

**Preferred Health Partnership of
Tennessee, Inc.**

**For the Period
January 1, 1995, Through December 31, 1997**

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March 15, 1999

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
and
The Honorable Fredia Wadley, M.D., Commissioner
Department of Health
344 Cordell Hull Building
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the report on the compliance review of the managed care organization (MCO) Preferred Health Partnership of Tennessee, Inc., for the period January 1, 1995, through December 31, 1997.

The review of the operations disclosed certain deficiencies, which are detailed in the Findings and Recommendations section of this report. This report is intended to aid the Bureau of TennCare in its review to determine whether the MCO has adhered to the terms of the managed care organization contracts. The Department of Commerce and Insurance should take whatever action it deems appropriate regarding the findings contained in this report.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/pn
97/016

cc: Joe Keane
Theresa Clarke-Lindsey

State of Tennessee

Review Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Review

Preferred Health Partnership of Tennessee, Inc.

For the Period January 1, 1995, Through December 31, 1997

REVIEW OBJECTIVES

The objectives of the review were to determine if the managed care organization (MCO) is meeting its contractual obligations, including, but not limited to, proper claims payment, proper accounting for payments from the TennCare Bureau, proper enrollment counts, maintenance of sufficient financial reserves, and recordkeeping sufficient to meet program requirements.

REVIEW FINDINGS

Failure to Maintain Minimum Equity Requirements and Deficiency in Financial Reporting

Preferred Health Partnership of Tennessee, Inc., (PHP) failed to maintain minimum equity requirements. As of December 31, 1997, PHP had a review-adjusted retained earnings of negative \$3,238,103. The annual statement for the year ended December 31, 1997, contained deficiencies (page 7).

Deficiencies in Claims-Processing System

Preferred Health Partnership of Tennessee, Inc., did not adhere to contract reporting requirements and processing-efficiency requirements. PHP's explanations of benefits (EOBs) did not effectively communicate to the TennCare member any amounts owed to the medical provider. All data elements required for individual encounter/claims data reporting were not accurately recorded from claims providers submitted. PHP did not coordinate members' out-of-pocket expenses with TBH. An electronic billing option was not offered to PHP's contracted providers (page 8).

Deficiencies in Provider Agreements

Preferred Health Partnership of Tennessee, Inc., did not include all requirements specified by the TennCare contract in the provider agreements (page 11).

"Review Highlights" is a summary of the report. To obtain the complete review report which contains all findings, recommendations, and management comments, please contact

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Compliance Review
Preferred Health Partnership of Tennessee, Inc.
For the Period January 1, 1995, Through December 31, 1997

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**Compliance Review
Preferred Health Partnership of Tennessee, Inc.
For the Period January 1, 1995, Through December 31, 1997**

INTRODUCTION

PURPOSE OF THE REVIEW

This report details the results of a compliance review of the transactions, books, and accounts of Preferred Health Partnership of Tennessee, Inc. The purpose of this review was to evaluate the programmatic operations of the managed care organization (MCO) and to determine if Preferred Health Partnership of Tennessee, Inc., was administered in accordance with the requirements of *Tennessee Code Annotated* and the contracts between the state and the MCO. The objectives of the review were

1. to determine whether the MCO was meeting its contractual obligations under the TennCare agreement with the state;
2. to determine whether the MCO had properly adjudicated claims from service providers and had made payments in a timely manner;
3. to determine whether enrollment counts and categories were accurate and whether monthly payments and withhold amounts from TennCare to the MCO were accurate;
4. to determine if the MCO had sufficient financial capital to ensure uninterrupted delivery of health care;
5. to determine if the MCO's records were adequate to determine compliance with the rules and contract requirements of the Bureau of TennCare; and
6. to recommend appropriate actions to correct any deficiencies.

