GEORGIA TRAUMA CARE NETWORK COMMISSION

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA

AGREED UPON PROCEDURES

For the Year Ending December 31, 2010
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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, 2010. 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.

August 24, 2012
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

Procedures:
The following are the agreed-upon procedures that Gifford, Hillegass & Ingwersen, LLP (GH&I) was engaged to perform related to the Georgia-designated Trauma Centers (Trauma Centers) listed above.

1. GH&I 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, 2010 (CY2010). GH&I will deliver the survey instrument to all Trauma Centers that were designated for all or part of CY2010 as listed above.

2. GH&I will collect the CY2010 uncompensated care claims survey instruments and detailed listings of uncompensated care claims submitted by each Trauma Center during the period that Trauma Center was designated in CY2010.

3. GH&I will consider each Trauma 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:
ATTACHMENT A

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA: PROCEDURES

a. GH&I will evaluate the quantity and trending of the historical error rate for uncompensated care claims based on the test results of GH&I procedures in prior years.

b. GH&I will consider the consistency or variances noted in the number of claims that each Trauma Center has submitted in the current year compared with prior years.

c. GH&I will consider the volume of claims submitted by each Trauma Center.

d. GH&I will consider the types of errors that were identified during GH&I’s first year of testing (CY2008 data) and evaluate whether the Trauma Center had the same types of errors in GH&I’s CY2009 testing. We will also consider the types of errors that were identified during CY2008 and CY2009 testing and determine if these errors were addressed by the Assistant Attorney General’s letter to Dr. Ashley dated March 15, 2011.

e. GH&I will exclude only one or two Level I Trauma Centers from our testing each year. GH&I will not exclude any Level I Trauma Center from testing for more than one consecutive year.

f. For Level II, III and IV Trauma Centers, GH&I may propose excluding a Trauma Center from testing for two consecutive years, but in the third year GH&I will include the Trauma Center in the sample for testing.

g. GH&I 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.

h. GH&I will also exercise professional judgment in determining the proposed sample of Trauma 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 Center selected for testing as outlined in procedure #3 above, GH&I will select a sample of the uncompensated care claims for testing as follows:

a. For Trauma Centers with less than 25 claims, GH&I will test 5 claims;

b. For Trauma Centers with between 25 and 50 claims, GH&I will test 10 claims;

c. For Trauma Centers with between 50 and 150 claims, GH&I will test 20 claims; and,

d. For Trauma Centers with greater than 150 claims, GH&I will test 40 claims.

5. For each claim selected in procedure #4 above, GH&I will view (on site at the Trauma Center location) the electronic billing record (EBR) or documents comparable to the EBR to determine that as of March 31, 2012 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;
ATTACHMENT A

VALIDATION OF UNCOMPENSATED CARE CLAIM DATA: PROCEDURES

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.

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

7. GH&I will verify that the ISS (Injury Severity Score) assigned to each claim selected in our sample (as defined above) matches the ISS for that patient in NTRACS (trauma registry software) used by all Trauma Centers.

8. GH&I 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.
GH&I 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, GH&I was engaged to perform the following additional procedures:

1. Provide each Trauma Center with the findings from our agreed-upon procedures as described in Attachment A. See the information that was provided to each Trauma Center in Attachment B-2.

2. Request revised lists of uncompensated care claims from the following Trauma Centers:
   - MCCG
   - Memorial
   - Grady
   - Columbus

   These revised lists should be duplicates of the original list provided to GH&I 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 GH&I 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 GH&I AUP report to report the updated uncompensated care claims for each Trauma Center. Results are presented in Attachment B-2.

5. Present our draft report at Georgia Trauma Care Network Commission meeting on August 16, 2012 in Macon, Georgia.

6. Make any additional revisions to our draft report as requested by the Commission.

GH&I 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 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 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
      • Grady
      • Memorial
      • Archbold
      • Columbus

      Recommendation: We recommend the GTCNC consider requesting that these Trauma Centers revise their CY2010 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
      • Columbus
      • North Fulton

      Recommendation: We recommend the GTCNC consider requesting that these Trauma Centers revise their CY2010 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.
      • Grady
      • MCGG
      • GHS
      • Memorial
      • Athens
      • Floyd
      • Columbus
Recommendation: We recommend the GTCNC consider requesting that these Trauma Centers revise their CY2010 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%
   - Morgan

Recommendation: We recommend the GTCNC consider requesting that this Trauma Center revise its CY2010 uncompensated care claim list to exclude all claims where patients paid greater than 10% of the total charges.

