IN THE MATTER OF	*	**BEFORE THE STATE BOARD**
JOHN CUSIC, P.T.	*	**OF PHYSICIAL THERAPY**
Respondent	*	**EXAMINERS**
License No.: 16869	*	**Case No.: 01-BP-129**

* * * * * * * * * * * * * *

FINAL CONSENT ORDER

Based on information received and a subsequent investigation by the State Board of Physical Therapy Examiners (the "Board"), and subject to Md. Health Occ. Code Ann. § 13-101 *et seq.* (the "Act"), the Board charged John Cusic, P.T., (the "Respondent"), with violations of the Act. Specifically, the Board charged the Respondent with violation of the following provisions of H.O. § 13-316:

> Subject to the hearing provisions of § 13-317 of this subtitle, the Board may deny a license, temporary license, or restricted license to any applicant, reprimand any licensee or holder of a temporary license or restricted license, place any licensee or holder of a temporary license or restricted license on probation, or suspend or revoke a license, temporary license, or restricted license if the applicant, licensee or holder:

(5) In the case of an individual who is authorized to practice physical therapy is grossly negligent;

(ii) In the direction of an individual who is authorized to practice limited physical therapy;

(15) Submits a false statement to collect a fee;

(16) Violates any provision of this title or rule or regulation adopted by the Board;

(21) Grossly over utilizes health care services;

(26) Fails to meet accepted standards in delivering physical therapy care.

The Board further charges the Respondent with the following violations of the Code of Maryland Regulations (Code Md. Regs.) tit. 10, § 38.03.02 Standards:

K. The physical therapist shall provide direction, periodic on-site supervision, and instruction for the physical therapy assistant that is adequate to ensure the safety and welfare of the patient;

L. At least once in every ten visits or every 60 calendar days, whichever comes first,, there shall be a joint on-site visit with treatment rendered by the physical therapist assistant under the direct supervision of the physical therapist. At this visit, the physical therapist is to assess the treatment performed by the physical therapist assistant, reevaluate the patient's program, and document the program.

The Board also charged the Respondent with violations of the Code Md. Regs. tit. 10, § 38.03.02-1 Requirements for Documentation:

A. As established by the American Physical Therapy Association of Maryland, and as approved by the Board, the physical therapist shall document the patient's chart as follows:

(1) For initial visit:

(a) Date,
(b) Condition/diagnosis for which physical therapy is being rendered,
(c) Onset,
(d) History, if not previously recorded,
(e) Evaluation and results of tests (measurable and objective data),
(f) Interpretation,
(g) Goals,
(h) Plan of care and
(i) Signature, title (PT) and license number;

(2) For subsequent visits:

(a) Date,
(b) Modalities, procedures, etc.,
(c) Cancellations, no-shows,
(d) Response to treatment,

(e) Signature and title (PT), with identifying signatures appearing on the patient's chart, although the flow chart may be initialed,
(f) Weekly progress or lack of it,
(g) Unusual incident/unusual response,
(h) Change in plan of care;
(i) Temporary discontinuation or interruption of services and reasons,
(j) Reevaluation,
(k) If there is a physical therapy assistant, reevaluate and document as required by Regulation .02L of this chapter;

(3) For discharge or last visit:

(a) Date,
(b) Reason for discharge,
(c) Status for discharge,
(d) Recommendations for follow-up, and
(e) Signature and title.

The Board issued the charges on January 21, 2003. Thereafter, a Case Resolution Conference was held on April 1, 2003. Following the Case Resolution Conference, the parties agreed to resolve the matter by way of settlement. The parties and the Board agreed to the following:

FINDINGS OF FACT

The Board makes the following findings:

1. The Respondent is licensed to practice physical therapy in the State of Maryland. The Respondent was originally licensed on December 10, 1990.

2. At all times relevant hereto, the Respondent was employed as a physical therapist by Concentra Medical Centers, Inc. ("Concentra").

