DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

January 31, 2011

Report Number: A-04-09-04034

Mr. Lanier M. Cansler
Secretary
North Carolina Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Mr. Cansler:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Part A Bad Debts at John Umstead Hospital for Fiscal Year Ended June 30, 2005*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Mark Wimple, Audit Manager, at (919) 790-2765, extension 24, or through email at Mark.Wimple@oig.hhs.gov. Please refer to report number A-04-09-04034 in all correspondence.

Sincerely,

/Peter J. Barbera/
Regional Inspector General
for Audit Services

Enclosure

(docu name 904034Ftr.doc) HHS/OIG/OAS/R IV/MWimple/TRauch/EZyga

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health & Human Services
OFFICE OF
INSPECTOR GENERAL

REVIEW OF MEDICARE PART A BAD DEBTS AT JOHN UMSTEAD HOSPITAL FOR FISCAL YEAR ENDED JUNE 30, 2005

Daniel R. Levinson
Inspector General

January 2011
A-04-09-04034

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency within the U.S. Department of Health & Human Services that administers the Federal Medicare program and provides Federal oversight of State Medicaid programs. CMS contracts with Medicare fiscal intermediaries and administrative contractors to, among other things, process and pay claims submitted by Medicare providers. Fiscal intermediary and Medicare administrative contractor responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Fiscal intermediaries and Medicare administrative contractors use the Medicare cost report for final settlement of Medicare reimbursement with providers.

Section 1813 of the Social Security Act (42 U.S.C. § 1395e) mandates that beneficiaries should share in defraying the costs of inpatient care through paying various deductibles and coinsurance amounts. When Medicare patients do not pay these deductibles and coinsurance amounts, hospitals incur Medicare bad debts. Provided these Medicare bad debts meet Medicare reimbursement criteria, they are reimbursable on a hospital's annual Medicare cost report.

Federal regulations (42 CFR § 413.89(e)) provide that, for bad debts to be eligible for reimbursement, the hospital must show that (1) the bad debts are related to Medicare covered services and derived from unpaid deductible and coinsurance amounts, (2) it made reasonable collection efforts, (3) the debts were actually uncollectible when claimed as worthless, and (4) sound business judgment established there was no likelihood of recovery at any time in the future. Furthermore, Federal regulations (42 CFR § 413.89(f)) require hospitals to reduce their bad debts by the amount that they recover from previously written off bad debts.

John Umstead Hospital

John Umstead Hospital (Umstead) was a 420-bed psychiatric hospital located in Butner, North Carolina. During our audit period, the North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the State) operated Umstead. However, in July 2008 the State made Umstead Hospital a satellite operation of the newly constructed Central Regional Hospital, also operated by the State. Because Umstead is now only a satellite operation of the new hospital and not a separate free-standing hospital, we have directed our recommendations to the State. On its hospital cost report for July 1, 2004, through June 30, 2005, Umstead claimed $473,268 for Medicare inpatient bad debts (bad debts). Because Federal regulations (42 CFR § 413.89(h)) reduced reimbursement for bad debts by 30 percent in fiscal year (FY) 2005, Medicare reimbursed 70 percent, or $331,288, of the bad debts claimed by Umstead on its FY 2005 Medicare cost report.

OBJECTIVE

Our objective was to determine whether Umstead claimed bad debts on its FY 2005 hospital cost report that were allowable under Medicare regulations and were reduced by bad debt recoveries.

SUMMARY OF FINDINGS

Umstead properly reported 95 out of our sample of 100 bad debts on its FY 2005 hospital cost report. The remaining five sampled bad debts totaling $15,901 were partially unallowable. Three of these bad debts were partially unallowable because Umstead did not subject the accounts to reasonable collection efforts and two were partially unallowable because a portion of the amount claimed did not relate to Medicare deductible and coinsurance amounts. The total unallowable portion of these five bad debts was $2,289.

Umstead claimed unallowable bad debts because it did not always follow State policies and procedures, as outlined in the *North Carolina Cash Management Plan*. In addition, Umstead lacked sufficient controls to ensure that only bad debts that related to Medicare deductibles and coinsurance were reported on the cost report.

Finally, Umstead did not reduce its bad debts by bad debt recoveries. Umstead did not properly report $2,102 in bad debt recoveries on the cost report because it did not have adequate controls to ensure that it accurately transferred the bad debt recoveries from supporting documentation to the cost report.

