PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D3

PROVIDER –
Maine Medical Center
Portland, Maine

Provider No.: 20-0009

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services

DATE OF HEARING
November 15, 2011

Cost Reporting Periods Ended -
September 30, 2002 and September 30, 2003

CASE NOs.: 06-1318 and 07-1386

INDEX

ISSUE:

Whether the Intermediary's exclusion of the crossover bad debts for cost reporting periods ended September 30, 2002 and September 30, 2003 due to a lack of documentation was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. *See* 42 U.S.C. § 1395 *et seq*. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. § 1395h and §1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. The cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. *See* 42 C.F.R. § 413.20. Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). *See* 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the receipt of the NPR. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

As previously mentioned, Medicare is a federal program that provides health insurance to the aged and disabled. Medicaid is a federal-state program that enables states to provide necessary medical care to individuals whose resources are inadequate to pay for such care. 42 U.S.C. §§ 1396-1396v. Individuals who are entitled to Medicare and are eligible for some form of a state's Medicaid benefit are referred to as dual eligible beneficiaries ("dual eligibles").

Under the federal Medicaid statute, "[A] State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost-sharing to the extent that payment under subchapter XVIII of this chapter for the service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a Medicare beneficiary." 42 U.S.C. § 1396a(n)(2). In the case in which a State's payment for Medicare cost-sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated, the amount of payment made under Title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service, and the beneficiary shall not have any legal liability to make payment for the service. 42 U.S.C. § 1396a(n)(3).

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[1] FIs and MACs are hereinafter referred to as intermediaries.

In 1987, Congress enacted § 4008 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987),[2] which became known as the Bad Debt Moratorium:

> (c) CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.— In making payments to hospitals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort).

In 1988, Congress added the following language to the Bad Debt Moratorium:

> SEC. 8402. MAINTENANCE OF BAD DEBT COLLECTION POLICY. Effective as of the date of the enactment of the Omnibus Budget Reconciliation Act "42 USC 1395f note" of 1987, section 4008(c) of such Act is amended by inserting after "reasonable collection effort" the following: ", including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency."[3]

In the implementing regulations, bad debts are defined as deductions from revenue that are not to be included in allowable costs. 42 C.F.R. § 413.80(a).[4] In order to ensure that costs attributable to covered services furnished to Medicare beneficiaries are not borne by individuals who are not covered by the Medicare program, bad debts attributable to Medicare deductibles and coinsurance are reimbursable. 42 C.F.R. § 413.80(d).

To be allowable, bad debts must meet the following criteria:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
(2) The provider must be able to establish that reasonable collection efforts were made.
(3) The debt was actually uncollectible when claimed as worthless.
(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

42 C.F.R. § 413.80(e)(2002 and 2003).

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[2] *See* OBRA 1987, Pub. L. No. 100-203, § 4008(c), 101 Stat. 1330, 1355 (1987) (reprinted in 42 U.S.C. § 1395f note).

[3] Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8402,102 Stat. 3342, 3798 (1988) (reprinted in 42 U.S.C. § 1395f note).

[4] For the cost reporting periods at issue, the bad debt regulation was 42 C.F.R. § 413.80. The regulation was subsequently re-designated as 42 C.F.R. § 413.89. *See*, 69 FR 49254, Aug. 11, 2004.

CMS publishes a Provider Reimbursement Manual ("PRM") (CMS Pub. 15-1 and 15-2) that contains guidelines and policies to implement the Medicare regulations. Specific to the instant case, PRM 15-1 § 308 mirrors 42 C.F.R. § 413.89(e) in outlining the four main criteria that must be satisfied in order for bad debts to be reimbursable by Medicare.

PRM 15-1 § 310 addresses the concept of "reasonable collection effort" as follows:

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

PRM 15-1 § 312 states that, "providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively." For such beneficiaries, the debt may be deemed uncollectible without applying the collection procedures outlined in CMS Pub. 15-1, § 310.

