IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

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KOLBE & KOLBE HEALTH & WELFARE BENEFIT PLAN and KOLBE & KOLBE MILLWORK CO., INC.,

OPINION AND ORDER

Plaintiffs,

09-cv-205-bbc

v.

MEDICAL COLLEGE OF WISCONSIN, INC. and CHILDREN'S HOSPITAL OF WISCONSIN,

Defendants.

- -

Plaintiffs Kolbe & Kolbe Health & Welfare Benefit Plans and Kolbe & Kolbe Millwork Co., Inc., are suing defendants Medical College of Wisconsin, Inc. and Children's Hospital of Wisconsin for breach of contract. They seek the return of approximately $1,670,000 in medical expenses they paid on behalf of a plan participant's child before they determined that the child was not eligible for benefits under the terms of plaintiffs' health plan. The case is before the court on the parties' cross motions for summary judgment and defendants' motions to strike portions of plaintiffs' reply brief, dkt. #133, and for sanctions under Fed. R. Civ. P. 11. Dkt. #118.

Plaintiffs believe that they are entitled to refunds of the money they paid defendants under the terms of agreements between defendants and "network providers" (independent

organizations that contract with health care providers on behalf of plans such as the Kolbe & Kolbe Health & Welfare Benefit Plan). Alternatively, they argue that if the terms of the agreements do not support their claim, the parties' prior course of dealing or the cusstoms of the industry do. Defendants take issue with plaintiffs' claim in all respects.

Plaintiffs brought suit in this court initially under the Employee Retirement Income Security Act of 1974, ERISA, asserting claims under ERISA and Wisconsin common law. At the outset, defendants moved to dismiss the case for failure to state a claim. The motion was granted in a series of three orders, dkts. ## 33, 38 and 47; judgment was entered in defendants' favor; and they were awarded attorney fees. On appeal, the Court of Appeals for the Seventh Circuit upheld the dismissal of the ERISA claims, but reversed this court's ruling on the state common law claims and the attorney fees award and remanded the case. The court of appeals left it to this court's discretion either to dismiss the state law claims without prejudice so that they could be resolved in state court or to decide them under the court's supplemental jurisdiction. Kolbe & Kolbe Health & Welfare Benefit Plan v. The Medical College of Wisconsin, 657 F.3d 496 (7th Cir. 2011).

After the parties briefed the issue of this court's exercise of supplemental jurisdiction over the state law claims, I concluded that this was an appropriate case in which to exercise that jurisdiction. The remaining claims were relatively straightforward; the state had no particular interest in the resolution of the claims; and this court had familiarity with the case. Order, dkt. #94.

Before turning to the motions for summary judgment, I will take up defendants'

motion to strike plaintiffs' arguments in their reply brief, dkt. #131. Plaintiffs briefed the issues of the parties' course of dealing and custom of the industry in response to defendants' arguments that the agreements at issue were ambiguous, which was a reasonable response on plaintiffs' part. The argument is moot, because I am deciding that the agreements were neither ambiguous nor incomplete. In any event, defendants had ample opportunity to discuss the newly raised issues in their briefing in support of their own motion for summary judgment. The motion will be denied.

I will also deny defendants' motion for sanctions under Rule 11. The court of appeals' opinion prevents this court from considering the ERISA preemption argument that defendants have raised, which means that a good part of defendants' briefing has been irrelevant. As to the rest, the issues plaintiffs have raised and argued are close ones that do not merit sanctions.

Plaintiffs' motion for summary judgment will be denied as well. The agreements under which they are third party beneficiaries impose no duty on defendants to provide refunds to plaintiffs of payments made for services rendered to a person who was held out to defendants as a Beneficiary of an employee benefit plan. The agreements are not ambiguous, so it is not necessary to consider the evidence the parties have produced on the parties' course of dealing and custom in the industry.

From the findings of fact proposed by the parties and from the court record, I find that the following facts are undisputed and relevant to the resolution of their contract dispute.

