PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D33

PROVIDER –
Cardinal Hill Rehabilitation Hospital
Lexington, Kentucky

Provider No. 18-3026

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
AdminaStar Federal

DATE OF HEARING -
June 7, 2002

Cost Reporting Periods Ended
December 31, 1997
December 31, 1998

CASE NO. 01-1779 and 02-0270

INDEX

ISSUE:

Was the all inclusive rate allocation methodology proper?[1]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Cardinal Hill Rehabilitation Hospital (the Provider) is a voluntary, not-for-profit rehabilitation hospital located in Lexington, Kentucky. The Provider is an all-inclusive rate (one charge covering all services) hospital and thus does not have charge information with which to apportion costs between Medicare and non-Medicare patients with regard to routine or ancillary services. In FYE 1997 and 1998, the Provider used the Departmental Statistical Data – Method A under CMS Pub 15-1 § 2208.1.A for apportionment purposes in the cost reports.[2] The FYE 1997 cost report was finalized using the relative value units (RVUs) as the statistical basis on which to apportion the ancillary costs. In FYE 1998, the Provider requested a modification to the apportionment method in an amended cost report. The Provider also requested, in the appeal of the FYE 1997 cost report, that the method proposed in the amended FYE 1998 cost report be applied to FYE 1997. AdminaStar Federal (the Intermediary) denied the requests. The Provider filed appeals of its FYEs 1997 and 1998 cost reports to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. 405.1835-405.1841 and has met the jurisdictional requirements of those regulations.[3] The amount of Medicare reimbursement at issue is $285,000 for FYE 1997 and $510,000 for FYE 1998.

CMS has specified rules in CMS Pub 15-1 § 2208.1 for all-inclusive rate or no-charge structure hospitals. The rules state in pertinent part that:

> The approved methods for apportioning allowable cost between Medicare and non-Medicare patients under the program are not readily adaptable to those hospitals having an all-inclusive rate (one charge covering all services) or a no-charge structure. Therefore, alternative methods of apportionment have been developed for all-inclusive rate or no-charge structure hospitals. These methods are available only to those hospitals which do not have charge structures for individual services rendered. The alternative methods described herein are presented in the order of their preference, A through E.
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> For cost reporting periods ending before January 1, 1970, the statistical method (Method A) should be used where there are

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[1] See Provider letter of March 22, 2002 withdrawing all other issues in these appeals.

[2] See Provider Exhibit 6.

[3] The Intermediary challenged jurisdiction. See intermediary Position Paper at 4. The Board determined that jurisdiction was proper by letter dated January 22, 2002. Neither party submitted a position paper for Case No. 02-0270. Since the issue and arguments were the same for both cases, the parties agreed that the arguments in 01-1779 would apply to both cases. See Intermediary Letter dated May 13, 2002.

sufficient and usable data available. Alternative Methods B through E are offered to accommodate the varying degrees of data available in these hospitals . . . .

For cost reporting periods ending after December 31, 1969, the statistical method (Method A) shall be considered the permanent method of cost apportionment. Where the permanent method is not used, the intermediary may grant specific permission for a hospital to continue to use--on a temporary basis--a less sophisticated method.

Having used an alternative of higher preference, a hospital may not elect to use an alternative of lower preference in subsequent reporting periods. For example, if a hospital used Method D, Comparative Hospital Data, for its first reporting period, it cannot, thereafter, elect to use alternative Method E. It can, however, use methods A, B, or C. Where the statistical method is not used, the intermediary will add to the cost report a statement explaining why the method selected was used, and why methods of higher priority could not be used.

In the application of these alternatives, cost report forms plus associated instructions and definitions currently in use should be used where applicable.

A. Departmental Statistical Data-Method A.--In the absence of charge data which would permit the use of methods approved under §§ 2200.1-2200.3, this method is to be used where adequate departmental statistics are available. The step-down procedures for cost finding required in §2306.1 must be used.

