PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2006-D35

PROVIDER -
East Lake Community Health Center
Chicago, Illinois

Provider No.: 14-4646

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
AdminaStar Federal

DATE OF HEARING
August 15, 2005

Cost Reporting Period Ended -
December 31, 1998

CASE NO. 01-0991

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ISSUES:

Issue 1: Whether the Intermediary's adjustment to complete all cost reporting forms in conformity with current regulations and instructions was proper.

Issue 2: Whether the Intermediary's adjustment to correct all math and flow-through errors arising on revision of the cost report was proper.

Issue 3: Whether the Intermediary's adjustment to the amortization of start-up costs applicable to the 1998 cost reporting period was proper.

Issue 4: Whether the Intermediary's adjustment to unsupported/unliquidated expenses related to accounting and consulting services, legal fees, computer billing expenses, housekeeping costs and accrued A&G costs was proper.

Issue 5: Whether the Intermediary's adjustment reclassifying costs associated with medical and professional services was proper.

Issue 6: Whether the Intermediary's adjustment to expenses associated with the Chicago Community Education Program was proper.

Issue 7: Whether the Intermediary's adjustment to food costs from Sam's Club was proper.

Issue 8: Whether the Intermediary's adjustment to unsupported interest and banking charges, contract labor, psychiatrist's services, professional services – group therapy and catering expenses was proper.

Issue 9: Whether the Intermediary's adjustment to rent expense was proper.

Issue 10: Whether the Intermediary's adjustment to depreciation expense was proper.

Issue 11: Whether the Intermediary's adjustment reclassifying telephone and wire service expenses to the Administrative and General (A&G) cost center was proper.

Issue 12: Whether the Intermediary's adjustment reclassifying security and maintenance expenses to the Plant Operations cost center was proper.

Issue 13: Whether the Intermediary's adjustment incorporating Medicare charges per the Provider Statistical and Reimbursement Report (PS&R) dated 2/29/00 was proper.

Issue 14: Whether the Intermediary's adjustment to reflect gross salaries statistics on Worksheet B-1 was proper.

Issue 15: Whether the Intermediary's adjustment to the square footage statistics was proper.

Issue 16: Whether the Intermediary's adjustment to reflect the settlement data shown on the PS&R dated 2/29/00 was proper.

Issue 17: Whether the Intermediary's adjustment to bad debts was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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). 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Medicare regulations at 42 C. F. R. §§413.20 and 413.24 require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. 42 C. F. R. §413.24 further requires that cost data must be based on an approved method of cost finding.

During the period under review, community mental health centers were reimbursed for services provided to Medicare patients on the basis of reasonable cost. The principles of reasonable cost reimbursement are set forth in CMS Publication 15, Part 1; Part 2, Chapter 18 contains instructions for completing the community mental health cost report (CMS Form 2088-92).

For providers that are reimbursed on the basis of reasonable cost, the intermediary makes interim payments during the year that are based on a percentage of billed charges. The final amount of reimbursement due a provider for a given year is based upon the reasonable cost incurred in furnishing services to Medicare beneficiaries, and it is computed using the methods of cost

finding and cost apportionment prescribed by the Provider Reimbursement Manual (CMS Pub. 15). The ratio of Medicare charges to total charges is applied to total allowable costs to arrive at Medicare reimbursable costs. For community mental health centers, reimbursement is limited to 80 percent of the lesser of reasonable costs or gross charges, plus reimbursable bad debts.

The issues in this appeal involve the determination of allowable costs and the apportionment of those costs to the Medicare program.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

East Lake Community Health Center (Provider) was a for-profit outpatient community mental health center located in Chicago, Illinois. The Provider was initially certified for Medicare participation on November 19, 1996. It ceased its operations on April 4, 1999. The Provider experienced difficulty preparing its Medicare cost report for the fiscal year ended December 31, 1998 and finally filed a Medicare cost report with AdminaStar Federal (Intermediary) on February 28, 2000. In its filed cost report the Provider challenged Medicare's cost reimbursement and apportionment principles, including the way in which the Medicare cost report computes reimbursement, the use of the forms prescribed by the program and the instructions for completing those forms. As a result of these challenges, the filed cost report was not completed in accordance with the provisions of the Provider Reimbursement Manual.