UNDISPUTED FACTS

A. The Parties

Plaintiff Kolbe & Kolbe Millwork Co., Inc. is a Wisconsin corporation. It is the sponsor and plan administrator for plaintiff Kolbe & Kolbe Health & Welfare Plan, which is a self-funded employee welfare benefit plan under the Employee Income Security Act of 1974. (In this opinion it is not necessary to distinguish between the plan and its sponsor, so I will refer to them together simply as "plaintiffs.") Defendant Children's Hospital of Wisconsin, Inc. is a Wisconsin non-stock corporation that operates Children's Hospital of Wisconsin, a private, not-for-profit pediatric hospital in Milwaukee, Wisconsin. Defendant Medical College of Wisconsin, Inc. is a Wisconsin non-stock corporation that employs medical professionals to provide patient care at Children's Hospital and other facilities.

Scott Gurzynski is employed by plaintiff Kolbe Millwork. Until August 2007, when he became the father of a new baby, K.G., who was born with serious health problems, he participated in plaintiffs' plan as a single person. At that time he submitted an employee enrollment form to the plan, so that he could add K.G. as a dependent. He did not answer several questions on the form, such as whether K.G. resided with him, whether she was dependent on him for more than 50% of her support and whether she qualified as an exemption from his taxes. An answer of "no" to any one of these questions would have disqualified K.G. for coverage under the plan. The same month, plaintiffs' insurance administrator, Connie Rindfleisch, entered employee change information into UMR's online system, listing Gurzynski's level of coverage as "Employee Plus One." (UMR is plaintiffs'

third-party administrator of its health plan.) UMR issued Gurzynski an identification card listing both him and K.G. as covered under the plan.

B. The Provider Agreements

At all relevant times, the following agreements involving the parties were in existence: (1) a network physician agreement between defendant Medical College of Wisconsin, Inc. and North Central Health Care Alliance, dkt. #27-1; and (2) a network provider agreement between defendant Children's Hospital and Bowers & Associates. Dkt. #27-3. Plaintiffs had their own agreements with North Central and Bowers, but the parties do not rely on these agreements for any purpose.

Under the agreements, defendants promised North Central or Bowers, depending on the agreement, to "[p]rovide Covered Services to Beneficiaries for the Allowed Charges" listed on an exhibit attached to each agreement, dkt. #327-3, ¶ II(A); dkt. #27-3, ¶ II(A), and "[a]ccept the Allowable Charges . . . as payment in full for Covered Services provided to Beneficiaries and not bill any Beneficiary for any amount (except for copayments, coinsurance, and deductibles which shall be deducted from the Allowable Charges." Dkt. #27-1,¶ II(B); dkt. #27-3, ¶ II(B). Defendants promised to "bill only the appropriate Entity for Covered Services provided to a Beneficiary and [Bowers or North Central] would "have no responsibility for payment of any charge for services rendered to any beneficiary." Dkt. #27-1, ¶ IV; dkt. #27-3, ¶ IV.

A "Recital" at the beginning of the document signed by Bowers and Children's Health

System reads:

> **Whereas**, Provider is desirous of contracting with Bowers to provide services for Beneficiaries (defined below) eligible to receive health care paid for by Entities [such as plaintiffs], on and subject to the terms and conditions hereof;

A "Recital" at the beginning of the document signed by North Central and Medical College of Wisconsin reads:

> Whereas NCHA has entered or intends to enter contracts with Entities (hereafter defined), who will make payment for certain health care expenditures incurred by their employees, dependents and other designated individuals eligible to have their health care paid by such Entities, to arrange for the provision of certain health care services; and
>
> Whereas, Physician is desirous of contracting with NCHA to provide services for those [for] whose benefits NCHA contracts, on and subject to the terms and conditions hereof;

Under the agreements, "Covered Services" are "those medical services covered under a Plan, subject to any limitations on such coverage as may be contained in such Plan"; "Plan" means an "Entity's self-insured Medical Benefits Plan." "Beneficiary" is "any employee, retiree or any of their respective dependents or any other persons participating under a Plan of an Entity and who are eligible to have their medical services paid under the terms of a Plan of an Entity." "Entity" included plaintiffs.

The third party agreements say nothing about the providers' responsibility for making refunds for money paid by "Entities" (such as the Kolbe plan) or about the Entities' right to any such refunds. The parties agreed that the agreements constituted the entire agreement between them and superseded "all prior and contemporaneous understandings, negotiations, and discussions, oral or written. There are no warranties, representations or other

agreements between the parties in connection with the subject matter hereof except as set forth herein." Dkt. #27-1 at 8; dkt. #27-3 at 8.