POST-AUDIT AUTHORITY

This review was conducted pursuant to Section 2-14 of the Provider Risk Agreement between Preferred Health Partnership of Tennessee, Inc., and the State of Tennessee which states:

The CONTRACTOR shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees for the purposes of audit requirements. Records other than medical records may be kept in original paper state, or preserved on micromedia or elec-

tronic format. Medical records shall be maintained in their original form. These records, books, documents, etc., shall be available for review by authorized federal, state, and Comptroller personnel during the Agreement period and five (5) years thereafter, except if an audit is in progress or audit findings are yet unresolved in which case records shall be kept until all tasks are completed. During the Agreement period, these records shall be available at the CONTRACTOR's chosen location subject to the approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR and subcontractor or provider records must be requested and approved by TENNCARE.

SCOPE OF THE REVIEW

The review examined the records, transactions, and contract provisions of the plan for the period January 1, 1995, through December 31, 1997. We tested insurance claims, reviewed accounting records, and performed other testing procedures considered necessary.

BACKGROUND INFORMATION

Effective January 1, 1994, the State of Tennessee received approval from the U.S. Department of Health and Human Services to begin a five-year Medicaid waiver project which changed most services covered under the Medicaid program to a managed care capitated system. Under the waiver program, known as TennCare, the state contracts with managed care organizations that manage and provide enrollees' care for a stated monthly capitation fee. In addition to recipients eligible under Medicaid criteria, certain uninsured or uninsurable persons may enroll in the TennCare Program. The managed care organizations in turn arrange for a network of hospitals, doctors, and other health care providers to furnish health care services for persons enrolled in the plan.

The Tennessee Department of Health is the state agency responsible for administering the managed care program in Tennessee. The department is authorized to contract with MCOs to provide specified services to people who are or would have been eligible for Medicaid as it was administered during fiscal year 1992-93 and to other Tennesseans who are eligible for and are enrolled in the TennCare system. The managed care organization must

1. be appropriately licensed to operate within the State of Tennessee;
2. demonstrate the existence of a network of health care providers capable of providing comprehensive health care services throughout the community where the plan is offered;

3. clearly demonstrate the capability and intent to provide case management services;
4. ensure the availability of service providers outside the community service network for covered services that are not commonly provided in that particular community area;
5. demonstrate sufficient financial capital to ensure uninterrupted delivery of health care;
6. demonstrate sufficient financial capital, network capability, and willingness to accept a reasonable number of enrollees from any failed health plan operating in the community;
7. agree to move to electronic billing for all its TennCare plans within three years of the effective date of the agreement;
8. unanimously agree with other MCOs in the TennCare system for the provision of pharmacy services to TennCare enrollees who reside in long-term care facilities so that only one pharmacy shall be responsible for their pharmacy services;
9. agree not to require service providers to accept TennCare reimbursement amounts for services provided under any non-TennCare plan operated or administered by the managed care organization; and
10. mutually agree to such other requirements as may be reasonably established by TennCare.

Preferred Health Partnership of Tennessee, Inc., is a wholly owned subsidiary of PHP Companies, Inc. Effective January 1, 1994, Preferred Health Partnership of Tennessee, Inc., contracted with the State of Tennessee as a preferred provider organization (PPO) to provide medical services under the newly established TennCare Program. Effective January 1, 1997, PHP no longer contracted as a PPO, but as a health maintenance organization (HMO). At December 31, 1995, the enrollment for the plan was approximately 58,600 members; at December 31, 1996, approximately 58,500 members; and December 31, 1997, approximately 91,200 members.

As a PPO, Preferred Health Partnership of Tennessee, Inc., (PHP) must establish risk reserves in an amount equal to what would have been required by the Tennessee Department of Commerce and Insurance if the company had been a health maintenance organization licensed by the State of Tennessee. Also, PHP is allowed to retain up to 10 percent of the monthly capitation amount paid by TennCare as a management fee, with the remainder of the monthly capitation amount available for the payment of covered benefits. TennCare is not liable for any excess benefit costs. Any and all excess administrative expenses are borne by PHP. In the event of savings, PHP, as provided for in Section 2-10(e)(2) of the TennCare contract, is required to share with TennCare a portion of such savings after medical benefits and allowable administrative expenses are paid. The contractor is permitted to share 5 percent of the savings with the providers and to retain 5 percent for the contractor's efficiency. The remainder of the savings are returned to TennCare.

