THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

UNITED STATES OF AMERICA *ex rel.* CARL CRAWLEY,	)	
Plaintiffs,	)	
v.	)	**Case No. 2:09-CV-01810-RDP**
RURAL/METRO CORPORATION, RURAL/METRO OF CENTRAL ALABAMA, INC., MERCURY AMBULANCE SERVICE, INC. d/b/a RURAL/METRO AMBULANCE,	)	
Defendants.	)	

COMPLAINT IN INTERVENTION

The United States of America, by and through its undersigned counsel, alleges as follows:

I. INTRODUCTION

1. In this action, the United States alleges that Rural/Metro Corporation, Rural/Metro of Central Alabama, and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance (hereinafter referred to collectively as the "Defendants") are liable under the False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, and under the common law or equitable theories of payment by mistake and unjust enrichment due to the Defendants' conduct in submitting false and fraudulent records, statements, and claims for payment by the United States to the Medicare and

Medicaid Programs from September 11, 2003 to the present.

II. JURISDICTION AND VENUE

2. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1345.

3. This Court has personal jurisdiction over the Defendants pursuant to 31 U.S.C. § 3732(a). Jurisdiction is proper over the Defendants because at least one of the Defendants can be found in, resides in, and/or has transacted business within this Court's jurisdiction, and some of the acts in violation of 31 U.S.C. § 3729 occurred within this district.

4. Venue is proper in this district under 28 U.S.C. §§ 1391(b)-(c), and 31 U.S.C. § 3732(a) because at least one of the Defendants resides in or transacts business in this district and because a substantial portion of the events or omissions giving rise to the claims alleged herein occurred in this district.

III. THE PARTIES

5. Plaintiff in this action is the United States of America, suing on behalf of the United States Department of Health & Human Services ("HHS") and its operating division, the Centers for Medicare & Medicaid Services ("CMS"). At all times relevant to this Complaint, CMS was an operating division of HHS that administered and supervised the Medicare Program.

6. Relator Carl Crawley is a resident of the state of Alabama and citizen of the United States. Crawley formerly worked for defendant Rural/Metro of Central Alabama, Inc. from 2008 to 2009. Crawley filed a *qui tam* action against Rural/Metro Corporation and its subsidiary, Rural/Metro of Central Alabama, Inc., on September 10, 2009.

7. At all times relevant to the events described in this Complaint, defendant Rural/Metro Corporation was a Delaware corporation with its principal corporate headquarters in Scottsdale, Arizona. At all times relevant to the events described in this Complaint, defendant Rural/Metro Corporation, through its subsidiaries and affiliates, was engaged in the business of providing medical transportation services to individuals, including ambulance transportation services to Medicare and Medicaid beneficiaries in approximately twenty states.

8. At all times relevant to the events described in this Complaint, defendant Rural/Metro of Central Alabama, Inc. was a Delaware corporation with its principal place of business in Bessemer, Alabama. At all times relevant to the events described in this Complaint, defendant Rural/Metro of Central Alabama, Inc. was engaged in the business of providing transportation services to individuals in Alabama, including ambulance transportation services to Medicare and Medicaid beneficiaries.

9. At all times relevant to the events described in this Complaint, defendant Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance was a Kentucky corporation with its principal place of business in Louisville, Kentucky. At all times relevant to the events described in this Complaint, defendant Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance was engaged in the business of providing transportation services to individuals, including ambulance transportation services to Medicare and Medicaid beneficiaries.

IV. THE FALSE CLAIMS ACT

10. The False Claims Act provides, in pertinent part, that any person who

> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; [or]
>
> (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim . . .
>
> ***
>
> is liable to the United States Government [for statutory damages and such penalties as are allowed by law].

31 U.S.C. §§ 3729(a)(1).

11. The False Claims Act further provides that "knowing" and "knowingly"

> (A) mean that a person, with respect to information--
> (i) has actual knowledge of the information;
> (ii) acts in deliberate ignorance of the truth or

falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud.

31 U.S.C. §§ 3729(b)(1).

V. FEDERAL HEALTHCARE PROGRAMS

A. The Medicare Program

12. Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, establishes the Health Insurance for the Aged and Disabled Program, commonly referred to as the Medicare Program (the "Medicare Program" or "Medicare").