C. Plaintiffs' Payments for Medical Services for K.G.

Plaintiffs began paying bills for K.G. from defendants through its third party administrator, UMR, in November 2007. Sometime in that same month, plaintiff Kolbe & Kolbe's vice president of finance, Mike Tomsyck, became aware that Bowers (the provider of Children's Hospital services) had directed UMR to suspend payment of claims provided to K.G. because of questions regarding her eligibility and coordination of benefits. On November 28, 2007, plaintiffs' insurance administrator, Connie Rindfleisch, spoke to Gurzynski about whether K.G. qualified as an eligible dependent under the plan. Gurzynski told Rindfleisch that K.G. lived with her mother when she was not in the hospital, that he was planning to live with K.G. and her mother, that he provided 50 percent of K.G.'s support and that he was not claiming K.G. as a dependent on his federal income tax return. He also said that K.G.'s mother had applied for Title XIX medical assistance but did not know when those benefits would become effective. Sometime that day or the day after, a UMR employee entered a note in UMR's computer system to the effect that K.G. might not be eligible under plaintiffs' plan and closed with the warning: "HOLD ALL CLAIMS TIL DETERMINATION MADE BY [EMPLOYER]."

On November 30, 2007, Tomsyck and Rindfleisch met with Gurzynski in Rindfleisch's office and told him he would have to provide Rindfleisch a copy of the Title

XIX card and award letter so that plaintiffs could determine the effective date of Title XIX for K.G. They added that they would refund the premium he had paid for K.G. upon receipt of the information.

On one or more occasions, Bowers precertified K.G. for services. It included at the end of every precertification letter it sent to defendants: "This letter does not guarantee payment. Payment is subject to patient eligibility and plan provisions at the time service is provided."

In a December 11, 2007 email to UMR, Tomsyck wrote that "[Plaintiffs] have been able to ascertain the existence of other insurance that would cover the claims for this child instead of [plaintiffs' plan]. We will continue our investigation but for now I realize the providers need to be paid. So go ahead and process her claims. If facts dictate otherwise, I understand that the claims can be reprocessed and refunds obtained." Two days later, UMR sent defendant Children's Hospital a check for $414,376.59. Ultimately, plaintiffs paid this defendant $1,203,885.88 and defendant Medical College $472,263.24 for medical treatment given to K.G. between August 2007 and June 2008. Along with each payment, UMR sent a document called "Remittance Advice" that contained columns labeled Charged Amount, Allowed Amount, Discount Managed Care Adjust and Paid. Neither the "Remittance Advice" documents nor the checks themselves indicated that the payments were conditional or made subject to a later determination of K.G.'s eligibility for benefits.

On February 11, 2008, UMR sent defendant Children's Hospital a fax in which it certified that K.G. was covered by plaintiffs' plan effective August 2, 2007, and gave

defendant information about her medical benefits. The fax included the statement that "Benefit payment is subject to all terms, conditions, exclusions, and eligibility of the plan." Both defendants submitted claims for payment of K.G.'s medical care directly to UMR.

Subsequently, plaintiffs made inquiries of Gurzynski or of K.G.'s mother on about 17 occasions between November 28, 2007 and June 24, 2008, without clarifying K.G.'s eligibility for coverage. Finally, on June 24, 2008, after conducting an audit to determine the eligibility of dependents under the plan, requiring all employees with "single plus one" or family coverage to provide documentation of eligibility, the plan notified Gurzynski that because it had received no information about K.G.'s eligibility for services, it was deeming K.G. ineligible and would be reprocessing any additional claims that were submitted to the plan.

In 2007 and 2008, K.G. was treated primarily at defendant Children's Hospital and by physicians from defendant Medical College. Defendants submitted invoices to the plan and requested payment through plaintiffs' third party administrator for the services rendered to K.G. The plan paid defendant Medical College $472,357.84 and defendant Children's Hospital $1,197,406.95 for these services. On August 1 and August 21, 2008, Children's Hospital was informed that K.G. was no longer covered by plaintiffs' plan. On September 9, 2008, UMR informed defendant Medical College for the first time that plaintiffs would be seeking a refund of the payments they had made on behalf of K.G. When defendants balked at providing the refunds, plaintiffs brought this suit against them.