Beginning January 1, 1997, Preferred Health Partnership of Tennessee, Inc., files quarterly and annual statements with the Department of Commerce and Insurance. The statements are filed on a statutory basis of accounting, which differs from generally accepted accounting principles in that assets must be easily converted to cash to pay outstanding claims. Assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and are reduced from equity.

At December 31, 1995, the plan reported \$13,035,808 in assets, \$13,045,221 in liabilities, and (\$9,413) in equity on its annual statement. The plan reported total revenues of \$84,013,131, and total expenses of \$83,886,282, producing net income of \$126,849 for the period January 1 through December 31, 1995. Revenue comprised \$83,389,620 in capitation fee payments from TennCare and \$623,511 in investment income. The plan reported \$75,866,324 in medical expenses, \$7,871,398 in administrative expenses, and \$148,560 in provision for federal income taxes.

At December 31, 1996, the plan reported \$22,729,832 in assets, \$19,710,502 in liabilities, and \$3,019,330 in equity on its annual statement. The plan reported total revenues of \$80,272,793 and total expenses of \$79,960,675, producing net income of \$312,118 for the period January 1 through December 31, 1996. Revenue comprised \$79,610,952 in capitation fee payments from TennCare, \$605,183 in investment income, and \$56,658 in miscellaneous revenue. The plan reported \$69,671,154 in medical expenses, \$10,149,269 in administrative expenses, and \$140,252 in provision for federal income taxes.

At December 31, 1997, the plan reported \$25,425,495 in assets, \$27,597,752 in liabilities, and (\$2,172,257) in equity on its annual statement. The plan reported total revenues of \$112,614,439 and total expenses of \$117,816,169, producing a net loss of \$5,201,730 for the period January 1 through December 31, 1997. Revenue comprised \$110,589,993 in capitation fee payments from TennCare, \$1,369,035 in investment income, and \$655,411 in other revenue. The plan reported \$104,676,262 in medical expenses, \$13,121,164 in administrative expenses, and \$18,743 in provision for federal income taxes. At December 31, 1997, the plan maintained a restricted deposit of \$2,200,000 to satisfy requirements of the Tennessee Department of Commerce and Insurance.

PRIOR REVIEW FINDING

The previous review of Preferred Health Partnership of Tennessee, Inc., for the year ended December 31, 1994, included a finding about the plan's insolvency. At December 31, 1994, Preferred Health Partnership of Tennessee, Inc., (PHP) according to statutory requirements, was considered insolvent, with adjusted negative equity of (\$312, 945). This finding has not been resolved and is repeated in the applicable section of this report.

RESULTS OF THE REVIEW

Our review of the plan revealed discrepancies in the claims-processing system, provider agreements, accounting, and financial data. These discrepancies are further discussed in the Findings and Recommendations section of the report.

The Tennessee Department of Finance and Administration and the Tennessee Department of Health reached a settlement with PHP for calendar years 1994 through 1996 for the determination of savings calculated under the preferred provider organization contract. The settlement determined that PHP had no savings calculated as due for calendar year 1994. Also, the settlement determined that PHP owed the state a total savings of \$4,435,482, for calendar years 1995 and 1996.

Subsequent material events and error corrections affected the reporting of the operation of Preferred Health Partnership of Tennessee, Inc., for the period January 1, 1995, through December 31, 1997. PHP's balance sheet and income statement were adjusted by the Division of State Audit as follows:

- TennCare premium revenue and TennCare receivable were decreased by \$508,494 to adjust the rate increase receivable amount to the actual amount received in 1998.
- Premium tax expense and payable were increased by \$109,946 to reflect the adjustment to premium revenue.
- Medicare accounts receivable of \$500,000 were reclassified as non-admitted.
- The intercompany receivable of \$21,530 due from parent company was reclassified as non-admitted.
- A reinsurance receivable of \$62,563 over 90 days old was reclassified as non-admitted.
- The amount payable to medical providers was increased by \$174,130 to account for the portion of the savings settlement to be paid to PHP's providers.
- The payable to the State of Tennessee for the savings settlement was decreased by \$277,688, the amount of the medical technologies payment that was not part of the settlement.
- Long-term investments were increased by \$33,129.