RECOMMENDATIONS

We recommend that the State:

- follow its policies and procedures with regard to determining the patient's ability to pay and attempting to collect from the patient;

- establish additional controls to ensure that only bad debts relating to Medicare deductibles and coinsurance are claimed for Medicare reimbursement, including establishing a separate transaction code to record write-offs of non-covered charges or other items not qualifying for Medicare bad debt reimbursement; and

- establish additional controls to ensure that Medicare bad debt recoveries are reported.

For CMS or a fiscal intermediary to reopen a cost report that has been settled, it must mail a notice of intent to reopen the cost report within 3 years of the date of the final settlement of the cost report (42 CFR § 405.1885 (b)). Because the final settlement for Umstead's FY 2005 cost report occurred on May 19, 2006, the 3-year period to issue a notice of intent to reopen has expired. Accordingly, we are not recommending that the fiscal intermediary reopen the cost report and recoup the excess reimbursement that resulted from the errors.

STATE COMMENTS

The State concurred with our findings and listed the actions it is taking in response to our recommendations. However, the State said that designing and developing a revenue write-off transaction code would be too costly due to information technology system limitations.

The State's comments are included in their entirety as Appendix B.

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INTRODUCTION

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency within the U.S. Department of Health & Human Services that administers the Federal Medicare program and provides Federal oversight of State Medicaid programs.

Medicare Fiscal Intermediaries and Administrative Contractors

CMS contracts with Medicare fiscal intermediaries[1] and administrative contractors to, among other things, process and pay claims submitted by Medicare providers. Fiscal intermediary and Medicare administrative contractor responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Fiscal intermediaries and Medicare administrative contractors use the Medicare cost report for final settlement of Medicare reimbursement with providers.

Medicare Bad Debt Policy

Section 1813 of the Social Security Act (42 U.S.C. § 1395e) mandates that beneficiaries should share in defraying the costs of inpatient care through paying various deductibles and coinsurance amounts. When Medicare patients do not pay these deductibles and coinsurance amounts, hospitals incur Medicare bad debts. Medicare bad debts are amounts considered to be uncollectible from accounts and notes receivable created or acquired in providing services for Medicare patients. Hospitals claim reimbursement for these bad debts on their annual Medicare cost reports.

The Medicare program reimburses hospitals for bad debts associated with uncollectible Medicare deductible and coinsurance amounts if the bad debts meet Medicare reimbursement criteria. Federal regulations (42 CFR § 413.89(e)) provide that, for bad debts to be eligible for reimbursement, the hospital must show that (1) the bad debts are related to Medicare covered services and derived from unpaid deductible and coinsurance amounts, (2) it made reasonable collection efforts, (3) the debts were actually uncollectible when claimed as worthless, and (4) sound business judgment established there was no likelihood of recovery at any time in the future. Furthermore, Federal regulations (42 CFR § 413.89(f)) require hospitals to reduce their bad debts by the amount that they recover from previously written off bad debts.

The *Provider Reimbursement Manual* (PRM) (CMS Pub. No. 15-1, chapter 3, § 312) allows for a hospital to write off a bad debt without collection efforts if the hospital determines the patient to be indigent. In such cases, hospitals are required to determine that no source other

[1] Effective October 1, 2005, Congress amended the Social Security Act to require that CMS contract with Medicare administrative contractors instead of fiscal intermediaries (Part A) and carriers (Part B) by October 2011. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. No. 108-173 § 911), Social Security Act, §§ 1816 and 1842, and 42 U.S.C. §§ 1395h, 1395u and 1395kk-1.

than the patient would be legally responsible for the patient's medical bill, including Medicaid for Medicaid-eligible patients, unless the services were categorically precluded from Medicaid reimbursement by Federal statute.

John Umstead Hospital

John Umstead Hospital (Umstead) was a 420-bed psychiatric hospital located in Butner, North Carolina. As a hospital that was primarily engaged in providing diagnosis and treatment of persons with mental diseases, Umstead was considered an institution for mental diseases (IMD). During our audit period (fiscal year (FY) 2005), the North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the State) operated Umstead. However, in July 2008 the State made Umstead Hospital a satellite operation of the newly constructed Central Regional Hospital, also operated by the State. Because Umstead is now only a satellite operation of the new hospital and not a separate free-standing hospital, we have directed our recommendations to the State.