E. Receipt of a third party payment
   - Grady
   - MCCG
   - Memorial
   - Athens
   - Columbus
   - Clearview

Recommendation: We recommend that the GTCNC consider requesting these Trauma Centers revise their CY2010 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
   - Columbus

Recommendation: We recommend the GTCNC consider requesting that these Trauma Centers revise their CY2010 uncompensated care claim list to exclude all claims where there were no collection attempts made.
ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

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 20.

- Archbold reported 66 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:
- We verified that the ISS reported is the same as that listed in the hospital’s trauma registry software.

<table>
<thead>
<tr>
<th>Medrec #</th>
<th>Trauma #</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>442165</td>
<td>2316</td>
<td>04/07/2010</td>
<td>9</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>The patient had an Aflac insurance supplemental policy. The patient received a payment but did not pay the hospital.</td>
<td></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: COLUMBUS

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

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

Columbus reported 182 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 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>ACCT ID</th>
<th>Registry #</th>
<th>ISS</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>713575017</td>
<td>7656</td>
<td>4</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>P</td>
<td>Patient had insurance and the hospital received a payment of $645 from Blue Cross Blue Shield. The hospital applied a $8,119.66 contractual adjustment for PPO discount.</td>
</tr>
<tr>
<td>713020048</td>
<td>7261</td>
<td>6</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>The patient was approved for Alabama Medicaid. The hospital received two payments on this account. The hospital received $1,000 from an attorney and $3,152 from Alabama Medicaid.</td>
</tr>
<tr>
<td>713520785</td>
<td>7603</td>
<td>9</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>The hospital received $2,000 from an attorney.</td>
</tr>
<tr>
<td>712908686</td>
<td>7267</td>
<td>12</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>The patient had Tricare insurance. The hospital received a Tricare payment of $5,681.</td>
</tr>
<tr>
<td>713577641</td>
<td>7660</td>
<td>13</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>The patient was approved for GA Medicaid. The hospital received a payment of $18,299.48 from GA Medicaid.</td>
</tr>
<tr>
<td>713363554</td>
<td>7409</td>
<td>14</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>The patient was a Columbus inmate. The hospital has a contract with the state to treat prisoners. There were no collection attempts due to the contract with the state.</td>
</tr>
<tr>
<td>713686186</td>
<td>7741</td>
<td>14</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>The hospital received a $2,000 payment from an attorney.</td>
</tr>
<tr>
<td>713357119</td>
<td>7487</td>
<td>17</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>The patient had Blue Cross Blue Shield (BCBS) insurance. The hospital received a payment of $16,850 from BCBS.</td>
</tr>
<tr>
<td>713089563</td>
<td>7315</td>
<td>22</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>The patient had Medicaid but the hospital did not get authorization to process the Medicaid. The hospital did not receive any payments from Medicaid since the hospital did not get the proper authorization.</td>
</tr>
<tr>
<td>713219582</td>
<td>7410</td>
<td>50</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>X</td>
<td>The patient was approved from Alabama Medicaid. The hospital received a payment of $16,610.72 from Alabama Medicaid.</td>
</tr>
</tbody>
</table>

Tickmark Explanations:

P Step performed without exception
X Step performed with exception, see explanation to right
**ATTACHMENT B-1**

**DETAIL FINDINGS BY LOCATION**

**HOSPITAL: FLOYD**

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

**Procedures:** For hospitals with between 25 and 50 claims, we will test 10. Floyd Medical Center reported 31 claims, therefore we selected a sample of 10 for testing.

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 No</th>
<th>Admit Date</th>
<th>Registry No</th>
<th>ISS</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>F0000961077</td>
<td>8/15/2010</td>
<td>2711</td>
<td>8</td>
<td>P</td>
<td></td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>The hospital's attorney found through his own research that the patient was awarded and received $5,000 from auto insurance medical pay. The hospital did not receive any payments from the patient.</td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**

- **P** Step performed without exception
- **X** Issue noted, see explanation to the right of claim.
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 676 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:

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

2. The patient received a settlement of $850,000. The total charges from the hospital were $23,065.15. The hospital received a payment of $22,921.15 on this account.

