Critical Access Hospital 2012 Financial Leadership Summit

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OVERVIEW

On June 7 and 8, 2012, the National Rural Health Resource Center, with funding from the Health Resources and Services Administration (HRSA) Office of Rural Health Policy (ORHP), brought a small group of critical access hospital (CAH) financial leaders and experts together in Minneapolis, Minnesota to address issues related to CAH financial performance. The goals of the two day event were to:

- Consider the definition of financial crisis in CAHs;
- Identify the most important CAH financial measures;
- Identify strategic interventions to improve CAH financial performance; and,
- Provide input on the availability and/or development of useful financial resources for both CAHs and state Medicare Rural Hospital Flexibility (Flex) Programs.

Participants included financial experts from hospital consulting firms with extensive experience in rural hospital finance, CAHs, state Medicare Flex Program representatives, a rural health researcher from the University of North Carolina and an official from the HRSA Office of Rural Health Policy. The participants did extensive pre-work and then engaged in a structured dialog. The information that follows is an abbreviated product of their discussions. It is intended as a resource for both CAHs and state Medicare Flex Programs.

MOST IMPORTANT CAH PERFORMANCE INDICATORS

Financial indicators closely aligned with financial strength can be used to determine the financial status of a CAH. Financial indicators, oftentimes ratios, combine line items from the balance sheet, statement of operations and/or statement of cash flows in a meaningful way to help interpret strengths or weaknesses in operations or financing activities. Examining these ratios over time can also help in determining an organization's trajectory or momentum into the future.

Of the many identified financial ratios proven useful for assessing organizations' financial conditions, the Summit participants identified the 10 most important indicators for evaluating CAH financial performance. These indicators are listed below with subsequent definitions, formulas and benchmarks from the *2012 CAH Financial Indicators Report* distributed by the Flex Monitoring Team. The tables below are meant to be used as a reference when calculating these ratios for a specific CAH. The formulas in red font indicate how the ratio was derived from example financial statements (balance sheet, statement of operations and statement of cash flows), which are presented in the Appendix. Table A displays

each of the indicators with the 2010 CAH U.S. medians as indicated in the *Flex Monitoring Team Data Summary Report No. 10: CAH Financial Indicators Report: Summary of Indicator Medians by State, August 2012*. Each indicator has an arrow pointing up or down, displaying if favorable values are above or below the median.

Table A. CAH Financial Indicator Medians, 2010

CAH Financial Indicator	2010 U.S. Median	
Days in Accounts Receivable	52.24	▼
Days Cash on Hand	68.43	▲
Total Margin	1.94%	▲
Operating Margin	0.75%	▲
Debt Service Coverage	2.58	▲
Salaries to Net Patient Revenue	44.78%	▼
Medicare Inpatient Payor Mix*	72.59%	▼
Average Age of Plant (years)	9.87	▼
Long Term Debt to Capitalization	26.37%	▼

* Summit participants agreed that Overall Payor Mix of the CAH was a more comprehensive indicator of financial performance than Medicare Inpatient Payor Mix alone.

Source: Flex Monitoring Team Data Summary Report No. 10: CAH Financial Indicators Report: Summary of Indicator Medians by State, August 2012.

1. Days in Net Accounts Receivable

Days in Net Accounts Receivable measures the number of days it takes an organization to collect its payments.

Table B. Example Calculation: Days in Net Accounts Receivable

	2009	2010	2011
Days in Net Accounts Receivable			
Net Accounts Receivable [B-C]	771,000	802,000	778,000
Net Patient Revenue [Q]	5,195,000	5,330,000	5,388,000
Days in Net Accounts Receivable [[B-C]/[Q/365]]	**54**	**55**	**53**

High values reflect a long collection period and indicate problems in the organization's business office with regards to billing or collecting payments. The ability to collect payments for services is increasingly difficult, but extremely important. Improvement in days in accounts receivable can mean hundreds of thousands of dollars in improvement in cash on hand. Common problems include out of date chargemasters, poor registration processes and bad communication. "Days in Accounts Receivable" is a good measure of how the billing process is working, but it does not indicate the overall financial strength of the hospital. Favorable values are **below** the median, and the 2010 CAH U.S. Median = **52.24 days**. Reductions to accounts receivable will improve cash on hand.

2. Days in Gross Accounts Receivable

Days in Gross Accounts Receivable tests the net days in accounts receivable with a goal of being the same amount of time as net days in accounts receivable.