On its hospital cost report for July 1, 2004, through June 30, 2005, Umstead claimed $473,268 for Medicare inpatient bad debts (bad debts). Because Federal regulations (42 CFR § 413.89(h)) reduced reimbursement for bad debts by 30 percent in FY 2005, Medicare reimbursed 70 percent, or $331,288, of the bad debts claimed by Umstead on its FY 2005 Medicare cost report.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Umstead claimed bad debts on its FY 2005 hospital cost report that were allowable under Medicare regulations and were reduced by bad debt recoveries.

Scope

Our review included $473,268 in bad debts that Umstead claimed on its FY 2005 hospital cost report. We limited our review of Umstead's internal controls to those controls applicable to managing and reporting its bad debts.

We conducted our fieldwork at the State offices in Raleigh, North Carolina, and at Umstead in Butner, North Carolina.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;

- interviewed CMS officials regarding Medicare bad debt program guidance;
- evaluated Umstead's policies and procedures regarding the collection of deductibles and coinsurance amounts;
- obtained a list of bad debts claimed in FYs 2004, 2005, and 2006;
- verified that Umstead claimed no duplicate bad debts on its FY 2005 cost report;
- validated the population of FY 2005 bad debts written off;
- reviewed the accuracy and completeness of bad debt recoveries reported by Umstead for FY 2005;
- selected and reviewed a random sample of 100 bad debts totaling $134,757; and
- reviewed the patient accounting financial records, Medicare remittance documents, and collection activity records for the 100 bad debts in our random sample.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Umstead properly reported 95 out of our sample of 100 bad debts on its FY 2005 hospital cost report. The remaining five sampled bad debts totaling $15,901 were partially unallowable. Three of the remaining bad debts were partially unallowable because Umstead did not subject the accounts to reasonable collection efforts and two were partially unallowable because a portion of the amount claimed did not relate to Medicare deductible and coinsurance amounts. The total unallowable portion of these five bad debts was $2,289.

Umstead claimed unallowable bad debts because it did not always follow State policies and procedures, as outlined in the *North Carolina Cash Management Plan*. In addition, Umstead lacked sufficient controls to ensure that only bad debts that related to Medicare deductibles and coinsurance were reported on the cost report.

Finally, Umstead did not reduce its bad debts by bad debt recoveries. Umstead did not properly report $2,102 in bad debt recoveries on the cost report because it did not have adequate controls to ensure that it accurately transferred the bad debt recoveries from supporting documentation to the cost report.

ACCOUNTS NOT SUBJECTED TO REASONABLE COLLECTION EFFORTS

Federal regulations (42 CFR § 413.89(e)(2)) state that, for a bad debt to be allowable, "[t]he provider must be able to establish that reasonable collection efforts were made." In addition, the PRM (CMS Pub. No. 15-1, chapter 3, § 310.2) states that "[i]f after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible." The PRM (Pub. No. 15-1, chapter 3, § 310.B) requires that the provider's collection efforts be documented in the patient's file.

According to the PRM (Pub. No. 15-1, chapter 3, § 312), a hospital may write off a bad debt without collection efforts if the patient is determined by the hospital to be indigent. Otherwise, some collection efforts are required. The patient's file should, however, "contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination." As an IMD, Umstead was not required to bill Medicaid for Medicaid-eligible indigent patients aged 22 to 64 because Federal law[2] precludes Medical Assistance coverage for services provided to these individuals.[3.]

The *North Carolina Cash Management Plan* requires hospitals to calculate a patient's ability to pay (ATP) based on several factors, including the patient's income, expenses, and property ownership. Under this policy, the hospital must try to collect the ATP amount, but may immediately write off the remainder of the patient's balance without collection efforts. This approach amounts to a determination of indigence for the portion that is immediately written off and complies with the PRM (CMS Pub. No. 15-1, chapter 3, § 312) cited above.

For three bad debts totaling $4,488, Umstead considered the accounts to be entirely uncollectible based on patient indigence and, consequently, made no collection efforts on these claims. However, Umstead did not sufficiently document the basis for considering the patients indigent. For two of these accounts, Umstead wrote off the accounts without collection efforts because the Social Security Administration was sending the patients' checks to persons other than the patients. For the other account, Umstead accepted as proof of indigence a simple declaration from the patient's power of attorney that the patient was unable to pay. The unallowable portion of the three bad debts totaled $142, which represents the sum of the calculated ATP amounts.