During audits of the 1996 and 1997 cost reports the Intermediary noted significant problems with the Provider's documentation of claimed costs and its failure to liquidate accrued liabilities in a timely manner. These audits formed the basis of the Intermediary's audit plan for the 1998 cost report.

The Intermediary requested documentation for the 1998 audit in May 2000. The Provider responded that its accountant had the records and would not return them, but that it would try again to have them returned. When the requested documentation was not provided, the Intermediary made numerous adjustments to the cost report − all of which Provider appealed.

There is no dispute that the Provider furnished community mental health services to patients. This case concerns the determination of reimbursement due the Provider under Medicare reimbursement rules and regulations for services furnished to program beneficiaries.

PARTIES' CONTENTIONS:

The Provider raised 17 issues with the Intermediary's adjustments. These issues have been aggregated into three groups based upon the rationale cited by the Intermediary for its adjustments.

Group 1: General Corrections to the Cost Report

The Intermediary's initial review of the cost report revealed that it had not been prepared in

accordance with CMS instructions. The Intermediary revised the cost report using the Provider's data and CMS' instructions. The Provider challenged seven adjustments in this category:

Issue 1: Whether the Intermediary's adjustment to complete all cost reporting forms in conformity with current regulations and instructions was proper.

Issue 2: Whether the Intermediary's adjustment to correct all math and flow-through errors arising on revision of the cost report was proper.

Issue 5: Whether the Intermediary's adjustment reclassifying costs associated with medical and professional services was proper.

Issue 11: Whether the Intermediary's adjustment reclassifying telephone and wire service expenses to the Administrative and General (A&G) cost center was proper.

Issue 12: Whether the Intermediary's adjustment reclassifying security and maintenance expenses to the Plant Operations cost center was proper.

Issue 14: Whether the Intermediary's adjustment to reflect gross salaries statistics on Worksheet B-1 was proper.

Issue 15: Whether the Intermediary's adjustment to the square footage statistics was proper.

The Provider argues that the adjustments and reclassifications made by the Intermediary are not specifically permitted or even discussed in the Social Security Act (the Act). The Provider argues further that CMS, in requiring this method of cost reporting, is attempting to amend the Social Security Act without the authority to do so. Further, the Provider argues that the Intermediary's method of cost reporting produced a substantial disallowance of its legitimate reimbursement claims.

The Intermediary contends that the Act designates the types of services that the Provider offered as covered services. The Act, as codified at 42 U.S.C. Section 1395hh, also grants the Secretary the authority to prescribe regulations to carry out the administration of the program. To that end the Secretary has promulgated extensive cost reporting and cost finding rules and regulations, all of which apply to the cost reporting period that is the subject of this appeal. Those rules are not an attempt to amend the statute but are simply intended to carry out the terms of the statute.

This group of adjustments deals with general corrections to the cost report. The adjustments were made to correct math and/or flow-through errors in the presentation of costs or statistics within the cost report or to make reclassifications necessary to ensure consistency from one work sheet to another. The Intermediary maintains that none of the adjustments had any impact on the Provider's reimbursement.

Group 2: Lack of Documentation

The Intermediary considered the documentation offered in support of some costs insufficient for adequate cost finding, and it disallowed those costs. The Provider challenged six adjustments in this category:

Issue 4: Whether the Intermediary's adjustment to unsupported/unliquidated expenses related to accounting and consulting services, legal fees, computer billing expenses, housekeeping costs and accrued A&G costs was proper.

Issue 6: Whether the Intermediary's adjustment to expenses associated with the Chicago Community Education Program was proper.

Issue 7: Whether the Intermediary's adjustment to food costs from Sam's Club was proper.