13. The Medicare Program is comprised of four parts. Medicare Parts A, C and D are not directly at issue in this case. Medicare Part B provides federal government funds to help pay for, among other things, ambulance services provided to Medicare beneficiaries. *See* 42 U.S.C. § 1834(l); *see generally* 42 U.S.C. §§1831 – 1848.

14. Medicare Part B is funded by insurance premiums paid by enrolled Medicare beneficiaries and by contributions from the federal treasury. Eligible individuals may enroll in Part B to obtain benefits in return for payments of monthly premiums as established by HHS. *See* 42 U.S.C. §§ 1836, 1839.

15. Payments under the Medicare Program are often made directly to service providers, such as ambulance services, rather than to the patient (the

"beneficiary"). This occurs when the provider accepts assignment of the right to payment from the beneficiary. In that case, the provider submits its bill directly to Medicare for payment.

16. The Secretary of HHS administers the Medicare Program through CMS, an operating division of HHS.

17. CMS, in turn, contracts with Medicare Administrative Contractors, formerly known as Part B Carriers (hereinafter "MACs") to administer, process and pay Part B claims from the Federal Supplementary Medical Insurance Trust Fund (the Medicare Trust Fund). In this capacity, the MACs act on behalf of CMS.

18. From September 11, 2003 to the present, the Defendants submitted claims to the MACs in their respective states for ambulance transportation services.

19. For example, in Alabama, from September 11, 2003 to the present, defendant Rural/Metro of Central Alabama, Inc., submitted claims to Cahaba GBA, the MAC for Alabama.

20. For example, in Kentucky, from September 11, 2003 to the present, defendant Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance

submitted claims to National Government Services (formerly known as Adminastar Federal), the MAC for Kentucky.

21. The Medicare Program, through the MAC, pays a significant portion of every claim. The Medicare beneficiary, or his or her supplemental insurance carrier, is required to pay the balance owed the provider. The beneficiary's payment is sometimes referred to as a "co-payment." Beneficiaries also pay deductibles.

22. In order to bill the Medicare Program, a provider must submit an electronic or hard-copy claim form called a CMS-1500 form. When the CMS-1500 form is submitted, the provider certifies that the services in question were "medically indicated and necessary for the health of the patient."

23. On the CMS-1500 form, the provider must state, among other things, the procedure(s) for which it is billing Medicare, the identity of the patient, the provider number, and a brief narrative explaining the diagnosis and the medical necessity of the services rendered.

24. All healthcare providers, including ambulance services, must comply with applicable statutes, regulations and guidelines in order to be reimbursed by Medicare Part B. A provider has a duty to have knowledge of the statutes,

regulations and guidelines regarding coverage for the Medicare services, including, but not limited to, the following:

a. Medicare reimburses only reasonable and necessary medical services furnished to beneficiaries. *See* 42 U.S.C. § 1395y(a)(1)(A); and

b. Providers must assure that they provide economical medical services, and then, only when, and to the extent, medically necessary. *See* 42 U.S.C. § 1320c-5(a)(1).

25. Medicare regulations exclude from payment services that are not reasonable and necessary. *See* 42 C.F.R. § 411.15(k)(1).

26. Because it would not be feasible to review medical documentation before paying each claim, the MACs generally make payment under Medicare Part B on the basis of the providers' certification included on the Medicare claim form.

B. The Medicaid Program

27. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq.*, established what is commonly known as the Medicaid Program (the "Medicaid Program" or "Medicaid"). Medicaid is a joint federal-state program that provides health care benefits for certain groups, primarily the poor and disabled. The United States provides matching funds to a state to fund the program and also

ensures that the state complies with minimum standards in the administration of the Medicaid Program.

28. Medicaid programs are administered by the states in accordance with federal statutes and regulations and pursuant to state plans which must be approved by the Secretary of HHS. *See* 42 C.F.R. § 430.0.

29. While Medicaid programs are administered by the states, they are jointly financed by the federal and state governments. The annual federal share of Medicaid expenditures during the relevant period varied from year to year in each state.

