STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to HCMC Inc. - D.B.A. "We Care Medical"

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

August 2002 *AOS/FWAP-03-004C*

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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Mr. Howard Coomes, Owner
HCMC Inc. - D.B.A. "We Care Medical"
8914 Glendale Milford Road, Suite A
Cincinnati, Ohio 45140

Re: Medicaid Review of Provider Number 0991566

Dear Mr. Coomes:

We have completed our review of selected medical services rendered to Medicaid recipients by HCMC Inc.(D.B.A. "We Care Medical") for the period October 1, 1998 through September 30, 2001. We identified findings amounting to $187,627.52, which must be repaid to the Ohio Department of Job and Family Services (ODJFS). Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment is not made to the Ohio Department of Job and Family Services within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's office for collection. A "provider remittance form" is located at the back of this report for remitting payment.

We also identified questioned costs of $493,617.20 for services that we believe were billed in excess of the Provider's usual and customary fee for oxygen services. We are recommending that ODJFS make the final determination on the questioned costs and pursue the appropriate recovery action.

As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, and the Ohio State Medical Board. If you have any questions, please feel free to contact Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

August 20, 2002

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ABBREVIATIONS

CMS	Center for Medicare and Medicaid Services (formerly known as HCFA)
CPT	Physician's Current Procedural Terminology
DME	Durable Medical Equipment
FWAP	Fraud, Waste and Abuse Prevention (Division of)
HCFA	Health Care Financing Administration (now known as CMS)
HCPCS	HCFA Common Procedure Coding System
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
TCN	Transaction Control Number

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SUMMARY OF RESULTS

The Auditor of State performed a review of HCMC Inc.(D.B.A. "We Care Medical"), Provider #0991566, doing business at 8914 Glendale Milford Road, Suite A Cincinnati, Ohio 45140. Findings amounting to $187,627.52 were identified for recovery. The cited funds are recoverable as they resulted from Medicaid claims submitted by HCMC Inc. (D.B.A. "We Care Medical") for services that did not meet reimbursement rules under the Ohio Medicaid Provider Handbook and the Ohio Administrative Code (OAC). Additionally, we also identified questioned costs of $493,617.20 for services that appear to have been billed in excess of the Provider's usual and customary fee for oxygen services.

BACKGROUND

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services, performs reviews to assess Medicaid providers' compliance with Federal and State claims reimbursement rules. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients.

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a federal/state financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. The Ohio Department of Job and Family Services (ODJFS) administers the Medicaid program. The rules and regulations that providers must follow are issued by ODJFS in the form of the Ohio Medicaid Provider Handbook and Ohio Administrative Code Section 5101:3.

ODJFS' Medicaid Provider Handbook, Chapter 3334, General Information, Section II, Subsection (B) states, "Medical necessity" is the fundamental concept underlying the Medicaid program. A physician must authorize medical services within the scope of his/her licensure and based on their professional judgement of those services needed by an individual. Medically necessary services are services which are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice.

Durable medical equipment services are among the services reimbursed by the Medicaid program when delivered by eligible providers to eligible recipients. Durable medical equipment encompasses equipment which can stand repeated use and is primarily and customarily used to serve a medical purpose. Requirements for providers of durable medical equipment services are covered in ODJFS' Durable Medical Equipment Manual, which is a part of the Ohio Medicaid Provider Handbook.

All durable medical equipment services that are reimbursed by Medicaid must be prescribed by a physician. For ongoing services or supplies, a new prescription must be obtained at least every twelve months. Providers must keep copies of prescriptions which include a diagnosis in their files.

Pursuant to the Medicaid Handbook, Chapter 3334, Section IV, Subsection B, and the Ohio Administrative Code Section 5101:3-1-172, (E), providers are required to: "Maintain all records

necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer".

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6), (OAC Section 5101:3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

In addition, rule 5101:3-1-29 (C) of the OAC states: "In all instances of fraud and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general."

"Abuse" is defined in rule 5101:3-1-29 (B) as "...those provider practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the medicaid program."

PURPOSE SCOPE AND METHODOLOGY

The purpose of this review was to determine whether the Provider's claims to Medicaid for reimbursement of durable medical equipment services were in compliance with regulations and to calculate the amount of any overpayment resulting from non-compliance.

We informed the Provider by letter that they were selected for a compliance review. An Entrance Conference was held on December 11, 2001 at the Provider's facility in Cincinnati, Ohio with Mr. Howard Coomes, owner, and his legal representative. Subsequently, at least two more meetings were held with the Provider and legal representative during the course of the audit.

