Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INPATIENT HEMODIALYSIS PROCEDURE SERVICES PROVIDED BY VISTA DEL MAR MEDICAL GROUP, INC.

JANET REHNQUIST
Inspector General

OCTOBER 2001
CIN: A-09-01-00084

Office of Inspector General

http://www.hhs.gov/progorg/oig/

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DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

CIN: A-09-01-00084

November 14, 2001

Dr. Henry E. Elson
Vista Del Mar Medical Group, Inc.
1200 West Gonzales Road
Oxnard, California 93030

Dear Dr. Elson:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Inpatient Hemodialysis Procedure Services Provided by Vista Del Mar Medical Group, Inc." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, OAS reports are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.) As such, within ten business days after the final report is issued, it will be posted on the world wide web at http://www.hhs.gov/progorg/oig.

To facilitate identification, please refer to Common Identification Number A-09-01-00084 in all correspondence relating to this report.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. David Sayen
Associate Regional Administrator
Division of Financial Management
Centers for Medicare & Medicaid Services
75 Hawthorne Street, 4th Floor
San Francisco, California 94105-3901

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INAPTIENT HEMODIALYSIS PROCEDURE SERVICES PROVIDED BY VISTA DEL MAR MEDICAL GROUP, INC.

JANET REHNQUIST
Inspector General

NOVEMBER 2001
A-09-01-00084

NOTICES

THIS REPORT IS AVAILABLE TO THE PUBLIC

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions

Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

CIN: A-09-01-00084

Dr. Henry E. Elson
Vista Del Mar Medical Group, Inc.
1200 West Gonzales Road
Oxnard, California 93030

Dear Dr. Elson:

The purpose of this report is to provide Vista Del Mar Medical Group, Inc. (Group) with the results of our audit of inpatient hemodialysis procedure services provided to Medicare beneficiaries by the Group in Calendar Years (CY) 1998 and 1999. The objective of our audit was to determine whether hemodialysis services provided by Group physicians to beneficiaries residing in the State of California were allowable and documented in the medical records in accordance with Medicare requirements.

We reviewed a random sample of 100 hemodialysis services to determine if they met the inpatient hospital place of service, the physician's presence, and the medical necessity requirements. We found that all 100 services met the Medicare requirement for inpatient hospital place of service. However, 11 services did not meet the Medicare requirement for documenting the physician's presence during the hemodialysis procedure. In addition, 61 services did not meet the Medicare requirement for documenting the medical necessity for the physician's repeated evaluation of patients during the hemodialysis procedure. As a result, we estimated that, of the $542,996 paid to the Group for hemodialysis services in CY 1998 and 1999, at least $151,566 was unallowable for Medicare reimbursement.

These overpayments occurred because:

- The Group physicians failed to ensure that their presence during the hemodialysis procedure was documented in the medical records before billing hemodialysis services, and

- The Group established a standard procedure to provide a repeated evaluation of patients during the hemodialysis procedure without considering the Medicare requirement for medical necessity.

We recommend that the Group:

1. Refund the overpayment of $151,566 to the Medicare program, and

2. Develop policies and procedures to ensure that the physician's presence and medical necessity requirements are met and documented in the medical records before billing the Medicare program for hemodialysis services.

In a written response to our draft report (see APPENDIX A), the Group agreed with our findings.

INTRODUCTION

BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act, provides health insurance coverage to people age 65 and over, the disabled, and people with end-stage renal disease (ESRD)[1]. Administered by the Centers for Medicare & Medicaid Services (CMS)[2] within the Department of Health and Human Services (HHS), the program consists of two components - Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Part B covers a multitude of medical services including physician services. The Medicare Carriers Manual (MCM), published by CMS, sets forth the billing requirements for paying physician services under Part B. Medicare claims for Part B are processed by Acarriers@ which are agents contracted by HHS.

In our audit, we reviewed physician services provided to Medicare beneficiaries requiring dialysis services. There are two types of renal dialysis, hemodialysis[3] and peritoneal dialysis[4]. Dialysis services can be provided at either an inpatient or outpatient setting. Our audit focused on inpatient hemodialysis procedure services provided by physicians.

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[1]The term ESRD means that Astage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life@ [MCM '2230.1.A].

[2]The former name of Centers for Medicare & Medicaid Services (CMS) was Health Care Financing Administration (HCFA).

