

# Financial Statement Overview

## LANGUAGE OF FINANCIAL DECISIONS

Accounting is the system that measures business activities by processing information into reports, and communicating the findings to decision makers. It is not bookkeeping! Here's a tidbit for you: Did you know that bookkeeping is the only word in the English language that has three double letters? Bookkeeping is a procedural element of accounting, just as arithmetic is a procedural element of mathematics. Bookkeeping is the record keeping part of accounting. Beware of oversophisticated accounting procedures. Keep to the basics.

All businesses must retain/maintain accounting records. These form the source document, and are not necessarily financial statements.

### Why It Matters

- Industry experts estimate that the cost of inefficiencies is currently at least 20 to 30 percent of revenues. Most health care entities are suffering from lack of profits, not lack of revenues.
- Market share is being captured by low-cost/high-quality providers.
- Increasing revenue may lead to lower margins.

- It is necessary to establish fees, insurance agreements, financial policies and billing procedures.

## **Know Where You're Going**

A favorite phrase is "You have to know where you're going before you can know when you've arrived." This fundamental idea has guided us through a lot of messes over the years. What should we see, what result is reasonable, what is supposed to be the answer? In other words, if theory were applied to the situation at hand, what would the outcome be?

Here we are, in a very complex, changing environment with competition intruding and the government intervening from every angle, and "health care" becoming the buzz word in political campaigns. Service providers are asking, "How do we fight back?" The answer is simple: Become more sophisticated. We didn't say that the financial statement process must become more sophisticated, but that the decision makers must. The first step is to form a clear vision of where you are going or want to go. What obstacles have to be overcome? What contributions do you feel are warranted by you and the team around you? Your vision of the elements of effective practice management may differ somewhat from the following, but ours may influence you:

- Service-oriented personnel (teamwork and cross training)
- Financial planning and budget analysis
- Well-designed physical facility
- Written policies/procedures and appropriate job descriptions
- Efficient collections and accounts receivable follow-up
- Good information systems/practice management software
- Appropriate coding and medical records management

In addition to "you have to know where you're going," you have to have some perspective of what happens in a typical physician practice if you intend to affect the results in a way that will eventually be re-

flected in the financial statements. In actuality, the financial statements are the report card of the business—the conscience of the business. Exhibit 1.1 outlines a typical service delivery routine in a physician practice.

### **Know When You've Arrived**

The financial statement process, as noted earlier, is not bookkeeping—although bookkeeping is a requisite element of the financial statement process.

### **Know Where You're Going, Revisited**

Now that we understand the work flow in a medical practice, we need to apply the same thought process to understanding the financial statement process. It is difficult to identify when and where the financial statement process actually begins, so we will not elaborate on that point here. Let it suffice to say that at some point the process begins, and it is your task to summarize the individual processes in a meaningful output, that being the financial statement.

The *financial statement* is a culmination of many tasks, gathering information from many sources, analysis of perceived variances, and confirmation of balances with third-party information. The *chart of accounts*, discussed in chapter 2, is the basis for presenting the financial statement information in a format that is acceptable to the user. In many instances, the user is not informed of alternatives to this presentation style and, more often than not, does not know what to ask for. The traditional process for financial statement review is that the user gets a financial statement prepared internally or by an outside accountant, opens the statements to review the cash balance or some other account that he/she generally believes to be the representation of where the company is financially, and then quickly stuffs the statement in a cabinet, never to be bothered again. This is where, in our opinion, opportunity abounds. Expectation is often low to nonexistent although the information is available. All that is needed from the preparer and the user are creativity and a thorough understanding of the financial statement process.