Table C. Example Calculation: Days in Gross Accounts Receivable

	2009	2010	2011
Days in Gross Accounts Receivable			
Gross Accounts Receivable [B]	1,001,000	1,012,000	993,000
Gross Revenue [P]	6,395,000	6,460,000	6,503,000
Days in Gross Accounts Receivable [B/[P/365]]	**57**	**57**	**56**

Days in gross accounts receivable is important to track and compare to net accounts receivable to assess the revenue cycle performance. Gross and net days are close in value in highly functioning business offices. Gross accounts receivable does not include any accounting adjustments which makes it a good measure of overall performance when compared to net days in accounts receivable. For example, if gross days are higher than net days, the organization's allowances (e.g. write offs) may require further analysis. Favorable values are **below** the median, and the 2010 CAH U.S. Median = **52.24 days**.

3. Days Cash on Hand

Days Cash on Hand measures the number of days an organization could operate if no additional cash was collected or received. This reflects the organization's "safety net" relative to the size of the hospital's expenses.

Table D. Example Calculation: Days Cash on Hand

	2009	2010	2011
Days Cash on Hand			
Cash and Investments [A]	1,120,000	1,280,000	1,831,000
Operating Expenses [X]	5,688,000	5,747,000	5,817,000
Depreciation Expense [U]	229,000	218,000	211,000
Bad Debt Expense [W]*	102,000	107,000	126,000
Total [X-U-W]	5,357,000	5,422,000	5,480,000
Days Cash on Hand [A/[[X-U-W]/365]]	**76**	**86**	**122**
** Only if classified as operating expense on income statement*			

Lending organizations view this ratio as critical in the assessment of a project's feasibility, as it represents the amount of dollars readily available to meet short term obligations and make debt payments should an organization experience short term financial distress. Favorable values are **above** the median, and the 2010 CAH U.S. Median = **68.43 days**.

4. Total Margin

Total Margin measures the control of expenses relative to revenues.

Table E. Example Calculation: Total Margin

	2009	2010	2011
Total Margin			
Change in Net Assets [Z]	64,000	87,000	159,000
Total Revenue [S]	5,752,000	5,834,000	5,976,000
Total Margin [Z/S]	**1.1%**	**1.5%**	**2.7%**

Total margin indicates the organization's overall profit. While total margin is a good indicator of financial strength, it is important to look at operating margin as well. An organization might have a high total margin ratio if, for example, it is the recipient of non-operating sources of revenue, such as a county subsidy to provide quality health care to indigent residents. Margin driven by supplemental funding sources may be at risk with more pressure on local and county governmental budgets, for example. Favorable values are **above** the median, and the 2010 CAH U.S. Median = **1.94%**.

5. Operating Margin

Operating Margin measures the control of operating expenses relative to operating revenues related to patient care. Operating expenses are all expenses incurred from the hospital in delivering services. Examples are salaries and benefits, purchased services, professional fees, supplies, interest expense, depreciation and amortization and bad debt expense.

Table F. Example Calculation: Operating Margin

	2009	2010	2011
Operating Margin			
Net Operating Income [R-X]	(7,000)	10,000	63,000
Total Operating Income [R]	5,681,000	5,757,000	5,880,000
Operating Margin [[R-X]/R]	**-0.1%**	**0.2%**	**1.1%**

This measure reflects the overall performance on the CAH's core business: providing patient care. It is important to note that it takes into account the deductions from revenue, such as contractual allowances, bad debt and charity care. Favorable values are **above** the median, and the 2010 CAH U.S. Median = **0.75%**.

6. Debt Service Coverage Ratio

Debt Service Coverage Ratio measures the ability to pay obligations related to long-term debt.

Table G. Example Calculation: Debt Service Coverage Ratio

	2009	2010	2011
Debt Service Coverage Ratio			
Change in Net Assets [Z]	64,000	87,000	159,000
Interest Expense [V]	28,000	17,000	13,000
Depreciation Expense [U]	229,000	218,000	211,000
Total [Z+V+U]	321,000	322,000	383,000
Principal Payments [AA]	169,000	145,000	90,000
Interest Payments [BB]	28,000	17,000	10,000
Total [AA+BB]	197,000	162,000	100,000
Debt Service Coverage Ratio [[Z+V+U]/[AA+BB]]	**1.6**	**2.0**	**3.8**

The measure reflects the availability of capital after debt obligations have been satisfied. The debt service coverage represents a key ratio in determining the ability of an organization to take on additional debt, whether for IT, equipment or a building project. The higher the value of the debt service coverage ratio, the greater the "cushion" to repay outstanding debt or take on additional obligations. Favorable values are **above** the median, and the 2010 CAH U.S. Median = **2.58**.