[3] Hemodialysis is a process A[w]here blood is passed through an artificial kidney machine and the waste products diffuse across a man-made membrane into a bath solution known as dialysate after which the cleansed blood is returned to the patient's body@ [MCM 2230.1.B.1].

[4] Peritoneal Dialysis is a process A[w]here the waste products pass from the patient's body through the peritoneal membrane into the peritoneal (abdominal) cavity where the bath solution (dialysate) is introduced and removed periodically" [MCM 2230.1.B.2].

The Physician's Current Procedural Terminology (CPT)[5] includes the following codes for hemodialysis services provided on an inpatient basis:

CPT 90935 - Hemodialysis procedure with single physician evaluation, and

CPT 90937 - Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription.

For physicians to receive payments based on inpatient dialysis procedure codes, the MCM requires:

< The place of service to be at an inpatient hospital [MCM '15062.1.D],

< The medical record must document that the physician was physically present with the patient at some time during the course of the dialysis [MCM '15062.1.C.2], and

< The medical record must document that the physician's repeated evaluation of patients during the hemodialysis procedure was medically necessary [MCM '15062.1.A.1 and 15062.1.C.1].

In the September 1988 Medicare Newsletter, the Carrier[6] informed physicians of the presence requirement by stating, "[p]hysicians may bill inpatient dialysis procedure codes only if they visit the patient during the dialysis treatment and the medical record documents this." In addition, in the July 1989 Medicare Newsletter, the Carrier informed physicians of the medical necessity requirement by stating, "…multiple visits on the same day must be documented to indicate the visits were at different times and were **medically necessary**." [*Emphasis Added*.]

The Group, located in Oxnard, California was incorporated on December 26, 1991. There were five physicians practicing under the Group in CY 1998 and 1999.

OBJECTIVE, SCOPE AND METHODOLOGY

OBJECTIVE

The objective of our audit was to determine whether hemodialysis services provided by Group physicians to California beneficiaries during CY 1998 and 1999 were allowable and documented in the medical records in accordance with Medicare requirements.

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[5] Current Procedural Terminology (CPT) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The CPT book is published by the American Medical Association annually.

[6] Transamerica Occidental Life Insurance was the former Carrier, which handled Medicare billings for the area where the Group was located. National Heritage Insurance Company is the current Carrier for the State of California.

SCOPE

Our audit was conducted in accordance with generally accepted government auditing standards.

Our audit was limited to determining whether:

- The place of service was an inpatient hospital,
- The medical record documented the physician's presence with the patient during the hemodialysis procedure, and
- The medical record documented the medical necessity for the physician's repeated evaluation of patients during the hemodialysis procedure.

Our review of the Group=s internal control structure was limited to those controls relating to the submission of claims to Medicare. The objective of our audit did not require an understanding or assessment of the entire internal control structure at the Group.

Our fieldwork, which included visits to hospitals in the Oxnard, California area; the Carrier; and the Group's office in Oxnard, California, was performed during the period April 2001 to August 2001.

METHODOLOGY

To accomplish our objective, we performed the following steps:

< Reviewed the Medicare criteria related to hemodialysis services,

< Interviewed appropriate CMS and Carrier officials to obtain an understanding of how the hemodialysis services should be documented in the medical records,

< Identified the universe of Medicare Part B payments for CY 1998 and 1999 for the Group using the National Claims History Files (NCHF) for California beneficiaries,

< Selected a random sample of 100 hemodialysis services based on our approved sampling plan,

< Reviewed all other services provided to beneficiaries associated with the 100 services and determined if additional Evaluation and Management (E & M)[7] services were paid to the same physician who received the payment for hemodialysis services,

[7] E & M services represent the classification of physicians= work. They are divided into broad categories such as office visits, hospital visits and consultations.

- Interviewed dialysis nurses to obtain an understanding of how physicians care for patients during the hemodialysis procedure,
- Interviewed Group officials to obtain an understanding of how physicians care for patients during the hemodialysis procedure,
- Collected medical records at hospitals where the services were provided and analyzed them to determine whether the services met the MCM requirements for billing Medicare Part B,
- Utilized medical review staff from the Carrier to evaluate the 100 services, and
- Used a variable appraisal program to estimate the dollar impact of overpayments in the universe.

Details on our statistical sampling methodology are presented in APPENDIX B.