Under the statistical method, the cost of routine services are apportioned on the basis of the relative number of patient days for beneficiaries and for other patients, i.e., an average per diem basis. The costs of ancillary services is apportioned departmentally on the basis of the ratio of covered beneficiary inpatient statistics to total inpatient statistics applicable to such costs. Statistics must be weighted to reflect relative values. Since weighting factors may vary among various types of institutions, the intermediary may approve the use of those factors which in its judgment produce the most equitable results in each situation. In any event, the data collected must satisfy audit verification. The amounts computed as the program's share of the provider's routine and ancillary costs are then combined in determining the amount of program reimbursement.

> Application.--Hospitals that have maintained a count of services by type rendered to Medicare and non-Medicare patients may apply such statistics in the apportionment of ancillary costs. Hospitals that did not record such statistics during their first Medicare cost reporting period may use statistical sampling techniques where approved by the intermediary. However, hospitals that began to record such statistics during the second cost reporting period may use the statistical data gathered in the second period to apportion costs of the first period. In such cases, however, the intermediary must have established that procedures followed in gathering data are proper. The statistics must represent an adequate segment of the period in which gathered, preferably 6 months or longer.
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> Certain ancillary services may not be considered sufficiently significant to justify a separate calculation of costs for Medicare and non-Medicare patients. For example, a provider may have very limited physical therapy services which may represent less than 1 percent of the total direct and indirect costs and therefore a separate cost apportionment is not necessary. Other ancillary services such as regular drugs and medical supplies may be significant but present special difficulties in identifying and measuring usage. For cost reporting periods ending before January 1, 1970, the total expenditures for such services can be segregated and assumed to have been incurred by Medicare and non-Medicare patients in equal quantity per patient day. The cost of these ancillary services will be apportioned to the program on the basis of an ancillary average cost per diem for all patients multiplied by the total number of Medicare patient days. For periods ending after December 31, 1969, where such services are significant, adequate procedures must be established for measuring the use of these services by Medicare beneficiaries.

Using the statistical basis the cost settlement shall be determined as follows:

1. Determine total allowable cost using Form SSA-1562, Schedule A through Worksheet B-1-2.

2. Complete Schedule C and C-1 Form SSA-1562 to allocate total allowable costs between inpatient and outpatient services using the ratios of total inpatient charges and total outpatient charges to total combined charges, weighted statistics, occasions of service, or other basis with the intermediary's approval.

3. Multiply the average per diem cost of routine services by the total Medicare days, or apply the ratio of Medicare inpatient charges to total

> **inpatient charges to total inpatient routine services costs to determine Medicare's share of routine service costs.**
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> **4. Determine the Medicare portion of ancillary costs by applying departmentally, the statistical ratio of Medicare utilization to total utilization. Such statistical data may be shown on the "Calculation of Reimbursement Settlement, Inpatient Services," Form SSA-1563, page 2, for cost reporting periods ending before April 1, 1968, or Exhibit B, Form SSA-1992 for cost reporting periods ending after March 31, 1968.**
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> **5. The statistics used in 4 above should be supported by a supplementary schedule showing how they were developed.**
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> **6. The amount determined in 3 above should be inserted on line 16, column 6, page 2 of Form SSA-1563 or line 20, column 6 of Exhibit B, Form SSA-1992.**
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> **7. All other pages of Form SSA-1563 or Form SSA-1992 when applicable will be completed in the usual manner. If separate identifiable charges for outpatient services are not available, statistical data or an average cost per occasion of service may be used in the outpatient cost settlement (page 3, Form SSZ-1563 or Exhibit E, Form SSA-1992)**

(Emphasis added).

The Provider maintained RVU data for each ancillary department and used RVUs to allocate ancillary services between inpatient and outpatient and between Medicare and non-Medicare patients for the years at issue. Instead of using RVUs to allocate ancillary costs between inpatient and outpatient in step 2 of Method A, the Provider proposes to derive a single statistic to allocate all ancillary departmental costs between inpatient and outpatient areas. The proposed statistic used is the ratios of total inpatient charges (which includes inpatient routine costs) and total outpatient charges divided by total combined charges in step 2 of the applicable instruction.

The difference between the two methods is displayed in the following chart from Intermediary Exhibit 17 at 2.

