Chapter Ins 17

HEALTH CARE LIABILITY INSURANCE PATIENTS COMPENSATION FUND

Ins 17.001 Definitions. In this chapter:

(1) "Board" means the board of governors established under s. 619.04 (3), Stats.

(1m) "Commissioner" means the commissioner of insurance or deputy commissioner acting under s. 601.11 (1) (b), Stats.

(2) "Fund" means the patients compensation fund established under s. 655.27 (1), Stats.

(3) "Hearing" has the meaning given in s. Ins 5.01 (1).

(4) "Plan" means the Wisconsin health care liability insurance plan, a nonprofit, unincorporated association established under s. 619.01 (1) (a), Stats.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; am. (intro.) to (4), cr. (1m), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.005 Purpose. This chapter implements ss. 619.01 and 619.04 and ch. 655, Stats.

History: Cr. Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.01 Payment of mediation fund fees. (1) PURPOSE. This section implements s. 655.61, Stats., relating to the payment of mediation fund fees.

(2) FEE. (a) Each physician subject to ch. 655, Stats., except a resident, and each hospital subject to ch. 655, Stats., shall pay to the commissioner an annual fee to finance the mediation system created by s. 655.42, Stats.

(b) The fund shall bill a physician or hospital subject to this section under s. Ins 17.28 (7) (a). The entire annual fee under this section is due and payable 30 days after the fund mails the bill.

(d) The fund shall notify the medical examining board of each physician who has not paid the fee as required under par. (b).

(e) The fund shall notify the department of health and social services of each hospital which has not paid the fee as required under par. (b).

(f) Fees collected under this section are not refundable except to correct an administrative billing error.

emerg. am 6/14/95

(3) FEE SCHEDULE. The following fee schedule shall be effective July 1, 1994:

(a) For physicians — $ 50.00

(b) For hospitals, per occupied bed — $ 3.00

History: Cr. Register, August, 1978, No. 272, eff. 9-1-78; emerg. r. and recr. eff. 7-2-86; r. and recr., Register, September, 1986, No. 369, eff. 10-1-86; cr. (2) (f), am. (3), Register, June, 1987, No. 378, eff. 7-1-87; am. (1), (2) (a), (d) and (e), (3), r. and recr. (2) (b), r. (2) (c), Register, June, 1990, No. 414, eff. 7-1-90; emerg. am. (3), eff. 7-1-91; am. (3) (intro.), Register, July, 1991, No. 427, eff. 8-1-91; am. (3) (a) and (b), Register, October, 1991, No. 430, eff. 11-1-91; emerg. am. (3), eff. 4-28-92; am. (3), Register, July, 1992, No. 439, eff. 8-1-92; emerg. am. (1), (3) (intro.), (a), eff. 7-22-93; am. (1) (3) (intro.), (a), Register, September, 1993, No. 453, eff. 10-1-93; am. (3) (intro.), Register, June, 1994, No. 462, eff. 7-1-94.

Ins 17.24 Review of classification. (1) Any person insured by the plan or covered by the fund may petition the board for a review of its classification by the plan or fund. The petition shall state the basis for the petitioner's belief that its classification is incorrect. The board shall refer a petition for review to either of the following:

(a) If the petitioner is a hospital or a nursing home or other entity affiliated with a hospital, to a committee appointed by the commissioner consisting of 2 representatives of hospitals, other than the petitioner's hospital, and one other person who is knowledgeable about insurance classification.

(b) If the petitioner is any person other than a person specified in par. (a), to a committee appointed by the commissioner consisting of 2 physicians who are not directly or indirectly affiliated or associated with the petitioner and one other person who is knowledgeable about insurance classification.

(2) The plan, the fund or both shall provide the committee with any information needed to review the classification.

(2m) The committee shall review the classification and report its recommendation to the petitioner and the board within 5 days after completing the review.

(3) Any person that is not satisfied with the recommendation of the committee may petition for a hearing under ch. 227, Stats., and ch. Ins 5 within 30 days after the date of receipt of written notice of the committee's recommendation.

(4) At the hearing held pursuant to a petition under sub. (3), the committee report shall be considered and the members of the committee may appear and be heard.