FINDINGS AND RECOMMENDATIONS

The audit included a review of a random sample of 100 hemodialysis services to determine if they met the inpatient hospital place of service, the physician's presence, and the medical necessity requirements as stated in the MCM. These 100 services were comprised of 6 services for hemodialysis procedure with single physician evaluation (CPT 90935) and 94 services for hemodialysis procedure requiring repeated evaluation (CPT 90937).

We found that all 100 services met the inpatient hospital place of service requirement. However, 11 of the 100 services did not meet the Medicare requirement for documenting the physician's presence during the hemodialysis procedure. For these 11 services, the Group billed and was paid for CPT 90935 and CPT 90937 even though the documentation in the medical records did not support the physician's presence during the hemodialysis procedure. In addition, 61 of the 100 services did not meet the Medicare requirement for documenting the medical necessity for the physician's repeated evaluation of patients during the hemodialysis procedure. For these 61 services, the Group billed and was paid for CPT 90937 even though the documentation in the medical records did not support the medical necessity for the physician's repeated evaluation of patients during the hemodialysis procedure.

As a result, we determined that, of the $13,245 reviewed, $4,113 was unallowable. We projected the results of the statistical sample to the population using standard statistical methods and estimated that at least $151,566 of the $542,996 paid to the Group for CY 1998 and 1999 was ineligible for Medicare reimbursement. These overpayments occurred because the Group physicians failed to ensure that their presence during the hemodialysis procedure was documented in the medical records before billing hemodialysis services. Also, the Group established a standard procedure to provide a repeated evaluation of patients during the hemodialysis procedure without

considering the Medicare requirement that the repeated evaluation be medically necessary to bill CPT 90937. Details of our findings are presented in APPENDIX C.

PHYSICIAN PRESENCE

We determined that 11 of the 100 services reviewed did not have sufficient documentation to support the physician's presence during the hemodialysis procedure. Of 11 services, 1 service was billed and paid for as CPT 90935, and 10 services were billed and paid for as CPT 90937.

In order to be paid for the hemodialysis service, the MCM '15062.1.C.2 requires that the physician be physically present with the patient during the hemodialysis procedure and the medical record must document the physician's presence. It also states that:

> If the physician visits the dialysis inpatient on a dialysis day, but not during the dialysis treatment, do not pay the physician on the basis of a [hemodialysis] procedure code. The nature of these services is the same as physicians= services furnished to any inpatient during a hospital visit. Therefore, use the same hospital visit codes that apply to any other physicians treating hospital inpatients. [MCM '15062.1.C.2]

In addition, the July 1989 Medicare Newsletter issued by the Carrier states that the physician's repeated evaluation of patients on the same day must be documented to indicate that the **physician's evaluations were at different times** and were medically necessary.

For one service that was billed and paid for as CPT 90935 and lacked documentation to support the physician's presence, we determined that this service would be allowable as a subsequent hospital care service. Because the payment for CPT 90935 is higher than the one for subsequent hospital care, the Group received an overpayment of $36, representing the difference between the payment for CPT 90935 and subsequent hospital care service.

For 10[8] services that were billed and paid for as CPT 90937 and lacked documentation to support the physician's presence for the repeated evaluation, we determined that these services would be allowable as CPT 90935. The documentation in the medical records supported only a single physician evaluation of patients during the hemodialysis procedure. Because the payment for CPT 90937 is higher than the one for CPT 90935, the Group received an overpayment of $580, representing the difference between the payment for CPT 90935 and CPT 90937.

These overpayments occurred because the Group physicians failed to ensure that their presence during the hemodialysis procedure was documented in the medical records before billing hemodialysis services.

[8] These 10 services also did not meet the medical necessity requirement.

MEDICAL NECESSITY

We determined that 61 of the 100 services reviewed did not have sufficient documentation to support the medical necessity for billing CPT 90937.

The MCM '15062.1A.1 and 15062.1C.1 states that the Medicare program covers physician's services that are medically necessary. The MCM '15062.1A.1 further states, "[t]he hospital medical record must document the services furnished and the medical reasons for them." The July 1989 Medicare Newsletter issued by the Carrier states, "… multiple visits on the same day must be documented to indicate the visits were at different times and **were medically necessary**." [*Emphasis Added*.]