The effect of these adjustments on equity for Preferred Health Partnership of Tennessee, Inc., as of December 31, 1997, was to decrease negative equity from (\$2,172,257) to

(\$3,238,103). Therefore, PHP was not in compliance with the minimum equity requirements of \$2,220,291, as of December 31, 1997. A summary of review adjustments to statutory equity is shown on schedule 1. It should be noted that by March 1998, PHP had contributed capital of \$7.8 million to comply with minimum equity requirements.

FINDINGS AND RECOMMENDATIONS

1. Deficiency in financial reporting and failure to maintain minimum equity requirements

Finding

The following deficiencies in financial reporting were noted on the annual statement of PHP for the year ended December 31, 1997:

- TennCare premium revenue and TennCare receivable is overstated by \$508,494 because the rate increase receivable amount was not adjusted to the actual amount received in 1998.
- Premium tax expense and payable is increased by \$109,946 to reflect the adjustment to premium revenue.
- Medicare accounts receivable of \$500,000 is incorrectly classified as an admitted asset. It is uncertain when or if this receivable will be collected; therefore, pursuant to statutory accounting principles, it should be reclassified as a non-admitted asset.
- The intercompany receivable of \$21,530 due from parent company is incorrectly classified as an admitted asset. According to *Tennessee Code Annotated*, this amount is considered an unsecured stockholder obligation which cannot be included as an admitted asset.
- A reinsurance receivable of \$62,563 over 90 days old is incorrectly classified as an admitted asset.
- The amount payable to medical providers is understated by \$174,130 to account for the portion of the savings settlement to be paid to PHP's providers.
- The payable to the State of Tennessee for the savings settlement is overstated by \$277,688, the amount of the medical technologies payment that was not part of the settlement.
- Long-term investments is understated by \$33,129.

Section 2-12 of the TennCare contract with PHP states, "The Contractor shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this Agreement and any other costs and expenditures made under the Agreement." Section 56-32-201 et seq., *Tennessee Code Annotated*, addresses the statutory requirement for health maintenance organizations.

The effect of review adjustments on the retained earnings for PHP was to increase the deficit from \$4,392,549 to \$5,458,394 as of December 31, 1997. The adjustment reduced the equity from a negative \$2,172,257 to a negative \$3,238,103. Therefore, at December 31, 1997, the plan did not meet the minimum financial reserve requirement equal to the statutory deposit specified in the TennCare contract and in *Tennessee Code Annotated*. It should be noted that by March 1998, PHP had contributed capital of \$7.8 million to comply with minimum equity requirements.

Recommendation

Preferred Health Partnership of Tennessee, Inc., should maintain the minimum risk reserve requirements. Receivables over 90 days old or whose collectibility is uncertain should not be included in the determination of admitted assets. Intercompany receivables should not be included in the determination of admitted assets.

Management's Comment

On November 30, 1998, PHP hired Lance Hunsinger to serve as its new Chief Financial Officer. Mr. Hunsinger has nine years of managed care financial management background, all of which has included management of Medicaid contracts in the states of Maryland and North Carolina. This experience will bring a heightened sense of awareness and responsibility for compliance with the financial responsibilities of PHP under the contract with the Bureau of TennCare. As a result, PHP will dramatically improve its accounting efforts, particularly as they relate to the recognition of admitted and non-admitted assets. Further, monthly monitoring of statutory net worth levels will occur with immediate actions being taken to assure ongoing compliance.