3. The patient had BCBS insurance. The hospital wrote off the account to “untimely write-off” because insurance was not filed on time.

4. Patient was a prisoner of the city of Atlanta. The hospital has a contract with the city to treat prisoners. There were no collection attempts due to the contract with the city.

**Tickmark Explanations:**

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

<table>
<thead>
<tr>
<th>Acct No</th>
<th>Medical Record No</th>
<th>Admit Date</th>
<th>ISS</th>
<th>a</th>
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<th>d</th>
<th>e</th>
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<td>457304301</td>
<td>20545795</td>
<td>8-Apr-10</td>
<td></td>
<td></td>
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<td>20572887</td>
<td>10-Oct-10</td>
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<td>X</td>
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<td>P</td>
<td>P</td>
<td>P</td>
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<td>3</td>
<td>456444371</td>
<td>4255833</td>
<td>2-Mar-10</td>
<td>25</td>
<td></td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
</tr>
</tbody>
</table>
ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: MCCG

**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.

MCCG reported 270 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 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 No.</th>
<th>AMIT DATE</th>
<th>Registry No</th>
<th>ISS SCORE</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>1 98628077-0358</td>
<td>24-Dec-10</td>
<td>20230</td>
<td>4</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>The hospital received victim of crime payments on 2/7/11 and on 3/18/11 of $7,500 each.</td>
</tr>
<tr>
<td>2 98200178-0079</td>
<td>20-Mar-10</td>
<td>18907</td>
<td>5</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>The hospital received a victim of crime payment on 5/24/10 of $13,193.50.</td>
</tr>
<tr>
<td>3 98598351-0037</td>
<td>6-Feb-10</td>
<td>18740</td>
<td>10</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>The hospital received victim of crime payments on 4/5/10 and on 6/10/10 of $7,500 each.</td>
</tr>
<tr>
<td>4 98119892-0252</td>
<td>9-Sep-10</td>
<td>19762</td>
<td>17</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>The hospital received a check from Ken Nugent on 2/2/11 for $10,000 as a result of a settlement.</td>
</tr>
<tr>
<td>5 9855013-0001</td>
<td>1-Jan-10</td>
<td>18603</td>
<td>41</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>The hospital received victim of crime payments on 3/11/10 and 6/24/10 for $7,500 each.</td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**

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

**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.

GHS reported 232 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:

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

<table>
<thead>
<tr>
<th>MRN</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>9036710</td>
<td>10/7/10</td>
<td>11</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>Patient received a settlement of $25,000. The attorney requested a discount based on the settlement and the hospital accepted the attorney’s request but the hospital never received a payment.</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: 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 272 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:

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

<table>
<thead>
<tr>
<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>1010700017</td>
<td>4/17/2010</td>
<td>1</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>The hospital received a victim of crime payment of $11,239 on 8/20/10 that was greater than 10% of the patient’s total charges.</td>
</tr>
<tr>
<td>1012200263</td>
<td>5/2/2010</td>
<td>4</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>The patient account was sold to a collection agency.</td>
</tr>
<tr>
<td>1009900925</td>
<td>4/9/2010</td>
<td>4</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>The patient account was sold to a collection agency.</td>
</tr>
<tr>
<td>300007061</td>
<td>5/23/2010</td>
<td>13</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>The patient had a supplemental indemnity plan insurance that paid the patient $200/day up to $1,000. The hospital, however, never received a payment from the patient or the insurance provider.</td>
</tr>
<tr>
<td>1015400540</td>
<td>6/3/2010</td>
<td>14</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>The patient had BCBS medical insurance. A payment from BCBS was received on May 2, 2012 for $5,500 on total charges of $37,867.87. While the payment was received after the cut-off date of March 31, 2012, it is not eligible due to the patient having insurance when admitted.</td>
</tr>
<tr>
<td>1005200036</td>
<td>2/23/2010</td>
<td>19</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>The patient account was sold to a collection agency.</td>
</tr>
<tr>
<td>300007702</td>
<td>1/4/2010</td>
<td>59</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>The patient received a settlement of $25,000. The hospital asked the attorney to pay $10,000 of the amount awarded. The attorney’s office countered with $5,000. The hospital countered with $7,500 and the attorney accepted. The hospital received a payment of $7,500 on 12/8/10 from Progressive Insurance. Total hospital charges were $291,000.</td>
</tr>
</tbody>
</table>

