

Wade, Goldstein, Landau & Abruzzo, P.C.

61 Cassatt Avenue, Berwyn, PA 19312

610-296-1800

610-296-1802 (fax)

Website: <http://www.wadegold.com>

A New Doctor's Guide to Deciphering Financial Reports

By:

Robert A. Wade, Esq., rwade@wadegold.com
Mark D. Abruzzo, Esq., mabruzzo@wadegold.com

I. The Purpose of Financial Statements

A practice's financial statements are of particular interest to its internal and external decision makers. Internal decision makers are the owners and managers of the practice who can use this information to plan for the future of the practice and identify problems. External decision-makers include, among others, potential physicians considering buying (or buying into) the practice, bankers and other lending institutions, equipment vendors and landlords for the purpose of ascertaining value or creditworthiness of a practice and the risk involved in entering into business ventures. Financial statements provide needed information—if one knows how to read and interpret them properly.

In what follows, we shall make some very important distinctions as to the kind of accounting that is done in order to prepare financial statements (cash vs. accrual) and then look at the basic financial statements an ophthalmologist or administrator may encounter and the information those statements should provide as well as the purposes for which that information may be used.

II. Cash Accounting Versus Accrual Accounting

In the world of big business, financial statements are normally prepared in accordance with what are called *generally accepted accounting principles*. Although, this term sounds a bit fuzzy, it actually has a very specific meaning. It requires the use of the **accrual method** of accounting. Under the accrual method, revenue is considered earned and is recognized in statements for the period when the revenue transaction occurred, regardless of when the related cash is collected. So, for example, under the accrual method, a practice's earnings are posted at the time services are provided. Similarly, expenses are incurred at the moment the liability is incurred, regardless of payment terms. This is very different from the cash-basis accounting. Under the **cash-basis method** of accounting, revenue is not recognized until it is received and expenses are not recognized until they are paid.

Most medical practices, however, particularly small or solo practices, use the cash-basis method of accounting. It is, quite frankly, simpler because the financial statements are

constructed only for the practice's owner(s) and perhaps a local banker and not for regulators or the general public. That said, the accrual-basis reports will be, by their nature, more comprehensive and have greater utility. Nonetheless, there are ways to glean a good deal of the information that would be contained in an accrual based statement from other statements—which we will discuss later on. Indeed, even practices that prepare their financial statements using the accrual method generally use the cash-basis method of accounting for filing their tax returns.

Cash-basis filings are generally permitted by the IRS, but don't confuse financial statements and income tax returns—they are two very different things. The former are used for decision making, the latter to report income to the Internal Revenue Service. While they overlap, they have different purposes and sometimes define things differently.

III. Basic Financial Statements

The financial statements most commonly prepared for medical practices are balance sheets and income statements. Financial statements are usually prepared as of the final date of each fiscal year, although they can also be prepared on an interim basis as well. Indeed, a well-run practice should be preparing these reports—though somewhat less formally—at least quarterly, if not monthly. Financial statements are also often prepared comparatively reporting, for example, results for the fiscal year just completed and for the year immediately preceding year (*i.e.*, 2011 and 2010) or for the 1st quarter current year and 1st quarter prior year, etc.

A. Balance Sheet

The balance sheet presents the assets, liabilities and owner's equity of a business as of a specific date. The calendar year is generally the fiscal year end date; however, the fiscal year can have different beginning and end dates.

1. Assets. *Assets* are the economic resources or entitlements owned by the practice, including equipment, cash, and accounts receivable. Typical asset classes appearing on an *accrual-based* balance sheet are cash and cash equivalents; accounts receivable; furniture, fixtures and equipment; leasehold improvements; and security deposits on property (*i.e.*, office) leases. Also included may be “capital leases”—essentially financing arrangements for equipment and similar assets where upon the conclusion of the lease term, ownership of the equipment converts over to the lessee (the practice) for no or nominal value (such as \$1.00). In effect, under capital leases, the “lease” payments are the equivalent of purchase payments. Therefore, equipment being “purchased” under capital leases may be, and usually are included as assets on the balance sheet. The balance sheet typically does not contain a detailed *description* of the assets, but is rather a summary of the asset classes. (Most practices should also have a detailed inventory of what they own from which the balance sheet data are derived.) A cash-basis balance sheet will include the same categories of assets but will not include accounts receivable.