7. Salaries to Net Patient Revenue

Salaries to Net Patient Revenue measures labor costs relative to the generation of operating revenue from patient care.

Table H. Example Calculation: Salaries to Net Patient Revenue

	2009	2010	2011
Salaries to Net Patient Revenue			
Salaries [T]	2,895,000	2,908,000	2,958,000
Net Patient Revenue [Q]	5,195,000	5,330,000	5,388,000
Salaries to Net Patient Revenue [T/Q]	**56%**	**55%**	**55%**

Salaries are a major part of the expense structure and require close management. Reviewing the costs can help a CAH assess its staffing efficiency. Favorable values are **below** the median, and the 2010 CAH U.S. Median = **44.78%**.

8. Payor Mix Percentage

Payor Mix Percentage is the proportion of patients represented by each payor type. As displayed below, inpatient and outpatient payor mix are calculated differently. **Inpatient Payor Mix** measures the percentage of total inpatient days that are provided to patients of each payor type. The 2010 CAH U.S. Median for Medicare inpatient payor mix was 72.59%. Favorable values are **below** the median.

$$\frac{\text{Inpatient Days for Payor}}{\text{Total Inpatient Days} - \text{Nursery Bed Days} - \text{Nursing Facility Swing Bed Days}}$$

Outpatient Payor Mix measures the percentage of total outpatient charges that are for patients of each payor type.

$$\frac{\text{Outpatient Charges for Payor}}{\text{Total Outpatient Charges}}$$

Payor mix percentages are particularly important in estimating provider revenue, because the final reimbursement amount for any patient ultimately depends on the payment source. For CAHs, reimbursement for Medicare is 101% of costs. Real costs for Medicare patients are already below 100% since some cost, such as physician recruiting, are not reimbursed by Medicare. The only alternative source of profits is providing services to privately insured patients. It is often the challenge of rural health care providers to operate profitably with a patient population that is comprised of more Medicare and Medicaid business than urban providers.

9. Average Age of Plant

Average Age of Plant measures the average age in years of the buildings and equipment of an organization.

Table I. Example Calculation: Average Age of Plant

	2009	2010	2011
Average Age of Plant			
Accumulated Depreciation [E]	1,874,000	1,755,000	1,896,000
Depreciation Expense [U]	229,000	218,000	211,000
Average Age of Plant [E/U]	**8.2**	**8.1**	**9.0**

Lower, decreasing values indicate a newer facility or more frequent reinvestments in buildings or equipment over time. The status of newer facilities has been shown to have a positive effect on the recruitment and retention of physicians and staff, for example. Average age of plant is a good indicator of distress with older hospitals having greater problems. Favorable values are **below** the median, and the 2010 CAH U.S. Median = **9.87 years**.

10. Long Term Debt to Capitalization

Long Term Debt to Capitalization measures the percentage of net assets (or equity) that is debt.

Table J. Example Calculation: Long Term Debt to Capitalization

	2009	2010	2011
Long Term Debt to Capitalization			
Long Term Capital Liabilities [K]	186,000	183,000	178,000
Net Assets [M]	1,835,000	2,173,000	2,694,000
Long Term Debt to Capitalization [K/[K+M]]	**9.2%**	**7.8%**	**6.2%**

This ratio measures the amount of capital that is financed with debt, which is important to lenders for long term viability. Higher values signify a riskier situation and may have a harder time sustaining debt payments in the future and/or getting financing from lenders. Favorable values are **below** the median, and the 2010 CAH U.S. Median = **26.37%**.

FINANCIAL DISTRESS MODEL

The CAH Financial Distress Model was developed by researchers from the North Carolina Rural Health Research and Policy Analysis Center at University of North

Carolina at Chapel Hill.[1] A well-functioning prediction model, such as this, can be used as an early warning system to identify hospitals at increased risk of facing financial distress. State Medicare Flex Programs, CAH CEOs and boards reviewing the model could identify areas of particular distress and develop strategies, or interventions, to improve financial performance.