**Exhibit 1.1**Typical routine of physician service delivery

---

## Patient check-in:

- ✓ Demographic information is obtained
- ✓ Past medical history is obtained
- ✓ Insurance information (referral and authorization numbers) is obtained and verified
- ✓ Superbill/encounter form is prepared and attached to chart
- ✓ Demographics are entered into computer system
- ✓ Patient name is recorded on daily summary (paper system)
- ✓ Patient name is checked off on schedule and sign-in sheet
- ✓ Patient waits

## Patient service delivery

- ✓ Back office performs procedures
- ✓ Physician or nurse codes superbill (denotes services performed)
- ✓ CPT codes and ICD-9 codes are checked
- ✓ Additional tests, outgoing appointment are scheduled by back office
- ✓ Follow-up appointment is made

## Charges:

- ✓ Encounter forms are picked up at check-out area
- ✓ Encounter forms are examined for clarity, then properly coded and prepared for charge entry (includes verification of financial information, if not already completed)
- ✓ Charges are keyed into computer system
- ✓ Charges are recorded on daily summary
- ✓ Encounter forms are compared with patient sign-in sheet

## Payments:

- ✓ Co-pays are collected
- ✓ Fees are collected
- ✓ Payments are keyed into computer system
- ✓ Payments are recorded on daily summary
- ✓ Money is deposited

## Insurance claims and statements:

- ✓ Insurance claims are generated the same or following day and are QA'd by a claims control system
- ✓ Claims are electronically transmitted
- ✓ Statements are generated daily
- ✓ Information is entered into daily production report, permitting monitoring of the daily balance necessary for EOM purposes

**Exhibit 1.1** (Continued)

## End-of-day procedures:

- ✓ Daily summary is balanced
- ✓ Daily reconciliation is completed
- ✓ Encounter forms, daily summary, and system report are reconciled
- ✓ Deposit slip is gathered
- ✓ Insurance claims and statements are generated

## Reimbursement:

- ✓ Payment, including daily pickup of lock box deposit from bank, is entered
- ✓ Electronic remittance is input to system
- ✓ Payments in computer system are confirmed against pertinent account

## Follow-up:

- ✓ Private pay and insurance accounts are reviewed daily
- ✓ Edit reports and unacceptable electronic transmits are worked and corrected
- ✓ Insurance companies are contacted
- ✓ “Largest, oldest, first”—The biggest and oldest balances handled first

## Collections:

- ✓ All EOB's are examined for low payments, denials, and unacceptable UCR
- ✓ Insurance companies are contacted
- ✓ All accounts aged 90 days or more are examined for possible turnover to collection agency
- ✓ Collection letters are sent out
- ✓ Accounts are sent to collection agency
- ✓ Bad debt recovery is monitored closely

**UNDERSTANDING THE FINANCIAL STATEMENT PROCESS****Normal Balances of Accounts**

The sum of the increases recorded in an account is usually equal to or greater than the sum of the decreases recorded in the account. For this reason, the normal balances of all accounts are positive rather than negative. For example, the total debits (increases) in an asset account will ordinarily be greater than the total credits (decreases). Thus, asset accounts normally have debit balances.

The rules of debits and credits and the normal balances of the various types of accounts are summarized in Exhibit 1.2. Note that the

**Exhibit 1.2**  
Rules of debits, credits, and normal balances

<b>Balance Sheet Accounts</b>	<b>Increase</b>	<b>Decrease</b>	<b>Normal Balance</b>
Assets	Debit	Credit	Debit
Liabilities	Credit	Debit	Credit
Owner's Equity—Capital and Retained Earnings	Credit	Debit	Credit
Drawing and Dividends	Debit	Credit	Debit
<b>Income Statement Accounts</b>			
Revenue	Credit	Debit	Credit
Expenses	Debit	Credit	Debit

drawing, dividend, and expense accounts are considered in the positive sense. Increases in these accounts, which represent decreases in the owner's equity, are recorded as debits. When an account that normally has a debit balance actually has a credit balance, or vice versa, it indicates either an accounting error or some unusual situation that should be investigated. For example, a credit balance in the office equipment account could result from an accounting error; a debit balance in an accounts payable account could result from an overpayment.

A handy acronym tossed around from time to time is DEACLR, meaning that the normal debit (D) accounts are expenses (E) and assets (A), and the normal credit (C) accounts are liabilities (L) and revenue (R). Stated another way, debits are expenses and assets, credits are liabilities and revenue. If you know what you should see, then you can deal with information that differs from what you expect.