Cost Center	Total	IP RVUs	%	OP RVUs	%	Provider Step 3 Share IP	OP
Radiology -Diagnostic	8,153	5,027	61.60%	3,126	38.40%	89.70%	10.30%
Laboratory	129,657	118,883	91.70%	10,774	8.30%	89.70%	10.30%
Physical Therapy	88,779	53,797	60.60%	34,982	39.40%	89.70%	10.30%
Occupational Therapy	69,467	49,670	71.50%	19,797	28.50%	89.70%	10.30%
Speech Therapy	27,713	15,965	57.70%	11,748	42.30%	89.70%	10.30%
Drugs Charged to Patients	321,266	340,708	91.80%	30,558	8.20%	89.70%	10.30%
Psychiatric/Psychological	3,839	1,448	37.70%	2,291	62.30%	89.70%	10.30%
Other Diagnostic	3,394	3,156	92.90%	238	7.10%	89.70%	10.30%
Purchased Technical Services	98,586	98,856	100%	0	0.00%	89.70%	10.30%
Clinic	231,945	0	0.00%	231,946	100%	89.70%	10.30%

The Provider was represented by Scott C. Jolly, CPA, of Pinnacle Healthcare Consulting. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the central issue in the subject case is the validity and efficacy of the applicable program instruction set forth at CMS Pub. 15-1 § 2208.1 and, more specifically, the validity and reasonableness of using one alternative expressly noted in this program instruction in implementing Step 2 of Method A (ratios of total inpatient charges and total outpatient charges to total combined charges) instead of another alternative, RVUs. The Provider proposed to use the "ratios of total inpatient charges and total outpatient charges to total combined charges" to allocate total ancillary costs between inpatient and outpatient areas as provided for in the applicable program instruction. Id.

The Provider contends that its proposed methodology is in compliance with this program instruction for all-inclusive rate providers. The Provider submitted detailed data in support of its proposed methodology,[4] and testimony that it was in compliance with the applicable program instruction.[5]

The Provider contends that if it accurately implements the specific directions of the applicable program instruction (using the alternate methodology), the resulting Medicare reimbursement is presumed to be reasonable. The Provider asserts that the Intermediary cannot logically contend that expressly following and implementing a duly promulgated program instruction results in anything but reasonable reimbursement. In addressing the concept of reasonable cost, Congress authorized the Secretary to promulgate "regulations establishing the method or methods to be used . . . in determining such costs." 42 U.S.C. § 1395x(v)(1)(A). The program instructions, including CMS Pub. 15-1 § 2208.1,

[4] Provider Exhibit 21.

[5] Tr. at 117-l18.

resulted from this Congressional mandate. The Provider contends that the applicable program instruction is valid, that it properly followed the plain reading of such instruction in its revised cost reports, and that the resultant reimbursement is reasonable.

The Provider indicates that the decision in County of Los Angeles v. Sullivan, No. 90-55253 (9th Cir. June 29, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,355, (County of Los Angeles) supports its argument. The most significant similarities with the subject case are that both deal with the all-inclusive rate issue, and specifically how the program instructions are to be implemented. The County of Los Angeles case involves a group of three all-inclusive rate hospitals. The Secretary argued that the hospital providers could not revise their methodology of allocating ancillary costs and contended that they were required to use the methodology preferred by the Secretary.

Considering the express language of CMS Pub. 15-1 § 2208.1, the court found the subject program instruction to be valid, with one notable exception. It found that one provision of Method B was too restrictive in atypical cases and determined that the Medicare program could not use the program instructions to limit reimbursement under one set of circumstances (that is, Medicare patients with a higher average length of stay compared to non-Medicare patients) without also accepting the corollary of reimbursing higher Medicare reimbursement under a different set of circumstances (Medicare patients with an average length of stay lower than non-Medicare patients). The court found that the statute and regulations required the Secretary to promulgate a reimbursement method calculated to reasonably estimate ancillary costs. Id. The court also found that there was no legal basis for penalizing the hospitals for failing to use the actual cost method preferred by the Secretary. The Provider contends that, based on the factual similarities of this case, the same decision applies in the subject case.