For 61 services that lacked documentation to support the medical necessity, we determined that these services would be allowable as CPT 90935. Because the payment for CPT 90937 is higher than the one for CPT 90935, the Group received an overpayment, representing the difference between the payment for CPT 90937 and CPT 90935. The following example illustrates our decision making process for the medical necessity and the calculation of the overpayment for one service reviewed.

The physician billed a service as CPT 90937 and received a payment of $129.30. A review of the documentation in the medical records revealed that the physician visited the patient twice during the hemodialysis procedure. His two visits were 20 minutes apart. The patient was stable and tolerated the hemodialysis procedure well with no obvious problems. We determined that the documentation did not support the medical necessity for the physician's repeated evaluation of patients during the hemodialysis procedure.

We allowed the payment for CPT 90935 for this service. We disallowed the difference between the payment made for CPT 90937 and the payment that would have been made for CPT 90935.

CPT 90937……..…….....	$129.30	(Paid)
CPT 90935…….....	75.38	(Allowed)
Unallowable	$ 53.92	

Note: As stated in the Methodology section, we consulted with the Carrier medical review staff to determine whether the documentation supported the medical necessity for the physician's repeated evaluation of patients during the hemodialysis procedure. If the documentation did not support the medical necessity, the staff determined the appropriate service to replace the service billed.

The Group received an overpayment of $3,497 for these 61 services by billing CPT 90937 when CPT 90935 should have been billed. These overpayments occurred because the Group established a standard procedure to provide a repeated evaluation of patients during the hemodialysis procedure without considering the Medicare requirement for medical necessity.

Conclusion

Our audit of 100 randomly selected hemodialysis services disclosed that the 72 services did not meet the Medicare requirements for billing either CPT 90935 or CPT 90937. As a result, we determined that, of $13,245 reviewed for CY 1998 and 1999, $4,113 was unallowable. We projected the results of the statistical sample to the population using standard statistical methods and estimated that at least $151,566 of the $542,996 paid to the Group for CY 1998 and 1999 was ineligible for Medicare reimbursement.

RECOMMENDATIONS

We recommend that the Group:

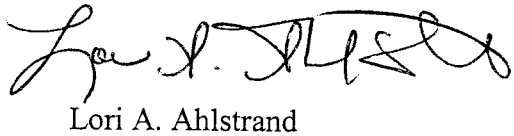
1. Refund the overpayment of $151,566 to the Medicare program, and

2. Develop policies and procedures to ensure that the physician's presence and medical necessity requirements are met and documented in the medical records before billing the Medicare program for hemodialysis services.

GROUP COMMENTS

In a written response, dated October 1, 2001, (see APPENDIX A) to our draft report, the Group agreed with our findings. The Group stated that it would take corrective actions to ensure that the physician's presence and medical necessity requirements are met and documented in the medical records before billing hemodialysis services. It also stated that a prompt refund of overpayment of $151,566 would be made to the Medicare Carrier when requested.

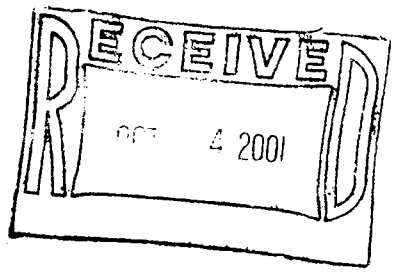
Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

APPENDICES

Vista Del Mar Medical Group, Inc,
1200 W. Gonzales Rd., Ste. 300
Oxnard, CA 93030



October 1, 2001

Lori A. Ahlstrand, Regional Inspector General
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

RE: CIN: A-09-01-00084

Dear Ms. Ahlstrand:

In the following you will find our formal response to your review of our documentation practices.

We respect the time and effort that your organization put forth to gather data on the services rendered to our hospitalized patients in CY 1998 and 1999. In summary, we have decided to abide by your request for return of an estimated overpayment of $151,566 and we have developed policies and procedures to adopt your definition of the medical necessity of our hemodialysis services into our billing practices.

Response

1) Vista Del Mar Medical Group, Inc. (VDM) will make prompt refund of overpayment of $151,566 when requested by the Medicare Carrier.

2) VDM will concur with the recommendation insuring physician presence at dialysis procedures when the procedure is billed for and the medical requirements are met and documented as to level of care.