Issue 8: Whether the Intermediary's adjustment to unsupported interest and banking charges, contract labor, psychiatrist's services, professional services – group therapy and catering expenses was proper.

Issue 9: Whether the Intermediary's adjustment to rent expense was proper.

Issue 17: Whether the Intermediary's adjustment to bad debts was proper.

The Provider challenged the Intermediary's authority to make adjustments absent specific language in the statute that authorized such action. Further, the Provider argues that while it did not have access to its financial records, it offered alternative documentation in the form of cancelled checks and patient care records for all costs claimed. The Provider asserts that the record shows that services were delivered and should be reimbursed as claimed.

The Intermediary contends that the regulations at 42 C. F. R. §413.24 and the Provider Reimbursement Manual (PRM) §2304 require the Provider to maintain sufficient detailed records to support its claimed costs. The Intermediary further contends that the limited documentation available for its review did not support the costs claimed by the Provider in the 1998 cost report.

Group 3: Start-up Costs, Depreciation, and the Provider Statistical and Reimbursement Report (PS&R)

The Intermediary made adjustments to the cost report for start-up costs and depreciation. In addition, the Intermediary incorporated the settlement data statistics accumulated by the PS&R into the cost report. The Provider challenged four adjustments in this category:

Issue 3: Whether the Intermediary's adjustment to the amortization of start-up costs applicable to the 1998 cost reporting period was proper.

Issue 10: Whether the Intermediary's adjustment to depreciation expense was proper.

Issue 13: Whether the Intermediary's adjustment incorporating Medicare charges per the PS&R dated 2/29/00 was proper.

Issue 16: Whether the Intermediary's adjustment to reflect the settlement data shown on the PS&R dated 2/29/00 was proper.

The Intermediary conducted a number of audit procedures to measure the accuracy of the amounts claimed on the cost report for depreciation and start-up costs. These procedures included extensive vouching and comparative analyses with national standards regarding the useful lives established for furniture and equipment. In addition, the Intermediary incorporated the settlement data statistics on the PS &R into the cost report. The Intermediary adjusted the cost report to reflect the amounts verified through its audit procedures.

The Provider challenged the Intermediary's use of the American Hospital Association's (AHA) asset useful life guidelines and proffered that International Accounting Standards Number 16 should be used to establish the useful lives of its assets. The Provider argues further that its patient records are the most appropriate evidence available to support its claimed costs, and that it is entitled to the costs that it claimed based upon its charges and current fee schedule.

The Intermediary contends that it is bound by the instructions promulgated by the Secretary, and that the instructions require the use of AHA's asset useful life guidelines. Further, the Intermediary acknowledges that the patient records are evidence that services were furnished to patients; however, it is not the provision of patient services that is in dispute. Rather, it is the adequacy of the documentation the Provider supplied to support the costs claimed and the proper apportionment of allowable costs to the Medicare program. The paid claims information accumulated in the PS&R contains the Medicare charges and other data essential for the proper apportionment of costs to the Medicare program.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions, and the evidence offered at the hearing and contained in the record, finds and concludes as follows:

There is no dispute that the services offered by the Provider are services that the Act designates as covered services.

The central issue in this appeal involves the proper authority of the Secretary to develop, issue and enforce reimbursement regulations that interpret and apply the provisions of Titles XVIII

and XIX of the Social Security Act. The Provider argues that the language of the statute does not specifically allow CMS or its contracted intermediaries to adjust or otherwise modify the costs claimed by servicing providers on their cost reports. Absent such language, CMS' reimbursement regulations, instructions and cost reporting methodologies constitute unauthorized amendments to the Act that may not be enforced at law. The Board disagrees. Section 1871 of the Social Security Act, as codified at 42 U.S.C. Section 1395hh, grants the Secretary broad authority to prescribe regulations to carry out the administration of the Medicare program.