History: Cr. Register, July, 1979, No. 283, eff. 8-1-79; r. and recr. (1) and (2), cr. (2m), am. (3) and (4), Register, June, 1990, No. 414, eff. 7-1-90.

Ins 17.25 Wisconsin health care liability insurance plan. (1) FINDINGS. (a) Legislation has been enacted authorizing the commissioner to promulgate a plan to provide health care liability insurance and liability coverage normally incidental to health care liability insurance for risks in this state which are equitably entitled to but otherwise unable to obtain

(g) "Primary coverage" means health care liability insurance meeting the requirements of subch. III of ch. 655, Stats.

(h) "Provider" means a health care provider, as defined in s. 655.001 (8), Stats.

(hm) "Resident" means a licensed physician engaged in an approved postgraduate medical education or fellowship program in any specialty specified in par. (c) 1 to 4.

emerg. cr. (hs) 6/14/95

(i) "Temporarily cease practice" means to stop practicing in this state for any period of time because of the suspension or revocation of a provider's license, or to stop practicing for at least 90 consecutive days for any other reason.

emerg. cr. eff 6/14/95

(3e) PRIMARY COVERAGE REQUIRED. Each provider shall ensure that primary coverage is in effect on the date the provider begins practice or operation and for all periods during which the provider practices or operates in this state. A provider does not have fund coverage for any period during which primary coverage is not in effect.

(3m) EXEMPTIONS; ELIGIBILITY. A medical or osteopathic physician licensed under ch. 448, Stats., or a nurse anesthetist licensed under ch. 441, Stats., may claim an exemption from ch. 655, Stats., if at least one of the following conditions applies:

(a) The provider will not practice more than 240 hours in the fiscal year.

(c) During the fiscal year, the provider will derive more than 50% of the income from his or her practice from outside this state or will attend to more than 50% of his or her patients outside this state.

(3s) LATE ENTRY TO FUND. (a) A provider that begins or resumes practice or operation during a fiscal year, has claimed an exemption or has failed to comply with sub. (3e) may obtain fund coverage during a fiscal year by giving the fund advance written notice of the date on which fund coverage should begin.

Next page is numbered 531

6. The payment due date.

(i) *Billing; partial fiscal year.* The fund shall issue each provider entering the fund after the beginning of a fiscal year an initial bill which shall include all of the following;

1. The total amount due calculated under par. (b).

2. Notice of the provider's right to pay the amount due in full or in instalments.

3. The minimum amount due if the provider elects instalment payments.

4. The payment due date.

(j) *Balance billing.* If a provider pays at least the minimum amount due but less than the total amount due by the due date, the fund shall calculate the remainder due by subtracting the amount paid from the amount due and shall bill the provider for the remainder on a quarterly instalment basis. Each subsequent bill shall include all of the following:

1. The total of the remainder due.

2. Interest on the remainder due. The daily rate of interest shall be the average annualized rate earned by the fund on its short-term funds for the first 3 quarters of the preceding fiscal year, as determined by the state investment board, divided by 360.

3. A $3 administrative service charge.

4. The minimum amount due.

5. The payment due date.

(k) *Prompt payment required.* A provider shall pay at least the minimum amount due on or before each due date. If the fund receives payment later than the due date specified in the late payment notice sent to the provider by certified mail, the fund, notwithstanding par. (n) 5, may not apply the payment retroactively to the annual fee unless the board has authorized retroactive coverage under sub. (3s) (b).

(n) *Application of payments.* Except as provided in par. (k), all payments to the fund shall be applied in chronological order first to previous fiscal years for which a balance is due and then to the current fiscal year. The amounts for each fiscal year shall be credited in the following order:

1. Mediation fund fee imposed under s. Ins 17.01.

2. Administrative service charge under par. (j) 3.

3. Interest under par. (j) 2.

4. Surcharge imposed under s. Ins 17.285.

5. Annual fee under sub. (6).

(o) *Waiver of balance.* The fund may waive any balance of $50 or less, if it is in the economic interest of the fund to do so.

(5) FILING OF CERTIFICATES OF INSURANCE. (a) *Electronic filing.* Except as provided in par. (b), each insurer and self-insured provider required under s. 655.23 (3) (b) or (c), Stats., to file a certificate of insur-

ance shall file the certificate electronically in the format specified by the commissioner by the 15th day of the month following the month of original issuance or renewal or a change of class under sub. (6).