2. Liabilities. *Liabilities* are the debts and other practice obligations, which may include bank debt and vendor accounts payable. Short-term liabilities are those due and payable within one year. Accounts payable are an example of a short-term liability. Long-term liabilities are those due and payable in a year or more. A five-year bank loan is partly long-term and partly short-term. That is, the portion due within one year is considered a short-term

liability and the remaining balance long-term. On the liability side of the ledger, the cash-basis balance sheet's most-common significant omissions are:

- Accounts payable
- Accrued payroll
- Accrued retirement contribution

3. Owners' Equity. *Owners' equity* represents the residual financial interest in a business. Put another way, the owners' equitable interest in the practice is what remains after subtracting its liabilities from its assets. This remainder is commonly referred to as the practice's *book value*. Owners' equity includes contributions paid into the practice by its owners. It also includes any retained profits.

**Sample Balance Sheet
USA MEDICAL SPECIALISTS**

**COMPARATIVE BALANCE SHEET
CASH BASIS
FOR YEARS ENDED DECEMBER 31, 2010 AND 2011**

	<u>2010</u>	<u>2011</u>
Assets:		
Current Assets		
Cash	\$30,000	\$130,000
Property		
Furniture, Equipment	3,010,000	3,075,000
Leasehold Improvements	80,000	95,000
	(2,900,000)	(3,050,000)
Other		
Leasehold Deposits	<u>17,500</u>	<u>17,500</u>
Total Assets	237,500	267,500
Liabilities:		
Current Liabilities	45,000	
Bank Loan, portion due within one year		25,000
Long-Term Liabilities	<u>75,000</u>	
Bank Loan, portion due after one year		<u>50,000</u>
Total Liabilities	120,000	75,000
Owner's Equity:	50,000	
Capital Stock,	<u>67,500</u>	50,000
Retained earnings		<u>142,500</u>
	\$117,500	\$192,500

**Sample Accrual-Basis Balance Sheet
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**COMPARATIVE BALANCE SHEET
ACCRUAL BASIS
FOR YEARS ENDED DECEMBER 31, 2009 AND 2010**

	<u>2010</u>	<u>2011</u>
Assets:		
Current Assets		
Cash	30,000	130,000
Accounts Receivable	550,000	570,000
Property		
Furniture, Equipment	3,010,000	3,075,000
Leasehold Improvements	80,000	95,000
Accumulated Depreciation	(2,900,000)	(3,050,000)
Other		
Leasehold Deposits	<u>17,500</u>	<u>17,500</u>
Total Assets	787,500	837,500
Liabilities:		
Current Liabilities		
Accounts Payable	42,000	52,000
Bank Loan, portion due within one year	45,000	25,000
Accrued Pension	224,000	244,000
Long-Term Liabilities		
Bank Loan, portion due after one year	<u>75,000</u>	<u>50,000</u>
Total Liabilities	386,000	371,000
Owner's Equity:		
Capital Stock, amount received	50,000	50,000
Retained Earnings	<u>351,500</u>	<u>416,500</u>
Total Owner's Equity	401,500	466,500

B. Depreciation Worksheet

Accounting policies and the tax law provide for the write-off, or *depreciation*, of assets over time, to reflect wear and tear. The depreciation rules can be complex. However, suffice it to say a newly acquired \$50,000 asset would initially be reflected or “booked” on the balance sheet at that cost—but it would not remain so forever. Wear and tear on equipment and the like is expected, and, as such, the cost of the capital acquisition can be “expensed” over time or “depreciated”. Gradually, the value of the asset on the balance sheet decreases, and eventually it will cease to be listed at all.

