td>16</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
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<td>5000034235</td>
<td>10032072</td>
<td>7/27/2011</td>
<td>16</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Prisoner of Atlanta write off</td>
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<td>7</td>
<td>1000263986</td>
<td>100016772</td>
<td>3/23/2011</td>
<td>22</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>ISS in registry is 29, isolated incident</td>
</tr>
</tbody>
</table>

Tickmark Explanations:

P Step performed without exception

X Issue noted, see explanation to the right of claim.
HOSPITAL: MEMORIAL

**Purpose:** To test that uncompensated care claims are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with greater than 150 claims, we will test 40.

Memorial Health reported 297 claims, therefore we selected a sample of 40 for testing. For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

- The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
- The EBR shows the patient was not eligible for medical assistance coverage.
- The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
- The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
- The EBR shows that there were no third party payments received.
- The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each claim selected we determined the following:

1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Trauma Registry No.</th>
<th>Patient ID</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>l</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>38211</td>
<td>1117600538</td>
<td>6/27/2011</td>
<td>4</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>F</td>
<td>Received payment from attorney</td>
</tr>
<tr>
<td>38100</td>
<td>1115700681</td>
<td>6/6/2011</td>
<td>5</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>F</td>
<td>There was $5,000 in medical pay available from auto insurance, the hospital did not receive complete information to file claims to auto insurance</td>
</tr>
<tr>
<td>38283</td>
<td>1119200813</td>
<td>7/11/2011</td>
<td>13</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>There was $5,000 in medical pay available from auto insurance, the patient received the money but did not pay the hospital</td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**

- **F** Step performed without exception
- **X** Issue noted, see explanation to the right of claim.
### ATTACHMENT B-I

**DETAIL FINDINGS BY LOCATION**

**HOSPITAL: ATHENS**

**Purpose:** To test that uncompensated care claims are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with 50-150 claims, we will select 20.

- Athens reported 85 claims, therefore we selected a sample of 20 for testing.
- For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
- We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:
  - (a) The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - (b) The EBR shows the patient was not eligible for medical assistance coverage.
  - (c) The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - (d) The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - (e) The EBR shows that there were no third party payments received.
  - (f) The hospital has documented attempts at collection via documentation available at the hospital.

- Additionally, for each claim selected we determined the following:
  - (1) We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Trauma No</th>
<th>Account No</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
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<th>Comments</th>
</tr>
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<td>5537864</td>
<td>6/8/11</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Patient had auto insurance but would not file a claim, the patient was eligible for medicare but since the hospital could not obtain an insurance denial, they could not file a claim to medicare.</td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**

- **P** Step performed without exception
- **X** Step performed with exception, see comments to the right for more information.
**HOSPITAL: GWINNETT**

**Purpose:** To test that uncompensated care claims are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with greater than 150 cases we will test 40
- Gwinnett Medical Center reported 221 claims, therefore we selected a sample of 40 for testing.
- For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.
- We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:
  - a. The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
  - b. The EBR shows the patient was not eligible for medical assistance coverage.
  - c. The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
  - d. The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
  - e. The EBR shows that there were no third party payments received.
  - f. The hospital has documented attempts at collection via documentation available at the hospital.
- Additionally, for each claim selected we determined the following:
  - We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Medical Record No</th>
<th>Registry No</th>
<th>Admit Date</th>
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<th>a</th>
<th>b</th>
<th>c</th>
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<tbody>
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<td>0041333809</td>
<td>7228</td>
<td>9/9/2011</td>
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<td></td>
<td>Patient had medical insurance</td>
</tr>
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<td>P</td>
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<td></td>
<td></td>
<td>Patient had Medicare part B, hospital received payment from Medicare</td>
</tr>
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<td>7485</td>
<td>12/6/2011</td>
<td>5</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td></td>
<td></td>
<td>Patient had Tricare, hospital received payment from Tricare</td>
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<tr>
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<td>2/20/2011</td>
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<td>X</td>
<td>P</td>
<td>P</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td>Patient had Medicare part B</td>
</tr>
<tr>
<td>0041219300</td>
<td>6652</td>
<td>1/14/2011</td>
<td>9</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>F</td>
<td></td>
<td></td>
<td>Patient was eligible for out of state Medicaid hospital did not file a claim, wrote off to charity</td>
</tr>
<tr>
<td>0041409665</td>
<td>7452</td>
<td>11/24/2011</td>
<td>10</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Patient had medical insurance</td>
<td></td>
</tr>
<tr>
<td>0041251809</td>
<td>7430</td>
<td>11/16/2011</td>
<td>13</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>F</td>
<td>Patient has auto insurance and auto insurance made a payment</td>
<td></td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**
- P  Step performed without exception
- X  Issue noted, see explanation to the right of claim.
HOSPITAL: ARCHBOLD

**Purpose:** To test that uncompensated care claims are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with between 50 and 150 claims, we will test 10.