(b) *Exemption.* An insurer or self-insured provider may file a written request for an exemption from the requirement of par. (a). The commissioner may grant the exemption if he or she finds that compliance would constitute a financial or administrative hardship. An insurer or self-insured provider granted an exemption under this paragraph shall file a paper certificate in the format specified by the commissioner within 45 days after original issuance or renewal or a change of class under sub. (6).

emerg. r. + recr. eff. 6/14/95

(6) FEE SCHEDULE. The following fee schedule shall be effective from July 1, 1994 to June 30, 1995:

(a) Except as provided in pars. (b) to (g), for a physician for whom this state is a principal place of practice:

Class 1	$3,150	Class 3	$15,750
Class 2	$6,300	Class 4	$18,900

(b) For a resident acting within the scope of a residency or fellowship program:

Class 1	$1,575	Class 3	$7,875
Class 2	$3,150	Class 4	$9,450

(c) For a resident practicing part-time outside the scope of a residency or fellowship program:

All classes	$1,890

(d) For a medical college of Wisconsin, inc., full-time faculty member:

Class 1	$1,260	Class 3	$6,300
Class 2	$2,520	Class 4	$7,560

(g) For a physician who practices fewer than 500 hours during the fiscal year, limited to office practice and nursing home and house calls, and who does not practice obstetrics or surgery or assist in surgical procedures: $788

(gm) For a physician for whom this state is not a principal place of practice:

Class 1	$1,575	Class 3	$7,875
Class 2	$3,150	Class 4	$9,450

(h) For a nurse anesthetist for whom this state is a principal place of practice: $844

(hm) For a nurse anesthetist for whom this state is not a principal place of practice: $422

(i) For a hospital:

1. Per occupied bed $208; plus

2. Per 100 outpatient visits during the last calendar year for which totals are available $10.29

(j) For a nursing home, as described under s. 655.002 (1) (j), Stats., which is wholly owned and operated by a hospital and which has health

care liability insurance separate from that of the hospital by which it is owned and operated:

Per occupied bed $39

(k) For a partnership comprised of physicians or nurse anesthetists, organized for the primary purpose of providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of partners and employed physicians or nurse anesthetists is from 2 to 10 $118

2. If the total number of partners and employed physicians or nurse anesthetists is from 11 to 100 $1,178

3. If the total number of partners and employed physicians or nurse anesthetists exceeds 100 $2,945

(l) For a corporation with more than one shareholder organized under ch. 180, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of shareholders and employed physicians or nurse anesthetists is from 2 to 10 $118

2. If the total number of shareholders and employed physicians or nurse anesthetists is from 11 to 100 $1,178

3. If the total number of shareholders and employed physicians or nurse anesthetists exceeds 100 $2,945

(lm) For a corporation organized under ch. 181, Stats., for the primary purpose of providing the medical services of physicians or nurse anesthetists, whichever of the following is applicable:

1. If the total number of employed physicians and nurse anesthetists is from 1 to 10 $118

2. If the total number of employed physicians and nurse anesthetists is from 11 to 100 $1,178

3. If the total number of employed physicians or nurse anesthetists exceeds 100 $2,945

(m) For an operational cooperative sickness care plan:

1. Per 100 outpatient visits during the last calendar year for which totals are available $0.26; plus

2. 2.5% of the total annual fees assessed against all of the employed physicians.

(n) For an ambulatory surgery center, as defined in s. HSS 123.14 (2) (a), which is a separate entity not part of a hospital, partnership or corporation subject to ch. 655, Stats.:

Per 100 outpatient visits during the last calendar year for which totals are available $51

(o) For an entity affiliated with a hospital, the greater of $100 or whichever of the following applies:

1. 15% of the amount the entity pays as premium for its primary health care liability insurance, if it has occurrence coverage.

2. 20% of the amount the entity pays as premium for its primary health care liability insurance, if it has claims made coverage.