The length of time, for tax purposes, over which assets are depreciated is fixed by Treasury Regulations—which may or may not match up to how quickly, in reality, they actually wear out. Assets can be removed from service earlier than the “useful life” as prescribed by the IRS, but in any event, when an asset is no longer in service, it should be removed from the balance sheet, as the balance sheet should reflect only assets currently owned and in use.

The practice’s accountant will generally prepare a depreciation worksheet from information provided by the practice about purchases of equipment, furnishings and other capital items. The worksheet will list each purchased item by description, date put into service, original cost (or *cost basis*), section 179 (see next paragraph!), depreciation method and adjusted (depreciated) cost. The cost, accumulated depreciation and adjusted cost of the assets as per the depreciation worksheet should tie directly to the balance sheet.

Note that Internal Revenue Code Section 179 is a provision of the Tax Code that allows businesses to “write off” or “expense” new purchases up to \$100,000 per year, rather than writing them off according to the depreciation tables. So, for example, if practice purchases \$75,000 of computer equipment one year and nothing else, the practice elects to deduct as an expense the entire \$75,000 at the time of purchase. Otherwise, the \$75,000 purchase would be depreciable (*i.e.*, expensed) over a 5 year useful life. See the example, below. Section 179 is a special tax provision. For book accounting purposes, Section 179 is inapplicable. Thus, the books and tax return may show different depreciation in any given year as a result.

As mentioned, the balance sheet does not list individual assets; rather, it provides a summary. Therefore, the depreciation worksheet augments the utility of the balance sheet. Depreciation worksheets are probably most useful for determining asset values in connection with group practice buy-ins and pay-outs and in outright practice purchases or sales because a common valuation formula used in medical practices values *hard assets* (furniture, fixtures, equipment, leasehold improvements, etc.) according to depreciated cost.

In any event, it is important to understand that the accuracy of the information presented on the depreciation worksheet and other financial statements only ever reflects the information the accountant receives from the practice. The accountant should be notified each time an asset is purchased or retired so that it can be booked on the balance sheet and added to the depreciation worksheet or removed as the case may be.

Sample Asset Depreciation Worksheet

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DEPRECIATION WORKSHEET AS OF DECEMBER 31, 2010

Asset Description	Date Put into Service	Cost Basis	Section 179	Type Method	Useful Life
Leasehold Improvements	1/1/2003	22,000		SL	39 years
Widget Maker	1/1/2004	3,850	3,850	200DB	5 years
Sprocket Sorter	6/30/2005	2,315	2,315	200DB	5 years
Laptop	1/1/2006	1,225		200DB	5 years
Air Conditioner	7/1/2006	4,885		SL	15 years
Hoosiewatsit Machine	2/1/2007	55,266		200DB	5 years
Medical Equipment	1/1/2008	49,552		200DB	5 years
Furnishings	3/1/2009	14,355	14,355	200DB	7 years

There are two methods referred to in the above illustration. These are the “SL”, or Straight Line, method and “DB”, Declining Balance, method. These are the common methods used in the depreciation of medical practice assets. Under the Straight Line method, the asset is depreciated pro-rata over its Useful Life. The Air Conditioner costing \$4,885, for example, would be depreciated at the rate of \$325.66 per year (*e.g.*, $\$4,885/15 = \325.66). The Declining Balance method is an “accelerated” method of depreciation. The depreciation occurs not ratably but according to prescribed percentages that are higher in the early years (*e.g.*, Year 1- 20%, Year 2- 32%, Year 3- 19.2%, Year 4- 11.52%, etc.)

C. Income Statement. The income statement (also commonly referred to as a profit and loss statement) reports both the revenues and operating expenses of the entity for a given time period, usually the fiscal year, although income statements are often prepared more frequently. The remainder of revenues after subtracting the operating expenses constitutes the practice’s income (also referred to as profit). If the operating expenses exceed revenues, the deficit constitutes an operating loss.