PRM 15-1, § 322 addresses Medicare bad debts under State welfare programs. In pertinent part, § 322, states:

> Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically or medically needy persons. For example, a State which covers hospital care for only 30 days for Medicaid recipients is not obligated (unless made part of the State title XIX plan) to pay all or part of the Medicare coinsurance from the 61st day on. For services that are within the scope of the title XIX plan, States continue to be obligated to pay the full deductible and coinsurance for categorically needy persons for most services, but can impose some cost sharing under the plan on medically needy persons as long as the amount paid is related to the individual's income or resources.
>
> Where the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance

> amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements of §312 or, if applicable, §310 are met.

CMS Pub. 15-2, § 1102 contains the Provider Cost Report Reimbursement Questionnaire and Instructions Form CMS-339 (cost report). Specific to the instant case, and for the cost reporting periods at issue, CMS Pub 15-2 § 1102.3 addresses debt collection activities pertaining to crossover bad debts (bad debts relating to dual eligible beneficiaries). The instructions state in relevant part:

> Evidence of a debt arising from Medicare/Medicaid crossovers may include a copy of the Medicaid remittance showing the crossover claim and resulting Medicaid payment or non-payment. However, it may not be necessary for a provider to actually bill the Medicaid program to establish a Medicare crossover bad debt where the provider can establish that Medicaid is not responsible for payment. In lieu of billing the Medicaid program, the provider must furnish documentation of:
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> - Medicaid eligibility at the time services were rendered (via valid Medicaid eligibility number), and
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> - Nonpayment would have occurred if the crossover claim had actually been filed with Medicaid.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Maine Medical Center (the Provider) is a voluntary not-for-profit general short term hospital located in Portland Maine. For the cost reporting periods at issue, the Provider claimed crossover bad debts for uncollected coinsurance and deductible amounts related to the care of dual eligibles. National Government Services ("Intermediary") reviewed the cost reports and issued NPRs disallowing the crossover bad debts for which there were no state Medicaid remittance advices.

The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The Provider was represented by William Stiles, Esq. from the law firm Verrill Dana LLP. The Intermediary was represented by James Grimes, Esq. of the Blue Cross Blue Shield Association.

STIPULATION OF FACT:

The following facts were established by stipulations:[5]

- Prior to July 1, 1999, the Maine Medicaid program paid some

[5] Provider Exhibit P-28 (Case No. 06-1318); Provider Exhibit P-41 (Case No. 07-1386) (herein "Stipulation of Fact").

or all of the coinsurance and deductible amount for Medicare/Medicaid crossover patients. However, on or after July 1, 1999, the Maine Medicaid program no longer pays deductible and coinsurance amounts for crossover claims.

- The Maine Medicaid program ("MaineCare") and the Medicare program have a Trading Partner Agreement. Under the Trading Partner Agreement, the MaineCare program provides electronic eligibility tables, updated monthly, which allow the Medicare program to identify crossover patients and report them to MaineCare
- The Trading Partner Agreement was in place during the Provider's 9/30/2002 and 9/30/2003 cost report periods.
- The Provider's crossover claims were submitted to MaineCare by the MAC which provided an electronic tape of crossover claims directly to the MaineCare program on a weekly basis pursuant to the Trading Partner Agreement.
- According to the MaineCare program, between November 2001 and August 2003, an anomaly of unknown origin occurred wherein a large number of Medicare crossover claims from the Provider which were apparently sent to MaineCare by the Medicare Intermediary were never processed by MaineCare.
- Because MaineCare never processed the crossover claims, a MaineCare Remittance Advice was never issued.
- MaineCare has not been able to identify, retrieve and process those crossover claims, and cannot do so now.
- The Provider is unable to provide a MaineCare Remittance Statement because the MaineCare program has not, and cannot now, provide them.
- The MAC maintains the State Medicaid Remittance Advice is required by CMS policy before the unpaid deductible and coinsurance amount can be claimed as a bad debt.
- The Provider maintains under the unique circumstances involved in these cases, a state Medicaid Remittance Advice is not required. The Provider has submitted alternative evidence to support the claims as services to dual eligibles for which no payment is permitted under the State Medicaid plan.

PARTIES' CONTENTIONS:

The Provider contends that despite the lack of the state Medicaid remittance advice, the crossover bad debt claims at issue fully meet the regulatory criteria and program instructions as allowable bad debts.[6] Specifically, it is undisputed that the debts at issue related to covered

[6] Provider's Post-hearing brief at 3.

services and are derived from deductible and coinsurance amounts.[7] Next, the Provider conducted reasonable collection efforts in seeking payment for the crossover claims by virtue of a Trading Partner Agreement between Medicare and MaineCare, the state Medicaid program.[8] This agreement provides the process by which Medicare sends all confirmed crossover claims to MaineCare for adjudication.[9] Unfortunately and through no fault of the Provider, MaineCare never processed the Provider's claims.[10] When MaineCare declined to provide the remittance advices, the Provider was able to produce other documentation to support the crossover bad debts by utilizing information from the Medicare electronic remittance advice, Medicaid eligibility verification from the hospital records and updated MaineCare eligibility tables maintained by the Muskie Institute.[11]

The Provider further contends the debt was actually uncollectible when claimed as worthless, and using sound business judgment determined there was no likelihood of recovery at any time in the future.[12] This is because pursuant to state regulations, MaineCare eliminated deductible and coinsurance amounts for all crossover claims for dates of service on or after July 1, 1999. By virtue of the state regulation, and even if MaineCare issued the remittance advices the payment amount for the crossover debts would be zero.[13] The Provider notes that federal law prohibits the Provider from attempting to collect the amount from the Medicaid recipient. Consequently, considering the applicable federal and state law, the Provider determined the crossover bad debt was uncollectible when claimed with no likelihood of recovery anytime in the future.

The Provider acknowledges that in *Community Hospital of the Monterey Peninsula v. Thompson,* 323 F.3d 782 (9th Cir. 2003) ("*Monterey Peninsula*"), the court upheld CMS's must bill policy, requiring a state Medicaid remittance advice before writing off the crossover bad debts.[14] In *Monterey Peninsula*, the hospital affirmatively elected not to present certain crossover claims to Medi-Cal for adjudication. Consequently, the court found that because there was a possibility of some payment for some of the crossover claims, the claimed amounts were denied as a violation of the Secretary's "must bill" policy. The Provider asserts that *Monterey Peninsula* is readily distinguishable from the instant cases. First, unlike *Monterey Peninsula*, the claims at issue were actually presented to MaineCare for adjudication by way of the Trading Partner Agreement. The absence of a remittance advice was not the fault of the Provider, but instead due to an anomaly of unknown origin within MaineCare's claims processing system. In addition, and most importantly, there is no potential for MaineCare payment, as the state regulation is clear that payment for crossover claims have been eliminated. Therefore even if remittance advices had been issued, each one would have resulted in zero payment.

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[7] Stipulation of Fact No. 12
[8] *Id.* at No. 13
[9] *Id.* at No. 14 - 15; Transcript (Tr.) at 140.
[10] Stipulation of Fact No. 16; Provider Exhibit P-16 (Case No. 07-1386).
[11] Stipulation of Fact No. 21; Provider Exhibits P-21 and P-22 (Case No. 06-1318); Provider Exhibit P-14 (Case No. 07-1386); Tr. 54 – 57. The Muskie Institute is a quasi-state agency that assists various governmental entities, including MaineCare program Medicaid data. *See,* Tr. at 25, Provider Exhibit P-16 (Case No. 07-1386).
[12] Provider Post-hearing brief at 7.
[13] Provider Post-hearing brief at 2 and 3; Stipulation of Fact No. 11.
[14] Provider Post-hearing Brief at 12.

Lastly, the Provider contends that CMS' "must bill" policy, is beyond the scope of the regulations and manual sections.[15] Indeed, the only source of the must bill policy is the Joint Signature Memoradum-370, 08-03-04 ("JSM"), which by definition cannot create new policy.[16] The Provider asserts that since neither the regulation nor the PRM require a remittance advice, a JSM cannot be interpreted to create such a requirement.

Even if the JSM was applicable, the Provider contends that it is entitled to protection under the JSM's hold harmless provision.[17] This is because the cost reporting periods at issue pre-date January 1, 2004 and the cost reports were open as of August 10, 2004. Moreover, the Provider's documentation follows the instruction previously laid out in CMS Pub 15-2 § 1102.3L, which allowed other documentation in lieu of state Medicaid remittance advices. The Provider asserts that contrary to the Intermediary's suggestion, the JSM does not prohibit the application of the hold harmless provision only when an intermediary previously required a provider to use a Medicaid remittance advice. Indeed, the final substantive paragraph of the JSM states that if an Intermediary previously required remittance statements, it "may NOT reopen providers' cost report to accept alternative documentation for such cost reporting periods [prior to January 1, 2004].[18] In view of the unique circumstances in this case, the Provider was relying upon alternative documentation for these open cost reporting periods and this documentation undoubtedly satisfies the requirements of CMS Pub 15-2 § 1102.3L.[19] The Provider asserts that since it has satisfied the criteria required by the regulations and manual guidance, the Intermediary's disallowance of the crossover bad debts should be reversed.

The Intermediary responds that the Provider's method of writing off bad debts for dual-eligibles without obtaining a state Medicaid remittance advice does not constitute a reasonable collection effort as contemplated by the regulations, manual and CMS's must bill policy.[20] The Intermediary asserts that the Ninth Circuit Court of Appeals upheld the must bill policy in *Monterey Peninsula.*[21] The court found the must bill requirement to be a reasonable implementation of the Medicare reimbursement system and not inconsistent with the statute and regulations.

The Intermediary notes that the JSM includes a hold harmless provision for providers who could establish that they followed the instructions for using other documentation during cost reporting periods beginning prior to January 1, 2004.[22] The Intermediary asserts that the Provider is not entitled to the hold harmless provision because, as discussed at hearing, at no time prior to January 1, 2004 did the Provider follow the instructions for using other documentation in lieu of the remittance advice.[23]

The Intermediary advises that following discussion with CMS Central Office the Provider's

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[15] Provider Post-hearing brief at 8.
[16] *Id. See also*, Tr. at 130 - 33.
[17] Provider Post-hearing brief at 9.
[18] *Id.*
[19] *Id.*
[20] Tr. at 31 – 32.
[21] Tr. at 35 - 36, Intermediary Post-hearing Summary at 4.
[22] Intermediary Post-hearing Summary at 4.
[23] Tr. at 41 – 44; Intermediary's Post-hearing Summary at 4.

alternative methodology for determining the crossover bad debt was unacceptable.[24] This is because pursuant to the bad debt moratorium, the policy requiring a state Medicaid remittance advice could not be changed. As such, the Intermediary correctly denied all the crossover bad debt claims in which the Provider failed to submit a state Medicaid remittance advice.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions, and the evidence presented, the Board finds and concludes that the Provider has satisfied the regulatory and manual requirements for the crossover bad debts at issue.

The Board first considered whether there was an absolute requirement that the Provider bill the state Medicaid program and receives a Medicaid remittance advice (RA) prior to claiming unpaid deductible and coinsurance amounts as bad debts for dual eligible beneficiaries. The Board reviewed the applicable regulations at 42 C.F.R. § 413.89(e) and the program guidance at CMS Pub. 15-1 §§ 308, 310, 312 and 322 and finds that neither the regulation nor the manual sections contained a requirement to bill the state Medicaid agency. Rather, the regulation and manual sections require that a provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible when claimed.

CMS Pub. 15-1, § 310 provides guidance on establishing reasonable collection efforts. However, the section by its own terms, is inapplicable to the determination of reasonable collection efforts for indigent patients and specifically refers to § 312 for guidance as to indigent and or medically indigent patients. Section 312 states in pertinent part:

> Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, (emphasis added) the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines. . .

The plain language of the above section establishes that Medicaid eligible beneficiaries are deemed indigent and that a provider is not required to take further steps to prove indigence. However, the language of subsections A through D of § 312 is convoluted. Subsection C states:

> The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian . . .

A common sense reading of this guideline suggests that it imposes a universal requirement to collect the debt from responsible third parties. That requirement appears applicable except for the use of the term "otherwise" used in the first paragraph which effectively makes subsections A through D applicable to situations other than dual eligibles. Further, the duty demanded by

[24] Post-hearing Summary at 4; Intermediary Exhibit I-25 (Case No. 07-1386).

subsection C to collect from responsible third parties still does not rise to a specific billing requirement. Nowhere does the language of the section support the conclusion that the requirement to collect can only be established by submission of a bill and receipt of a remittance advice from state Medicaid agency. Indeed, at the hearing the Intermediary conceded to this point.[25]

CMS Pub. 15-1, § 322 addresses "Medicare Bad Debts Under State Welfare Programs." This section requires that deductible and coinsurance amounts not covered by state title XIX plans may be claimed as Medicare bad debts if they meet the requirements of § 312. Section 312 states in pertinent part:

> Where the State is obligated either by statute or under the terms of its plan to pay all or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible and coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided the requirements of § 312 or, if applicable, § 310 are met.

The Board finds that § 322 is consistent with the regulations in that it describes what constitutes a "reasonable collection effort" as that phrase is used in 42 C.F.R. § 413.89(e)(2). Where a provider can bill and the state is obligated to pay, the provider must implement reasonable collection efforts to obtain payment from the state under CMS Pub. 15-1, § 322. However, to read § 322 as an absolute bar, regardless of the collection effort, would conflict with the statute and regulation allowing payments for Medicare bad debts. In addition, the Intermediary's standard is inconsistent with the requirements for all other payors and is inconsistent with the concept of reimbursement for bad debts, which is premised on the inability to collect, despite reasonable collection efforts, from a payor with a legal obligation.

The Intermediary relies on the must bill policy in the JSM as the basis to disallow the crossover bad debts. The Board finds the JSM is entitled to little weight. This is because a JSM is not to be used to set policy, nor convey new instructions or clarification of existing requirements to intermediaries. Instead, the Board finds PRM 15-2 § 1102.3L, the policy in effective for the cost reporting periods at issue, in entitled to great weight. The instructions did not require a state Medicaid remittance advice, and instead allowed the provider to furnish other documentation in substantiating crossover bad debts. The instructions state in relevant part:

> "[I]t may not be necessary for a provider to actually bill the Medicaid program to establish a Medicare crossover bad debt where the provider can establish that Medicaid is not responsible for payment. In lieu of billing the Medicaid program, the provider must furnish documentation of:

- Medicaid eligibility at the time services were rendered (via valid Medicaid eligibility number), and

[25] Tr. at 131.

- Nonpayment would have occurred if the crossover claim had actually been filed with Medicaid.

PRM 15-2 § 1102.3L (November 1995).

The Board recognizes that the court in *Monterey Peninsula* upheld the agency's must bill policy; however, two key aspects readily distinguish the facts in Monterey Peninsula from the instant cases. First, in Monterey Peninsula, there was a possibility of some payment from Medi-Cal (the state Medicaid agency) for the crossover claims. In the current cases, there is absolute no possibility that MaineCare is liable for the claims because since July 1, 1999 state regulations eliminated payments for crossover claims. Second, in *Monterey Peninsula*, Medi-Cal's billing system was incompatible with Medicare's requiring the providers to hand-code bills to establish payment and eligibility. In the instant case, MaineCare has entered into a trading partner agreement with Medicare, which permits the automatic exchange of eligibility information pertaining to dual eligible beneficiaries.

The record shows the Provider billed MaineCare for the crossover bad debts through the Trading Partner Agreement. However, due to apparent problems with MaineCare's electronic billing system the state was unable and continues to be unable to issue any Medicaid remittance advices. The Board finds that the Provider had actively pursued obtaining the remittance advices, but due to circumstances beyond their control the Provider was unable to obtain the advices. The Board finds the Provider demonstrated reasonable collection efforts in their attempt to recover the bad debts.

Given the unique circumstances in this case, the Board finds that the Providers met the requirements for a reasonable collection effort related to the dual eligible beneficiaries as required by 42 C.F.R. §413.89 and the manual instructions. The Board finds that the bad debts were actually uncollectible when the Providers claimed them as worthless and that sound business judgment established that there was no likelihood of recovery at any time in the future.

DECISION AND ORDER:

The Intermediary improperly disallowed the bad debts arising from coinsurance and deductibles for dual eligible Medicare and Medicaid beneficiaries. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.

FOR THE BOARD:

Michael W. Harty,
Chairperson

DATE: NOV 29 2012