### **Cash versus Accrual Method of Accounting**

In situations in which the presentation blurs the distinction between the cash and accrual methods of accounting, the accrual method should be presented as the overriding one (see chapter 3 for a more in-depth discussion of these two types of accounting). In our opinion, the accrual method presents a more thorough summary of operations and financial position at a given point in time. The cash method or modified cash method is a means of determining cash flow; it is used to min-

imize exposure to income tax on revenue to be collected in the future, that is, accounts receivable. It is also the easier method to manipulate. For example, let's assume that on November 30 the practice has a year-to-date profit of \$125,000 after all traditional modified cash basis accruals are deducted. Let's further assume that the practice normally generates a profit in December of \$25,000. So it is anticipated that the practice will have taxable income for the year of \$150,000. The practice's patients want to make sure they use their respective cafeteria plan balances before year end. Herein lies a classic example of competing goals—those of the practice versus those of the patient.

Under the cash method of accounting, the practice would generally encourage patients to postpone payment until after being notified by the insurance company of their co-payment obligations. Understanding the rules regarding their patient's cafeteria plans is bonus: The practice knows that the definition of benefits is dependent on the date of service and not the date of payment. Therefore the staff can explain to the patients that they are making a holiday gesture and can encourage them to postpone payment until the following year. The practice would also postpone invoicing the insurance carrier and at the same time would purchase additional supplies and pay any obligations that would not ordinarily be accrued. This could easily result in a significant change in taxable income.

On the other hand, the accrual method of accounting would require that the practice identify accounts receivable that may need to be written off as uncollectable as well as expenses that should be accrued; purchase supplies that would normally be consumed over the next thirty days; and pay taxes on the balance. The objective is the same, the outcome probably quite different, and the direction for the most part different as well.

As mentioned before, the accrual method of accounting more accurately presents the results of operations and financial position at a specific point in time. Accrual method accounting is less susceptible to manipulation due to short-term timing differences. Further, it is not the favored method of accounting for medical practices, which generally have significant accounts receivable balances. No one wants to pay income tax on phantom income—and receivables, uncollected, are phantom income. It is doubtful that anything presented here will alter that perspective. Therefore, the accounting system should accommodate both theories of presentation. For management of the practice,

use the accrual basis financial statement presentation style; for income tax reporting, use the modified cash method.

The accrual method of accounting records revenues as earned and expenses as incurred. In other words, revenue is recorded when services are rendered regardless of when they are billed to third-party payers; and expenses are recorded when the obligation to pay becomes fixed, following the same logical process you would use for your personal expenses. When you buy something you owe for it. Using a credit card doesn't change the fact that you just purchased something. You just repositioned whom and when you will pay.

If the intent is to share information with banks or other lending institutions, it would be in the best interest of the borrower to present accrual basis financial statements. Without sharing information about receivables relative to a medical practice and due to income tax planning that generally takes place relative to reportable income, the chances of securing a loan would be minimal at best if you presented cash basis financial statements.

The cash method is, as it implies, the reporting of transactions as they are paid or when cash is received. Generally, most practices use what is referred to as "modified cash basis" reporting, in which they record some liabilities before cash is actually paid but rarely record revenue before cash is received—a little like getting your cake and eating it too.

Unless a medical practice maintains an inventory of goods for resale to patients, it can use the modified cash basis of accounting for income tax reporting. If it does maintain such an inventory, it must use the accrual basis for tax reporting. An example of a medical practice that would be required to use the accrual basis is an optometry practice that sells eyeglasses and contact lenses.

A textbook example of a typical medical expense, the reporting for which differs significantly under these methods, is professional liability (or malpractice) insurance. Generally, the premium is paid annually or semiannually and is paid prior to the coverage period. Therefore, it is a prepaid expense because the benefit (i.e., coverage) has not commenced. To illustrate the recording of this transaction please review the journal entries in Exhibit 1.3.

To record January's expense for malpractice insurance for Doctor Domino, the same second entry would be made at the end of every month through June. At the end of the six-month period the account

**Exhibit 1.3**  
Journal entry—transaction

---

**Cash Method**

Dr	Professional Liability Insurance	\$6,000	
Cr	Cash in Bank		\$6,000

To record Doctor Domino's malpractice insurance for the period January 1, 2000, through June 30, 2000.