D. Refunds from Health Providers

Plaintiffs receive refunds from various health care providers every month and have received refunds in the past for services provided to dependents ineligible for coverage. The record contains limited evidence about the size of the refunds, why they were made, when or under what circumstances the dependents were found ineligible for services or the sources of the refunds.

Both defendants have provided refunds to UMR. Both follow their own refund protocols under which they provide refunds.

OPINION

A. Scope of Remand

Although it seems plain from the language of the court of appeals' opinion that it is no longer an open question whether K.G. was ever a Beneficiary under plaintiffs' plan, defendants contend that it must be because of the posture in which the case was heard by the court of appeals, that is, on an appeal from the grant of defendants' motion to dismiss. (Plaintiffs used the term "Covered Person" to refer to a person eligible to receive benefits under their plan; the agreements at issue use the term "Beneficiary" to refer to a person who is eligible to receive benefits paid for by any Entity represented by Bowers or North Central. For clarity, I will use the term in the agreements.) In deciding plaintiffs' appeal, the court of appeals accepted as true the allegations in plaintiffs' complaint, including their allegation that K.G. had never been enrolled in the plan and was not a Beneficiary. From these

allegations, the court of appeals concluded that K.G. could never have been a Beneficiary under the provider agreements for purposes of medical treatment by defendants. Therefore, because the plan term that plaintiffs sought to enforce applied only to beneficiaries, plaintiffs could not pursue their claim for the right to recover refunds for money paid in error on behalf of a non-plan participant under § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3). (This section permits participants and beneficiaries to bring claims in equity, but not legal claims, to enforce provisions of the law.) Kolbe & Kolbe Health & Welfare Benefit Plan, 657 F.3d 496, 503 (7th Cir. 2011). In addition to holding that plaintiffs could not proceed under § 502(a)(3), the court of appeals affirmed this court's denial of plaintiffs' claim of unjust enrichment brought under the federal common law of ERISA on the ground that neither ERISA nor the plan had been violated. The court held that "'[B]ecause there is no gap in ERISA's test regarding a fiduciary's right to bring a civil action for legal remedies to enforce plan terms or ERISA provisions, a federal common law remedy cannot be recognized.'") (quoting North America Coal Corp. Retirement Savings Plan v. Roth, 395 F.3d 916, 917 (8th Cir. 2005)). Id. The court added that plaintiffs had not shown that defendants' actions violated either ERISA or the plan. Rather, plaintiffs were asserting claims that were beyond the reach of ERISA and "because the rights and obligations under the Plan are not at issue, i.e., there is no dispute that K.G. was not a [Beneficiary] under the Plan, there is no need to interpret the provisions of ERISA and develop federal common law under ERISA." Id. at 504.

Finally, the court of appeals addressed plaintiffs' two state law breach of contract

claims against defendants that were based upon the agreements defendants made with the third-party network providers, North Central and Bowers. Plaintiffs had alleged that defendants breached these agreements by retaining payments made by the plan for a person who was not covered under the plan. The court of appeals held the two claims not preempted because they did not require interpretation or application of the plan and did not relate to the plan in any significant way. Id. at 505 ("[I]t is undisputed that the information required for K.G. to enroll in the plan —i.e., for her to qualify as a [Beneficiary]—was never submitted properly, and thus that she was never a [Beneficiary].") The court then remanded these two state law claims to this court.

On its face, the court of appeals' opinion seems clear: the only matters to be decided on remand are plaintiffs' state law claims for breach of contract and deciding these matters "does not require interpreting or applying the Plan." Id. at 504. Defendants resist this conclusion, arguing that the appeal was before the court after the grant of a motion to dismiss, which required the court to assume the truth of plaintiffs' allegations. They contend that it was error for the court of appeals to find as a matter of law that K.G. was never a Beneficiary under the plan before defendants had a chance to file an answer and plead their own case in opposition.

Defendants have not abandoned their contention that the evidence raises a genuine issue of fact about K.G.'s enrollment in the plan. Despite plaintiffs' denial that K.G. was ever a covered person, defendants point to the undisputed facts that she was entered into UMR's online system, indicating that she was covered under the plan; premiums were

deducted from Scott Gurzynski's paychecks; plaintiffs issued Gurzynski an insurance identification card, showing that K.G. was eligible for services; and plaintiffs paid $1,800,000 over ten months for services rendered to K.G.