3. On or about March 11, 1999, the Board received a complaint from the Special Investigation Unit of the Injured Workers' Insurance Fund ("IWIF") that

Concentra over utilized the following physical therapy procedures, as identified by the Current Procedural Terminology ("CPT") assigned to them:

> **95831**- muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report
>
> **95851**- range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)

4. Thereafter, the Board conducted an investigation of services provided and claims submitted to IWIF by Physical Therapists ("PTs") and Physical Therapist Assistants ("PTAs") employed by Concentra at the time the complaint was filed. The investigation revealed documentation and coding deficiencies in addition to those originally alleged in the IWIF complaint.

CPT CODES

5. CPT codes provide a uniform language that accurately describes medical, surgical and diagnostic procedures. According to the CPT Manual, the CPT is "the most widely accepted nomenclature for the reporting of physician procedures and service under government and private health insurance programs. CPT is also useful for administrative management purposes such as claims processing and for the development of guidelines for medical care review."

a. Codes 95831 and 95851

6. The CPT codes identified in the IWIF complaint, 95831 and 95851, are classified as Neurology and Neuromuscular Procedures.[1] Both codes are appropriate to evaluate a patient who has suffered deficiencies as a result of a neurological disorder or disease such as stroke or multiple sclerosis in order to document the patient's

[1] The most common CPT codes recorded in Concentra patient records are listed in the Physical Medicine and Rehabilitation section, the first two digits are "97."

progression or regression. Both of these codes require the physical therapist to generate a separate report.

7. In the CPT manual, the term "separate procedure," as used in the description of the codes, identifies a procedure that is commonly carried out as an integral component of a total service or procedure. The CPT manual states further:

> The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component. However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending the modifier "-59" to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries).

8. Code 95831 is defined in the CPT manual as follows: Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report.

9. Code 95851 is defined in the CPT manual as follows: Range of motion ("ROM") measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine).

10. Objective findings such as muscle strength and range of motion are a standard of physical therapy documentation and are to be performed once a week at a minimum. It is not standard physical therapy practice to bill separately for these measurements except when being performed as re-evaluation. It is standard physical therapy practice to assess and interpret objective findings that result from muscle

testing and range of motion testing in order to determine whether changes should be made to the patient's treatment plan and/or goals.

b. Code 97110-Therapeutic exercise

11. Code 97110 is classified in the CPT manual as a therapeutic procedure. A therapeutic procedure is, "a manner of effecting change through the application of clinical skills and/or services that attempt to improve function. Physician or therapist required to have direct (one on one) patient contact."

12. Code 97110 is defined in the CPT manual as follows: Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercise to develop strength and endurance, range of motion and flexibility.

13. Teaching the patient how to perform the exercise is a component of therapeutic exercises and is not to be billed as a separate charge by the provider.

c. Code 97112- Neuromuscular re-education

14. Neuromuscular re-education (Code 97112) is classified as a therapeutic procedure and incorporates all of the elements of therapeutic exercises. Neuromuscular re-education is further defined as the neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and proprioception.

d. Code 97530- Therapeutic activity

15. Therapeutic activity (Code 97530) is classified as a therapeutic procedure and is defined as, "direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes."

General Allegations of Deficiencies

16. Throughout the patients' treatment records, the Respondent noted and billed for therapeutic exercises and therapeutic activities in the absence of documentation that the patients required one-on-one supervision, contact or instruction during these activities.

17. The Respondent billed under the neuromuscular re-education code in the absence of supporting documentation.

18. Treatment plans as written in initial evaluations are inadequate in that they lack treatment procedures and/or modalities to be provided.

19. CPT codes are used for tests conducted shortly after a patient's initial evaluation. These tests include: range of motion, manual muscle testing, reflexes, girth and grip strength. Objective findings are a standard of physical therapy documentation and are to be performed on a weekly basis at minimum. It is not standard practice to bill separately for these measurements, except as part of a re-evaluation. The Respondent failed on most occasions to prepare reports for those procedures that are defined in the CPT manual as a "separate procedure" but billed for the procedure nonetheless.