**Accrual Method**

Dr	Prepaid Expense—Professional Liability Insurance	\$6,000	
Cr	Cash in Bank		\$6,000

To record payment of Doctor Domino's malpractice insurance for the period January 1, 2000, through June 30, 2000

**To Record/Post Expense for Current Month**

Dr	Professional Liability Insurance	\$1,000	
Cr	Prepaid Expense—Professional Liability Insurance		\$1,000

---

balances will be exactly the same as reported under the cash method. However, during the course of the six-month period, under the accrual basis, management has the opportunity to evaluate the practice on a monthly basis with the advantage of a more accurate recurring cost structure; whereas under the cash method, only the June 30 statement would be of similar usefulness. This is a significant improvement in opportunity through a minor change in presentation.

Another significant deviation between the methods of presentation is that under the cash method, practices tend not to monitor as closely the bad debt experience of their operations as compared to those of their peer group. Out of sight, out of mind, as the adage goes, and so goes the profit!

### Ratio/Percentage Analysis

In most instances, presentation follows method, as prescribed in accounting literature. The ideal is to present data in the manner that best informs the reader. All too often data are presented in the controllable/noncontrollable format with percentages based on total revenue. Review Exhibit 1.4 and the alternative presentation in Exhibit 1.5

**Exhibit 1.4**

Dr. Quizno Clinics statement of revenue and expense—modified cash basis  
August 31, 1998 and 1997

	Actual			Percentages	
	1998	1997	Variance	1998	1997
Service fee revenue	1,328	896	432	0.10%	0.07%
Income—professional services	1,014,128	965,979	48,149	76.34%	80.62%
Lab fee revenue	257,334	209,814	47,520	19.37%	17.51%
Radiology/imaging revenue	55,630	21,554	34,076	4.19%	1.80%
<b>Total net revenue</b>	<b>1,328,420</b>	<b>1,198,243</b>	<b>130,177</b>	<b>100.00%</b>	<b>100.00%</b>
<b>Non-physician expenses</b>					
Non-physician salaries	348,431	367,798	19,367	26.23%	30.69%
Non-physician benefits	53,176	73,849	20,673	4.00%	6.16%
Information services	22,478	24,550	2,072	1.69%	2.05%
Laboratory expenses	43,904	41,368	(2,536)	3.30%	3.45%
Radiology/imaging expenses	38,941	10,777	(28,164)	2.93%	0.90%
Medical/surgical supplies	89,992	121,956	31,964	6.77%	10.18%
Building/occupancy costs	139,186	141,669	2,483	10.48%	11.82%
Equipment lease expenses	23,914	2,194	(21,720)	1.80%	0.18%
Admin. supplies/service expenses	11,580	19,282	7,702	0.87%	1.61%
Outside services	99,779	59,632	(40,147)	7.51%	4.98%
Promotion/marketing	4,685	14,448	9,763	0.35%	1.21%
Recruiting expenses	8,048	6,413	(1,635)	0.61%	0.54%
Other operating expenses	31,068	3,155	(27,913)	2.34%	0.26%
Interest expenses	54,386	90,614	36,228	4.09%	7.56%
Total non-physician costs	969,568	977,705	8,137	72.99%	81.59%
<b>Net revenue before distribution</b>	<b>358,852</b>	<b>220,538</b>	<b>138,314</b>	<b>27.01%</b>	<b>18.41%</b>
Physician salaries/advances	327,365	275,425	(51,940)	24.64%	22.98%

for an example of using data, through accounting analysis, to supply the reader with critical information.

Based on the income statement in Exhibit 1.4, one might conclude that the practice is doing quite well as compared to the prior year. Net revenue before distribution is up 63% over the prior year, while net revenue is up only 11%. The clinic has made significant improvements in controlling costs while at the same time increasing revenue.