1. Revenues. The sum of all revenues-- patient services, research, lectures, and sales, is referred to as “*gross revenue*.” If a practice’s revenues are derived from various sources, the different revenue streams are often stated and identified separately. Any “adjustments”, like patient refunds, will also be reported separately. In the case of an optical medical practice, direct costs of goods sold, such as the cost of the purchase of frames and

lenses, are included in this portion of the income statement as adjustments to gross revenues. The after-adjusted gross revenue is referred to as *net revenue*.

2. Expenses. *The expenses that appear on the income statement are operating expenses. Operating expenses (also commonly referred to as overhead) are distinguishable from capital expenses, which are not included on the income statement, but instead appear on the balance sheet.*

3. Redefining Profit for Incorporated Practices. While net revenue is an indicator of success, the ultimate success of a practice is revealed in its bottom line: its income or “profit”, as sometimes referred to. However, in almost all practices, the owners receive salaries and bonuses from the practice, often drawing out all the profit to avoid double taxation or for various other reasons. Accordingly, many practices typically show little or no profit on the bottom line. Therefore, to determine what matters most, how well the owners are doing financially— you need to start with the profit shown on the income statement and add back in the owners’ compensation and fringe benefits.

Note that adding back owners’ compensation may not yield “true” economic or accounting profit—to do that one would need to “normalize” the owner’s compensation to take into account the work effort of the owners as “line producers” and as business managers. And indeed, that kind of analysis can be quite helpful in determining a practice’s value for purposes of sale or purchase. That said, adding back the owner’s compensation does allow us to take that number and determine what the non-owner (and non-doctor) “overhead” of a practice is.

A practice’s *overhead rate*, *i.e.*, the ratio of operating expenses to net revenue measured for any given period, is often a good indicator of how well a practice is operating (but, like all indicators, it is important not to put too much stock in any one measure). For example, if for a given year a practice’s revenue was \$1,000,000 and its operating expenses were \$600,000, so that the practice owners received \$400,000 in compensation/profit distributions, the practice’s overhead rate would be 60 percent: $600,000 \div 1,000,000$). This calculation is discussed below.

Be aware that a high overhead rate does not mean a practice necessarily has an overhead problem. This is the usual assumption, but it is often wrong. As mentioned, the determination involves two variables: overhead and net revenue. Consequently, a high overhead rate can imply low net revenue or high overhead, or both. A practice’s operating expenses may be appropriate—and completely necessary and subject to no further cost cutting. But if the practice has insufficient volume, the overhead rate will be high, though the overhead cost is not out of line.

Sample Overhead Rate Calculation

Step 1	Total Operating Expenses		\$5,917,398
Step 2	Subtract: Provider Compensation and Benefits	\$2,297,244	
	Professional Auto	13,495	
	Excess CME	<u>19,017</u>	<u>(2,329,756)</u>
Step 3	Adjusted Operating Expenses (i.e., Overhead)		3,587,642
Step 4	Net Revenue		5,988,614
Step 5	Overhead (\$3,587,642) ÷ Net Revenue (\$5,988,614)	=	59.91%

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COMPARATIVE INCOME STATEMENT