We utilized ODJFS' Medicaid Durable Equipment Manual and the Ohio Administrative Code (OAC) as guidance in determining the extent of service and applicable reimbursement rates. We obtained the provider's claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to Medicaid and paid to providers. This computerized claims data includes patient name, place of service, date of service, and type of procedure/service. These healthcare procedures and services are codified using one or more of the following five digit coding systems:

- Current Procedural Terminology (CPT)[1],

[1]The CPT is published by the American Medical Association (AMA) for the purpose of providing a uniform language to describe medical services.

- Health Care Financing Administration's[2] (HCFA) Common Procedural Coding System (HCPCS), and
- ODJFS' local level codes.

The scope of our review was limited to Medicaid claims for which the Provider was paid during the period October 1, 1998 through September 30, 2001. During this audit period, the Provider was reimbursed $933,161.65 for 4,767 claims for durable medical equipment services provided to 869 Medicaid recipients.

To facilitate an accurate and timely review of paid claims, we analyzed a stratified statistically random sample of oxygen recipient dates of service. A recipient date of service is generally a charge for one recipient for one month's oxygen service. The review involved comparing the Provider's records for oxygen services with the claims payment history from MMIS. The sample reviewed amounted to $37,174.04 of Medicaid reimbursements made to the Provider during the audit period for 130 recipient dates of service. In addition, we looked for "duplicate" payments – payments in which two or more claims were filed for the same procedure code, the same recipient, and the same month of service. We also checked for other types of overpayments, such as payments for services to recipients who were deceased at the time of service and whether the Provider charged Medicaid more than their usual and customary fee for oxygen concentrator services.

Our audit work was performed during December 2001 through July 2002, and in accordance with government auditing standards.

FINDINGS

Our finding of $187,627.52 was the combined result of our statistical sample and a separate complete review of potential duplicate services and services to deceased recipients. A projected finding of $153,344.00 resulted from overpayments caused by billings for claims without sufficient documentation in the following categories: Missing Documentation, Missing Physician Orders or Missing Physician Signatures, Missing Meter Readings, Oxygen PRN, Certificate of Medical Necessity (CMN) Signed after the Fact, Level of Service Overstated, and an Erroneous Payment. An additional $34,283.52 in findings not based on a projection was found for Billings for Deceased Recipients and Duplicate Payments. We also identified Questioned Costs totaling $493,617.20 for services that appear to have been billed in excess of the Provider's usual and customary fee for oxygen services.

Section 5101:3-10-13 (C)(2) of the Ohio Administrative Code pertains to oxygen services provided to recipients residing in long-term care facilities and states "...the oxygen provider must have on file, *prior to submitting any claim for reimbursement [emphasis added],* a prescription from a physician who has examined the patient and signed and dated the prescription within thirty days prior to or thirty days after the first date of service. The prescription, or certification of medical necessity, must

[2]The Center for Medicare and Medicaid Services (CMS formerly known as HCFA) has federal oversight of the Medicaid program. The CMS has federal oversight of the Medicaid program.

specify: (a) diagnosis; (b)oxygen flow rate; and (c) duration (hours per day);or (d) indications for usage."

After we requested supporting documentation from the Provider at the beginning of our review, the Provider obtained much of the documentation from patient records maintained by the long term care facilities where the Medicaid recipients resided. Because the Provider relied on outside sources (i.e. the nursing homes) to maintain the documentation, the Provider was not in compliance with Section 5101:3-10-13 (C)(2) of the OAC. Although we allowed the Provider to use documentation from other sources as support for billed services, and we did not identify monetary findings associated with this matter, we believe the Provider's failure to maintain documentation contributed to the deficiencies and findings we describe below.

The basis for the findings in our sample, the number of instances found, and the dollar amount overpaid are shown below in Table 1 and detailed in the ensuing discussion.

Table 1: Missing and Invalid Services found in Recipient Date of Service Sample of HCMC Inc. - D.B.A. "We Care Medical"

Basis for Exceptions from Sample of 130	Number of Occurrences
No documentation found to support billings	14
No physician order and/or no physician signature	3
No meter reading was found to support billing	1
Oxygen prescription stated as PRN	3
Certificate of Medical Necessity (CMN) signed after the fact	3
Level of service Overstated	4
Erroneous payment	1
Total Exceptions	**29**

Source: AOS analysis of Provider's medical records

Missing Documentation

Chapter 3334 (IV-B) of the Ohio Medicaid Provider Handbook states:

> the provider must maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The

> provider will maintain such records for a period of six years from the date of receipt of payment or until any initiated audit is completed, whichever is longer.