(6e) MEDICAL COLLEGE RESIDENTS' FEES. (a) The fund shall calculate the total amount of fees for all medical college of Wisconsin affiliated hospitals, inc., residents on a full-time-equivalent basis, taking into consideration the proportion of time spent by the residents in practice which is not covered by the fund, including practice in federal, state, county and municipal facilities, as determined by the medical college of Wisconsin affiliated hospitals, inc.

(b) Notwithstanding sub. (4) (h), the fund's initial bill for each fiscal year shall be the amount the medical college of Wisconsin affiliated hospitals, inc., estimates will be due for the next fiscal year for all its residents. At the end of the fiscal year, the fund shall adjust the fee to reflect the residents' actual exposure during the fiscal year, as determined by the medical college of Wisconsin affiliated hospitals, inc., and shall bill the medical college of Wisconsin affiliated hospitals, inc., for the balance due, if any, plus accrued interest, as calculated under par. (j) 2, from the beginning of the fiscal year. The fund shall refund the amount of an overpayment, if any.

(6m) (a) The fund may require any provider to report, at the times and in the manner prescribed by the fund, any information necessary for the determination of a fee specified under sub. (6).

(b) For purposes of sub. (6) (k), (l) and (lm), a partnership or corporation shall report the number of partners, shareholders and employed physicians and nurse anesthetists on July 1 of the previous fiscal year.

(6s) SURCHARGE. (a) This subsection implements s. 655.27 (3) (bg) 1, Stats., requiring the establishment of an automatic increase in a provider's fund fee based on loss and expense experience.

(b) In this subsection:

1. "Aggregate indemnity" has the meaning given under s. Ins 17.285 (2) (a).

2. "Closed claim" has the meaning given under s. Ins 17.285 (2) (b).

3. "Provider" has the meaning given under s. Ins 17.285 (2) (d).

4. "Review period" has the meaning given under s. Ins 17.285 (2) (e).

(c) The following tables shall be used in making the determinations required under s. Ins 17.285 as to the percentage increase in a provider's fund fee:

1. For a class 1 physician or a nurse anesthetist:

Aggregate Indemnity During Review Period			Number of Closed Claims During Review Period			
			1	2	3	4 or more
Up to	$	67,000	0%	0%	0%	0%
$ 67,001 to	$	231,000	0%	10%	25%	50%
$ 231,001 to	$	781,000	0%	25%	50%	100%
Greater Than	$	781,000	0%	75%	100%	200%

2. For a class 2 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period			
	1	2	3	4 or more
Up to $ 123,000	0%	0%	0%	0%
$ 123,001 to $ 468,000	0%	10%	25%	50%
$ 468,001 to $ 1,179,000	0%	25%	50%	100%
Greater Than $ 1,179,000	0%	50%	100%	200%

3. For a class 3 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or more
Up to $ 416,000	0%	0%	0%	0%	0%
$ 416,001 to $ 698,000	0%	0%	10%	25%	50%
$ 698,001 to $ 1,275,000	0%	0%	25%	50%	75%
$ 1,275,001 to $ 2,080,000	0%	0%	50%	75%	100%
Greater Than $ 2,080,000	0%	0%	75%	100%	200%

4. For a class 4 physician:

Aggregate Indemnity During Review Period	Number of Closed Claims During Review Period				
	1	2	3	4	5 or more
Up to $ 503,000	0%	0%	0%	0%	0%
$ 503,001 to $ 920,000	0%	0%	10%	25%	50%
$ 920,001 to $ 1,465,000	0%	0%	25%	50%	75%
$ 1,465,001 to $ 2,542,000	0%	0%	50%	75%	100%
Greater Than $ 2,542,000	0%	0%	75%	100%	200%

Note: Applicability. (1) Except as provided in sub. (2), the treatment of s. Ins 17.28 (4) (b), (c) 1 (intro.) and 2 to 4, (cs) 1, (f) and (h) to (n), (5), (6e) (b) and (7) by the March, 1992 revision first applies to patients compensation fund annual fee bills for fiscal year 1992-93.

(2) If the patients compensation fund's new computerized billing system becomes operational on or before March 1, 1992, the treatment of s. Ins 17.28 (4) (b), (c) 1 (intro.) and 2 to 4, (cs) 1, (f) and (h) to (n), (5), (6e) (b) and (7) by the March, 1992 revision first applies to patients compensation fund annual fee bills for the last quarter of fiscal year 1991-92.