Tickmark Explanations:

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

14
ATTACHMENT B-1
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 91 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>
<th>P</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2055</td>
<td>5393332</td>
<td>9/14/10</td>
<td>F</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>The hospital received a payment of $621 from the patient’s medical pay auto insurance.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2141</td>
<td>5448523</td>
<td>12/26/10</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>The patient was eligible for bodily injury coverage through auto insurance. There was $25,000 available for all of her bills. The insurance company wants the entire amount to be written off and the hospital has countered but no settlement has been reached.</td>
<td></td>
</tr>
</tbody>
</table>

**Tickmark Explanations:**

- **P** Step performed without exception
- **X** Step performed with exception, see comments to the right for more information.
**ATTACHMENT B-1**

**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 73 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.

| Registry No | Patient Account Number | Admit Date     | Injury Severity Code | a | b | c | d | e | f | l | Comments                                                                 |
|-------------|------------------------|----------------|----------------------|---|---|---|---|---|---|-----------------------------|---|--------------------------------------------------------------------------|
| 1           | 4416                   | 18805978       | 2010/07/02           | X | P | P | P | P | P | Patient was eligible and approved for Medicaid coverage. No payments were received as of 5/8/12. |

**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: CLEARVIEW

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.

Clearview reported 17 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>Medical Record No</th>
<th>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>
<tbody>
<tr>
<td>1</td>
<td>2280275</td>
<td>718</td>
<td>17-May-10</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>The hospital sold the account to a collection agency.</td>
</tr>
<tr>
<td>2</td>
<td>2307060</td>
<td>891</td>
<td>15-Dec-10</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>The hospital sold the account to a collection agency.</td>
</tr>
<tr>
<td>3</td>
<td>2298652</td>
<td>840</td>
<td>10-Oct-10</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>The hospital sold the account to a collection agency.</td>
</tr>
<tr>
<td>4</td>
<td>2266077</td>
<td>635</td>
<td>28-Jan-10</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>The hospital sold the account to a collection agency.</td>
</tr>
<tr>
<td>5</td>
<td>2275880</td>
<td>690</td>
<td>14-Apr-10</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td>The hospital sold the account to a collection agency.</td>
</tr>
</tbody>
</table>

Tickmark Explanations:

P Step performed without exception
X Issue noted, see explanation to the right of claim.

Results: The results of our testing of the sample of 5 claims indicated there was an issue with criteria e. All 5 of the claims in our sample were sold to a collection agency.

We tested the remaining 12 claims specifically for criteria e to determine if these accounts were also sold to a collection agency. Based on this additional testing, we determined that all 17 claims that were originally submitted by Clearview were sold to a collection agency and, therefore, were not eligible as uncompensated care claims. We did not request Clearview to resubmit their list since we determined that all claims were ineligible.
ATTACHMENT B-1

DETAIL FINDINGS BY LOCATION

HOSPITAL: MORGAN

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.

Morgan reported 6 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:

I 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>p</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>83</td>
<td>279832</td>
<td>10/17/2010</td>
<td>4</td>
<td>P</td>
<td>P</td>
<td>X</td>
<td>P</td>
<td>P</td>
<td></td>
<td>The patient made payments that are more than 10% of the total patient charges. Total charges were $1,352 and the patient paid $345 for a total of 26%.</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