Today's characteristics (recent financial performance and measures of a market in which a hospital operates) are used to assign CAHs to one of four "risk levels" that predict whether a CAH will be in financial distress two years later. Many financial performance and market characteristics were considered for inclusion. The final model was selected due to its ability to predict performance in a straightforward manner. Variables used in the model are noted below in Table K.

Table K. Descriptive Measures of Variables Included in CAH Financial Distress Model

Financial Performance	
Variable	**Description**
Profitability	Earnings before interest and taxes divided by total assets, operating margin and the 2-year change in operating margin
Reinvestment	Retained earnings divided by total assets
Hospital Size	Net patient revenue
Market Characteristics	
Variable	**Description**
Competition	Distance to the nearest hospital with at least 100 beds and percent market share, if less than 25 percent
Economic Status	Percent unemployment in the market area
Market Size	Population in the market area
Financial Distress Signals	
Variable	**Description**
Equity Decline	Whether the fund balance declined more than 25% and whether the fund balance was negative
Unprofitability	Indicator variables for a negative cash flow margin and three consecutive years of negative operating margin
Closure	Whether the hospital closed

The model separates hospitals into risk of financial distress categories; hospitals in the highest risk category had up to 15 times the rate of financial distress events as hospitals in the lowest category. Financial distress events include:

[1] Mark Holmes, PhD and George H. Pink, PhD; North Carolina Rural Health Research and Policy Analysis Center, University of North Carolina at Chapel Hill

- Closure;
- Negative fund balance;
- Declining (>25%) fund balance;
- 3 years negative operating margin; and,
- Negative cash flow margin.

Accurate assignment of hospitals to categories that reflect low, mid-low, mid-high and high risk of financial distress can provide an effective early warning system to CAHs, allowing CAH Administrators and state Medicare Flex Program Coordinators to target efforts to those at higher risk. A *Financial Indicators Report* is provided to individual CAHs late each summer, with a state summary report provided to the state Medicare Flex Programs. For more information, please visit: http://flexmonitoring.org/indicators.html. Many of the financial indicators chosen by Summit participants as most indicative of financial performance are included in the financial distress model which is described above. The Summit participants agreed that the financial distress model is a beneficial prediction model for CAH and state Medicare Flex Program personnel to review annually.

CAH FINANCIAL INTERVENTIONS

A number of significant financial improvement interventions were identified by the Summit participants as a means of optimizing the financial performance of CAHs.

Review and Assessment

Cost Report Review and Strategy

A review of the CAH cost report can be conducted by an outside party to look for common errors in preparation. Because it drives Medicare payments, errors on the cost report directly affect the hospital's bottom line. Errors may include incorrect allocations of expenses and inaccurate statistics, for example. Most cost reports are "outsourced" to accounting firms, but understanding direct and indirect costs and how cost reports work is critical input to making sound decisions for CEOs and CFOs.

Strategic, Financial and Operational Assessments

Strategic, financial and operational assessments help identify specific opportunities for CAH improvement. These studies provide an objective review of the areas where many CAHs need help, including:

- Matching services to community needs;
- Staffing to benchmarks;
- Clinic management;

- Medical staff planning; and,
- Organizational culture.

Assessments are recommended periodically to determine areas of focus for follow-up improvement work.

Revenue Cycle Management

Reviews and training workshops can help CAHs identify opportunities for improvement and directions on how to implement them. These activities should result in specific recommendations and action plans, which may lead to substantial amounts of additional revenue. Specific areas of focus may include:

- Comprehensive chargemaster and revenue cycle review;
- Business office and patient financial services review;
- Development of training protocols for revenue capture;
- Implementation of an effective revenue control process;
- Pricing analysis;
- Recovery Audit Contractor (RAC) preparedness and revenue cycle process improvement; and,
- Revenue process capture audits.

Physician Practice Management Assessments

As more and more physicians align and become employees of CAHs, it is critically important to contract with physicians and operate the clinics according to best practices. A practice management assessment looks at physician and mid-level provider productivity, scheduling, staffing, billing and collection practices specific to this area. These assessments should result in specific recommendations and action plans that have the potential to bring in additional revenue and improve clinic efficiency.