In response to Physician's presence, upon evaluation:

Multiple reasons were found in the failure to ensure documentation at the time of the procedure. They included physician error in making exact time entry of the dialysis rounds as well as hemodialysis nurses failure to document the physician's presence. It appears as if there are no written policies or procedures by the hemodialysis staff as to documentation. Some nurses seldom document physician's presence, others document on the records every 30 minutes the events that occurred over the previous 30 minutes-including the physician's visits.

Corrective Action

1) Physicians will note the time on both the dialysis record and on the progress note.
2) Nurses will be encouraged to document physician's presence at that time.

Regarding multiple visits during dialysis procedures.

The physicians of VDM have interpreted the Medicare regulation regarding 90937 as care required by an unstable patient.

Most of the hospital patients have multiple system diseases including cardiac with coronary artery problem, CHF, arrythmias, unstable Diabetes Mellitus, Pulmonary problems, etc. By the very nature of these problems the patient would be considered unstable. The audit demonstrated that the 90937 code was established for return visits by the Nephrologist and if the patient's condition deteriorates during the dialysis procedure and a return visit by the Nephrologist is necessary to manage the problem.

Remedy:

The Nephrologist will only use the 90937 code if the patient's condition deteriorates during the procedure and the Nephrologist is notified by the hemodialysis staff, the physician's presence is requested, and it is deemed necessary to return to the bedside to evaluate and solve the problem. The medical record will be well documented by the Nephrologist in the progress note as to the rounds, reasons for returning, and evaluation and management rendered.

Again, we appreciate the many courtesies extended by your staff.

Yours truly,

Richard K. Westerdoll, CMM, CAAMA
Executive Director

APPENDIX B

VISTA DEL MAR MEDICAL GROUP, INC.

STATISTICAL SAMPLING METHODOLOGY

POPULATION		SAMPLE		ERRORS	
Items:	4,111	Items:	100	Items:	72
Payments:	$542,996	Payments:	$13,245	Payments:	$4,113

PROJECTION OF SAMPLE RESULTS
At the 90 Percent Confidence Level

Point Estimate:	$169,080
Lower Limit:	$151,566
Upper Limit:	$186,595

VISTA DEL MAR MEDICAL GROUP, INC.

Sample Number	Billed CPT[9]	Audited CPT[10]	Paid Amount[11]	Audited Amount[12]	Difference (Paid-Audited)
1	90937	90935	$141.21	$81.51	$59.70
2	90937	90935	$129.30	$75.38	$53.92
3	90937	90935	$141.20	$81.51	$59.69
4	90937	90935	$129.30	$75.38	$53.92
5	90937	90935	$141.21	$81.51	$59.70
6	90937	90937	$129.31	$129.31	$0.00
7	90937	90935	$141.21	$81.51	$59.70
8	90937	90935	$141.21	$81.51	$59.70
9	90937	90935	$129.30	$75.38	$53.92
10	90937	90935	$141.21	$81.51	$59.70
11	90937	90935	$141.21	$81.51	$59.70
12	90937	90935	$141.21	$81.51	$59.70
13	90937	90937	$141.21	$141.21	$0.00
14	90937	90935	$141.21	$81.51	$59.70
15	90937	90935	$141.21	$81.51	$59.70
16	90937	90937	$129.31	$129.31	$0.00
17	90937	90935	$129.30	$75.38	$53.92
18	90937	90937	$141.21	$141.21	$0.00
19	90937	90935	$129.31	$75.38	$53.93
20	90937	90935	$141.21	$81.51	$59.70
21	90937	90935	$141.21	$81.51	$59.70
22	90937	90935	$129.31	$75.38	$53.93
23	90937	90935	$141.21	$81.51	$59.70
24	90937	90935	$141.21	$81.51	$59.70
25	90937	90935	$141.21	$81.51	$59.70
26	90937	90937	$141.21	$141.21	$0.00
27	90937	90935	$141.21	$81.51	$59.70
28	90937	90935	$141.21	$81.51	$59.70
29	90935	90935	$81.51	$81.51	$0.00
30	90937	90935	$141.21	$81.51	$59.70

[9] The term "Billed CPT" denotes the CPT code which was originally billed by and paid to the Group.

[10] The term "Audited CPT" denotes the CPT code allowed during our audit.

[11] The term "Paid Amount" denotes the amount paid by Medicare Part B.

[12] The term "Audited Amount" denotes the amount allowed during our audit.

VISTA DEL MAR MEDICAL GROUP, INC.