Patient-Specific Allegations

Patient A

20. Patient A, a female born in 1947, initially presented to Concentra on June 11, 1998 with complaints of back pain. Patient A reported that she had slipped and fallen on the floor in a work-related accident on the previous day.

21. The Respondent was evaluated by the Respondent on June 11, 1998. The Respondent noted on Patient A's treatment plan, "[A]ppropriate physical therapy modalities and procedures will be utilized to achieve the above goals."

22. The Respondent's treatment plan is not adequate because he failed to indicate the modalities/therapeutic procedures with parameters and the duration/frequency with which he planned to treat the patient. The Respondent also failed to state an adequate goal of treatment.

23. The Respondent treated Patient A on June 15, 1998. He noted the following charges for that visit: Modalities - Hot/Cold Packs (97010) and Electrical stimulation (97014); Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112) , Myofascial Release (97250); and Tests - Range of Motion (95851)[2].

24. The Respondent's documentation of the June 15, 1998 visit fails to support charging under the Neuromuscular Re-education code or the Test code.

Patient B

25. Patient B, a male born in 1964, initially presented to Concentra on December 19, 1998 with injuries to his lumbar region and right knee . Patient B reported that he sustained the work-related injury in a motor vehicle accident. Patient B was evaluated by a PT other than the Respondent on his first visit.

26. The Respondent treated Patient B when he returned on December 18, 1998. The Respondent noted on Patient B's treatment plan: "use PT mod procedures to achieve goals."

[2] Charges under the "Supplies" category are not at issue in this case and are not set forth herein.

27. The Respondent's treatment plan is not adequate because he failed to indicate the modalities/therapeutic procedures with parameters and the duration/frequency with which he planned to treat the patient.

28. On the December 18, 1998 charge ticket, the Respondent noted the following charges: Modalities - Hot/Cold Packs (97010) (2 units), Electrical Stimulation (unattended) (97014) (2 units); Procedures - Therapeutic Exercises (97110), Therapeutic Activity (97530); and Tests - Manual Muscle Testing (95831) and Range of Motion (95851) (2 units).

29. The Respondent's documentation of the December 18,1998 visit fails to support charging under the Manual Muscle Testing code or the Range of Motion code.

Patient C

30. Patient C, a 55 year old male, initially presented to Concentric on September 18, 1998 after straining his right knee and thigh. Patient C reported that he sustained the work-related injury as he was getting into his truck. Patient C was evaluated on his initial visit by a PT other than the Respondent.

31. Patient C returned for treatment on September 21, 1998 and was treated by the Respondent. The Respondent's treatment plan on that date states in part, "Use PT mod/procedures to achieve goals." The Respondent's treatment plan is not adequate because he failed to indicate the modalities/therapeutic procedures with parameters and the duration/frequency with which he planned to treat the patient.

32. On September 29, 1998, after two (2) treatments by individuals other than the Respondent, the Respondent treated Patient C.

33. On the September 29, 1998 charge ticket, the Respondent noted the following charges: Procedures - Therapeutic Exercises (97110); Therapeutic Activity (97530); and Tests - Manual Muscle Testing (95831) and Range of Motion (95851) (2 units).

34. The Respondent's documentation of the September 29,1998 visit fails to support charging under the Manual Muscle Testing code or the Range of Motion code.

35. The Respondent treated Patient C on October 1, 1998.

36. On the October 1, 1998 charge ticket, the Respondent noted the following charges: Procedures - Therapeutic Exercises (97110) (2 units); Therapeutic Activity (97530) and Neuromuscular Re-education (97112).

37. The Respondent's documentation of the October 1, 1998 visits fails to support charging for two units under the Therapeutic Exercise code or under the Neuromuscular Re-education code.

Patient D

38. Patient D, a female born in 1969, initially presented to Concentra on August 19, 1998 with a contused left knee which she sustained while slipping on concrete stairs.