Education

Lean Process Improvement Training

Lean focuses on increasing efficiency and eliminating waste. This creates greater value for customers and uses fewer resources. In the health care setting, Lean processes can result in substantial cost savings, fewer delays and increased patient and staff satisfaction. Lean education, Lean networks and shared Lean expertise have all been successfully used by individual CAHs and networks of rural hospitals.

Financial Education for CAH Department Managers

CAH department managers often lack basic skills in budgeting, financial planning and financial management. Education targeted specifically to managers can enhance financial capabilities in each of these important skill areas. This type of financial education has been done successfully with rural hospitals using both on-site workshops and web-based presentations, which are often stored and accessible online.

Financial Education for CAH Boards

Financial education for CAH Boards provides a fundamental grounding on cost-based reimbursement and CAH financial strategies. Hospital financial management is complex and rural hospital boards need a basic understanding of CAH finances to provided needed oversight. Again, education of this type can be done online via web-based modules and on-site.

Collaboration

Pooling Small Rural Hospital Improvement Program (SHIP) Dollars

Pooling SHIP dollars among a group of CAHs has provided an effective means of providing financial or Lean education to hospital staff and boards. Economies of scale, shared expertise, access to speakers and resources, and peer learning and support have all been reported as outcomes of pooling resources.

Developing CFO Networks

CFO networks have proven to be a popular method of education, peer learning and peer support. In more than a dozen states, rural hospital CFOs meet periodically, either in person or virtually, to discuss common issues, gain new skills and share experiences and techniques.

Benchmarking Financial Indicators

Benchmarking financial outcomes among groups of hospitals is a common means of measuring performance and comparing results. By collaboratively comparing results, CAHs identify areas of strengths and weaknesses and measure progress toward strategic goals. This collective benchmarking also provides an opportunity for the hospitals to share common issues, best practices and lessons learned. The University of North Carolina-Chapel Hill's distribution of an annual *CAH Financial Indicators Report* is a useful source for benchmarking, but other information sources are also available.

LOOKING AHEAD

Changes in the health care market place are expected to accelerate. The intense focus on the Triple Aim (population health, higher quality, lower cost) will provide important challenges to rural hospitals and their communities. CAHs cannot afford to remain on the sidelines. Instead, CAHs should actively position themselves for the transformed payment systems which will include:

- Emphasis on value over volume;
- Quality incentives and penalties; and,
- Overall reductions in revenue.

Changes in Medicare and Medicaid payment and delivery systems are anticipated to have the following impact:

- Increased pressure on operating margins caused by payment reductions, both federal and state;
- Physician integration will be necessary to support accountable care models;
- Capital will be required to implement a sound physician alignment strategy;
- Quality will drive reimbursement levels and will become a market differentiator;
- Quality reporting will require the development of a more sophisticated infrastructure; and,
- Collaboration and effective alignment with the physician-provider community will be imperative as health care moves away from a volume-based system to a value-based system.

$$\text{Patient Value} = \frac{\text{Quality + Service}}{\text{Cost}}$$

As CAHs begin to understand their future value, they will need to look at their economic value in a new world consisting of transitioned payments.

The challenges rural hospitals face are not insurmountable. To meet them head on will require a strong commitment to the communities served, as well as the desire to problem solve and work collaboratively. This commitment, desire and collaboration are qualities that define rural hospitals and rural leaders. Because they are the lifelines for the residents that they call neighbors, rural hospitals can lead the way in transforming the American health care system. They are smaller, less complex and, therefore, able to change quicker than their urban counterparts. Rural hospitals are also more closely connected to their local communities than their urban counterparts. Transformational change will be difficult and will take time and energy to implement. Rural hospitals must begin now to prepare for the future.

CONCLUSION

CAHs must address current financial challenges while preparing for their place in the future American health care system. This paper, a product of the 2012 CAH Financial Leadership Summit meeting, has suggested strategies, resources, indicators, interventions and information that should be of value to both CAHs and state Medicare Flex Programs. It will be important to closely monitor the financial performance of CAHs and to document the outcomes of specific financial improvement interventions. State Medicare Flex Programs will be an important resource to support rural hospitals in the anticipated transition to a value-based health system.