History: Cr. Register, June, 1980, No. 294, eff. 7-1-80; am. (6), Register, June, 1981, No. 306, eff. 7-1-81; r. and recr. (6), Register, June, 1982, No. 318, eff. 7-1-82; am. (6) (h) and (i), Register, August, 1982, No. 320, eff. 9-1-82, am. (6), Register, June, 1983, No. 330, eff. 7-1-83; am. (6) (i), Register, September, 1983, No. 333, eff. 10-1-83; am. (6) (intro.), (a) to (h), (j) and (r), Register, June, 1984, No. 342, eff. 7-1-94; am. (6) (i), Register, August, 1984, No. 344, eff. 9-1-84; am. (3) (c) and (6) (intro.), (a) to (e) 1., (f) to (h), (j) and (k), r. (intro.), cr. (3) (c) 1. to 9. and (7), Register, July, 1985, No. 355, eff. 8-1-85; am. (7) (a) 2. and (c), r. (7) (a) 5., renum. (7) (a) 3. and 4. to be 4. and 5. and am., cr. (7) (a) 3., Register, December, 1985, No. 360, eff. 1-1-86; emerg. r. and recr. (3) (c) intro., 1. to 9., (4), (6) (intro.), (a) to (k) and (7), eff. 7-2-86; r. and recr. (3) (c) intro. and 1. to 9., (4), (6) (intro.), (a) to (k) and (7), Register, September, 1986, No. 369, eff. 10-1-86; am. (2), (4) (b) and (d), (6) and (7) (intro.), Register, June, 1987, No. 378, eff. 7-1-87; am. (6) (i) and (j), cr. (6) (k) to (o) and (6m), Register, January, 1988, No. 385, eff. 7-1-88; cr. (6s), Register, February, 1988, No. 386, eff. 3-1-88; am. (6) (intro.) to (j), (m) 1. and (n), Register, June, 1988, No. 390, eff. 7-1-88; renum. (3) (a) to be (3) (d), cr. (3) (a), (bm), (e) to (i), (3e), (3m) and (3s), r. and recr. (3) (b) and (4), r. (7) (intro.) and (b) 4., am. (7) (a), (b) (intro.) to 3. and (c), Register, April, 1989, No. 400, eff. 5-1-89; emerg. r. (4) (c) 1. b., am. (4) (c) 2. and 3., (6) (intro.) to (j), (l) (intro.), (m) 1., (n) and (o), cr. (4) (c) 4., (6) (k) 1. to 3. and (6) (l) 3. and (lm), renum. (6) (k) to be (6) (k) (intro.) and am., r. and recr. (6) (l) 1. and 2., eff. 6-1-89; r. (4) (c) 1. b., am. (4) (c) 2. and 3., (6) (intro.) to (j), (l) (intro.), (m) 1., (n) and (o), cr. (4) (c) 4., (6) (k) 1. to 3. and (6) (l) 3. and (lm), renum. (6) (k) to be (6) (k) (intro.) and am., r. and recr. (6) (l) 1. and 2., Register, July, 1989, No. 403, eff. 8-1-89; am. (1), (2), (3) (c) and (f), (3e), (6) (intro.), (a) (intro.), (b) (intro.), (c) (intro.), (d) (intro.), (e) (intro.), (f) (intro.), (g), (h), (i) (intro.), (j) (intro.), (k) (intro.), (l) (intro.), (lm) (intro.), (m) (intro.), (n) (intro.) and (o) and (6m), renum. (3m) (a) (intro.), 1., 2., 3. intro., b. and c., and (6m) to be (3m) (intro.), (a), (b), (c), and (6m) (a), r. (3m) (a) 3. a. and (b), r. and recr. (5), (6) (a) (intro.), (b) (intro.), (d) (intro.), (e) (intro.), (f) (intro.), (6s) (c) 1. intro., 2. intro., 3. intro. and 4. intro., cr. (3) (intro.) and (hm), (4) (em) and (g), (6e) and (6m) (b), Register, June, 1990, No. 414, eff. 7-1-90; emerg. am. (6) (b) and (6e), r. (6) (e) and (f), eff. 7-1-90; am. (6) (b) and (6e), r. (6) (e) and (f), Register, October, 1990, No. 418, eff. 11-1-90; cr. (4) (cs), am. and (3s) (b) (4) (g), Register, April, 1991, No. 424, eff. 5-1-91; emerg. am. (3) (c) 2. and 3., (6) (intro.), eff. 7-1-91; am. (3) (c) 2. and 3., (6) (intro.), Register, July,