### Locations Tested With Claims Resubmitted

<table>
<thead>
<tr>
<th>Location</th>
<th>ISS Category 0-4</th>
<th>ISS Category 5-8</th>
<th>ISS Category 9</th>
<th>ISS Category 10-15</th>
<th>ISS Category 16-24</th>
<th>ISS Category &gt;24</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grady</strong></td>
<td>Per Original Survey</td>
<td>228</td>
<td>66</td>
<td>117</td>
<td>116</td>
<td>80</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Per AUP</td>
<td>227</td>
<td>66</td>
<td>117</td>
<td>114</td>
<td>80</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Difference 1</td>
<td>(1)</td>
<td>-</td>
<td>-</td>
<td>(2)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Per Revised List</td>
<td>204</td>
<td>62</td>
<td>105</td>
<td>99</td>
<td>66</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Difference 2</td>
<td>(24)</td>
<td>(4)</td>
<td>(12)</td>
<td>(17)</td>
<td>(14)</td>
<td>(10)</td>
</tr>
<tr>
<td></td>
<td>Per AUP</td>
<td>65</td>
<td>46</td>
<td>28</td>
<td>58</td>
<td>40</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Difference 1</td>
<td>(1)</td>
<td>(1)</td>
<td>-</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Per Revised List</td>
<td>42</td>
<td>35</td>
<td>20</td>
<td>52</td>
<td>34</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Difference 2</td>
<td>(24)</td>
<td>(12)</td>
<td>(8)</td>
<td>(7)</td>
<td>(7)</td>
<td>(14)</td>
</tr>
<tr>
<td><strong>MCCG</strong></td>
<td>Per Original Survey</td>
<td>66</td>
<td>47</td>
<td>28</td>
<td>59</td>
<td>41</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Per AUP</td>
<td>65</td>
<td>46</td>
<td>28</td>
<td>58</td>
<td>40</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Difference 1</td>
<td>(1)</td>
<td>(1)</td>
<td>-</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Per Revised List</td>
<td>42</td>
<td>35</td>
<td>20</td>
<td>52</td>
<td>34</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Difference 2</td>
<td>(24)</td>
<td>(12)</td>
<td>(8)</td>
<td>(7)</td>
<td>(7)</td>
<td>(14)</td>
</tr>
<tr>
<td><strong>Memorial</strong></td>
<td>Per Original Survey</td>
<td>60</td>
<td>48</td>
<td>41</td>
<td>55</td>
<td>49</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Per AUP</td>
<td>57</td>
<td>48</td>
<td>41</td>
<td>53</td>
<td>48</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Difference 1</td>
<td>(3)</td>
<td>-</td>
<td>-</td>
<td>(2)</td>
<td>(1)</td>
<td>(1)</td>
</tr>
<tr>
<td></td>
<td>Per Revised List</td>
<td>51</td>
<td>43</td>
<td>40</td>
<td>54</td>
<td>44</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Difference 2</td>
<td>(9)</td>
<td>(5)</td>
<td>(1)</td>
<td>(1)</td>
<td>(5)</td>
<td>1</td>
</tr>
</tbody>
</table>

**Columbus**

<table>
<thead>
<tr>
<th>ISS Category 0-4</th>
<th>ISS Category 5-8</th>
<th>ISS Category 9</th>
<th>ISS Category 10-15</th>
<th>ISS Category 16-24</th>
<th>ISS Category &gt;24</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Original Survey</td>
<td>36</td>
<td>27</td>
<td>34</td>
<td>41</td>
<td>34</td>
<td>10</td>
</tr>
<tr>
<td>Per AUP</td>
<td>35</td>
<td>26</td>
<td>33</td>
<td>37</td>
<td>32</td>
<td>9</td>
</tr>
<tr>
<td>Difference 1</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(4)</td>
<td>(2)</td>
<td>(1)</td>
</tr>
<tr>
<td>Per Revised List</td>
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**Total**

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**Difference 1:** ineligible claims determined by GH&I

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

**SUMMARY FINDINGS BY LOCATION—Continued**

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<th>Athens</th>
<th>Morgan</th>
<th>Floyd</th>
<th>Clearview</th>
<th>Archbold</th>
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**Difference 1: ineligible claims determined by GH&I**
### ATTACHMENT B-2

#### SUMMARY FINDINGS BY LOCATION—Continued

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*Difference 1: ineligible claims determined by GH&I*

*Difference 2: ineligible claims determined by GH&I plus ineligible claims determined by center during resubmission process*
## SUMMARY FINDINGS BY LOCATION—Continued

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---

**ATTACHMENT B-2**
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]

GIFFORD, HILLEGASS & INGWERSEN, LLP