BAD DEBTS NOT RELATED TO DEDUCTIBLES AND COINSURANCE

Federal regulations (42 CFR § 413.89(e)(1)) state that for a bad debt to be allowable, it must be related to covered services and derived from deductible and coinsurance amounts. However, for two bad debts, totaling $11,413, Umstead did not derive the entire amount claimed from Medicare deductible and coinsurance amounts. The unallowable portion of

[2] Social Security Act, § 1905(a)(1), (14), (16), 42 U.S.C. § 1396d(a)(1), (14), (16); 42 CFR § 435.1008(a)(2).

[3] Of the 100 sampled patients, 99 were aged 22 to 64 and the remaining patient was not Medicaid eligible for the dates of service sampled.

these bad debts was $2,147 and was derived primarily from non-covered charges. Umstead did not have a separate transaction code to record write-offs of non-covered charges or other items not qualifying for Medicare bad debt reimbursement.

MEDICARE BAD DEBT RECOVERIES NOT REPORTED

According to Federal regulations (42 CFR § 413.89(f)), the amounts uncollectible from specific beneficiaries are to be written off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to the Medicare program may be recovered in a subsequent accounting period; in such cases, the income from the bad debt recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made.

Contrary to these guidelines, Umstead did not properly report $2,102 in bad debt recoveries on the cost report, which resulted in excess reimbursement of $1,471. The error occurred because the amount that Umstead claimed for reimbursement excluded a column from a bad debts worksheet that contained net recoveries. Umstead did not have adequate controls to ensure that the bad debt recoveries were accurately transferred from supporting documentation to the cost report.

CONCLUSION

Our sample review identified five bad debts totaling $15,901 that were partially unallowable because they were either not subject to reasonable collection efforts or not related to Medicare deductibles and coinsurance. The unallowable portion of these bad debts totaled $2,289 and resulted in $1,602 in excess reimbursement. In addition, Umstead's improper reporting of its bad debt recoveries resulted in a $2,102 overstatement of bad debts claimed and excess reimbursement of $1,471.

RECOMMENDATIONS

We recommend that the State:

- follow its policies and procedures with regard to determining the patient's ability to pay and attempting to collect from the patient;

- establish additional controls to ensure that only bad debts relating to Medicare deductibles and coinsurance are claimed for Medicare reimbursement, including establishing a separate transaction code to record writeoffs of noncovered charges or other items not qualifying for Medicare bad debt reimbursement; and

- establish additional controls to ensure that Medicare bad debt recoveries are reported.

For CMS or a fiscal intermediary to reopen a cost report that has been settled, it must mail a notice of intent to reopen the cost report within 3 years of the date of the final settlement of the cost report (42 CFR § 405.1885 (b)). Because the final settlement for Umstead's FY 2005

cost report occurred on May 19, 2006, the 3-year period to issue a notice of intent to reopen has expired. Accordingly, we are not recommending that the fiscal intermediary reopen the cost report and recoup the excess reimbursement that resulted from the errors.

STATE COMMENTS

The State concurred with our findings and listed the actions it is taking in response to our recommendations. However, the State said that designing and developing a revenue write-off transaction code would be too costly due to information technology system limitations.

The State's comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicare Part A bad debt accounts that John Umstead Hospital (Umstead) claimed on its fiscal year (FY) 2005 hospital cost report.

SAMPLING FRAME

The North Carolina Health and Human Services Controller's office provided us with a Microsoft Excel file containing all of Umstead's FY 2005 Medicare Part A bad debt accounts. The file contained 1,149 different accounts totaling $473,268. We sorted the spreadsheet in descending order and created two groups—those bad debts that were less than $500 and those $500 or greater. There were 726 accounts totaling –$78,329 that had balances ranging from $496 to a negative balance of –$4,584. We excluded from our sampling frame all of these accounts with a balance less than $500. The sampling frame was the remaining 423 accounts totaling $551,597 that were $500 or greater.

SAMPLE UNIT

The sample unit was a "Medicare Part A bad debt account." A "Medicare Part A bad debt account" is the deductible and/or coinsurance from a patient's Medicare remittance advice that has not been collected after reasonable efforts to collect have been made.

Because the facility billed and was paid by Medicare on a monthly basis for patients who were hospitalized for multiple months, the deductible and/or coinsurance from each remittance advice was its own Medicare Part A bad debt account (i.e., any given patient could account for multiple sampling units for the same stay).