Without a patient's chart and any other documentation required by ODJFS for reimbursement, we are unable to verify if oxygen services were actually provided to the recipient. Specifically, for oxygen services provided to residents of long term care facilities, we identified 14 out of 130 recipient dates of service sampled where the Provider was missing a patient chart or documentation for the recipient receiving the service.

Missing Physician Orders and/or Physician Signatures

Section 5101:3-10-05 (A) of the Ohio Administrative Code states:

> For each claim for reimbursement, providers must keep in their files a legible written or typed prescription, including a diagnosis, signed and dated not more than sixty days prior to the first date of service by the recipient's attending physician. . . . For medical supplies only, *other than incontinence garments and related supplies*, an oral prescription with all the required information recorded in writing by the provider will suffice. For ongoing services or supplies, a new prescription must be obtained at least every twelve months. Medical supply providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-172 and 5101:3-1-173 of the Administrative Code.

In addition, Section 5101:3-10-13 (C)(2) of the Ohio Administrative Code states:

> The oxygen provider must have on file, prior to submitting any claim for reimbursement, a prescription from a physician who has examined the patient and signed and dated the prescription within thirty days prior to or thirty days after the first date of service. The prescription, or certification of medical necessity, must specify: (a) diagnosis; (b) oxygen flow rate; and (c) duration (hours per day); or (d) indications for usage.

Prescriptions for durable medical equipment services are a physician's tool to verify that a patient truly needs medical goods and/or services. By retaining prescriptions, the durable medical equipment supplier verifies the need to provide all necessary medical equipment for a patient. For ongoing prescriptions, the medical equipment supplier must verify that more services are necessary by obtaining a new prescription every twelve months.

In our sample review of oxygen services provided to residents of long term care facilities we found that 15 of the 130 sampled recipient dates of service were not supported by a prescription, which prevented us from verifying whether or not a service was medically necessary.

No Meter Readings

Section 5101:3-10-13 (C) (5) of the Ohio Administrative Code states:

> All claims must show billed charges for one month's service. Billed charges shall be the provider's usual and customary charge for the oxygen actually used by the recipient. The amount of oxygen actually used each month (as determined from a meter reading), must be determined and documented by the provider prior to submitting the monthly claim for reimbursement. Documentation of the amount of oxygen used each month must be maintained in the provider's file.
>
> Provider maintenance and documentation of the amount of oxygen used does not meet the requirements of this rule when such documentation is created, or collected, from sources other than the provider, after the service has been billed.

All oxygen services are billed in cubic feet according to the amount of oxygen used. Providers must use meter readings to calculate the cubic feet of oxygen used for the month's services. Therefore, a meter reading is essential in determining the correct code to bill for oxygen services.

During our review of the Provider's oxygen records, one of the 130 sampled recipient dates of service did not contain meter readings to support amounts of oxygen used. Without the meter reading, the Provider could not determine the correct level of oxygen to claim for reimbursement.

Oxygen Prescription Stated as PRN

Section 5101:3-10-13 (C)(3) of the Ohio Administrative Code states that prescriptions written as "oxygen PRN" without liter flow or indications of usage do not meet the requirements for a prescription as stated in rule 5101:3-10-05 (A). Physicians use "PRN" to indicate "as needed", which inappropriately in this case leaves the determination of medical necessity up to a nursing home or the DME provider. During our review, we found 3 of the 130 recipient dates of service where the Provider maintained a prescription for oxygen services with the indications for usage as PRN. As such, the prescription is invalid as it does not contain information to make the service medically necessary.

Certificate of Medical Necessity Signed After the Fact

Section 5101:3-10-13 (C)(2) of the Ohio Administrative Code states that an oxygen provider must have on file, prior to submitting any claim for reimbursement, a prescription from a physician who has examined the patient and signed and dated the prescription within thirty days prior to or thirty days after the first date of service. Furthermore, Section 5101:3-10-13 (C)(5) states that "provider maintenance of documentation of the amount of oxygen used does not meet the requirement of this rule when such documentation is created, or collected from sources other than the Provider, after the service has been billed." We identified 3 of the 130 recipient dates of service involving two

recipients where the certificate of medical necessity was signed by a physician after the service was performed.

Level of Service Overstated

Section 5101:3-10-13 (C)(2) of the Ohio Administrative Code states the oxygen provider must have on file, prior to submitting any claim for reimbursement, a prescription from a physician who has examined the patient and signed and dated the prescription within thirty days prior to or thirty days after the first date of service. The prescription, or certification of medical necessity, must specify:

(a) Diagnosis;
(b) Oxygen flow rate; and
(c) Duration (hours per day); or
(d) Indications for usage.