**Exhibit 1.5**

Dr. Quizno Clinics statement of revenue and expense—modified cash basis  
August 31, 1998 and 1997

	Actual			Percentages	
	1998	1997	Variance	1998	1997
Service fee revenue	1,328	896	432	0.10%	0.07%
Services—physician	760,596	821,082	(60,486)	56.97%	68.53%
—non-provider	253,532	144,897	108,635	19.09%	12.09%
Lab fee revenue	257,334	209,814	47,520	19.37%	17.51%
Radiology/imaging revenue	55,630	21,554	34,076	4.19%	1.80%
<b>Total net revenue</b>	<b>1,328,420</b>	<b>1,198,243</b>	<b>130,177</b>	<b>100.00%</b>	<b>100.00%</b>
<b>Non-physician expenses</b>					
Physician's asst./nurses	106,300	89,760	16,540	41.93%	61.95%
RN/LPN	85,095	105,437	20,342	33.56%	72.77%
Total direct patient wages	191,395	195,197	3,802	75.49%	134.71%
Lab research / technician	63,008	84,209	21,201	24.48%	40.14%
Administrative services	46,028	45,392	(636)	3.46%	3.79%
Business managers	48,000	43,000	(5,000)	3.61%	3.59%
Total non-physician wages	348,431	367,798	19,367	26.23%	30.69%
Non-physician benefits	53,176	73,849	20,673	4.00%	6.16%
Information services	22,478	24,550	2,072	1.69%	2.05%
Laboratory expenses	43,904	41,368	(2,536)	3.30%	3.45%
Radiology/imaging expenses	38,941	10,777	(28,164)	2.93%	0.90%
Medical/surgical supplies	89,992	121,956	31,964	6.77%	10.18%
Building/occupancy costs	139,186	141,669	2,483	10.48%	11.82%
Other operating expenses	31,068	3,155	(27,913)	2.34%	4.44%
Interest expenses	54,386	90,614	36,228	4.09%	7.56%
Grouping for presentation	148,006	101,969	(46,037)	11.14%	8.51%
Total non-physician costs	969,568	977,705	8,137	72.99%	81.59%
<b>Net revenue before distribution</b>					
	358,852	220,538	138,314	27.01%	18.41%
Physician salaries/advances	327,365	275,425	(51,940)	24.64%	22.98%

Now take this same data, modify the format, adjust the presentation (as in Exhibit 1.5), and see if your conclusions remain the same.

The only thing to change in the presentation in Exhibit 1.5 is the wage section. Note how Lab Research/Technician wages decreased by 25%, but as a percentage of Lab Fee Revenue, the costs dropped by 39%—a significant improvement in costs associated with a respectable

increase in revenue. This presentation uses available information to inform the user of changes in patterns that impact the bottom line. Please remember that you must educate the user whenever you make presentation changes such as this and when subsequent modifications occur. The following paragraphs explain the presentation modifications that are presented in Exhibit 1.5.

The Total Direct Patient Wages as a percentage of revenue is based on Services—Non-Provider and not Total Net Revenue. Why? It is perceived that the wages associated with this category are directly involved in the delivery of professional services to the patient and not in the other categories of revenue.

The Lab/Research Technician wages are calculated as a percentage of Lab Fee Revenue. Why should we consider anything else? Why shouldn't we monitor the wage costs classification to revenue from the same specialization? No, we are not ignoring the value of retaining specialists on staff who contribute to the goodwill and overall efficiency of the practice; but ignoring that there is a *definable* value in relation to this *perceived* value is not prudent business management.

The wages for Administrative Services and Business Managers are calculated as a percentage of Total Net Revenue as the allocation of costs exceeds the benefits to be derived from any greater specificity (for purposes of reviewing and monitoring interim financial statements).

Please note that the calculation of Total Non-Physician Wages as a percentage of Total Net Revenue is no different than that in the previous example. Yes, the columns no longer foot/total and do not follow traditional accounting literature, but the benefits to be derived outweigh the negatives of footings.

Total Direct Patient Wages as a percentage of Services—Non-Provider is 75.49% as compared to 134.71%. Provided the practice implemented some monitoring strategy for improving efficiency, its members should be pleased to see the results in a readable and meaningful format. The Physician's Assistant/Nurses wage as compared to the RN/LPN wage implies that the change from non-direct assistants to direct is more efficient.

Let's take this example one step further for the analysis of other categories that also impact the bottom line. Please note the change in costs for Radiology/Imaging Expenses, now presented as a percent-

age of Radiology/Imaging Revenue. The analysis doesn't stop here; there are a significant number of other opportunities.