APPENDIX

EXAMPLE CRITICAL ACCESS HOSPITAL

BALANCE SHEET

		2009	2010	2011
ASSETS				
	Current Assets:			
A	Cash and Temporary Investments	1,120,000	1,280,000	1,831,000
B	Patient Accounts Receivable, Gross	1,001,000	1,012,000	993,000
C	Less: Provision for Doubtful Accounts	(230,000)	(210,000)	(215,000)
	Other Accounts Receivable	-	24,000	24,000
	Supplies	162,000	169,000	169,000
	Other Current Assets	68,000	57,000	57,000
D	Total Current Assets	2,121,000	2,332,000	2,859,000
	Property, Plant and Equipment:	2,663,000	2,612,000	2,712,000
E	Less: Accumulated Depreciation	(1,874,000)	(1,755,000)	(1,896,000)
	Net Fixed Assets	789,000	857,000	816,000
F	TOTAL ASSETS	2,910,000	3,189,000	3,675,000
LIABILITIES AND NET ASSETS				
	Current Liabilities:			
G	Current Portion of Long Term Debt	144,000	89,000	49,000
H	Accounts Payable and Accrued Liabilities	115,000	148,000	158,000
	Estimated Amounts Due to Third Party	260,000	226,000	226,000
I	Other Current Liabilities	370,000	370,000	370,000
J	Total Current Liabilities	889,000	833,000	803,000
K	Long Term Debt, Net of Current Portion	186,000	183,000	178,000
L	TOTAL LIABILITIES	1,075,000	1,016,000	981,000
NET ASSETS				
M	Accumulated Earnings (Deficit)	1,835,000	2,173,000	2,694,000
	TOTAL LIABILITIES AND NET ASSETS	2,910,000	3,189,000	3,675,000

EXAMPLE CRITICAL ACCESS HOSPITAL
STATEMENT OF OPERATIONS

		2009	2010	2011
REVENUE				
N	Total Inpatient Revenue	2,402,000	2,445,000	2,471,000
O	Total Outpatient Revenue	3,993,000	4,015,000	4,032,000
P	Total Gross Revenue	6,395,000	6,460,000	6,503,000
	Less: Contractual Allowances	(1,200,000)	(1,130,000)	(1,115,000)
Q	Net Patient Revenue	5,195,000	5,330,000	5,388,000
	Other Operating Revenue	486,000	427,000	492,000
R	Total Operating Revenue	5,681,000	5,757,000	5,880,000
	Gain (Loss) on PP&E Disposal	(2,000)	(3,000)	-
	Contributions/Grants	65,000	69,000	77,000
	Investment Income	8,000	11,000	19,000
S	Total Revenue	5,752,000	5,834,000	5,976,000
EXPENSES				
T	Salaries	2,895,000	2,908,000	2,958,000
	Benefits, Supplies, & Other	2,434,000	2,497,000	2,509,000
U	Depreciation and Amortization	229,000	218,000	211,000
V	Interest	28,000	17,000	13,000
W	Provision for Doubtful Accounts/Bad Debt	102,000	107,000	126,000
X	Total Expenses	5,688,000	5,747,000	5,817,000
Y	EXCESS OF REVENUES OVER EXPENSES	64,000	87,000	159,000
	Restricted Contributions		-	-
Z	CHANGE IN NET ASSETS	64,000	87,000	159,000

EXAMPLE CRITICAL ACCESS HOSPITAL
STATEMENT OF CASH FLOWS

	2009	2010	2011
CASH FLOWS FROM OPERATING ACTIVITIES			
Change in Net Assets	522,000	547,000	542,000
Adjustments to reconcile change in net cash provided by operating activities:	246,000	459,000	(210,000)
Purchase of Other Assets	(3,000)	(6,000)	-
Other Current Liabilities	34,000	-	-
Net Cash Provided by Operating Activities	799,000	1,000,000	332,000
CASH FLOWS FROM FINANCING ACTIVITIES			
AA Repayment of Debt	(169,000)	(145,000)	(90,000)
Purchases of PP&E	(63,000)	(189,000)	(100,000)
BB Interest Paid on Long Term Debt	(28,000)	(17,000)	(10,000)
Gifts to Purchase Capital Assets	46,000	-	-
Net Cash Used by Investing Activities	(214,000)	(351,000)	(200,000)
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest and Dividends on Investments	8,000	11,000	19,000
Net Cash Used by Investing Activities	8,000	11,000	19,000
NET INCREASE (DECREASE) IN CASH	593,000	660,000	151,000
CASH, BEGINNING OF YEAR	527,000	1,120,000	1,780,000
CASH, END OF YEAR	1,120,000	1,780,000	1,931,000