CASH BASIS

FOR YEARS ENDED DECEMBER 31, 2010 AND 2011

Gross Revenue:	<u>2010</u>	<u>% of Net Revenue</u>	<u>2011</u>	<u>% of Net Revenue</u>
Professional Fees	5,574,909		5,714,282	
Less: Patient and Insurance Refunds	(12,113)	0.002	(12,416)	0.002
Product Sales	435,007		445,882	
Less: Cost of Goods Sold	(155,253)	0.028	(159,134)	0.028
Net Revenue:	5,842,550		5,988,614	
 Operating Expenses:				
Staff Payroll & Benefits	2,298,379	0.412	2,355,838	0.412
Provider Compensation and Benefits	2,188,212	0.393	2,297,244	0.402
Staff Development	13,974	0.003	14,323	0.003
Maintenance	22,665	0.004	35,004	0.006
Professional Auto	13,165	0.002	13,495	0.002
Supplies	181,205	0.031	185,736	0.031
Rents and Leases	407,398	0.073	408,112	0.071
Insurance	102,467	0.018	105,029	0.018
Travel and Entertainment	27,125	0.005	24,335	0.004
Postage and Shipping	10,189	0.002	10,444	0.002
Vending	4,774	0.001	4,893	0.001
Professional Fees	14,035	0.003	14,386	0.003
Utilities	84,314	0.015	86,422	0.015
Office Expense	2,908	0.001	2,981	0.001
Other Taxes	19,798	0.004	20,293	0.004
Continued Education	23,334	0.004	23,917	0.004
Marketing and Advertising	78,415	0.014	80,375	0.014
Information Systems	63,219	0.011	64,800	0.011
Bank Fees	1,541	0.000	1,579	0.000
Interest	51,657	0.009	52,949	0.009
Depreciation	132,445	0.024	115,245	0.020
Total Operating Expenses	5,741,219		5,917,398	
Net Income	101,331		71,215	

D. Statement of Cash Flows. The *statement of cash flows* is similar in appearance to the Balance Sheet. However, the purpose of the statement of cash flows is to provide a clear picture of the practice's money flow, as distinguished from profit. What is the difference? Well, certain payments, while actual cash outlays, do not constitute operating expenses. As mentioned above, capital expenditures are not operating expenses. Similarly, loan repayments are not expenses. Conversely, the income statement may show certain operating expenses that do not represent actual cash outlays, such as depreciation expense. Thus, it is entirely possible — and is in fact usually the case — that although a practice's income statement may report a certain amount of "profit," the combination of what the practice's owners actually took home or retained in the practice may be significantly less, or more, than that figure. The statement of cash flows essentially ties to the income statement and then shows adjustments that in effect convert profit to cash.

IV. Informal/Internal Financial Reports

Using practice management system software, practices can prepare many internal financial reports that can be useful. Most of these are rooted in the accounting principles discussed above. Some of the more commonly used internal financial reports are discussed below.

A. Satellite Offices. Some practices operating from multiple offices maintain separate financial statements and other accounts for each office. Other multiple-office practices do not. It is difficult to ascertain the value of satellite offices without good, clear information — namely, the income and expenses generated directly by those offices. Satellite offices, like a main office, have assets and liabilities. Therefore, balance sheets should be maintained in addition to income statements. In many cases, the true issue is not simply a matter of determining whether a satellite office is profitable but whether it has a "cannibalizing" effect on the practice's primary office. This can be determined, in part, by comparatively analyzing revenue trends of the different offices over an extended period of time, particularly for the first year or two after the opening of a satellite office — and understanding, of course, that market demographics and other reasons may lead to shifting revenues.

B. Reports by Physician.

Some groups account for their physicians as individual cost centers within the practice, creating an income statement of sorts for each physician because they divide income and expenses among the partners in a way that allocates to each partner the income he or she generates, as well as a share of the practice's expenses; the net constitutes the compensation share each receives. The same tenets of accounting for satellite offices are at play here, but on a more direct level. As with office accounting, allocation of expenses is needed, and that involves some discretion. Each physician's individual collections are allocated to him or her, as direct expenses, such as malpractice insurance, retirement contributions and fringe benefits, expenses related to societies, CME, journals, automobile, and other perks. If the physician is a subspecialist, other direct costs to produce collections may also be allocated. In the case of a retina specialist, for example, high-cost medications, such as injectables for the treatment of macular degeneration or dedicated supplies or instruments should be directly allocated.

The practice's general operating expenses are allocated too, and this is where discretion is involved. These expenses can be allocated in different ways. One method is based on the relative collections of the doctors. Another is according to ownership percentage. More commonly, allocations are made in a hybrid fashion—some equally or in proportion to ownership percentage and some in proportion to production. In answer to which expenses fall into which category, there is no right or wrong answer. Fixed expenses such as rent are often allocated equally or according to ownership. Expenses that vary with work volume, such as staff compensation and benefits, are often allocated according to relative production.