30. Generally, state Medicaid agencies pay health care providers for services rendered to Medicaid beneficiaries from state or local funds and from federal funds made available to them by the federal government for that purpose. Each quarter, based on the state's estimate of anticipated Medicaid expenditures, CMS makes available to the state federal funds for reimbursement of Medicaid expenditures. *See* 42 C.F.R. § 430.30.

31. The state periodically draws down those federal funds and uses those funds to pay providers.

32. Each state must have a single state agency to administer the Medicaid program. *See* 42 U.S.C. § 1396a(a)(5). The Alabama Medicaid Agency

administers the Medicaid Program in Alabama. The Cabinet for Health and Family Services administers the Medicaid Program in Kentucky.

33. Ambulance providers bill Medicaid beneficiaries by submitting claim forms to the applicable state agency or its designated agent(s). As with Medicare, these claim forms contain certain information regarding the service provided, upon which the state agencies rely in making payment to the ambulance provider.

VI. GENERAL ALLEGATIIONS

A. Medicare's Rules for Transportation of Dialysis Patients

34. Medicare does not pay for any and all services furnished to beneficiaries, but only those which are "reasonable and necessary for the diagnosis or treatment of illness or injury . . . ." 42 U.S.C. § 1395y(a)(1)(A). With respect to ambulance services in particular, Medicare covers such services only "where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations." 42 U.S.C. § 1395x(s)(7).

35. The Medicare regulations regarding ambulance transport are set forth in 42 C.F.R. § 410.40, which is entitled "Coverage of ambulance services."

36. Accordingly, the regulations in effect for ambulance transportation services in effect for the entire period of time covered by this Complaint provide, in relevant part:

> (d) Medical necessity requirements—

> (1) General rule. Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Nonemergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations. For a beneficiary to be considered bed-confined, the following criteria must be met:
>
> (i) The beneficiary is unable to get up from bed without assistance.
>
> (ii) The beneficiary is unable to ambulate.
>
> (iii) The beneficiary is unable to sit in a chair or wheelchair.

42 C.F.R. § 410.40(d)(1).

37. In addition, CMS established a requirement that "nonemergency, scheduled ambulance services," such as maintenance dialysis, are covered if "the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that

the medical necessity requirements of paragraph (d)(1) of this section are met." 42 C.F.R. § 410.40(d)(2).

38. The Medicare Benefit Policy Manual (the "MBPM"), which sets forth the rules and regulations for Medicare reimbursement, further describes the requirements for coverage of ambulance transport. For example, the MBPM states:

> Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services. In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier/intermediary. It is important to note that the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

MBPM at § 10.2.1.

39. To obtain reimbursement for ambulance transport, the provider must submit and certify to details establishing that Medicare's medical necessity requirements were met. *See* 42 CFR 410.40(d)(3)(v).

B. Medicaid's Rules for Transport of Dialysis Patients

40. Medicaid also applies medical necessity and documentation requirements for reimbursement of ambulance patients.

41. In Alabama, for example, the Alabama Medicaid Provider Manual (the "AL Medicaid Manual") provides:

> All transportation must be medically necessary and reasonable. Documentation must state the condition(s) that necessitate ambulance service and indicate why the recipient cannot be transported by another mode of transportation. Medicaid will not reimburse ambulance service if some other means of transportation could have been used without endangering the recipient's health.

AL Medicaid Manual § 8.2 (2006).

C. The Submission of False Claims

42. From September 11, 2003 to the present, the Defendants knowingly submitted or caused the submission of false claims to Medicare and Medicaid, and created false records and statements in order to receive reimbursement from Medicare and Medicaid for transportation services provided to dialysis patients.

43. During this time, the Defendants knowingly falsely certified to the truthfulness and accuracy of electronic claim forms submitted to Medicare and Medicaid for transportation services provided to dialysis patients. Specifically, the Defendants created and/or submitted documentation that falsely represented that a

patient was either bed-confined or that transportation by ambulance was otherwise medically required. However, in fact, many of the patients were not bed-confined or moved by stretcher and did not require ambulance transportation or qualify for ambulance transport under the applicable Medicare or Medicaid requirements.

44. The Defendants' fraudulent conduct included, on certain occasions, assigning condition codes and International Classification of Disease (ICD-9) codes which indicated that the patient was bed-confined or, that transportation by ambulance was otherwise medically required, when the patient was able to sit in a wheelchair, thus not bed-confined according to the Medicare definition of bed-confinement, and the patient could have traveled by other means.

45. The Defendants' fraudulent conduct also included, on certain occasions, obtaining physician certification statements containing false information regarding a patient's condition.

46. During the period from September 11, 2003 to the present, the Defendants knew, deliberately ignored, or recklessly disregarded that the claims submitted to Medicare and Medicaid by the Defendants falsely described the condition of certain dialysis patients on the specific day the patient was transported and were false or fraudulent because they did not represent the accurate physical condition of the patient on that day.

47. For example, on or about February 21, 2008, the Defendants knowingly submitted a false claim to Medicare for payment for ambulance transportation services for Kentucky patient M.S. that did not meet the applicable Medicare guidelines because M.S.'s medical condition at the time was such that other means of transportation were not contraindicated.

48. For example, on or about October 3, 2008, the Defendants knowingly submitted a false claim to Medicare for payment for ambulance transportation services for Kentucky patient J.R. that did not meet the applicable Medicare guidelines because J.R.'s medical condition at the time was such that other means of transportation were not contraindicated.

49. For example, on or about January 17, 2009, the Defendants knowingly submitted a false claim to Medicare for payment for ambulance transportation services for Kentucky patient C.H. that did not meet the applicable Medicare guidelines because C.H.'s medical condition at the time was such that other means of transportation were not contraindicated.

50. For example, on or about February 2, 2009, the Defendants knowingly submitted a false claim to Medicare for payment for ambulance transportation services for Alabama patient E.B. that did not meet the applicable Medicare guidelines because E.B.'s medical condition at the time was such that other means

of transportation were not contraindicated.

51. For example, on or about March 23, 2009, the Defendants knowingly submitted a false claim to Medicare for payment for ambulance transportation services for Kentucky patient H.W. that did not meet the applicable Medicare guidelines because H.W.'s medical condition at the time was such that other means of transportation were not contraindicated.

52. For example, on or about February 13, 2010, the Defendants knowingly submitted a false claim to Medicare for payment for ambulance transportations services for Alabama patient W.K. that did not meet the applicable Medicare guidelines because W.K.'s medical condition at the time was such that other means of transportation were not contraindicated.

53. For example, on or about April 3, 2010, the Defendants knowingly submitted a false claim to Medicare for payment for ambulance transportations services for Ohio patient L.W. that did not meet the applicable Medicare guidelines because L.W.'s medical condition at the time was such that other means of transportation were not contraindicated.

54. For example, on or about July 27, 2010, the Defendants knowingly submitted a false claim to Medicare for payment for ambulance transportations services for Tennessee patient A.B. that did not meet the applicable Medicare

guidelines because A.B.'s medical condition at the time was such that other means of transportation were not contraindicated.

55. For example, on or about September 9, 2010, the Defendants knowingly submitted a false claim to Medicare for payment for ambulance transportations services for Ohio patient W.C. that did not meet the applicable Medicare guidelines because W.C.'s medical condition at the time was such that other means of transportation were not contraindicated.

56. For example, on or about October 28, 2010, the Defendants knowingly submitted a false claim to Medicare for payment for ambulance transportations services for Indiana patient F.G. that did not meet the applicable Medicare guidelines because F.G.'s medical condition at the time was such that other means of transportation were not contraindicated.

57. With respect to the claims where the Defendants received reimbursement but the beneficiaries' conditions did not justify transportation by ambulance under the applicable regulations/guidelines, Medicare and Medicaid would not have paid these claims if they had known that the patients' conditions did not meet Medicare and Medicaid's requirements for reimbursement of ambulance transportation.

58. Officials of the United States charged with responsibility to act did not know and could not reasonably have known the true medical condition of the beneficiaries for whom false or fraudulent claims for payment as described in this Complaint were submitted by the Defendants to Medicare and Medicaid.

FIRST CAUSE OF ACTION
(False Claims Act-31 U.S.C. § 3729(a)(1)(A))

59. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 58.

60. By virtue of the acts described above, defendants Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance knowingly presented or caused to be presented to the United States false or fraudulent Medicare and Medicaid claims for payment or approval, in violation of the False Claims Act, as amended, 31 U.S.C. § 3729(a)(1)(A); that is, Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance knowingly made or presented, or caused to be made or presented, to the United States claims for payment for services which were false, in that the services claimed for were not medically necessary or otherwise did not qualify for reimbursement under the Medicare or Medicaid programs.

61. By reason of the foregoing, the United States suffered actual damages in an amount to be determined at trial.

SECOND CAUSE OF ACTION
(False Claims Act-31 U.S.C. § 3729(a)(1)(B))

62. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 58.

63. By virtue of the acts described above, defendants Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance knowingly made or used a false record or statement to get a false or fraudulent Medicare and Medicaid claim paid or approved by the United States, in violation of the False Claims Act, as amended, 31 U.S.C. § 3729(a)(1)(B); that is, defendants Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance knowingly made or used or caused to be made or used false Medicare and Medicaid claim forms and supporting materials, such as internal billing forms, and false certifications of the truthfulness and accuracy of claims submitted, to get false or fraudulent Medicare and Medicaid claims paid or approved by the United States, in that the services claimed for were not medically necessary or otherwise did not qualify for reimbursement under the Medicare or Medicaid programs.

64. By reason of the foregoing, the United States suffered actual damages in an amount to be determined at trial.

THIRD CAUSE OF ACTION
(Payment Under Mistake of Fact)

65. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 58.

66. This is a claim for the recovery of monies paid to defendants Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance under mistake of fact.

67. The above-described false claims and false statements which defendants Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance submitted to the United States through the Medicare and Medicaid programs constituted misrepresentations of material fact in that they misrepresented the conditions of the patients and therefore the medical necessity for the transportation, as well as other facts necessary to establish entitlement to reimbursement under the Medicare or Medicaid programs.

68. The United States, acting in reasonable reliance on the accuracy and truthfulness of the information contained in the claims, paid defendants Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury

Ambulance Service, Inc. d/b/a Rural/Metro Ambulance certain sums of money to which they were not entitled, and defendants Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance are thus liable to account for and pay such amounts, which are to be determined at trial, to the United States.

FOURTH CAUSE OF ACTION
(Unjust Enrichment)

69. The United States re-alleges and incorporates by reference the allegations of paragraphs 1 through 58.

70. This is a claim for recovery of monies by which defendants Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance have been unjustly enriched.

71. By virtue of the false claims and false statements described above, defendants Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance were unjustly enriched for rendering fraudulent services to certain Medicare beneficiaries which in good conscience they should not be allowed to retain.

72. Defendants Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro

Ambulance were unjustly enriched at the expense of the United States, and are liable to account and pay such amounts, or the proceeds therefrom, which are to be determined at trial, to the United States.

PRAYER FOR RELIEF

WHEREFORE, the United States respectfully prays for judgment in its favor as follows:

a. As to First and Second Causes of Action (False Claims Act), against Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance, for: (i) statutory damages in an amount to be established at trial and such penalties as are allowed by law; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate;

b. As to the Third Cause of Action (Payment By Mistake of Fact), for: (i) an amount equal to the money paid by the United States through the Medicare and Medicaid programs to Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other

relief that this Court deems appropriate;

c. As to the Fourth Cause of Action (Unjust Enrichment), for: (i) an amount equal to the money paid by the United States through the Medicare and Medicaid programs to Rural/Metro Corporation, Rural/Metro of Central Alabama, Inc., and Mercury Ambulance Service, Inc. d/b/a Rural/Metro Ambulance, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate; and

d. for all other and further relief as the Court may deem just and proper.

Respectfully submitted this the 31st day of March, 2011.

JOYCE WHITE VANCE
UNITED STATES ATTORNEY

/s/ Lloyd C. Peeples
LLOYD C. PEEPLES, III
Assistant United States Attorney
1801 4th Avenue North
Birmingham, AL 35203
Telephone: (205) 244-2116

Counsel for United States

Certificate of Service

This is to certify that, on March 31, 2011, a copy of the foregoing has been served by electronically filing the foregoing with the Clerk of the Court via the CM/ECF system, which will send notification of the filing to all attorneys of record.

/s/
LLOYD C. PEEPLES