39. The Respondent conducted the initial evaluation of Patient D. On his treatment plan he noted: "Use PT mod/procedures to achieve goals." The Respondent's treatment plan is not adequate because he failed to indicate the modalities/therapeutic procedures with parameters and the duration/frequency with which he planned to treat the patient.

40. On the August 19, 1998 charge ticket the Respondent noted the following charges: Evaluation - PT evaluation New Patient II (97799-0004); Modalities – Hot/Cold Packs (97010); Electrical Stimulation (Unattended) (97014); Procedures - Therapeutic Activities (97110); Therapeutic Exercise and Other - Training in self-care skills/Daily mngt skills (97540).

41. The Respondent's documentation of the August 19, 1998 visit fails to support charging under self-care training code. Instructing Patient D in the use of ice does not constitute daily management skills.

42. The Respondent treated Patient D on August 21, 1998. The Respondent noted the following charges for that visit: Modalities – Hot/Cold Pack (97010), Electrical Stimulation (unattended); Procedures - Therapeutic Exercise (97110), ADL Training (97540); Tests - Manual Muscle Testing (95831), Manual Muscle - Hand (95851) and Girth Measurements (97799).

43. The Respondent's documentation of the August 21, 1998 visit fails to support charging under the Neuromuscular Re-education code or the ADL code. Instructing Patient D in the use of heat at home does not constitute ADL Training.

44. The Respondent also failed to document the necessity of charging under the Test codes during a visit that is a mere three (3) days after the initial evaluation.

Patient E

45. Patient E, a male born in 1964, initially presented to Concentra on June 17, 1999 with complaints of pain in his lower lumbar region, sustained when he was raking leaves.

46. The Respondent treated Patient E on June 21, 1999. On the charge ticket for that visit, the Respondent noted the following charges: Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530); and Tests - Range of Motion (95851).

47. The Respondent's documentation of the of June 21, 1999 visit fails to support charging under the Test code for a Range of Motion test conducted four (4) days after the initial visit.

Patient F

48. Patient F, a female born in 1943, initially presented to Concentra on December 7, 1998, with complaints of pain in her right hand and wrist. Patient F reported that she sustained the work-related injury when her right hand was caught in a metal door. She was referred for physical therapy by the evaluating physician.

49. Patient F was evaluated by an occupational therapist ("OT") on December 8, 1998. The OT's treatment plan stated in part: "OT/PT to maximize function...activities/modalities as needed."

50. The Respondent treated Patient F on December 9, 1998. He did not conduct a physical therapy evaluation of Patient F on that date.

51. On the December 9, 1998 charge ticket, the Respondent noted the following charges: Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530).

52. The Respondent's documentation of the December 9, 1998 visit fails to support charging under the Therapeutic Activity code.

53. The Respondent treated Patient F on December 11, 1998. On the charge ticket for that visit, the Respondent noted the following charges: Procedures - Therapeutic Exercise (97110) and Therapeutic Activity (97530). The Respondent's documentation fails to support charging under the Therapeutic Activity code.

Patient G

54. Patient G, a male born in 1958, initially presented to Concentra on August 10, 1998 complaining of pain in his right wrist. Patient G reported that he had sustained the work-related injury to his wrist the day before when he was unlocking a door. Patient G was referred to PT by a Concentra physician.

55. On August 11, 1998, Patient G was evaluated by a PT other than the Respondent. The treatment plan included limited modalities, manual therapy as needed, therapeutic exercise, therapeutic activities and work conditioning.

56. The Respondent treated Patient G on August 13, 1998. The Respondent noted the following charges for that visit: Modalities – Hot/Cold Packs (97010); Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112) and Therapeutic Activity (97530); and Tests - Manual Muscle Testing (95831), Manual Muscle - Hand (95851) and Jamar 1 (97750).

57. The Respondent's documentation of the August 13, 1998 visit fails to support charging under Neuromuscular Re-education code or the Test codes.

58. A PTA treated Patient G for the next five visits: August 17, 1998, August 19, 1998, August 21, 1998, August 24, 1998, and August 26, 1998. During several of these visits, the PTA performed Range of Motion and Jamar tests and made objective findings.