Archbold reported 42 claims, therefore we selected a sample of 10 for testing.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

- **a** The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
- **b** The EBR shows the patient was not eligible for medical assistance coverage.
- **c** The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
- **d** The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
- **e** The EBR shows that there were no third party payments received.
- **f** The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each claim selected we determined the following:

1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Medical Record #</th>
<th>Trauma Registry #</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>1</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>639056</td>
<td>2825</td>
<td>10/01/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td>2</td>
<td>154650</td>
<td>2806</td>
<td>09/15/11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>P</td>
<td>P</td>
<td>X</td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**

- **P** – Step performed without exception
- **X** – Issue noted, see explanation to the right of claim.
HOSPITAL: COLUMBUS

Purpose: To test that uncompensated care claims are properly recognized according to the criteria identified below.

Procedures: For hospitals with between 50 and 150 cases we will test 20.

Columbus reported 117 claims, therefore we selected a sample of 20.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a. The EBR shows the patient had no medical insurance, including Medicare Part B coverage.

b. The EBR shows the patient was not eligible for medical assistance coverage.

c. The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.

d. The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.

e. The EBR shows that there were no third party payments received.

f. The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each claim selected we determined the following:

1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Medical Record #</th>
<th>Registry #</th>
<th>ISS</th>
<th>Admit Date</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000155566</td>
<td>9070</td>
<td>8</td>
<td>12/24/2011</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Auto insurance and pending litigation</td>
</tr>
<tr>
<td>714787710</td>
<td>8532</td>
<td>24</td>
<td>6/17/2011</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>Medicaid payment received</td>
</tr>
</tbody>
</table>

Tickmark Explanations:

P  Step performed without exception

X  Step performed with exception, see explanation to right
ATTACHMENT B-I

DETAIL FINDINGS BY LOCATION

HOSPITAL: NORTH FULTON

**Purpose:** To test that uncompensated care claims are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with between 50 and 150 claims, we will test 20.

North Fulton reported 59 claims, therefore we selected a sample of 20 for testing.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR. We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

- The EBR shows the patient had no medical insurance, including Medicare Part B coverage.
- The EBR shows the patient was not eligible for medical assistance coverage.
- The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.
- The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.
- The EBR shows that there were no third party payments received.
- The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each claim selected we determined the following:

1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Registry No</th>
<th>Patient Account Number</th>
<th>Admit Date</th>
<th>Injury Severity Code</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>i</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5031</td>
<td>20024675</td>
<td>2011/11/20</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Patient had medical insurance and a claim was filed, insurance company has not denied or paid</td>
</tr>
<tr>
<td>2</td>
<td>4981</td>
<td>19878115</td>
<td>2011/10/08</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Received Insurance and Medicare payments</td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**

- **P** Step performed without exception
- **X** Issue noted, see explanation to the right of claim.
ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: TAYLOR

**Purpose:** To test that uncompensated care claims are properly recognized according to the criteria identified below.

**Procedures:** For hospitals with less than 25 claims, we will test 5.

Taylor reported 16 claims, therefore we selected a sample of 5 for testing.

For each claim selected, we viewed the electronic billing record (EBR) or documents comparable to the EBR.

We determined whether the claims selected met the criteria for consideration as an uncompensated care claim. The criteria are as follows:

a. The EBR shows the patient had no medical insurance, including Medicare Part B coverage.

b. The EBR shows the patient was not eligible for medical assistance coverage.

c. The EBR shows that the patient had no medical coverage for trauma care through workers’ compensation, automobile insurance, or any other third party, including any settlement or judgment resulting from such coverage.

d. The EBR shows that the patient has not paid more than 10% of total charges after documented attempts by the trauma care services provider to collect payments.

e. The EBR shows that there were no third party payments received.

f. The hospital has documented attempts at collection via documentation available at the hospital.

Additionally, for each claim selected we determined the following:

1. We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Trauma Registry No.</th>
<th>Medical Record No.</th>
<th>Date of Admission</th>
<th>ISS</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>1</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A00134</td>
<td>I96136</td>
<td>2/19/2011</td>
<td>1</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>Patient was listed in trauma registry but ISS was blank in registry</td>
<td></td>
</tr>
<tr>
<td>A00220</td>
<td>J41912</td>
<td>12/17/2011</td>
<td>21</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>The patient received a settlement but did not pay the hospital. The ISS in registry is 17</td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**

- P: Step performed without exception
- X: Exception noted; see comment for explanation
### ATTACHMENT B-2