During our review of oxygen services, we found 4 of the 130 sampled recipient dates of service where the Provider billed for a higher level of oxygen service than could be supported by the physicians' orders and meter readings. In all 4 TCNs, the Provider should have billed procedure code Y2083, which is reimbursed at $24.00. Billing in this manner resulted in the Provider being reimbursed an amount higher the $24.00 per recipient date service that they were entitled to receive.

Total Projected Findings

We identified 29 sampled recipient dates of service in our sample that did not meet Medicaid requirements for reimbursement and which were projected across the total population paid to the Provider. This resulted in a projected finding of $153,344.00. The finding was calculated by projecting the correct population reimbursement amount, ($740,025.00), and taking the difference between it and the actual amount paid to the Provider, ($893,369.24), during the audit period. The projected correct population reimbursement of $740,025.00 has a 95 percent certainty that the true value of the population would fall between $678,591.00 and $801,458.00; a precision of +/- 8.3 percent.

Erroneous Payment

Section 5101:3-1-198 of the Ohio Administrative Code states: "errors in payment, caused either by the provider or the department, must be corrected by advising the department by completing the appropriate request form (ODHS 6766 for hospitals or ODHS 6767 for all other provider types) as identified in the billing instructions. These forms are to be used for line items or entire claims having an erroneous payment or which are in paid status with a zero payment".

During our review of the Provider's billed claims, we identified a claim for oxygen service in which the provider had been reimbursed $14,463.36 for procedure code Y2076 with 81 units of service.

The Provider's documentation supported a reimbursement of $178.56 – the Medicaid maximum for

this amount of oxygen usage. Therefore, we are making a finding for $14,284.80, which represents the difference between $14,463.36 and $178.56.

Findings for Services Billed for Deceased Recipients

Pursuant to OAC Section 5101:3-1-198, overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery.

In our deceased recipient test, we determined that the Provider billed Medicaid for 33 services that involved 22 recipients of long term care facilities subsequent to the recipients' date of death. Therefore, a finding was made for $5,892.48, which represents the amount reimbursed to the Provider for services billed in months subsequent to the month of the recipients' deaths.

Findings for Duplicate Payments

According to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6) (OAC Section 5101:3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

During our field review, we checked for duplicate claims in which two or more claims were filed for the same procedure code, the same recipient, and the same month of service. We noted three different types of duplicates where this occurred. The first type identified were those instances in which duplicate claims were filed by HCMC. (D.B.A. "We Care Medical"). The second type identified were duplicate claims that involved a claim submitted by HCMC (D.B.A. "We Care Medical") and another claim submitted by another provider. The third type identified were claims in which the Provider billed both Medicaid and Medicare for the same oxygen services.

We analyzed the Provider's paid claims history for the audit period and identified the following for each type of duplicate: (1) the Provider was not able to produce any documentation to support the 55 pairs in which two separate claims were billed and reimbursed to the Provider; (2) the Provider submitted additional documentation to support 23 of 45 pairs involving one claim submitted by the Provider and one claim submitted by another provider; and (3) the Provider was not able to produce documentation to support the 27 pairs in which the Provider billed both Medicaid and Medicare for oxygen services.

This resulted in a total finding of $28,391.04, which included:

- $19,463.04 for the 55 instances in which two claims were filed by HCMC (D.B.A. "We Care Medical")[3],

[3]This finding includes the reimbursed amount for both the original and duplicated claim for 54 of 55 pairs, because the Provider failed to provide documentation that any service had been provided.

- $4,106.88 for the 22 claims that involved one claim submitted by HCMC (D.B.A. "We Care Medical") and one claim submitted by another provider, and
- $4,821.12 for the Medicaid portion of 27 claims where the Provider billed both Medicaid and Medicare for oxygen services. (The Medicare reimbursement totaled $5,020.60.)

Questioned Costs Regarding Usual and Customary Fee

In order to supply medical services to Medicaid recipients, providers sign a provider agreement. The Ohio Administrative Code § 5101:3-1-172 states, in part:

> A "Provider Agreement" is a contract between the Ohio department of job and family services and a provider of medical ASSISTANCE services in which the provider agrees to comply with the terms of the "Provider Agreement," state statutes and ODJFS Administrative Code rules, and federal statutes and rules, and agrees to:
>
> (B) Bill the Ohio department of job and family services for no more than the usual and customary fee charged other patients for the same service.

In addition, the Ohio Administrative Code § 5101:3-10-13 (A)(6), Oxygen: covered services and limitations, states billed charges shall be the provider's *usual and customary charge* for the oxygen actually used by the recipient.

Upon review of 14 rental contracts that the Provider held with long term care facilities during our audit period, we found that the Provider charged a wide range of rates for the use of oxygen concentrators, but the median rate charged by the Provider was $58.75 per month.