Many other presentation opportunities are available, such as monitoring bad debt expense as a percentage of specific receivable categories. Here also is a significant issue; most current practices' accounts receivable programs are not integrated with their accounting software, requiring significant manual reconciliation between the accounts. Often due to the burdens of reconciliation, many practices put their receivables monitoring on so-called "autopilot." Managing receivables creates a significant amount of revenue. You see, if you really evaluate receivables, they represent 100% revenue! All costs of the clinic have already been incurred. It would be wise for a practice to present an interest charge on receivables (see Exhibit 1.6) as part of the revenue section of the income statement.

### **Current Assets/Liabilities**

Classification as "current" implies that the asset will be consumed or the liability paid within the next 12 months. These balances are usually verified on an annual basis. When preparing interim financial statements, maintain the perspective of "current" as being the next 12 months. For example, the balance in the current maturity-L/T debt account is not reduced on a monthly basis by the principal portion of the debt and then replenished on the accounting anniversary. A rolling 12-month balance is maintained. It is also questionable to move the net change in current maturities on a monthly basis. The accuracy of the financial statements is not significantly improved. We suggest that, as in the example, the current portion be reflected on an annual basis with the monthly adjustment for payments of principal being posted to the long-term portion of the liability.

### *Various Journals*

In most businesses, the use of various accounting journals to make journal entries is commonplace. These journals are the Cash Receipts Journal, Cash Disbursements Journal, Sales Journal, Purchases Journal, and the General Journal. Most medical practices do not make use of the Sales and Purchases Journals, as they are primarily used for recording sales on

**Exhibit 1.6**

Dr. Quizno Clinics statement of revenue and expense modified cash basis  
August 31, 1998 and 1997

	Actual			Percentages	
	1998	1997	Variance	1998	1997
Service fee revenue	1,328	896	432	0.10%	0.07%
Services—physician	760,596	821,082	(60,486)	56.97%	68.53%
—non-provider	253,532	144,897	108,635	19.09%	12.09%
Lab fee revenue	257,334	209,814	47,520	19.37%	17.51%
Radiology/imaging revenue	55,630	21,554	34,076	4.19%	1.80%
<b>Total net revenue</b>	<b>1,328,420</b>	<b>1,198,243</b>	<b>130,177</b>	<b>100.00%</b>	<b>100.00%</b>
<b>Non-physician expenses</b>					
Physician's asst./nurses	106,300	89,760	16,540	41.93%	61.95%
RN/LPN	85,095	105,437	20,342	33.56%	72.77%
Total direct patient wages	191,395	195,197	3,802	75.49%	134.71%
Lab research / technician	63,008	84,209	21,201	24.48%	40.14%
Administrative services	46,028	45,392	(636)	3.46%	3.79%
Business managers	48,000	43,000	(5,000)	3.61%	3.59%
Total non-physician wages	348,431	367,798	19,367	26.23%	30.69%
Non-physician benefits	53,176	73,849	20,673	4.00%	6.16%
Information services	22,478	24,550	2,072	1.69%	2.05%
Laboratory expenses	43,904	41,368	(2,536)	3.30%	3.45%
Radiology/imaging expenses	38,941	10,777	(28,164)	70.00%	50.00%
Medical/surgical supplies	89,992	121,956	31,964	6.77%	10.18%
Building/occupancy costs	139,186	141,669	2,483	10.48%	11.82%
Other operating expenses	31,068	3,155	(27,913)	2.34%	4.44%
Interest expenses	54,386	90,614	36,228	4.09%	7.56%
Grouping for presentation	148,006	101,969	(46,037)	11.14%	8.51%
Total non-physician costs	969,568	977,705	8,137	72.99%	81.59%
<b>Net revenue before distribution</b>	<b>358,852</b>	<b>220,538</b>	<b>138,314</b>	<b>27.01%</b>	<b>18.41%</b>
Physician salaries/advances	327,365	275,425	(51,940)	24.64%	22.98%

account and purchases on account. Medical practices typically do not use their accounting system for recording accounts receivable. It is very common for a medical practice to use a completely separate and non-integrated system for accounts receivable management. This is due primarily to the requirements of healthcare in general and to the manner in which accounting and billing are performed for medical practices.