#### SUMMARY FINDINGS BY LOCATION

<table>
<thead>
<tr>
<th>Locations Tested With Claims Resubmitted</th>
<th>Severity Score Category</th>
<th>Locations Tested With Claims Resubmitted</th>
<th>Severity Score Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic</td>
<td>Moderate</td>
<td>Major</td>
</tr>
<tr>
<td>Grady Per AUP</td>
<td>405</td>
<td>260</td>
<td>90</td>
</tr>
<tr>
<td>Difference 1</td>
<td>(3)</td>
<td>(1)</td>
<td>(3)</td>
</tr>
<tr>
<td>Grady Per Revised List</td>
<td>349</td>
<td>225</td>
<td>78</td>
</tr>
<tr>
<td>Difference 2</td>
<td>(56)</td>
<td>(35)</td>
<td>(12)</td>
</tr>
<tr>
<td>Gwinnett Per Original Survey</td>
<td>106</td>
<td>72</td>
<td>17</td>
</tr>
<tr>
<td>Gwinnett Per AUP</td>
<td>103</td>
<td>68</td>
<td>17</td>
</tr>
<tr>
<td>Difference 1</td>
<td>(3)</td>
<td>(4)</td>
<td>-</td>
</tr>
<tr>
<td>Gwinnett Per Revised List</td>
<td>79</td>
<td>61</td>
<td>15</td>
</tr>
<tr>
<td>Difference 2</td>
<td>(27)</td>
<td>(11)</td>
<td>(2)</td>
</tr>
</tbody>
</table>

*Difference 1: ineligible claims determined by WA*

*Difference 2: ineligible claims determined by WA plus ineligible claims determined by center during resubmission process*
### ATTACHMENT B-2

**SUMMARY FINDINGS BY LOCATION**—Continued

| Locations Tested With Claims Resubmitted | Severity Score Category |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  | Basic | Moderate | Major | Severe | Total |  | Basic | Moderate | Major | Severe | Total |  | Basic | Moderate | Major | Severe | Total |
| **Columbus** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Per Original Survey | 39 | 52 | 16 | 10 | 117 |  |  |  |  |  |  |  |  |  |  |  |
| Per AUP | 38 | 52 | 16 | 9 | 115 |  |  |  |  |  |  |  |  |  |  |  |
| Difference 1 | (1) | - | - | (1) | (2) |  |  |  |  |  |  |  |  |  |  |  |
| Per Revised List | 38 | 52 | 15 | 10 | 115 |  |  |  |  |  |  |  |  |  |  |  |
| Difference 2 | (1) | - | (1) | - | (2) |  |  |  |  |  |  |  |  |  |  |  |
| **North Fulton** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Per Original Survey | 19 | 30 | 6 | 4 | 59 |  |  |  |  |  |  |  |  |  |  |  |
| Per AUP | 19 | 29 | 6 | 3 | 57 |  |  |  |  |  |  |  |  |  |  |  |
| Difference 1 | - | (1) | - | (1) | (2) |  |  |  |  |  |  |  |  |  |  |  |
| Per Revised List | 19 | 29 | 6 | 3 | 57 |  |  |  |  |  |  |  |  |  |  |  |
| Difference 2 | - | (1) | - | (1) | (2) |  |  |  |  |  |  |  |  |  |  |  |
| **Taylor** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Per Original Survey | 10 | 3 | 2 | 1 | 16 |  |  |  |  |  |  |  |  |  |  |  |
| Per AUP | 10 | 3 | 1 | 1 | 15 |  |  |  |  |  |  |  |  |  |  |  |
| Difference 1 | - | - | (1) | - | (1) |  |  |  |  |  |  |  |  |  |  |  |
| Per Revised List | 10 | 3 | 1 | 1 | 15 |  |  |  |  |  |  |  |  |  |  |  |
| Difference 2 | - | - | (1) | - | (1) |  |  |  |  |  |  |  |  |  |  |  |

**Total** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Per Original Survey | 706 | 550 | 186 | 94 | 1,536 |  |  |  |  |  |  |  |  |  |  |  |
| Per AUP | 695 | 543 | 182 | 93 | 1,513 |  |  |  |  |  |  |  |  |  |  |  |
| Difference 1 | (11) | (7) | (4) | (1) | (23) |  |  |  |  |  |  |  |  |  |  |  |
| Per Revised List | 613 | 501 | 169 | 84 | 1,367 |  |  |  |  |  |  |  |  |  |  |  |
| Difference 2 | (93) | (49) | (17) | (10) | (169) |  |  |  |  |  |  |  |  |  |  |  |

*Difference 1: ineligible claims determined by WA*

*Difference 2: ineligible claims determined by WA plus ineligible claims determined by center during resubmission process*
## ATTACHMENT B-2

### SUMMARY FINDINGS BY LOCATION—Continued

<table>
<thead>
<tr>
<th>Locations Tested Without Resubmission</th>
<th>Basic</th>
<th>Moderate</th>
<th>Major</th>
<th>Severe</th>
<th>Total</th>
<th>Severity Score Category</th>
<th>Basic</th>
<th>Moderate</th>
<th>Major</th>
<th>Severe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Per Original Survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Original Survey</td>
<td>180</td>
<td>121</td>
<td>49</td>
<td>29</td>
<td>379</td>
<td>Per Original Survey</td>
<td>79</td>
<td>67</td>
<td>32</td>
<td>15</td>
<td>193</td>
</tr>
<tr>
<td>Per AUP</td>
<td>180</td>
<td>120</td>
<td>49</td>
<td>29</td>
<td>378</td>
<td>Per AUP</td>
<td>79</td>
<td>67</td>
<td>32</td>
<td>15</td>
<td>193</td>
</tr>
<tr>
<td>Difference 1</td>
<td>-</td>
<td>(1)</td>
<td>-</td>
<td>-</td>
<td>(1)</td>
<td>Difference 1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total claims per AUP</td>
<td>180</td>
<td>120</td>
<td>49</td>
<td>29</td>
<td>378</td>
<td>Total claims per AUP</td>
<td>79</td>
<td>67</td>
<td>32</td>
<td>15</td>
<td>193</td>
</tr>
<tr>
<td><strong>Athens</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Per Original Survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Original Survey</td>
<td>17</td>
<td>41</td>
<td>16</td>
<td>11</td>
<td>85</td>
<td>Per Original Survey</td>
<td>7</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Per AUP</td>
<td>17</td>
<td>40</td>
<td>16</td>
<td>11</td>
<td>84</td>
<td>Per AUP</td>
<td>7</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Difference 1</td>
<td>-</td>
<td>(1)</td>
<td>-</td>
<td>-</td>
<td>(1)</td>
<td>Difference 1</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total claims per AUP</td>
<td>17</td>
<td>40</td>
<td>16</td>
<td>11</td>
<td>84</td>
<td>Total claims per AUP</td>
<td>7</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td><strong>Doctors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Per Original Survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Original Survey</td>
<td>90</td>
<td>17</td>
<td>6</td>
<td>5</td>
<td>118</td>
<td>Per Original Survey</td>
<td>17</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Per AUP</td>
<td>90</td>
<td>17</td>
<td>6</td>
<td>5</td>
<td>118</td>
<td>Per AUP</td>
<td>17</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Difference 1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Difference 1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total claims per AUP</td>
<td>90</td>
<td>17</td>
<td>6</td>
<td>5</td>
<td>118</td>
<td>Total claims per AUP</td>
<td>17</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Per Original Survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Original Survey</td>
<td>390</td>
<td>250</td>
<td>106</td>
<td>62</td>
<td>808</td>
<td>Per Original Survey</td>
<td>390</td>
<td>250</td>
<td>106</td>
<td>62</td>
<td>808</td>
</tr>
<tr>
<td>Per AUP</td>
<td>390</td>
<td>248</td>
<td>106</td>
<td>62</td>
<td>806</td>
<td>Per AUP</td>
<td>390</td>
<td>250</td>
<td>106</td>
<td>62</td>
<td>806</td>
</tr>
<tr>
<td>Difference 1</td>
<td>-</td>
<td>(2)</td>
<td>-</td>
<td>-</td>
<td>(2)</td>
<td>Difference 1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total claims per AUP</td>
<td>390</td>
<td>248</td>
<td>106</td>
<td>62</td>
<td>806</td>
<td>Total claims per AUP</td>
<td>390</td>
<td>250</td>
<td>106</td>
<td>62</td>
<td>806</td>
</tr>
</tbody>
</table>

*Difference 1: ineligible claims determined by WA*
### ATTACHMENT B-2

#### SUMMARY FINDINGS BY LOCATION—Continued

<table>
<thead>
<tr>
<th>Locations Not Tested</th>
<th>Severity Score Category</th>
<th>Summary</th>
<th>Severity Score Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic</td>
<td>Moderate</td>
<td>Major</td>
</tr>
<tr>
<td>GHS Per Original Survey</td>
<td>123</td>
<td>95</td>
<td>53</td>
</tr>
<tr>
<td>Floyd Per Original Survey</td>
<td>21</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Hamilton Per Original Survey</td>
<td>15</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Clearview Per Original Survey</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Egleston Per Original Survey</td>
<td>8</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Scottish Rite Per Original Survey</td>
<td>20</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Oconee Per Original Survey</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Wills Per Original Survey</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>190</td>
<td>142</td>
<td>71</td>
</tr>
</tbody>
</table>

**Difference 1:** ineligible claims determined by WA

**Difference 2:** ineligible claims determined by WA plus ineligible claims determined by center during resubmission process
CONCLUSION:

We appreciate the opportunity to be of service to you. This report summarizes the results of our engagement. If you have any questions, please let us know.

Very truly yours,

[Signature]

WARREN AVERETT, LLC