Pursuant to that authority, the Secretary promulgated the reasonable cost regulations, the cost reporting instructions, and the cost-finding methodologies that were in effect during the cost reporting period at issue. Further, the Secretary is duly authorized to delegate the enforcement of those regulations, rules and settlement processes to CMS' fiscal intermediaries.[1] The rules, and the Intermediary's participation in the settlement process, are not attempts to amend the statute; they are legally authorized directives that are intended to facilitate the terms of the Social Security Act. The Board concludes that the cost reporting and cost finding rules and regulations promulgated by the Secretary are applicable to the issues raised by the Provider in this appeal.

In addition to the primary challenge to the legality of the regulations and reimbursement process, the Provider also offered other arguments in support of its challenges to the Intermediary's adjustments. The Board's consideration and conclusions relative to those arguments are as follows:

Group 1: General Corrections to the Cost Report

The Intermediary revised the submitted cost report using the Provider's data and CMS' instructions. The Provider raised issue with all of the adjustments included in the revised cost report. However, the Board's examination indicated that the Provider's arguments addressing these adjustments and corrections were limited to the challenge of the regulations discussed above. The Board concludes that the Intermediary's adjustments were proper.

Group 2: Lack of Documentation

The Intermediary considered the documentation the Provider offered in support of some of its costs insufficient for adequate cost finding and disallowed those costs pursuant to 42 C. F. R. §413.24. The Provider disputed each adjustment based upon its challenge to the legality of the regulations and also argued that it had offered alternative evidence in the form of cancelled checks and patient care records for all costs claimed. The issues, alternative evidence, and the Board's findings on each are as follows.

Issue 4 The Intermediary included expenses claimed for accounting and consultation, legal fees, computer billing and housekeeping in this adjustment. The Intermediary requested copies of the invoices for each of the respective expenses

[1] See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

claimed so that it might relate those expenses to the period under review. The Intermediary also requested access to the contracts for which the expenses were incurred in order to verify the scope of the services. Prior to the hearing, the Provider submitted a number of checks in support of the amounts claimed and argued that the checks evidenced that services were purchased and should be reimbursed. The Intermediary reviewed the checks, but without the related invoices, it could not tie the costs claimed to the year under review. The Intermediary concluded that the adjustment was necessary.

The Board examined the cancelled checks and, like the Intermediary, could not tie the amounts claimed to this cost period. The Board cannot assume that the outlays evidenced by the checks pertain to 1998. Accordingly, the Board concludes that the Intermediary's adjustment was proper.

Issue 6 The Intermediary's review indicated that the contract with the Chicago Community Education Program (CCEP) was terminated before the start of the cost reporting period at issue. Consequently, the Intermediary requested invoices to determine if the costs claimed on the cost report were for services performed in 1998. When the Provider failed to supply the invoices, the Intermediary disallowed the costs. The Board cannot assume that the costs claimed were incurred during 1998. On the contrary, the termination of the contract before 1998 indicates otherwise; therefore, the Board finds that the Intermediary's adjustment was proper.

Issue 7 In the Employee Benefits cost center on its filed cost report, the Provider claimed $2,150 in costs related to food acquired from Sam's Club. The Intermediary noted that in prior years the Provider had maintained a non-reimbursable cost center for patient meals. The Intermediary requested copies of the invoices to support these costs so that it might verify the nature and the timing of the expenses. When the documentation was not supplied, the Intermediary eliminated the costs.

The Provider offered cancelled checks in its final position paper in support of some of the costs claimed. However, from the cancelled checks, the Intermediary could not establish the purpose of the expense or the period in which the costs were incurred. At the hearing the Provider supplied transportation records that indicated all of its 102 patients had been transported to the facility, had spent the entire day there, and were subsequently returned to their nursing facility. The Provider argued that the transportation records and cancelled checks demonstrate that food was supplied to the patients while at the Provider's location.

The Board examined the cancelled checks and could not tie the amounts claimed to this cost period. Furthermore, patient meals are non-allowable expenses in the Provider's service delivery setting. Absent information that demonstrates that the outlays were for a reimbursable activity that was conducted during the 1998 cost

reporting period, the Board concludes that the Intermediary's adjustment was proper.