Defendants make a forceful argument, but they make it in the wrong court. A district court cannot weigh in on the correctness of a ruling by the court of appeals. If defendants objected to this aspect of the decision, they could have asked for reconsideration from the court of appeals. This court cannot give them a new ruling on the subject. Clearly, when the court of appeals found that K.G. was not a Beneficiary under plaintiffs' plan, it was not limiting that finding. It did not say, for example, that the finding was made only for the purpose of deciding the motion to dismiss. Rather, it made it clear that the finding was for all purposes by stating on four occasions in its opinion that K.G. was not a Beneficiary under the plan, Kolbe, 657 F.3d at 502, 503, 504 & 505, and by eliminating all questions about the scope of its finding when it remanded the state law claims. As part of the remand, the court specified that the lower court's only job would be to interpret the member or service agreements and the provider agreements, since it was undisputed that the information required to enroll K.G. in the plan was never submitted properly and that she never became a Beneficiary. Id. at 504-05. Accordingly, I will limit this opinion to the interpretation of the third party network provider contracts and will not consider defendants' arguments that K.G. is a Beneficiary under plaintiffs' plan, that plaintiffs' breach of contract claims relate inexorably to ERISA or that disputes remain about the relationship of the plan to its employees.

Plaintiffs can prove their breach of contract claim if they can show that the provider agreements entered into on their behalf contain provisions that impose an obligation on defendants to refund money paid by plaintiffs for services provided by defendants to any individual later determined not to have been a Beneficiary at the time of the services. The fact that the definition of Beneficiary is a part of the plan does not make the claim one that is related to ERISA, as that term is used throughout the Act. Id. at 504 ("Since this case does not require interpreting or applying the Plan, nor does it relate to the Plan in any significant way, plaintiffs' state law claims are not preempted."). See also Trustees of AFTRA Health Fund v. Biondi, 303 F.3d 765, 780 (7th Cir. 2002) ("A state law claim is not expressly preempted under § 1144(a) merely because it requires a cursory examination of ERISA plan provisions.")

B. The Provider Agreements

Defendants concede that the third party agreements between Bowers and Children's Hospital and between North Central and Medical College of Wisconsin are enforceable by plaintiffs as third party beneficiaries of the agreements. However, they deny that those agreements contain any provision requiring them to refund money paid by plaintiffs for services provided to persons identified by plaintiffs as "Beneficiaries." Technically, defendants are correct. Nothing in the provider agreement between Bowers and Children's Health System, dkt. ##27-3, or in the Physician Agreement between Medical College of Wisconsin and North Central, dkt. #27-1, refers to any obligation on the part of the

providers to make refunds.

Plaintiffs do not disagree, but they contend that the obligation to provide refunds follows from any breach of the provider agreements and that the agreements can be read as saying that medical providers are in breach if they bill for medical treatment of a person who only appears to be a Beneficiary. In support of this contention, they cite the first sentence of ¶ IV of the provider agreements, which they read as a promise that the providers will bill the appropriate entity *only* for Covered Services provided to a Beneficiary. In fact, the paragraph reads: "Provider agrees that it shall "bill *only* the appropriate Entity . . . for Covered Services provided to a Beneficiary and Bowers [or North Central] shall have no responsibility for payment of any charge for services rendered to a Beneficiary." (Emphasis added.) The only duty imposed by this provision is a duty on the part of the medical providers not to hold the network providers, Bowers or North Central, liable for any services provided to "Beneficiaries."

Plaintiffs are trying to read more into the agreements than is there. It is clear from them that defendants would be in breach if they failed to provide services to a Beneficiary, if they provided services not covered by the agreements or if they charged more for a service than the allowable charge. In any of those instances, plaintiffs would be entitled to refunds or damages. But plaintiffs are not alleging that defendants did or failed to do any of these things. They are alleging that defendants breached the agreements by providing services to a person identified by plaintiffs as a Beneficiary but later determined to be ineligible for services. Nothing in the agreements speaks to that situation.