59. The Respondent knew, or should have known the permissible activities that fall within the scope of a PTA license. The Respondent, by permitting the PTA to charge under the test code and to make assessments regarding the patient's status, violated the Act by knowingly allowing the PTA to practice beyond the scope of the PTA's license.

Patient H

60. Patient H, a female born in 1948, initially presented to Concentra on December 9, 1998 with complaints of pain in her right knee. Patient H reported that she sustained the work-related injury when she slipped on a zucchini and fell on her knee.

61. Patient H was evaluated by a PT other than the Respondent on her first visit. The treatment plan included ionotophoresis, therapeutic exercise and functional training.

62. The Respondent treated Patient H on December 14, 1998. The Respondent noted the following charges for that visit: Modalities - Iontophoresis (97833); Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112) and Therapeutic Activity (97530).

63. The Respondent's documentation of the December 14, 1998 visit fails to support charging under the Therapeutic Activity code.

64. The Respondent treated Patient H on December 16, 1998. The Respondent noted the following charges for that visit: Modalities - Iontophoresis (97833); Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112) and Therapeutic Activity (97530); Tests - Manual Muscle Testing (95831), Range of Motion (95851) and Girth Measurements (97799).

65. The Respondent's documentation of the December 16, 1998 visit fails to support charging under the Therapeutic Activity code. The Respondent's documentation also fails to support charging under the Test codes one (1) week after the initial evaluation.

66. The Respondent treated Patient H on December 18, 1998. The Respondent noted the following charges: Procedures - Therapeutic Exercise (97110), Neuromuscular Re-education (97112) and Therapeutic Activity (97530).

67. The Respondent's documentation of the December 18, 1998 visit fails to support charging under the Therapeutic Activity code.

Patient I

68. Patient I, a male born in 1967, initially presented to Concentra on September 25, 1998 complaining of neck pain. Patient I reported that he sustained the injury in a work-related accident during which he swerved the van he was driving into a fence to avoid a deer. Patient I was evaluated by a Physician Assistant who diagnosed him with myalgia and myositits, unspecified, and referred him to physical therapy.

69. The Respondent treated Patient I on September 28, 1998 and September 30, 1998. On both dates, the Respondent noted the following charges: Modalities – Hot/Cold Packs (97010); Procedures - Therapeutic Exercise (97110), Myofascial Release (97250) and Therapeutic Activity (97530); and Tests - Range of Motion (95851).

70. The Respondent's documentation of the September 28, 1998 and September 30, 1998 visits fail to support charging under the Therapeutic Activity code or the Test code.

71. The Respondent treated Patient I on October 1, 1998. The Respondent noted the following charges for that visit: Modalities – Hot/Cold Packs (97010) and Electrical Stimulation (unattended) (97014); Procedures - Therapeutic Exercise (97110) (2 units), Myofascial Release (97250) and Therapeutic Activity (97530).

72. The Respondent's documentation of the October 1, 1998 visit fails to support charging for 2 units of Therapeutic Exercise, nor does it support charging under the Therapeutic Activity code.

73. The Respondent was interviewed by the Board during its investigation of this case. The Respondent's explanation of the difference between Therapeutic Exercise and Therapeutic Activity does not reflect the accepted and published definition of those terms. The Respondent's statements with regard to the codes for which he is alleged herein to have failed to provide adequate documentation likewise failed to support the use of those codes.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board finds that the Respondent violated Md. Health Occ. Code Ann. §§ 13-316 (5)(ii), (15), (16), (21), and (26). The Board also finds that the Respondent violated Code Md. Regs. tit. 10, § 38.03.02 K and L, and § 38.03.02-1.