C. Subspecialty Reporting. Some practices also use physician reports to determine the profitability of their subspecialists. If the objective is to determine whether the practice's decision to hire, for example, an ophthalmologist was financially worthwhile, it's best to approach the physician report from a different perspective. It's not sufficient to assume the only direct costs are those incurred to generate collections. In generating a report for this type of issue, we recommend only those overhead expenses that are incurred directly as a result of the physician should be included. For example, if a dedicated technician was hired, then this would be a direct expense. And if an additional biller was hired to cover the increased volume, that cost should also be allocated to the physician even though that person's functions are related to all the practice's physicians.

D. Considering Capital Expenses. What about capital expenses? Should they be accounted for in physician reports, and if so, how? Let's consider the purchase of an item of equipment for a specialist. Here, the practice does not need to maintain a specific balance sheet for the physician, but spending for equipment must be factored into the determination of physician profit. This happens in the same way capital expenses are handled in an income statement: by including the depreciation charges as allocable expenses. The actual outlay for the item of equipment is an investment in the specialist and represents a service the group wishes to offer to its patients which would have been referred out otherwise. It would not be fair to allocate the outlay for the purchase itself at the time it is made. However, because the depreciation charges represent wear and tear on the equipment it is appropriate to allocate depreciation on assets used by the specialist. Of course, you are ultimately allocating the outlay, but it's a matter of timing, and spreading the allocations over the useful life of an item of equipment makes sense.

E. Accounts Receivable. Accounts receivable represent an ophthalmic practice's largest material asset. Cash flow is a practice's lifeblood. Knowing that submitted claims are being paid and collected in timely fashion is vital.

Accounts receivable can generally be reported by patient, charge, payer adjustment, amount outstanding, date of claim submission and by payer. A full report can be quite lengthy and cumbersome, but summaries can usually be created. Most summaries show the total accounts receivable broken down by charge, payer adjustment and amount outstanding by aging group or "bucket": 0–30 days, 31–60 days, 61–90 days, 91–120 days, 121–180 days and more than 180 days. Typically, summaries can usually be customized. For example, a report might be prepared which shows outstanding balances by payer, rather than by patient. Customizing can be helpful when troubleshooting (*e.g.*, is the practice's issue with a particular payer or more general?)

As mentioned, the accounts receivable report can be useful in highlighting problems in a practice's collection function. It does not do the same with regard to the claim-submission function, since a claim cannot become a receivable until it is submitted.

The following can be indications that a collections problem exists.

- ***High Receivables Balance***

Many practices have a multiple week *turnaround cycle* from claim submission to payment. Most ophthalmic practices, for example, have on average about a six-week turnaround cycle. Of course, many claims are collected in three or four weeks, or less, but others take more time. And, of course, denials can back up collections. On average, however, at any given point in time, a practice's collectible receivable amounts, or *adjusted charges*, should total approximately 9 to 12 percent of the practice's annualized gross receipts. So, for example, if a practice's collections for the year on December 31 were \$2 million, its collectible accounts receivable balance should be in the neighborhood of \$210,000 (about 10.5 percent). If they are significantly or substantially higher, there may be a problem.

Yet, that problem may be nothing more than that the report contains old balances that should have already been written off. Old, uncollectible receivables should be purged regularly. If uncollectible balances are not purged, the accounts receivable become inflated and misleading, and this can in turn result in inflated partner buy-ins or buy-outs and misleading financial statements.

- ***Excessive Write-Offs***

While purging bad debt from the system is prudent, excessive write-offs indicate a problem, such as:

- Poor follow-up of claims denials;
- Claims are being submitted for services which are not reimbursable by the insurers;
- Claims are being submitted which are improperly coded; or
- Poor or insufficient attempts to collect delinquent amounts from insurers and/or patients.

Analysis by payer can indicate that there is a problem with collections from a specific payer — whether it is a high rate of claims denial or a longer-than-typical lag between billing and payment.