### *Physician Compensation*

Most medical practices, throughout the year, account for monies distributed to the owner/physician as salary. In some cases, this salary is treated just like any other wage compensation paid to other employees; in other cases, it is classified simply as an advance, with no withholding or matching of traditional employer taxes. In the latter case, at the end of the year, an adjusting entry is required to reclassify the advance as a distribution in which the monies are not treated as compensation for income tax reporting purposes. This is based on the level of ownership and the style of reporting for income tax purposes, and is further discussed in chapter 7.

### *Balance Sheet*

The balance sheet is a report card stating the financial health of the organization. It can only make representations based on the facts available to it. It is both a spokesperson sharing available information and a historical picture, explaining to the public what assets the organization has available to meet the demands of rendering services to the public; how it has acquired those assets (through the use of invested or borrowed money); how quickly its obligations can be paid; how well the business has been operated in the past; and whether the owners themselves have enough confidence in the business to invest their own capital. A significant amount of information may be gained through a review of the balance sheet. Therein lies the rationalization for preparing accrual basis financial statements. A stable, profitable business should have a representative balance sheet. It is often difficult to make a similar representation with typical cash basis presentations.

### *Income Statement*

Why is an income statement so important to business owners? Because it indicates to a large degree whether the business has achieved or failed its primary objective: earning a “profit” or net income.

### *Shifts in Practice's Payer Mix*

Many areas of the country have experienced or are experiencing a shift from commercial insurance to managed care. Some areas of the country have experienced a shift from 20 percent managed care to 70 per-

cent in as little as twelve months. Shifts in payer mix will have a significant impact on practice revenue. Failure to recognize this shift and make appropriate adjustments have a detrimental impact on physician compensation.

For example, when a practice has ballooning gross revenues and still is losing money, a thorough evaluation of the payer mix generally will identify the problem. In one organization in which we were involved, the PPO and capitation patients were contributing a first year \$100,000 gross. The physician couldn't understand why accrual basis profits were declining. We found that his costs to treat those patients amounted to nearly \$130,000. Although the shift in payer mix had contributed to the negative impact on profits, in reality, the larger problem was a lack of understanding of the internal cost structure of the practice. The shift in payer mix did result in lower earnings for the practice, but the problem was rooted in not understanding the costs of delivering services to the PPO and capitation patients or in underestimating those costs.

This makes understanding a fee structure and an overhead analysis crucial when considering a proposal that requires a reduction in fees covering a large group. Even the most naïve practitioner immediately understands the concept that it's unwise to work highly skilled fingers clear through their latex gloves to produce a loss. Of course, if you don't know you are handing the equivalent of a five-dollar bill to every patient who gets a blood test, how can there be a problem?

Exhibit 1.7 is a sample chart that can be used to monitor payer mix as it currently exists, and to review quarterly (or at minimum, annu-

**Exhibit 1.7**

Sample chart—monitoring payer mix

---

*Percent of patients in each insurance class:*

Medicare	_____ %
Medicaid	_____ %
Champus	_____ %
Workers' Comp.	_____ %
HMO FFS	_____ %
PPO FFS	_____ %
Capitation	_____ %
Blue Cross/Blue Shield	_____ %
Commercial Pay	_____ %
Self Pay	_____ %

---

ally) the shift that is taking place. The figures should be based on production generated, not production collected.

### *Standard Journal Entries*

A significant number of journal entries to the general ledger on a monthly basis are recurring in nature. In the previous example of malpractice insurance, the recurring entry from prepaids to insurance will occur for at least six months. If set to be a monthly recurring entry, should the balance in prepaids go to zero along with the next month's entry occurring without another payment for the prepaid covering the next six months, a credit would be reflected on the balance sheet. This would alert the bookkeeper that something may be wrong. It could be that the prepaid was posted to expense, or that the insurance premium may not have been paid. Either way, a situation exists that needs investigation. This is, in our opinion, the way it is supposed to work. The system should alert you to issues and allow you to deal with those issues and then move on.

Most software packages also allow you to set an entry for automatic reversal in the following month. This is of significant value in cases in which you make journal entries for accounts that should be adjusted on a monthly basis. Examples of items that fall into this category would be accruals for payroll taxes, inventory balances taken on a monthly basis, and accrued wages, to name a few.

## **CLINICS WITHOUT WALLS**

An arrangement that is not as rare today as it was twenty years ago is one in which physicians join together to leverage administrative functions, an arrangement generally referred to as a "clinic without walls." Here each doctor maintains his or her separate office but shares the administrative functions, including billing and collections, with several other doctors. For bookkeeping, each office is considered a profit center, with a separate financial statement report.

Collections present specific problems when each practice individually invoices its patients through the centralized billing office. Even though the invoices are sent from a single location, payments are often received at the respective physicians' offices, as are collections

for current services. All deposits go into a central bank account maintained for the group, not individual ones for each physician. You can imagine the trust necessary to make such an arrangement work. It is imperative that the accounting function support the needs of each individual practice unit. Detailed general ledger reports must be presented in layman's terms, ledgers must agree with receivable and collection reports, and administration of the separate practices must be better than would have been achieved in individual practices. It would be naïve to expect that the arrangement would continue should the collections of one particular practice go from an average receivable balance of, say, 65 days to 85 days. This represents capital that must come from somewhere, and it is doubtful that the other physicians would be pleased.

## **KEEPING THE BOOKS**

Everyone thinks there is nothing to it—any person with a basic level of intelligence can easily manage, everyone is trustworthy, and book-keeping is nothing more than reconciling the bank account, writing a few checks, and processing payroll checks with a computer that does all the calculations. So why do so many businesses find themselves with no cash, a significant amount of unpaid bills to vendors, and their accounting records in such a mess that it will cost a small fortune for someone else to come in and make sense of the whole thing? The problem is rooted in the perspective of the decision maker as to the level of knowledge required by the bookkeeper. Maintaining and presenting data in the most useful manner is akin to piecing together jigsaw puzzles. We have encountered many individuals who had the requisite technical training but lacked the common sense to bring it all together.

All too often the accounting staff attempt to record transactions based on the way things happened rather than on the obligations of the parties. See, for example, the journal entries for malpractice insurance given earlier. Other examples are personal use of company vehicles, collections in advance of services such as in many ob/gyn practices, and the physician compensation issue, already noted. Exercise caution when non-business accounting activity finds its way into the accounting for the business, as in the personal use of company vehicles. The Internal Revenue Service imposes on employers reporting obligations

that have no bearing on the earnings of the company. These reporting modifications may affect the employee's Form W-2, yet have no impact on the financial operations of the business. The adjustments affect the employee's personal income tax situation only. All too often, accounting staff attempt to make some journal entry for the adjustments to the employee Form W-2 when no adjustment is necessary.

Overhead creates another perplexing dilemma. Consider a business that is 100% leveraged as compared to one that is 50% leveraged. Also consider that the 100% leveraged business has an owner who is accustomed to a 100% higher recurring salary than is the owner of the other business. Do the facts require that the 100% example must have an overhead higher than that of the 50% example? Yes, to arrive at true cash flow breakeven. But is that a reasonable burden to place on the respective businesses in evaluating their respective performance? Not likely.

So, what exactly is overhead? *Overhead* should represent costs that are not directly identifiable to a particular process or product output; costs that are essential to the overall business; costs for which the direct allocation to a particular process or unit is not cost-justified. Overhead cannot be a basket to accumulate expenditures that are later charged back/allocated as a percentage of revenue or other costs. Overhead should and must be controlled.

Is it reasonable to consider or anticipate that a minimum level of overhead exist relative to a given business? In other words, is there a fixed element to overhead? Yes.

What level of overhead is reasonable? Overhead should be identified at the beginning of the particular year or process: what is categorized as overhead; reason it isn't charged based on the necessity of the expenditure; what is an acceptable amount of cost to be non-identified—all should be documented. It would be futile to argue that not every business or process has an associated level of overhead. An evaluation of the business is necessary to determine what level is reasonable. Good luck!