2. Deficiencies in claims-processing system

Finding

A review of a sample of claims for services provided from January 1, 1995, through December 31, 1997, revealed the following:

- a. PHP complied with the TennCare contract processing efficiency requirements for claims with dates of service January 1, 1995, through December 31, 1995. The average processing lag for clean claims was 22 days from receipt of the claim to final adjudication. "Clean claims" are claims which do not require additional information from the medical provider before processing. Section 2-18 of the contract effective in 1995 states, "The Contractor agrees to make payments within thirty (30) calendar days of receipt for at least ninety-five percent (95%) of all clean claims submitted by contract providers."

- b. Our review noted the following processing and payment errors in the 50 claims selected for review for dates of service January 1, 1996, through December 31, 1997:
- PHP's denial of three claims was improper:
 - PHP denied one claim indicating that the claim was the member's responsibility. The member, however, was Medicaid eligible and does not have any responsibility for this claim.
 - One claim was improperly denied for no prior authorization. When PHP discovered that the medical provider had obtained prior authorization, the claim was reversed and paid.
 - One claim was denied for no prior authorization. This claim, however, was for diagnostic testing, which does not require prior authorization. This claim was later reversed and paid.
 - One claim was paid to the wrong medical provider.
 - For one claim, the amount PHP paid could not be verified as the agreed-upon amount specified in the provider contract.
- c. PHP inadequately reported encounter data required by the TennCare contract. Encounter data, a record of medical service provided to enrollees, is necessary to evaluate quality of care and access to TennCare services. The following deficiencies were noted in the 50 claims selected for testing for dates of service January 1, 1996, through December 31, 1997:
- For two claims, the procedure codes entered into the claims-processing system did not agree with the procedure codes reported on the claims.
 - For two claims, the diagnosis codes entered into the claims-processing system did not agree with the diagnosis codes reported on the claims.
 - For one claim, the date of service entered into the claims-processing system did not agree with the date of service reported on the claim.
- d. An error was discovered in the explanation of benefits (EOB) sent to TennCare members. An EOB is a written communication to the TennCare member concerning any amounts the member may owe the medical provider. The EOBs from PHP informed members they owed the difference between the charged amount and the allowed amount. Members, however, are only responsible for any co-pay or deductible computed.
- e. PHP did not meet claims-processing requirements specified by the TennCare contract. Claims submitted by providers for medical services were not always processed within the 60-day requirement. PHP failed to pay or deny 95% of the clean claims tested

within the 30-day requirement and to pay or deny the remaining 5% or 100% of all clean claims within ten calendar days. Of the 50 claims tested, 47 were clean claims with the following time lags:

- 30 claims within 30 days (64%)
 - 11 claims within the next 10 days (23%)
 - 5 claims within 41 to 60 days (11%)
 - 1 claim after 60 days (2%)
- f. PHP did not coordinate with Tennessee Behavioral Health (TBH) for out-of-pocket limits for its participants. As a result, TennCare members could exceed their annual out-of-pocket limit because both the MCO and the behavioral health organization can charge a co-payment.
- g. PHP did not provide an electronic billing option to its providers as required by the TennCare contract of January 1, 1997.

These inaccuracies and inefficiencies in the claims-processing system indicate PHP's failure to fulfill the claims-processing requirements of the TennCare contract.

Recommendation

Preferred Health Partnership of Tennessee, Inc., should adhere to contract reporting requirements and claims-processing-efficiency requirements. The EOB should effectively communicate to the TennCare member any amount owed the medical provider. All data elements required for individual encounter/claims data reporting should be accurately recorded from claims providers submitted. PHP should coordinate out-of-pocket limits with TBH. An electronic billing option should be offered to PHP's contracted providers.

Management's Comment

In mid-1998, PHP's Executive Management recognized signs of impending problems. There was a complete turnover of the Claims management team. Staffing was increased and the CSC computer system was retooled. The Claims Department was reorganized to incorporate strong features of audit continually conducting systematic reviews. At the same time, PHP began the acquisition process of an up-to-date claims payment processing system (AMISYS) for implementation in 1999.

In researching the EOB error stated in the findings, PHP found that the member portion of the EOB from CSC (our previous computer system) could be incorrect because it is derived from other data on the claim. The CSC system performs a calculation in the program that creates an EOB print job. The member portion is calculated by the program that both extracts and formats

data for printing checks and EOBs. Correcting this calculation is a complicated task which is currently pending Y2K issues. Our new system (AMISYS), which went live January 4, 1999, extracts the EOB data with the exact same values as would appear on an AMISYS EOB including the member portion. After we receive the file, the data is reformatted and imported into the program to print checks and EOBs. Because we rely on AMISYS to do all the calculations, and the results are just printed, this alleviates “member portion” amounts other than co-pays showing on an EOB.

In 1997, PHP TennCare obtained approval from the Bureau of TennCare to move to a co-pay system with our membership instead of the deductible/coinsurance process originally set up with the inception of the TennCare Program. Based on an actuarial analysis, it was determined that the current co-pay system would keep the majority of members from ever reaching their yearly out-of-pocket limit. PHP is currently working with our pharmacy vendor and the behavioral health organization to exchange co-pay information and track through a data warehouse environment. If and when a member reached their yearly out-of-pocket maximum, a flag would be set in the claims payment system to prevent further co-pays being taken. The pharmacy vendor and behavioral health organization would be formally notified of the member reaching their out-of-pocket limit also.

With the implementation of the AMISYS computer system, screen sets have been set up for HCFAs and UB92s that facilitate data entry of information exactly as it was submitted by the provider. Diagnosis and procedure codes will not be changed as they are data entered. The master file for AMISYS is also capable of storing five-digit diagnosis codes, whereas CSC was not.

PHP will begin EDI testing on the AMISYS system in March 1999. PHP is currently waiting on the provider community to be ready to transmit claims data electronically. Also with the implementation of the AMISYS system, an auto adjudication rate of 50% has decreased claims processing turnaround times.

3. Deficiencies in provider agreements

Finding

Preferred Health Partnership of Tennessee, Inc., did not comply with the Bureau of TennCare’s requirements for provider agreements. The provider agreements did not contain all requirements specified in section 2-18 of the contract between TennCare and PHP.

Language describing the following requirements is excluded or deficient in contracts between PHP and its medical providers:

- Require that an adequate record system be maintained for recording services rendered to enrollees and that enrollees and their representatives be given access to the enrollee's medical records as provided for by *Tennessee Code Annotated*.
- Specify that both parties recognize that if the agreement between the MCO and TennCare is terminated, the provider agreement shall terminate immediately. The provider shall immediately make available to TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the MCO/provider agreement. The provision of such records shall be at no expense to TennCare.
- The Contractor shall submit the proposed arbitration procedure, existing alternative arbitration procedure, or any subsequent modification to the arbitration procedure to the Tennessee Department of Commerce and Insurance, TennCare Division, for review and approval/denial within 30 calendar days after receipt. If a modification to the arbitration procedure is sent, it shall be sent Certified Mail–Return Receipt Requested.

Recommendation

PHP should comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements should contain all items specified in section 2-18 of the TennCare contract.

Management's Comment

PHP has responded that they are currently in compliance with required provider contract language. The current language was approved by the Department of Commerce and Insurance in November 1998.

Preferred Health Partnership of Tennessee, Inc.
 Summary of Review Adjustments to Statutory Equity
 For the Period January 1, 1995, Through December 31, 1997
 Prepared by the Division of State Audit

Reported equity balance, December 31, 1997		(\$2,172,257)
State Audit adjustments:		
Decrease in receivable-rate increase	(\$508,494)	
Increase in premium tax payable	(109,946)	
Decrease in accounts receivable–Medicare	(500,000)	
Decrease in intercompany receivable	(21,530)	
Decrease in reinsurance receivable	(62,563)	
Increase in accounts payable providers-savings settlement	(174,130)	
Decrease in accounts payable state-savings settlement	277,688	
Increase in long-term investments	<u>33,129</u>	
		<u>(1,065,846)</u>
Adjusted equity balance, December 31, 1997		<u>(\$3,238,103)</u>