Issue 8 The Intermediary requested documentation that supported the amounts claimed by the Provider for bank charges and interest, medical ancillary services, group therapy and professional service costs. The Intermediary requested invoices, contracts and payroll information in support of the amounts claimed, and when the documentation was not provided, the costs were eliminated.

At the hearing the Provider offered cancelled checks and patient care records as evidence that the outlays had been made and that the costs should be reimbursed. The documentation demonstrates that outlays occurred but is insufficient to establish the reimbursable nature and timing of those outlays. Consequently, the Board concludes that the Intermediary's adjustment was proper.

Issue 9 The Intermediary obtained a copy of the facility lease during its audit of the Provider's prior cost report. The Provider claimed rental expense in excess of the amount required by the lease. The Intermediary requested a reconciliation of the amount claimed versus that evidenced by the lease. It also requested information about the lease and its parties in order to determine whether a related party relationship existed. When the information was not provided, the Intermediary removed the excess expense claimed. However, the Intermediary allowed the lease payments required by the lease despite the Provider's failure to provide information regarding the related party inquiry.

At the hearing the Provider supplied a copy of the rider to the lease and argued that it called for periodic rental increases and maintenance fees. However, no evidence was provided that indicated the amount of those increases or that reconciled the amounts claimed by the Provider. Absent such evidence, the Board cannot establish the amount that is reimbursable for the period and concludes that the Intermediary's adjustment was proper.

Issue 17 The Provider claimed $532,659 in bad debts on its filed cost report. The Intermediary noted that $112,560 of the bad debt write-offs did not appear to be related to deductible and coinsurance amounts. In addition, many of the claims were related to services performed just 90 days before the end of the cost reporting period. The Intermediary drew a statistical sample from the listing of bad debts claimed and requested supporting information for the sample. When the Provider failed to supply documentation necessary to support its claimed bad debts, the Intermediary eliminated them from the cost report in accordance with 42 C. F. R. §413.80. At the hearing the Provider argued that debt collection was the responsibility of CMS and challenged the authority of the Intermediary to shift that responsibility the Provider.

The Board finds that the regulations promulgated by the Secretary at 42 C. F. R. 413.80 set the parameters under which bad debts may be claimed and reimbursed: 1) the debts must be related to deductibles and coinsurance; 2) the provider must establish that reasonable collection efforts were made; 3) the debt must be actually uncollectible when claimed as worthless; and 4) sound business judgment established that there is no likelihood of recovery at any time in the future. The Board also finds that, while the Provider argued that its patients were indigent and that it would be inhumane to try to collect from the mentally ill, the Provider failed to document the indigent status of its patients so that it might avoid the collection effort mandated by the regulation. Clearly, the Provider did not provide the documentation necessary to establish its compliance with the bad debt regulations. Therefore, the Board concludes that the Intermediary's adjustment was proper.

Group 3: Start-up Costs, Depreciation, and the Provider Statistical and Reimbursement Report (PS&R)

The Intermediary made adjustments for start-up costs and depreciation, and it incorporated the settlement data statistics from the PS&R report into the cost report. The Provider disputed each adjustment in this category based upon its challenge to the legality of the regulations and also argued that it offered alternative support for all costs claimed. The issues, alternative support, and the Board's findings on each are as follows:

Issue 3

CMS Publication 15-1, §2132 sets the standards under which start-up costs may be claimed and limits start-up costs to those expenses incurred before the date that the first patient is treated. The Provider claimed a substantial amount for start-up costs in 1998. The Intermediary requested invoices, cancelled checks and contracts to support the amounts claimed on the cost report. The Intermediary's review indicated that the Provider included expenses that were incurred after its first patient was seen, expenses that were non-allowable due to the nature of the expense (capital asset, building rental deposit) and expenses for which no documentation was available. In addition, the Provider accelerated the write-off of start-up costs to account for its withdrawal from the Medicare program.