1991, No. 427, eff. 8-1-91; am. (6s) (c) (intro.), Register, January, 1992, No. 433, eff. 2-1-92; am. (4) (b), (c) 1. intro., 2 to 4., (cs) 1. and (f), (5) and (6e) (b), cr. (4) (h) to (o), r. (7), Register, March, 1992, No. 435, eff. 4-1-92; emerg. am. (4) (cm), (e) 1., (f), (j) 3., (5), (6) (intro.), (a) to (j), (k) (intro.), (l) (intro.), 1., (lm) (intro.), (m) and (n), r. (3m) (b) and (4) (e) 2., cr. (6) (gm) and (hm), r. and recr. (4) (c), renum. (4) (d), (l) and (m) to be (4) (d) 1., 2. and (e) 2., eff. 4-28-92; am. (4) (cm), (e) 1., (f), (j) 3., (5), (6) (intro.), (a) to (j), (k) (intro.), (l), (intro.), 1. (lm) (intro.), (m) and (n), r. (3m) (b) and (4) (e) 2., cr. (6) (gm) and (hm), r. and recr. (4) (c), renum. (4) (d), (l) and (m) to be (4) (d) 1., 2. and (e) 2., Register, July, 1992, No. 439, eff. 8-1-92; emerg. am. (3) (c) (intro.), (6) (intro.), (a) to (d) and (gm) to (n), r. and recr. (3) (c) 1 to 4, (5), (6) (g); am. (3) (c) (intro.), (6) (intro.), (a) to (d) and (gm) to (n), r. and recr. (3) (c) 1 to 4, (5), (6) (g), Register, September, 1993, No. 453, eff. 10-1-93; am. (4) (k) and (n) (intro.) and (6), Register, June, 1994, No. 462, eff. 7-1-94.

Ins 17.285 Peer review council. (1) PURPOSE. This section implements ss. 619.04 (5) (b) and (5m) (b), 655.27 (3) (a) 2m and (bg) 2 and 655.275, Stats.

(2) DEFINITIONS. In this section:

(a) "Aggregate indemnity" means the total amount attributable to an individual provider that is paid or owing to or on behalf of claimants for all closed claims arising out of one incident or course of conduct, including amounts held by the fund under s. 655.015, Stats. "Aggregate indemnity" does not include any expenses paid in the defense of the claim.

(b) "Closed claim" means a medical malpractice claim against a provider, or a claim against an employe of a health care provider for which the provider is vicariously liable, for which there has been either of the following:

1. A final determination based on a settlement, award or judgment that indemnity will be paid to or on behalf of a claimant.

2. A payment to a claimant by the provider or another person on the provider's behalf.

(c) "Council" means the peer review council appointed under s. 655.275, Stats.

(cg) "Health care provider" has the meaning given in s. 146.81 (1), Stats.

(cr) "Patient health care records" has the meaning given in s. 146.81 (4), Stats.

(d) "Provider," when used without further qualification, means a health care provider subject to ch. 655, Stats., who is a natural person. "Provider" does not include a hospital or other facility or entity that provides health care services.

(e) "Review period" means the 5-year period ending with the date of the first payment on the most recent closed claim reported under s. 655.26, Stats., for a specific provider.

(f) "Surcharge" means the automatic increase in a provider's plan premium or fund fee established under s. Ins 17.25 (12m) or 17.28 (6s) or both.

(2m) TIME FOR REPORTING. In reporting claims paid under s. 655.26, Stats., each insurer or self-insurer shall report the required information by the 15th day of the month following the date on which there has been a final determination of the aggregate indemnity to be paid to or on behalf of any claimant.

(2s) INFORMATION FOR PROVIDER. Upon receipt of a report under sub. (2m), the council shall mail to the provider who is the subject of the report all of the following:

Next page is numbered 539