The Provider contends that the methodology used on the final 1997 and 1998 cost reports does not reimburse the Provider equitable costs for providing healthcare services to Medicare beneficiaries. The Provider prepared a schedule that compares the per diem ancillary costs for Medicare and non-Medicare patients.[6] The objective of this schedule is to determine, as accurately as possible, if the cost reports, as finalized, provide an equitable allocation of ancillary costs to the Medicare and non-Medicare beneficiaries. The Medicare Part A and Part B ancillary cost amounts were scheduled from the finalized 1997 Medicare cost report. The total ancillary costs were also reflected on this schedule as reported on the finalized Medicare cost report. The non-Medicare ancillary costs were calculated as the difference between the total ancillary costs and the Medicare ancillary costs.

The corresponding patient days were then used to determine the respective per diem ancillary cost allocated to Medicare, non-Medicare and in total.

The Provider contends that the results of this analysis indicate that no equality exists in allocating inpatient ancillary costs between Medicare and non-Medicare beneficiaries ($277.38 and $390.52, respectively). In fact, there is a disparity of $113.14 between the

[6] See Provider Exhibit 9.

per diem ancillary costs allocated between Medicare and non-Medicare beneficiaries ($390.52 less $277.38). This disparity is further reflected in the percentage of Medicare per diem ancillary cost as a percentage of the non-Medicare per diem ancillary cost equal to 71% ($277.38 divided by $390.51), suggesting that Medicare is paying the Provider $.71 for every dollar of cost allocated to non-Medicare beneficiaries. Such disparity is in direct violation of applicable program regulations at 42 C.F.R. § 413.9(b)(1) and Tr. at 121-125.

To partially remedy this inequality, the Provider contends that applicable program instructions allow it to use an alternate allocation methodology at Step 2 of Method A[7] The Provider contends that using this alternative allocation methodology results in a much more favorable allocation between Medicare and non-Medicare ancillary costs.[8]

The per diem ancillary cost allocated to the Medicare program as a percentage of the per diem ancillary cost allocated to non-Medicare payors as reflected on the revised schedule is 81%, reflecting that, in total, the Medicare program is reimbursing $.81 for every dollar of ancillary cost that non-Medicare patients bear. While this is certainly an improvement from the 71% figure from the original cost report, it still indicates that Medicare is not bearing its equitable portion of ancillary costs as required by applicable program regulations at 42 C.F.R. § 413.9(b)(1).[9]

The Provider contends that no evidence exists that Medicare beneficiaries use less ancillary services than their non-Medicare counterparts.

The Intermediary asserts that these calculations are less sophisticated and inaccurate. The Provider responds that the proposed allocation methodology is more accurate. As noted above, the Provider's proposed change results in per diem ancillary costs allocated to the Medicare program that are more equal to the non-Medicare per diem ancillary costs. The Provider further asserts that the use of the ratios of total inpatient and outpatient charges divided by total charges is a more accurate representation of the costs incurred and the resources expended in providing healthcare services to its patients.

The Provider contends that the subject program instruction does not indicate which of the various alternative methods is the preferred or more sophisticated alternative. It further contends that by listing its proposed methodology first, the implication exists that it is the most preferred and results in a more accurate allocation.

The Provider does not differentiate between payors in its charging policies. That is, all inpatients and all outpatients are charged comparably. This prevents any inappropriate

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[7] These calculations (using the ratios of total inpatient and outpatient charges divided by total charges for Step 2) are presented at Provider Exhibit 21.

[8] Provider Exhibit 10.

[9] See also Tr. at127-131.

weighting of one class of beneficiary over another; Medicare and non-Medicare patients are treated equally.

The Provider contends that the applicable program instruction recognizes the necessity that departmental statistics are weighted to accurately reflect the resources expended to provide healthcare services. These program instructions simply state that "Statistics must be weighted to reflect relative values." See CMS Pub. 15-1 § 2208.1.

The Provider contends that the alternative allocation methodology is a more accurate weighting of departmental statistics. The vast majority of its resources are expended in caring for inpatients - either in the form of routine or ancillary care. This is accurately reflected in its charges - fully 90.64% of total 1997 Provider revenue is classified as inpatient revenue.[10]

The Provider contends that ancillary costs should be allocated strictly following the plain reading of 42 C.F.R. § 413.9(b)(1); that is, to allocate the same per diem inpatient ancillary cost to Medicare and non-Medicare beneficiaries. The Provider contends that only by so allocating the inpatient ancillary costs will equity be achieved.[11]

Alternatively, the Provider contends that if the Board determines that allocating the same inpatient per diem ancillary cost to both Medicare and non-Medicare beneficiaries is unacceptable, the alternate allocation methodology as noted above (using the ratios of total inpatient and total outpatient charges divided by total charges in Step 2 of the applicable program instructions) is more equitable.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends its determination is in accordance with CMS Pub. 15-1 § 2208.1, All-Inclusive Rate or No-Charge Structure Hospitals.