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law and agreement of the parties, it is this 30th day of MAY, 2003, by a majority of a quorum of the Board,

ORDERED that the Respondent shall be placed on probation for a period of two

(2) years, subject to the following conditions:

1. The Respondent shall pay a fine in the amount of three thousand dollars ($ 3,000.00), to be paid prior to the termination of probation;

2. Within the first year of probation, the Respondent shall take the Board-approved law and ethics course and pass the associated examination administered by the Board;

3. The Respondent shall successfully complete a Board-approved documentation course;

4. The Respondent shall successfully complete a Board-approved billing course;

5. The Respondent may apply the above coursework to the Respondent's continuing education requirements for licensure renewal;

AND IT IS FURTHER ORDERED that if the Respondent fails to comply with any of the terms or conditions of probation set forth above, that failure shall be deemed a violation of this Order; and it is further

ORDERED that the Respondent shall practice in accordance with the laws and regulations governing the practice of physical therapy in Maryland; and it is further

ORDERED that should the Board receive a report that the Respondent's practice is a threat to the public health, welfare and safety, the Board may take immediate action against the Respondent, including suspension or revocation, providing notice and an opportunity to be heard are provided to the Respondent in a reasonable time thereafter. Should the Board receive in good faith information that the Respondent has substantially violated the Act or if the Respondent violates any conditions of this Order

or of Probation, after providing the Respondent with notice and an opportunity of a hearing, the Board may take further disciplinary action against the Respondent, including suspension or revocation. The burden of proof for any action brought against the Respondent as a result of a breach of the conditions of the Order to Probation shall be upon the Respondent to demonstrate compliance with the Order or conditions; and it is further

ORDERED that, at the end of the probationary period, the Respondent may petition the Board to be reinstated without any conditions or restrictions on the Respondent's license, provided the Respondent can demonstrate compliance with the conditions of this Order. Should the Respondent fail to demonstrate compliance, the Board may impose additional terms and conditions of Probation, as it deems necessary; and it is further

ORDERED that the Respondent shall bear the expenses associated with the Consent Order; and it is further

ORDERED that for purposes of public disclosure, as permitted by Md. State Gov't Code Ann. § 10-617(h) (Repl. Vol. 1999), this document consists of the foregoing Findings of Fact, Conclusions of Law and Order and that the Board may also disclose same to any national reporting data bank to which it is mandated to report.

5.20.03
Date

Penelope D. Lescher, M.A., P.T., M.C.S.P., Chair
State Board of Physical Therapy Examiners

CONSENT

I, John Cusic, P.T., by affixing my signature hereto, acknowledge that:

1. I am represented by an attorney and have been advised by my attorney of the legal implication of signing this Consent Order;

2. I am aware that without my consent, my license to practice physical therapy in this State cannot be limited except pursuant to the provisions of H.O. § 13-317 and the Maryland Administrative Procedure Act, codified at State Gov't §§ 10-219 *et seq.*

3. I am aware that I am entitled to a formal evidentiary hearing before the Board;

4. By this Consent Order, I hereby consent and submit to the foregoing Findings of Fact, Conclusions of Law and Order, provided the Board adopts the foregoing Consent Order in its entirety. I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my behalf and to all other substantive and procedural protections as provided by law. I acknowledge the legal authority and the jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal.

5. I acknowledge that failing to abide by the condition set forth in this Order, I may, after an opportunity to be heard, suffer disciplinary action, including revocation of my license to practice physical therapy in the State of Maryland.

6. While I have consented and submitted to the foregoing Findings of Fact, Conclusions of Law and Order, I did not intentionally, knowingly or willfully submit a false statement to collect a fee.

7. I voluntarily sign this Consent Order after having an opportunity to consult with an attorney, without reservation, and I fully understand the language, meaning and terms of this Consent Order.

5/16/03
Date

John Cusic, P.T.
Respondent

STATE OF: Maryland

CITY/COUNTY OF: Baltimore City

I HEREBY CERTIFY that on this 16th day of May, 2003, before me, a Notary of the State of Maryland and the City/County of Baltimore, personally appeared John Cusic, P.T., and made oath in due form of law that signing the foregoing Consent Order was his/her voluntary act and deed, and that the statements made herein are true and correct.

AS WITNESS my hand and notarial seal.

Notary

My Commission expires: December 13, 2006