We are questioning $493,617.20 of Medicaid's costs for concentrator services because they appear to exceed the Provider's usual and customary charges. The Provider charged Medicaid $178.56 per concentrator per month of service 100 percent of the time, while the median rate charged by the Provider to the nursing facilities was $58.75 per month. We calculated the difference between what was paid to the Provider by Medicaid and the rate charged by the Provider to long term care facilities for the period of October 1, 1998 through September 30, 2001, which amounted to $586,589.76 for 4,896 service periods. This calculation excluded payments made to deceased recipients and duplicated payments. However, this calculation did include service periods for which we had projected findings for unsupported levels of service and no meter readings. Therefore, we adjusted our questioned costs to exclude the amount associated with service periods already projected to contain payment error.

We did not gather detailed information on any differences in services required for Medicaid and non Medicaid oxygen concentrators. However, due to the large disparity of $119.81 per month/per concentrator between what the Provider charged Medicaid and what was charged for patients in a similar setting, we question whether the amounts billed Medicaid were a "usual and customary" charge. Medicaid, like a nursing home, is a volume purchaser and should expect to benefit from

reductions or discounting of fees and charges. Therefore, we are recommending that ODJFS as the program administrator make the final determination on whether these questioned costs are appropriate under Ohio Administrative Code § 5101:3-1-172 and Ohio Administrative Code § 5101:3-10-13 and pursue the appropriate recovery action.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we sent the Provider a draft copy of the report on June 5, 2002. The Provider's legal representative responded in a June 26, 2002 letter, in which the Provider disagreed with findings from our sample ($153,344.00), a portion of the duplicate payment findings, and the questioned costs. We responded to each of the issues raised by the Provider in a July 23, 2002 letter that concluded with our belief that the findings and questioned costs were valid.

APPENDIX I

Table 1: Summary of Overpayment Results for HCMC Inc. - D.B.A. "We Care Medical"

Description	Audit Period October 1, 1998 to September 30, 2001
Oxygen Services - Long Term Care Facilities (Projected to the Population)	**$153,344.00**
Actual Finding for Deceased Recipients	**$5,892.48**
Actual Findings for ***3 Types of Duplicate Payments*** ***Type 1:*** Two claims were submitted by the Provider for the same patient, same month – $19,463.04. ***Type 2:*** One claim submitted by the Provider and one claim submitted by another provider for the same patient, same month – $4,106.88. ***Type 3:*** The Provider billed both Medicaid (Place of Service 32) and Medicare (Place of Service 33) for oxygen services – $4,821.12 (Medicaid Overpayment).	**$28,391.04**
TOTAL FINDINGS	**$187,627.52**

APPENDIX I

Table 2: Summary Projection for HCMC Inc. - D.B.A. "We Care Medical" Oxygen Services Provided to Residents of Long Term Care Facilities For the period October 1, 1998 to September 30, 2001

Description	Audit Period October 1, 1998 to September 30, 2001
Total Medicaid LTCF Oxygen Services Paid	$893,369.24
Number of LTCF Oxygen Recipient Dates of Service	4,925
Type of Sample Used	Stratified Random Sample
Number of Recipient Dates of Service Sampled	130
Amount Paid for Services Sampled	$37,174.04
Projected Correct Population Payment From Statistical Sample	$740,025.00
Upper Limit Estimate of Correct Population Payment at 95% Confidence Level	$801,458.00
Lower Limit Estimate of Correct Population Payment at 95% Confidence Level	$678,591.00
Achieved Precision of Estimate of Correct Population Payment at 95% Confidence Level	+/- $61,433.00 +/- 8.30%
Estimated Overpayment From Statistical Sample (Actual Amount Paid Less Projected Correct Population Payment)	$153,344.00

PROVIDER REMITTANCE FORM

Make your check payable to the Treasurer of State of Ohio and mail check along with this completed form to:

Ohio Department of Job and Family Services
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider:	Mr. Howard Coomes, Owner HCMC Inc. - D.B.A. "We Care Medical" 8914 Glendale Milford Road, Suite A Cincinnati, Ohio 45140
Provider Number:	0991566
Review Period:	October 1, 1998 through September 30, 2001
AOS Finding Amount:	$187,627.52
Date Payment Mailed:	
Check Number:	
IMPORTANT:	To ensure that our office properly credits your payment, please also fax a copy of this remittance form to: Charles T. Carle at (614) 728-7398.

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STATE OF OHIO
OFFICE OF THE AUDITOR

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HCMC INC. DBA WE CARE MEDICAL

HAMILTON COUNTY

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
AUGUST 20, 2002