The Intermediary adjusted the cost report to eliminate unallowable or unsupported expenses, including those that were incurred after the Provider saw its first patient. In addition, the Intermediary adjusted the Provider's accelerated write-off to comply with CMS 15-1, §2132.5. This section permits accelerated recovery of start-up costs in the final year of a provider's participation in the Medicare program; however, the 1998 cost reporting period was not the Provider's final period of participation in the program.

At the hearing, the Provider argued that start-up costs should be amortized evenly over the duration of the Provider's participation in the program, and that

substantially higher costs than those allowed by the Intermediary should be permitted. However, the Provider did not cite any Medicare regulations or instructions in support of its argument. Further, the Provider offered no additional documentation to refute the Intermediary's contention that the claimed costs were disallowed for lack of supporting documentation. Absent supporting documentation or proper regulatory foundation, the Board must apply existing regulatory and instructional requirements and concludes that the Intermediary's adjustment was proper.

Issue 10 The Provider claimed depreciation expense for which it supplied a detailed lapse schedule. The Intermediary's review indicated that the schedule included depreciation for assets purchased in periods subsequent to the year in issue. In addition, asset lives used in the schedule were not in accordance with AHA asset useful life guidelines, and the depreciation expense shown on the schedule represented more than 12 months of depreciation. The Intermediary disallowed the depreciation claimed on assets purchased in subsequent periods, adjusted the asset lives to the AHA guidelines, and eliminated depreciation in excess of 12 months.

At the hearing the Provider challenged the use of the AHA guidelines and argued that International Accounting Standard #16 sets the standard for depreciation for all of its signatories, including the United States government; and that since CMS is an instrumentality of that government, it should properly abide by standard #16. However, the Provider was unable to demonstrate that the application of standard #16 would produce results that differed in any way from the AHA guidelines, or that it had even used the standard for its depreciation calculation. Absent such demonstration, the Provider failed to establish a legitimate basis upon which to dispute the Intermediary's adjustment. Consequently, the Board concludes that the Intermediary's adjustment was proper.

Issue 13 The Provider claimed that it used its internal records to file its cost report. The Intermediary made adjustments to incorporate Medicare charges from the PS&R dated February 29, 2000. These adjustments caused Medicare charges to exceed total facility charges. The Intermediary was unable to determine the basis of the total facility charges reported by the Provider and adjusted total charges to equal Medicare charges.

At the hearing the Provider argued that Section 1833 of the Act contains no language that authorizes the use of the PS&R, and it challenged the authority of the Intermediary to do so. The Board addressed the Provider's argument earlier in this decision. The Board held that Section 1871 of the Social Security Act, as codified at 42 U.S.C. Section 1395hh, grants the Secretary broad authority to prescribe regulations to carry out the administration of the Medicare program, and that the reporting rules and cost finding regulations promulgated by the Secretary

are applicable to the issues raised by the Provider in this appeal. CMS Publication 13-2, §§2241, 2242, and 2243 require the use of the PS&R to determine Medicare charges unless a provider furnishes proof that inaccuracies exist. Absent a countervailing regulation or program instruction, the Board finds that the PS&R must be used to determine Medicare charges; accordingly, the Board concludes that the Intermediary's adjustment was proper.

Issue 16 The Intermediary adjusted the Provider's Medicare visits, deductibles, coinsurance and interim payments to reflect the data shown on the PS&R. At the hearing, the Provider raised an objection to the use of the PS&R in the absence of statutory language authorizing its use (see Issue 15 above). The Board held previously that the cost reporting and cost finding rules and regulations promulgated by the Secretary are applicable to the issues raised by the Provider in this appeal. CMS Publication 13-2, §§2241, 2242 and 2243 require the use of the PS&R to evaluate/determine Medicare settlement data. Absent a countervailing regulation or program instruction, or proof that the PS&R data is inaccurate, the Board finds that the PS&R must be used to determine settlement data and concludes that the Intermediary's adjustment was proper.

DECISION AND ORDER:

The Intermediary's adjustments to the Provider's cost report were proper and are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: July 20, 2006

Suzanne Cochran, Esquire
Chairperson