What is evident from the agreements is that the parties gave no thought to who would have to bear the monetary loss of providing services to persons who appear to be Beneficiaries, but who are determined later not to be. Had they done so, they might have considered who should bear the risk of providing services to a person misidentified as a Beneficiary. The parties contracting on behalf of employee benefit plans might have included a provision to the effect that "providers are entitled to be paid only if the patient for whom they billed the Entity is determined to have been a Beneficiary at the time of service, regardless when that determination is made." For their part, the providers might have insisted on a provision to the effect that "Entities may not obtain a refund for services provided to a person who is found not to have been a Beneficiary if, at the time the services were rendered, a reasonable provider would have believed the person to be a Beneficiary and the misunderstanding is not corrected by the Entity within 60 days of the first date of service."

Plaintiffs argue that even if the agreement does not speak explicitly about the providers' obligation to refund payments for services rendered to non-Beneficiaries, there are other reasons for reading the agreements as saying that rendering services to a non-Beneficiary patient breaches the agreements and requires a refund. They rely first on the interpretive rule that if it was foreseeable that refunds should have been provided for in the contract, the absence of such a provision implies that the risk was assumed. Plts.' Reply Br., dkt. #147 at 38 (citing R. Allen Farnsworth, Farnsworth on Contracts § 7.16 at 348-49 (3d ed. 2004). This argument does not help them, because the absence of such a provision in

the provider agreements means that, as the parties wanting refunds, plaintiffs would be the ones assuming the risk of not providing for them.

Second, plaintiffs argue that the parties had a "common expectation" about refunds and the court should give effect to that expectation. They do not explain what the common expectation might have been or cite any evidence to support their argument. They cannot argue that the parties' course of dealing supports their position because they have not identified any ambiguity in the contract, which is a necessary precondition to considering extrinsic evidence. To the contrary, they have asserted that "[T]he agreement is plain and unambiguous." Plts.' Br., dkt. #110, at 13.

Third, plaintiffs cite a number of cases for the proposition that a contract's direct expression of something implies preclusion of the opposite construction. E.g., Thomsen v. Olson, 219 Wis. 145, 151, 262 N.W. 601 (1935) (holding that agreement to buy stock and distribute shares in way that resulted in equal ownership by two remaining stockholders included unstated terms that neither stockholder could later buy shares and not split them between each other); see also Culligan, Inc. v. Rehaume, 269 Wis. 242, 248, 68 N.W.2d 810 (1955) (contract requiring licensee to purchase equipment and materials from Culligan implied negative: not to purchase them elsewhere); Fritsch v. Wepking, 259 Wis. 295, 299-300, 48 N.W.2d 606 (1951) (provision allowing sons to purchase farms during widow's lifetime "implies the exclusion of any additional period"). This argument falls short because this is not a case in which implying the preclusion of the opposite construction will help determine the issue. Defendants are not arguing that they have the contractual right to bill

Entities for services provided to persons they know are not covered by a plan. They are arguing that the agreements do not impose any duty on them to provide refunds when they have billed for services provided to persons they had good reason to believe were Beneficiaries.

Because I find that the provider agreements are neither ambiguous nor incomplete and impose no obligation on defendants to give refunds of payments made for services provided to a person who was held out to defendants as Beneficiary, it is not necessary to consider plaintiffs' arguments about the parties' course of dealing or the custom in the medical field. These arguments would be relevant only if the agreements were not complete in themselves or if they were ambiguous. Continental Casualty Co. v. Homontowski, 181 Wis. 2d 129, 135, 510 Wis. 2d 743 (Ct. App. 1993) (if a contract is unambiguous, a court has "no right, by process of interpretation, to relieve the [the parties] from any disadvantageous terms"). It is also unnecessary to consider defendants' argument that the voluntary payment doctrine bars plaintiffs' attempts to recover money they paid without protest and with full knowledge of the facts.

ORDER

IT IS ORDERED that

1. The motion of plaintiffs Kolbe & Kolbe Health and Welfare Plan and Kolbe & Kolbe Millwork Co. for summary judgment is DENIED;

2. The motion of defendants The Medical College of Wisconsin, Inc. and Children's

Hospital of Wisconsin, Inc. is GRANTED;

3. Defendants' motion for sanctions under Fed. R. Civ. P. 11, dkt. #118, is DENIED; and

4. Defendants' motion to strike portions of plaintiffs' reply brief, dkt. #133, is DENIED.

Entered this 16th day of November, 2012.

BY THE COURT:
/s/
BARBARA B. CRABB
District Judge