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 "Medicare Part A bad debt accounts."

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered our sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

OIG/OAS sampling policy requires six errors in a sample to estimate the amount of unallowable bad debts. We identified only five errors in our sample. Therefore, we did not estimate the total amount of bad debts that Umstead improperly reported on its FY 2005 hospital cost report.

APPENDIX B: STATE COMMENTS

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

January 11, 2011

Mr. Peter J. Barbera
Regional Inspector General for Audit Services
US DHHS Office of Inspector General
61 Forsyth Street SW
Suite 3T41
Atlanta, GA 30303

Re: Review of Medicare Part A Bad Debts at John Umstead Hospital for Fiscal Year Ended June 30, 2005
CIN A-04-09-04034

Dear Mr. Barbera:

The North Carolina Department of Health and Human Services (NCDHHS) received your December 1, 2010 letter and the draft report entitled "Medicare Part A Bad Debts at John Umstead Hospital for Fiscal Year Ended June 30, 2005" [Audit A-04-09-04034].

The recommendations were for the State to:

- follow its policies and procedures with regard to determining the patient's ability to pay and attempting to collect from the patient;
- establish additional controls to ensure that only bad debts relating to Medicare deductibles and coinsurance are claimed for Medicare reimbursement, including establishing a separate transaction code to record write-offs of non-covered charges or other items not qualifying for Medicare bad debt reimbursement; and
- establish additional controls to ensure that Medicare bad debt recoveries are reported.

For CMS or a fiscal intermediary to reopen a cost report that has been settled, it must mail a notice of intent to reopen the cost report within 3 years of the date of the final settlement of the cost report (42 CFR § 405.1885 (b)). Because the final settlement for Umstead's FY 2005 cost report occurred on May 19, 2006, the 3-year period to issue a notice of intent to reopen has expired. Accordingly, we are not recommending that the fiscal intermediary reopen the cost report and recoup the excess reimbursement that resulted from the errors.

DHHS Response: The Department concurs with the finding in Report Number A-04-09-04034 that John Umstead Hospital claimed unallowable bad debts because it did not follow State policies and procedures outlined in the North Carolina Department of Health and Human Services (DHHS) Cash Management Plan. The DHHS Controller's Office Accounts Receivable-Central Billing Office (AR-CBO) and John Umstead Hospital Patient Relations Office has taken corrective action by reviewing referenced policies and procedures to ensure that adequate financial information is gathered to support the Ability to Pay (ATP) documentation.

As indicated in the Cash Management Plan, the unpaid difference between the patient liability and the ATP amount is the "contractually compromised" amount under N.C. General Statute 143-118 or indigency allowance that is written-off the account. Hospital management has agreed that due diligence to accurately determine and document ATP is absolutely imperative for all accounts receivable deemed self pay. Furthermore, the Department is reviewing the current ATP determination methodology to ascertain that a most reasonable and effective approach for ATP determination is being utilized by Patient Relations Offices in NC DHHS Healthcare Facilities.

The Department concurs with the finding that John Umstead Hospital reported a portion of a bad debt amount unrelated to a Medicare deductible and coinsurance. However, the recommendation regarding the need for additional internal controls is not entirely feasible as the design and development of a revenue write-off transaction code is too costly due to information technology system limitations.

The Department agrees that CMS regulations allow indigence allowances and bad debt write-offs related to unpaid deductibles and coinsurances which are validated through a manual process performed by the AR–CBO. A thorough review of each Medicare patient account is required to ascertain Medicare Bad Debts are accurately reported and claimed on the Medicare Cost Report. The single instance of an unallowable amount identified in a Medicare account was simply the result of an AR–CBO oversight. This matter has been reviewed with AR–CBO staff and supervisors to ensure due diligence is exercised and this sort of error is minimized in the future.

The Department concurs with the finding that Medicare bad debt recoveries were identified and not accurately reported on the Medicare Cost report. As a result of the finding, the AR–CBO revised the reporting format to more effectively identify recoveries so Medicare bad debts will not be overstated.

Please contact Monica Hughes at (919) 855-3720 if you have any questions.

Sincerely,

Lanier M. Cansler

cc: Dan Stewart, CPA
Eddie Berryman, CPA
Laketha M. Miller, CPA
Larry Huffman
Leigh Ann Kerr