The Intermediary notes that the Provider believes that there is something wrong with its cost report because Medicare ancillary costs per day are significantly lower than non-Medicare ancillary costs. This view appears to be a misunderstanding on the Provider's part because, after reviewing eight cost reports, four of which were for rehabilitation hospitals with full charge structures, the Intermediary was unable to reach the same conclusion. All of the reviewed cost reports showed significantly lower Medicare ancillary per diems than non-Medicare.

The Intermediary asserts that the Provider has not followed the instructions correctly. As explained by CMS,[12] the instruction the Provider used was primarily based on the then existing cost reporting form, that is, Form SSA-1562. That cost reporting form has not

[10] Provider Exhibit 21 and Tr. at 178-179.

[11] Provider Exhibit 8.

[12] Intermediary Exhibit 5.

been in use for 20 years and was already replaced by several forms, including the Form HCFA -2552-96 that the Provider used for FYE August 31, 1997. This current cost reporting form no longer does the steps applicable to Form SSA-1562 since total costs are now divided by total charges and the resulting cost to charge ratios are used for both inpatient and outpatient (with outpatient ratios somewhat reduced for capital and operating cost reductions).

The Provider used the total inpatient all-inclusive rate charges (including routine) in calculating or estimating the amounts that relate to inpatient and outpatient.[13] The Intermediary's analysis of Form SSA-1562, Schedules C and C-1, shows that routine charges are not used in allocating ancillary costs between inpatient and outpatient. Costs are also not allocated in total, but departmentally, by using the inpatient and outpatient ancillary charges by department. In the Provider's case, however, the Provider does not record charges by department; thus, RVUs statistics were allowed to be used. The Provider did not have any alternative basis on which to correctly follow step 2 under CMS Pub 15-1 § 2208.1.A.

The Provider concluded that almost 90% of each ancillary cost center's charges relate to inpatient. That calculation, however, ignores the fact that a significant portion of the inpatient charges pertains to routine services. Also, that calculation yields an unacceptable amount that was not in keeping with the referenced Program instruction. Furthermore, just because the Provider's calculation resulted in a higher Medicare-related cost or Medicare reimbursement does not mean that the proposed modification to the methodology is more sophisticated than the previously used methodology.

The Intermediary and CMS correctly denied the Provider's request to modify the Departmental Statistical Data-Method A.[14]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, parties' contentions and evidence presented, finds and concludes as follows:

The issue in this case concerns the proper method for allocating ancillary costs between inpatient and outpatient services. Since the Provider is an all-inclusive rate provider it does not have charge information to make the allocation. CMS Pub. 15-1 § 2208 provides allocation methods for all-inclusive or no-charge structure providers with Method A being the preferred methodology. Under Method A, an all-inclusive rate provider is permitted, with intermediary approval, to use statistics other than charges to apportion the costs. The statistic must be weighed to reflect relative values. Id.

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[13] Intermediary Exhibit 9.

[14] See further details of CMS findings and decision in Intermediary Exhibits 5 and 11.

In prior years and in the years in question, FYEs 1997 and 1998, the Provider had RVU statistics by department and used those statistics in steps 2 and 4 of Method A to allocate costs between inpatient and outpatient services. Specifically, in step 2, for each department the Provider divided the inpatient and outpatient RVUs into the total RVUs to produce a percentage of departmental costs to be allocated to inpatient and outpatient services. After the departmental charges were allocated between inpatient and outpatient services, they were further allocated by RVUs between Medicare and non-Medicare patients. Under the method the Provider proposes to use, it would no longer use RVUs by department in Step 2 but instead would derive one statistic to allocate all departments between inpatient and outpatient statistics. The statistic to be used would be the ratio of total inpatient charges (which would include routine inpatient charges) and outpatient charges to total charges. This same percentage would be applied to each of the ancillary departments to allocate costs between inpatient and outpatient services. The Provider would continue to use its RVUs to allocate ancillary costs between Medicare and non-Medicare patients within inpatient and outpatient services.