Sample Number	Billed CPT	Audited CPT	Paid Amount	Audited Amount	Difference (Paid-Audited)
31	90937	90937	$129.30	$129.30	$0.00
32	90937	90937	$129.30	$129.30	$0.00
33	90937	90937	$141.21	$141.21	$0.00
34	90937	90935	$141.21	$81.51	$59.70
35	90937	90935	$141.21	$81.51	$59.70
36	90937	90937	$129.30	$129.30	$0.00
37	90937	90935	$129.30	$75.38	$53.92
38	90937	90935	$141.21	$81.51	$59.70
39	90937	90937	$129.30	$129.30	$0.00
40	90937	90935	$129.30	$75.38	$53.92
41	90937	90937	$141.21	$141.21	$0.00
42	90937	90935	$129.30	$75.38	$53.92
43	90937	90935	$129.30	$75.38	$53.92
44	90937	90937	$129.30	$129.30	$0.00
45	90937	90935	$129.30	$75.38	$53.92
46	90937	90935	$129.30	$75.38	$53.92
47	90937	90935	$129.30	$75.38	$53.92
48	90937	90935	$129.30	$75.38	$53.92
49	90937	90935	$141.21	$81.51	$59.70
50	90937	90935	$129.30	$75.38	$53.92
51	90937	90935	$129.30	$75.38	$53.92
52	90935	90935	$81.51	$81.51	$0.00
53	90937	90935	$141.21	$81.51	$59.70
54	90937	90937	$129.30	$129.30	$0.00
55	90937	90935	$129.30	$75.38	$53.92
56	90937	90935	$141.20	$81.51	$59.69
57	90937	90935	$129.30	$75.38	$53.92
58	90935	90935	$81.51	$81.51	$0.00
59	90937	90935	$141.21	$81.51	$59.70
60	90937	90937	$141.21	$141.21	$0.00
61	90937	90935	$141.21	$81.51	$59.70
62	90937	90937	$129.30	$129.30	$0.00
63	90937	90935	$141.21	$81.51	$59.70
64	90937	90937	$129.30	$129.30	$0.00
65	90937	90935	$129.30	$75.38	$53.92
66	90937	90937	$141.21	$141.21	$0.00
67	90937	90935	$129.30	$75.38	$53.92
68	90937	90935	$141.21	$81.51	$59.70
69	90935	90935	$81.51	$81.51	$0.00

VISTA DEL MAR MEDICAL GROUP, INC.

Sample Number	Billed CPT	Audited CPT	Paid Amount	Audited Amount	Difference (Paid-Audited)
70	90937	90935	$141.21	$81.51	$59.70
71	90937	90935	$141.21	$81.51	$59.70
72	90937	90935	$129.30	$75.38	$53.92
73	90937	90935	$141.22	$81.51	$59.71
74	90937	90937	$141.21	$141.21	$0.00
75	90937	90935	$141.21	$81.51	$59.70
76	90937	90935	$141.21	$81.51	$59.70
77	90935	90935	$81.51	$81.51	$0.00
78	90937	90935	$141.21	$81.51	$59.70
79	90937	90937	$129.30	$129.30	$0.00
80	90937	90935	$141.21	$81.51	$59.70
81	90937	90937	$141.21	$141.21	$0.00
82	90935	99232	$81.51	$45.50	$36.01
83	90937	90935	$141.21	$81.51	$59.70
84	90937	90935	$141.21	$81.51	$59.70
85	90937	90937	$141.21	$141.21	$0.00
86	90937	90935	$141.21	$81.51	$59.70
87	90937	90935	$129.30	$75.38	$53.92
88	90937	90935	$129.31	$75.38	$53.93
89	90937	90935	$141.21	$81.51	$59.70
90	90937	90937	$141.21	$141.21	$0.00
91	90937	90935	$141.21	$81.51	$59.70
92	90937	90935	$141.20	$81.51	$59.69
93	90937	90935	$129.30	$75.38	$53.92
94	90937	90935	$87.94	$34.02	$53.92
95	90937	90935	$141.21	$81.51	$59.70
96	90937	90937	$129.30	$129.30	$0.00
97	90937	90935	$129.30	$75.38	$53.92
98	90937	90935	$129.30	$75.38	$53.92
99	90937	90935	$141.21	$81.51	$59.70
100	90937	90935	$129.30	$75.38	$53.92
Total			**$13,245.07**	**$9,132.19**	**$4,112.88**