The Provider argues that the proposed methodology is permitted under the existing rules and that it is more accurate because it allocates a more equitable share of ancillary costs to Medicare. The Intermediary argues that the proposed method is no longer permitted under the existing rules, that it is a less accurate method of allocation and that mere lower costs for Medicare patients is not proof of cost shifting. The Board finds that the Provider's proposed method of allocation is not permitted under the current rules, that it is a less accurate method and that the Provider has not presented sufficient evidence of cost shifting.

The Board notes that one of the allowable allocation statistics in step 2 of the instructions is the "ratio of total inpatient charges and total outpatient charges to total combined charges." CMS Pub. 15-1 § 2208.1.A. The Board further notes, however, that the instructions also provide that providers are to use the cost reporting forms and associated instructions currently in use. CMS Pub. 15-1 § 2208.1. As pointed out by the Intermediary, Intermediary Position Paper at 31-32, the cost reporting form referenced in step 2, SSA-1562, no longer exists and has not been used for 20 years. The current reporting form, HCFA-2552-96, which the Provider used for FYE 1997, no longer has the steps applicable to Form SSA-1562. The current practice is for providers to utilize relative value units to determine Medicare reimbursement based on the actual inpatient and outpatient utilization in each department. The Board agrees with the Intermediary that by substituting a single derived charge ratio for the actual departmental RVUs, the Provider is improperly using current cost report forms to apply an outdated methodology.

With respect to the accuracy of the proposed methodology, the Board notes that using a single ratio for all departments is inherently less sophisticated than using the available data for each of the ancillary departments. As pointed out by the Intermediary,[15] the utilization of each department between inpatient and outpatient services produced by the actual RVUs as compared to the single imputed ratio makes more sense. For example, using the RVUs statistics, the percentages for the laboratory, drugs and other

[15] See Intermediary Exhibit 17.

diagnostic/purchased technical services are higher for inpatients, as one would expect. In addition, using the RVU statistics, the utilization of higher cost therapies such as physical, occupational and speech therapies reflects a significantly higher volume for outpatients; 39.4, 28.5 and 42.3 percent, respectively. These high percentages, reflected in the actual RVU data, are consistent with both the Provider's focus on outpatient services[16] as well as expectations for inpatient services.

The Board also notes the Provider is using inpatient all-inclusive charges, which include charges for inpatient–only routine services, to total inpatient and outpatients charges. The Board observes that routine inpatient costs are large and unrelated to ancillary utilization and, therefore, it is not appropriate to include these costs in the statistic used to allocate ancillary service costs. In addition to over-allocating ancillary costs to inpatient services, this further results in inappropriately higher Medicare reimbursement because there is higher Medicare utilization in the inpatient setting.

The Board further notes that the Provider indicated that it generated RVU statistics and does not have concerns regarding the accuracy of its data.[17] Since there are no concerns with the accuracy of the data that would permit a more sophisticated allocation, the Board finds no reason for the Intermediary to permit the Provider to use a less accurate methodology.

Finally, the Board notes that the Provider has argued that it has been underpaid for Medicare services because the amount paid for Medicare beneficiaries is less than that paid for non-Medicare patients. The Board finds that the disparity by itself does not prove underpayment. Many other factors, such as differences in diagnosis and acuity of patients, contribute to differences in the use of ancillary services. The Board finds that the record does not contain sufficient evidence to substantiate the Provider's claim that there has been cost shifting.

DECISION AND ORDER:

The Board finds that the methodology proposed by the Provider to allocate the costs between inpatient and outpatient services was improper. The Intermediary's determination is affirmed.

Board Members Participating:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Dr. Gary Blodgett
Martin W. Hoover, Jr., Esquire

[16] See Intermediary Exhibit 17a.

[17] Tr. at 66, lines 12-19 and 69, line 11-20, line 4.

DATE: June 12, 2003

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman