

THE SUCCESSFUL OPHTHALMIC ASC

Financial Reporting and Management

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THE SUCCESSFUL OPHTHALMIC ASC:

Financial Reporting and Management

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Financial Reporting and Management | This module discusses the relationship between financial reporting and financial management of ophthalmic ambulatory surgery centers (ASCs) and the importance of these two factors in maintaining the profitability and long-term stability of the enterprise. We discuss:

- **The goals of financial reporting**
- **The goals of financial management**
- **Development of focused reports that support management decision making**
- **Identification of elements of data collection, analysis and reporting that are unique to ophthalmic facilities**
- **Implementation of procedures and protocols that improve financial management**

Goals of Financial Reporting

To evaluate the performance of your facility's business operations objectively, you must capture and summarize critical data in a useful, timely and concise format that the organization's decision makers can use to:

- Identify trends that impact the facility's current or future success
- Ensure compliance with state/federal laws and regulations and material business contracts
- Most importantly, support and enable managerial decision making

Let's examine each of these goals in more depth.

Identifying Major Trends

Myriad factors, both internal and external, impact the operations of ASCs. Although many of these variables are outside the control of the financial manager, it is possible to anticipate their impact on the organization and to formulate strategies to minimize any negative impacts and capitalize on opportunities for improvement.

There is no doubt that the future will continue to bring pressure on our organizations to contain

costs and improve operating efficiencies and surgical outcomes. Additionally, we will undoubtedly be required to produce, evaluate and report more clinical and financial data to major payers and regulatory authorities.

Internally, we can expect continued pressure on our profit margins as per-surgery reimbursements will lag behind increases in facility operating costs, particularly labor costs.

The long-term success of the ophthalmic ASC will thus rely on the ability of the manager to generate and interpret precise information that is crucial to decision making, communicate the information to the organization's stakeholders and develop and implement strategies indicated by the data.

Ensuring Compliance

Facilities that have used long-term bank debt for development, expansion or renovation are frequently subject to lender-imposed requirements that may directly impact their ability to pay dividends or shareholder distributions, purchase or lease new equipment or borrow additional funds.

Often, these requirements are specific to the financial institution and require regular reporting to the lender. Commonly observed requirements include a debt service coverage ratio, maintenance of a minimum current ratio and, occasionally, maintenance of a minimum level of collectible accounts receivable.

The purpose of the **debt service coverage ratio** is to ensure that the cash flow from facility operations is sufficient to cover the principal and interest payments required by its debt instruments as well as to provide a suitable safety margin after other operating cash needs have been met. Although this general definition is commonly understood, the specific computation of this ratio may vary from financial institution to financial institution and is precisely defined in the loan documents supporting the loan. A particular concern relating to this requirement is that, for marginally profitable facilities, it may severely restrict the amount of cash distributable to the owners through dividends and/or shareholder distributions.

The **current ratio** is commonly defined as an enterprise's total current assets divided by its total current liabilities. This ratio measures the ability of the enterprise to meet its short-term cash needs to satisfy its creditors.

While both the current ratio and the debt service coverage ratio typically apply to long-term bank debt, the **collectible accounts receivable balance** is the principal asset that supports a working-capital line of credit. The line of credit is a revolving credit arrangement that is designed to enable the facility to meet short-term cash needs as they arise throughout the year. Typically, for a floating rate loan, many financial institutions require that the line of credit be paid in full, to a zero balance, for some period during each fiscal year.

Other documents that may contain compliance requirements include property and equipment leases, group purchasing organization contracts and, in certain states, certificate of need approvals.

Supporting Management Decision Making

The collection and analysis of financial and operational data and the development of summary reports of these data take place in, to use a current cliché, a "target-rich environment." Owners, regulators, vendors and facility managers, encouraged by sayings like "you can't manage what you don't measure," are limited only by their imagination in posing questions that can be addressed analytically. Although nominally true, such advice often induces its devotees to focus on "measurement" rather than "management."

It's important to remember that the goal of financial reporting is to drive and support decision making. Developing measurement tools that won't be used to enhance the quality of decisions

is, fundamentally, a misallocation of time, which is usually the financial manager's scarcest resource.

Goals of Financial Management

Profitability

Stephen Covey, the noted management consultant and author, is often quoted as saying, "No margin, no mission." That phrase concisely captures the importance of maintaining healthy operating margins in any business.

Profitability, however, needs to be defined more broadly. It encompasses not only the facility's income in the short term but also its future capital and/or expansion needs; includes its provision of adequate returns to support the owners' investment; and incorporates establishing appropriate cash and credit reserves so that the enterprise can respond to changes in the marketplace.

Efficiency

Since the 1990s, the health care industry has faced unprecedented and unrelenting downward pressure on the costs of providing care. For most of the decade, financial managers were able to identify nonessential expenses and other efficiency gains that offset much of the erosion in revenue.

In recent years, however, I've noticed that many organizations have begun to sacrifice their ability to be effective to their constant pursuit of efficiency. Some efficiency steps may improve financial performance in the short run, but their usefulness will be short-lived if they damage the future growth prospects of the organization or diminish its ability to adapt to market changes. Financial managers must develop tools that enable them to oversee an organization that is not only efficient but that also maintains its effectiveness.

Creation of Equity

Entrepreneurs assume business and financial risks for several reasons. Among them are the desire to improve the quality of health care delivered in their community, recognition that control of the surgical environment may enhance the quality of their personal and professional lives and, significantly, the prospect of realizing an appropriate financial return on their investment.

Thus, equity arising from the development and operation of an ASC has both qualitative and quantitative components. A further concern for the manager is that these components are often inherently contradictory. For example, purchasing less costly equipment and supplies may augment the center's profitability and creation of financial equity while adversely affecting the surgeons' perception of the quality and safety of the care being delivered.

Several variables that the manager can influence can affect the financial equity component of an ASC. Obviously, profitable operating results allow the center to provide cash distributions to its owners; less obviously, retiring debt through repayment of loans, leases and other financial obligations creates financial equity. Finally, activities that increase the future profitability of the business (e.g., recruiting new physicians, shortening case times and reducing turnover) can favorably impact the enterprise value of the business.

Long-Term Stability

ASCs are business organizations developed with the intention that they will remain operational and profitable over many years. The need to maintain a safe and effective surgical environment means that construction, equipment and maintenance costs are quite high compared with those for most other business entities. This produces a business structure characterized by high fixed costs and operating profits that are potentially subject to great variability as surgical volume, case mix or payer mix changes marginally. Clearly, sound financial management involves continually "looking around the corner" for changes in variables that directly affect the long-term stability of the organization.

Additionally, although these elements are not traditionally considered to be part of the financial reporting system, management must stay closely in tune with possible regulatory, governmental and technological changes that will require future accommodation.

Developing an Effective Financial Reporting System

We've looked at the principal goals of financial reporting and financial management of ASCs. Let's move on to the nuts and bolts of developing and

implementing financial reporting and management in your center.

Developing a financial reporting system or evaluating an existing system centers around developing data collection methods and presentation tools that provide the various stakeholders with timely and focused information *that they can use to make and implement decisions* that are important to the success of the organization.

The principal layers of the financial reporting and management information system consist of the following:

- **Data collection and record keeping:** the general ledger chart of accounts
- **Basic financial statements:** the balance sheet, the income statement and the statement of changes in cash
- **Management information reports:** various summaries (reports) that are customized to provide critical information to the organization's decision makers and other stakeholders

Data Collection and Record Keeping: The General Ledger Chart of Accounts

Good financial information is dependent on properly organizing the chart of accounts that will be utilized in your general ledger. If your ASC is currently in development, this step is straightforward; if your center has been in operation for a number of years, efficiently organizing the chart of accounts may require that you make some substantial modifications to what exists and carefully consider the timing of the changes you make. Specifically, it would be preferable to implement these changes at the beginning of a fiscal year to avoid creating inconsistencies in management reports and to ensure the propriety of tax return information.

The **general ledger chart of accounts** is the listing of individual asset, liability, equity, revenue and expense transactions that you want to identify separately in your detailed or summary financial statements. The chart of accounts should be organized in a manner that promotes effective summarization of individual transactions into meaningful aggregates that promote analysis and comparison to internally developed and external benchmarks.

Most accounting software packages allow the user to customize the chart of accounts to meet the needs of the unique business. The software structure utilizes a hierarchy of “master” accounts and “detail” accounts that collect data specific to a single area of revenue or expense.

For example, labor costs are always a substantial portion of the operating expenses of ASCs. However, most external benchmarks quantify “fully burdened” labor costs (see discussion later, under “Useful Labor Cost Benchmarks”), rather than simply “wages.” Thus, the labor costs section of the general ledger chart of accounts may include a master account for labor costs and detail accounts for salaries and wages, the employer portion of federal Social Security and Medicare taxes, federal unemployment taxes, state unemployment taxes, health and other employee-paid insurance and the employer’s contribution to a retirement plan, if any.

Withholding from staff paychecks for income taxes represents a liability that the employer must remit to the appropriate governmental agencies. Like labor costs, these liabilities are similarly recorded in a separate section of the general ledger in a series of detail accounts related to these accrued liabilities.

There are many ways to organize your chart of accounts to allow you to quickly and efficiently summarize key data and prepare meaningful summary financial statements and management reports.

Suggested Master Categories for the Chart of Accounts

Chart-of-account master categories that I recommend to my clients typically consist of the following:

BALANCE SHEET CATEGORIES

- Cash
- Accounts receivable
- Prepaid expenses
- Fixed assets
- Deposits and intangible assets
- Accounts payable, current
- Accrued liabilities, current
- Notes payable, current
- Notes payable, long term (the portion due more than one year from the date of the statement)
- Owners’ equity
- Capital contributions, current year

DISTRIBUTIONS, DIVIDENDS OR WITHDRAWALS

- Retained earnings
 - Income Statement Categories
 - Collections, Medicare
 - Collections, other
 - “Pass-through” revenues, net of “pass-through” expenses (more on this subject in the next section)
 - Surgical supplies, including disposables, implants, drugs and medications exclusive of items that are “pass-through” products
 - Labor expenses
 - Occupancy expenses, including rent, utilities and other costs associated with the physical plant and equipment
- Other operating expenses, including administrative costs, professional fees, equipment maintenance, postage and freight
- Other income and expenses, items that are typically not directly related to operations (e.g., interest expense and miscellaneous expense related to nonrecurring transactions)

These master categories represent the basic items to be displayed in the center’s balance sheet and income statement monthly, quarterly and annually. Additionally, they provide sufficient detail to give the center’s managers, owners and lenders a concise and accurate snapshot of the enterprise’s financial position and results of operation for the period being reported on.

All too often, when I’m asked to analyze financial information from a center struggling with financial management, I receive an income statement in which the accounts are sorted alphabetically (salaries with the “Ss,” wages with the “Ws,” health insurance under either “I” or “H” depending on the system). The plain truth is that in alphabetical order, accounting data are essentially useless for financial management. I have to manually recategorize the information as I’ve described above before I can make use of it.

Accounting for Pass-Through Expenses

Simply put, “pass-through” expenses relate to certain high-cost devices utilized during surgical procedures where the cost of the item and the revenue reimbursement are relatively equal. Examples

include premium intraocular lenses (IOLs), toric lenses and cornea transplant tissue.

In the case of these pass-through items, patients or insurance companies are billed for the approximate cost of the supply. Because the total annual cost of these items can be substantial, however, and because their utilization may vary from year to year, it is necessary to isolate their impact in the financial statements in order to preserve the comparability of ratios and internal benchmarks. Additionally, if not isolated, these costs and revenues can render a facility's financial management data incompatible with external benchmarks and industry standards.

As an example, consider two facilities, each of which performs 100 cataract surgeries involving implantation of an IOL in a given month. Center 1 uses only traditional monofocal lenses, whereas Center 2 has one surgeon who implants presbyopia-correcting lenses in 25 patients during the month. If the average cost of a monofocal lens is \$125 and the average cost of a premium lens is \$900, Center 2's IOL expense for the month will be \$19,375 higher than Center 1's due to the impact of the premium lenses. At the same time, the bulk of this cost differential will be collected from patients or insurance companies. Thus, the net impact of this cost differential on the monthly operating profit of the two facilities is minimal.

As we will see later, the **surgical supplies expense ratio** — the total cost of surgical supplies divided by net collections — is a crucial and widely reported financial benchmark. In the example just described, however, if the total surgical supplies costs and the net collections are not adjusted for the effect of the use of premium IOLs, Center 2's surgical supplies expense ratio will be substantially higher than Center 1's.

Comparing an unadjusted surgical supplies expense ratio to one for a prior month when the center's use of premium IOLs was lower, or to the ratio of a center that does not use premium lenses or to industry benchmarks that historically have not reflected premium lens costs could lead the manager to conclude — incorrectly — that the center's surgical supplies expense is abnormally high and requires corrective action.

It is my strong recommendation that facilities design their general ledger chart of account to isolate the financial impact of pass-through items. Doing so will allow financial statements and reports to be adjusted readily to eliminate potential distortions. This is easily accomplished by establishing what accounting professionals refer to as "contra" accounts. Within the revenue section of the general

ledger, the manager establishes accounts with names like "Premium IOL Revenue" and "Premium IOL Expense Contra." The revenue account is used to record collections for the sale of premium IOLs, while the expense contra account records the payments made to purchase the IOLs. For financial statement preparation and/or for management reports, the revenue and expense amounts are netted against one another, and the net residual amount is considered either an addition to or a reduction of net collections. In practice, this residual should be a relatively small amount reflecting management decisions to charge something other than the actual cost of the devices or timing differences between purchase of the items and their sale to patients.

Basic Financial Statements and Their Use

Most financial managers are familiar with the balance sheet and the income statement but frequently don't routinely employ the statement of changes in cash. In this section, we explore these reports, what they convey and what modifications may be necessary to maximize their utility. We also compare cash and accrual basis accounting and identify the value of using an outside accounting firm for some activities.

The Balance Sheet

The **balance sheet** is a static document — think of it as a still picture — of the financial position of the center at a specific point in time — typically, the end of a month, quarter or year. The balance sheet (see [Appendix A](#)) is divided into three main segments: assets, liabilities and owners' equity, and it conveys the relationship between the net assets of the firm and its liabilities at a given point in time. Obviously, healthy entities enjoy a surplus of net assets over liabilities and thus have positive owners' equity, an indication that, over time, the entity has been adequately capitalized and/or profitable from operations.

A further meaningful breakdown of the information contained in the balance sheet is to review the relationship between current assets and current liabilities, the "current" designation being defined as assets available to be converted into cash in less than one year and liabilities that must be paid in less than one year. This ratio, commonly called

the **current ratio**, is a measure of the liquidity of the organization and is a tool for identifying any impending cash shortfalls.

A bit later we will discuss the differences between cash basis and accrual basis accounting. In my experience, most ophthalmic ASCs routinely use cash basis accounting for convenience and because it allows them to manage their cash flow in a straightforward manner. At this point, just be aware the major items that entities using cash basis accounting do not record on their balance sheet are accounts receivable and accounts payable. Both are accrual-basis concepts that can, in some cases, have major implications for cash management.

The Income Statement

Whereas the balance sheet is a static tool, the **income statement**, sometimes referred to as a profit and loss statement, or P and L, is a dynamic representation of the operations of the business. The income statement (see [Appendix B](#)) captures and depicts the economic activity of the center over a stated period of time, often a month, quarter or year.

The critical information one can glean from the income statement is the current health of the business: Are the revenues being generated from operations adequate to pay all of the operating expenses and to return a margin that can be applied to the other incumbent financial obligations, including:

- Replacement of the fixtures and equipment as needed
- Payment of principal amounts due on loans and leases, if any
- A return to the owners for accepting entrepreneurial risk

The income statement is also the source for much of the benchmark data that are essential to the successful financial management of the center. We will discuss benchmarking and key ratios later in this module.

The Statement of Changes in Cash

Much less commonly produced than the balance sheet and the income statement, the **statement of changes in cash** often provides the financial manager with his or her most comprehensive view of the cash position of the business since this document captures critical elements from both the balance sheet and the income statement that impact cash.

Like the income statement, the statement of changes in cash (see [Appendix C](#)) is a dynamic

depiction. While the income statement reflects sources (collections) and uses (operating expenses) of cash from operations, the statement of changes in cash also includes sources and uses of cash from nonoperating transactions that nevertheless have a claim on the center's cash position.

As noted earlier, principal payments on bank debt or other notes payable, purchases of fixtures and equipment and dividends or distributions to the owners use cash, but aren't reflected in the income statement because they are recorded only in the balance sheet accounts. Similarly, depreciation and amortization expense is recorded as a reduction of operating income but, at least in the short run, does not require cash.

If you aren't currently preparing this very useful statement, I would recommend that you consult with your accounting firm to assist you in its preparation and to instruct you in how to prepare it on a regular basis.

Effect of Accounting Method — Cash or Accrual — on Financial Statements

As we noted previously, most ophthalmic ASCs use **cash basis accounting**, a system in which economic events are recorded into the books of account when cash (revenue or capital contributions) is actually received or obligations (expenses, capital acquisitions and debt payments) are actually paid.

Larger centers may elect or be required by regulatory authorities to maintain their accounting records on an **accrual** basis, a system in which economic events are recorded into the books of account when the events actually occur, not necessarily when cash changes hands. For example, in accrual basis accounting, revenue for a surgical procedure is recorded on the day the services are rendered, not when payment is received from the patient or insurance company. Recording revenue in this manner is what gives rise to accounts receivable.

In accrual basis accounting, operating expenses are recorded when obligations are incurred. Consider surgical supplies as an example. When ordered surgical supplies are received into inventory at the facility, the ownership of the products has been transferred to the facility, and, under the accrual method, the facility must record the obligation as an increase in its supplies expenses and an increase in accounts payable on the date of receipt, even though the vendor may not require payment for 15 to 30 days.

Accountants commonly recognize that accrual basis accounting is more accurate in representing the economic position of the business at any point in time or over any interval of time. Thus, accrual basis accounting is required for the preparation of financial statements “in accordance with generally accepted accounting principles.”

Unfortunately, preparing accrual basis accounting documents is somewhat more complicated than preparing the documents on a cash basis. Accurately reporting information on an accrual basis requires performing a “cutoff” of revenues and expenses at the end of the reporting period. This means that the charges for all surgeries and procedures performed through the last day of the period must be captured, totaled and entered into the accounts receivable account.

All invoices requiring payment must be reviewed for several days or a few weeks after the end of the period to ascertain if they relate to services received or obligations incurred during the reporting period. If so, they must be recorded as expenses of and accounts payable for that period.

Accrual basis accounting also requires that accounts receivable be recorded at their net realizable value — the amount the ASC actually expects to collect. This requires that the center develop data to support a write-off percentage to accurately reduce gross charges to their collectible value. This is extremely difficult for new centers and those with a relatively short operating history to do.

In most cases, it is feasible to produce materially accurate financial data using the cash method of accounting. Centers that exhibit stable operations from period to period can be expected to maintain relatively stable levels of accounts receivable and payable. Thus, their cash basis statements will approximate those that would be produced under the accrual method. Note, however, that unusual events that are financially significant can result in cash basis statements being inaccurate or, in the worst case, misleading to financial managers. Examples could include a major payer suspending payments for services rendered, the center’s making a bulk purchase of supplies that substantially raises its normal inventory level, or adding a new line of service that requires a large initial purchase of supplies and/or equipment. Financial managers must interpret cash basis statements in light of other events and transactions that may sometimes impact them.

Using an Outside Accounting Firm

Many high-level accounting functions are beyond the capabilities of the in-house financial managers of ophthalmic ASCs. It is usually a good decision to hire an independent accounting firm to perform these functions rather than trying to develop (and pay for) this expertise internally.

Typical among the tasks usually assigned to an independent firm are the preparation of income tax returns and other required regulatory reports, including governmental filings for retirement and other benefit plans. Independent accounting firms also routinely employ specialized software that computes depreciation for fixed assets and equipment in a manner that complies with the extremely complex federal tax regulations.

Finally, using the independent firm to “compile” or “review” financial statements periodically adds an additional layer of control and oversight to the accounting process, to ensure that the assets of the organization are being properly safeguarded. Management can also rely on the fact that the independently compiled statements are prepared on a basis consistent with prior periods and that they provide a reliable platform for comparison.

In that many ophthalmic ASCs are relatively small businesses with limited ability to segregate the duties of staff who control and safeguard assets, the financial manager may wish to engage the independent accounting firm to review the center’s internal controls and processes and report the results of this review to its owners.

Preparing Financial Reports

The data produced by your financial reporting system are the fundamental building blocks of the management information system. They must, however, be supplemented by other statistical data to develop a comprehensive package that will meet the needs of the ASC’s various stakeholders. Much of the remainder of this module explores how financial managers can develop and implement these tools.

It’s important to recognize that a number of other factors impact the development of a financial reporting structure. Such a structure provides the infrastructure for financial management, which, in essence, is the utilization of financial information to provide for the profitability, efficiency, productivity

and long-term stability of the organization. Let's look at these factors first.

Financial Reporting Considerations

Within the financial reporting framework developed by the ophthalmic ASC's managers, owners and other stakeholders, reports other than the balance sheet, income statement and statement of changes in cash will need to be identified and a schedule for their preparation established. Examples of reports that may be produced annually include:

- Charges by Payer
- Collections by Payer
- Surgical Case Costs by Physician
- Operating Expenses, Income and Non-Cash Charges as a Percentage of Collections

All of these reports provide insight into the longer-term changes occurring within the financial operations of the facility that may require strategic responses. Rarely do these changes appear during a short time frame.

Note that, other than the case cost reports, these reports are very effectively presented using pie charts. Results for two or three time periods should be displayed to allow the user to identify favorable or unfavorable trends in the underlying data. Figure 1 displays Operating Expenses, Income and Non-Cash Charges in pie chart form for two calendar years, so that the stakeholders of this hypothetical ASC can compare results and identify trends.

Finally, each facility will confront unique circumstances that will require the financial manager to identify emerging and future issues requiring financial planning beyond normal operational considerations. Ownership transition issues, recruitment of new physicians, adding new lines of service and acquisition of new, costly technologies are among the many possibilities.

Avoiding "Paralysis by Analysis"

Many kinds of unusual, nonrecurring transactions occur during the operation of an ophthalmic ASC — and virtually all of them have either a rational explanation or an immaterial impact on the center's financial well-being. It is all too easy for financial managers to become ensnared in the "thick of thin things," spending too much time developing tools or performing analyses that answer questions but don't influence strategic planning or decision making.

For example, detailed expense accounts such as insurance costs, tax payments, maintenance and repairs and the like may fluctuate substantially from month to month, because these expenses occur only irregularly. Although many financial managers and owners want to review the accounting details, it is important to develop a monetary "scope" for investigation of such fluctuations. Small dollar swings below the established scope are assumed to occur within the normal operating parameters of the facility.

Matching Stakeholder Groups and Information Needs

All business organizations have a number of different stakeholder groups with different information needs. The financial manager must identify these groups and communicate with them to clearly define the scope and frequency with which they will monitor performance. At a minimum, the financial manager will oversee the reporting of information to owners, staff members, lenders and regulatory authorities.

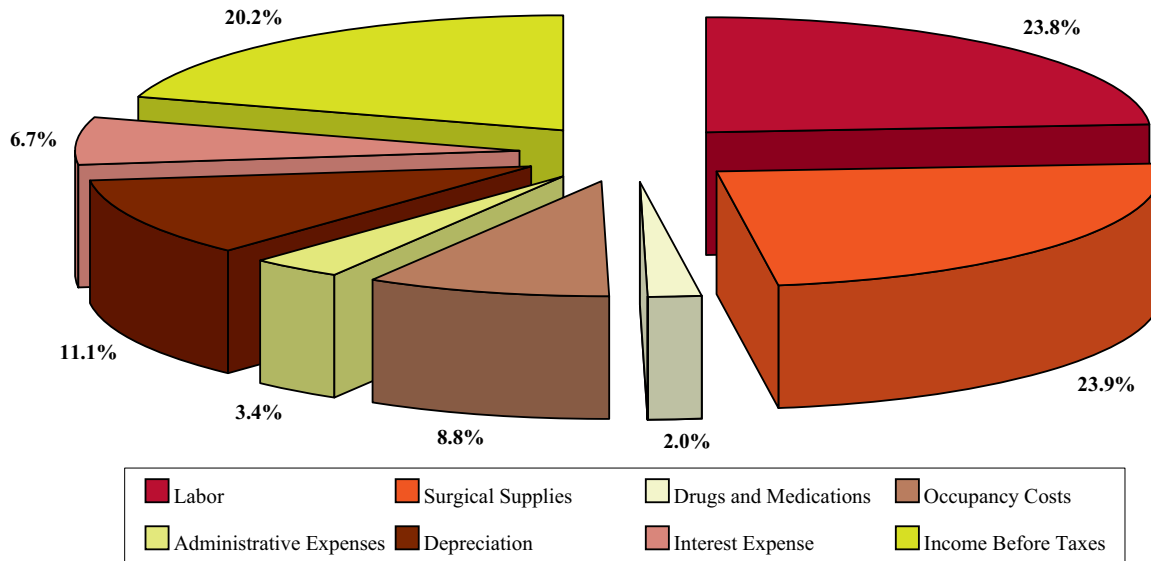
As we discussed earlier, owners are understandably concerned with virtually all aspects of the facility's finances, both short and long term. Accordingly, the bulk of the financial manager's time and effort will be dedicated to preparing and presenting information for this stakeholder group.

REPORTING TO OWNERS: THE ONE-PAGE REPORT

As we noted earlier, effective financial management depends on developing a structured set of tools and reports based on the enumerated organizational goals and information needs necessary for regulatory compliance. A fundamental characteristic of these tools and reports is that they summarize large amounts of detail to produce an overview of crucial aspects of organizational performance that highlights trends and shifts.

In this vein, I encourage my clients to develop and utilize a monthly one-page report of key financial indicators, a concept I learned many years ago from Paul N. Arnold, MD. (See Figure 2 for an example of such a report.) Data for compiling the report should be easily obtained from the facility's practice management, accounting or, when it is employed, electronic health records software. Ideally, the financial manager should be able to update this report each month in no more than an hour or two. Careful review of the report should identify

TYPICAL EYE SUGERY CENTER, LLC
Operating Expenses, Income and Non-Cash Charges
Calendar Year 2009



TYPICAL EYE SUGERY CENTER, LLC
Operating Expenses, Income and Non-Cash Charges
Calendar Year 2010

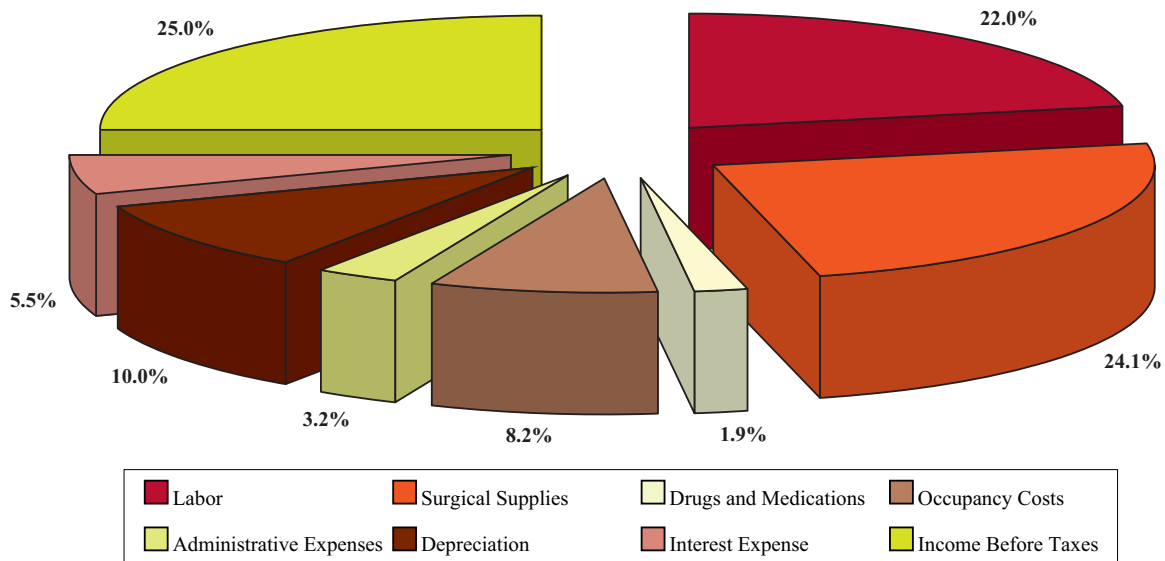


FIGURE 1: Operating Expenses, Income and Non-Cash Charges: Year-to-Year Comparison

Figure 2: Monthly Key Financial Indicators Report for Owners

ACCOUNT TIME FRAME	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	2010 YTD TOTAL	AVERAGE 2010	AVERAGE 2009	AVERAGE 2008	AVERAGE 2007
TOTAL PROCEDURES:														
Number of Surgery Days	18.0	15.0	18.0	17.0	17.0	19.0	15.0	20.0	14.0	153.0	17.0	17.4	16.4	15.4
Total Procedures	244.0	196.0	269.0	248.0	234.0	271.0	230.0	256.0	234.0	2,182.0	242.4	234.7	201.3	187.4
Projected Procedures	244.0	244.0	244.0	244.0	244.0	244.0	244.0	244.0	244.0	2,196.0	244.0	215.0	179.7	185.1
Procedures per Day	13.6	13.1	14.9	14.6	13.8	14.3	15.3	12.8	16.7	14.3	14.3	13.5	12.3	12.2
EYE PROCEDURES:														
Cataracts	194.0	156.0	182.0	190.0	177.0	213.0	181.0	201.0	179.0	1,673.0	185.9	173.9	159.6	152.3
Other	23.0	21.0	4.0	13.0	3.0	2.0	16.0	24.0	14.0	202.0	22.4	15.7	9.0	6.6
Corneal Transplant	7.0	2.0	4.0	6.0	3.0	2.0	2.0	5.0	5.0	36.0	4.0	4.5	1.8	0
Total Incisional Procedures	217.0	177.0	222.0	203.0	207.0	234.0	197.0	225.0	193.0	1,875.0	208.3	194.1	170.4	158.9
Yag Capsulotomy	27.0	19.0	47.0	45.0	27.0	37.0	33.0	31.0	41.0	307.0	34.1	40.6	31.0	28.6
Total Laser Procedures	27.0	19.0	47.0	45.0	27.0	37.0	33.0	31.0	41.0	307.0	34.1	40.6	31.0	28.6
Refractive Upgrades	23.0	12.0	11.0	21.0	20.0	26.0	22.0	31.0	22.0	188.0	20.9	17.3	14.4	5.8
PATIENT ENCOUNTERS:														
Number of Patients Seen	235.0	179.0	239.0	234.0	214.0	257.0	216.0	246.0	229.0	2,049.0	227.7	220.0	194.7	180.4
Average Patients per Day	13.1	11.9	13.3	13.8	12.6	13.5	14.4	12.3	16.4	13.5	13.5	12.6	11.9	11.7
Collections per Patient	\$ 495	800	1,189	720	1,035	583	1,203	777	900	856	856	995	959	792
Operating Expenses per Patient	\$ 574	819	683	537	643	588	655	480	664	620	620	557	594	600
OPERATING REVENUES:														
Collections — Facility Fees	\$ 116,320	143,138	284,159	168,578	221,518	149,884	259,819	191,063	206,088	1,740,568	193,396	191,791	192,336	142,881*
Charges	\$ 438,972	324,759	428,756	427,848	399,653	458,522	385,656	455,333	402,740	3,722,239	413,582	388,659	330,592	297,483
Collections/Charges	30.2%	53.3%	70.0%	42.7%	62.2%	37.0%	70.6%	47.1%	57.1%	51.7%	51.7%	55.6%	60.3%	49.2%
OPERATING EXPENSE:														
Revenues — Refractive/Toric/Cornea	\$ 16,112	29,855	16,071	14,165	27,030	19,660	12,470	23,190	24,026	182,579	20,287	24,194	6,922	3,483*
Expenses — Refractive/Toric/Cornea	\$ 35,575	18,850	14,495	23,790	18,695	26,763	21,930	16,621	42,648	219,367	24,374	28,563	16,102	3,728
Revenues — Patient Post-Op Kits	\$ 1,122	783	1,103	1,179	1,113	1,226	1,160	1,169	1,056	9,911	1,101	339	—	—*
Expenses — Patient Post-Op Kits	\$ 1,563	—	1,345	—	—	—	1,683	—	—	4,591	510	444	—	—*
Operating Expenses	\$ 134,810	146,625	163,354	125,714	137,507	150,993	141,544	118,081	152,037	1,270,664	141,185	120,851	114,605	110,079
Operating Expense Ratio	115.90%	102.44%	57.49%	74.57%	62.07%	100.74%	54.48%	61.80%	73.77%	73.00%	73.00%	63.01%	59.59%	77.04%

*Is there a note that goes with this?

Figure 2: Monthly Key Financial Indicators Report for Owners (continued)

ACCOUNT TIME FRAME	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	2010 YTD TOTAL	AVERAGE 2010	AVERAGE 2009	AVERAGE 2008	AVERAGE 2007
ACCOUNTS RECEIVABLE:														
Total Accounts Receivable	\$549,789	506,786	445,814	534,391	460,643	608,208	493,482	567,070	564,137					
Adjusted Accounts Receivable	\$ 304,143	280,354	246,624	295,625	254,828	336,461	272,994	313,703	312,081					
Current	\$ 303,898	306,549	243,146	329,608	261,455	326,022	253,465	303,308	287,130					
31+	\$ 113,209	85,360	45,449	60,459	72,952	118,905	75,196	84,926	75,759					
61+	\$ 33,630	25,399	36,959	14,690	24,908	50,457	31,898	35,293	40,758					
91+	\$ 20,024	10,327	28,093	34,343	18,022	13,804	43,337	28,394	23,958					
121+	\$ 17,502	13,640	18,441	19,712	25,232	12,414	15,817	43,216	37,753					
151+	\$ 61,527	65,510	73,727	75,578	58,075	86,606	73,770	71,933	98,781					
Days in Accounts Receivable	48	45	39	47	40	53	43	50	50					
ACCOUNTS PAYABLE:														
Month-End Accounts Payable	\$39,939	42,333	(115)	57,432	42,393	84,187	10,823	42,999	35,016					
PAYROLL/PERSONNEL:														
Non-MD Payroll	\$ 45,974	40,553	43,259	44,263	44,760	44,587	47,734	47,273	46,611	405,012	45,001	41,940	36,099	31,007
Non-MD Ratio	39.5%	28.3%	15.2%	26.3%	20.2%	29.7%	18.4%	24.7%	22.6%	23.3%	23.3%	21.9%	18.8%	21.7%
Hours Paid	1,457	1,205	1,318	1,231	1,103	1,041	1,157	1,140	1,220	10,871	1,208	1,347	1,128	996
Hours per Incisional Procedure	6.71	6.81	5.93	6.06	5.33	4.45	5.87	5.632	5.84	5.84	6.94	6.62	6.27	
FTE Hour's Paid	8.40	6.95	7.60	7.10	6.36	6.00	6.67	6.58	7.04	6.97	6.97	7.77	6.51	5.75
Operating Income/FTE Paid	\$ (4,568)	1,194	16,069	4,848	14,692	(1,164)	16,227	12,271	5,183	62,918	6,991	8,566	10,534	5,666
Collections Per FTE — Annualized	166,089	246,999	448,605	284,935	417,888	299,594	467,178	348,548	351,302	333,043	333,043	296,159	354,663	298,386
Incisional Cases Per FTE — Annualized	309.8	305.4	350.5	343.1	390.5	467.7	354.2	410.5	329.0	358.8	358.8	299.7	314.2	331.8
BUDGET:														
Operating Income — Actual (EBITDA)	\$ (38,394)	8,301	122,139	34,417	93,459	(6,986)	108,293	80,720	36,486	438,436	48,715	\$66,572	\$68,551	\$32,557
Budgeted Operating Income	\$65,019	65,019	65,019	65,019	65,019	65,019	65,019	65,019	65,019	585,171	65,019	67,234	74,610	—
Favorable (Unfavorable)	\$ (103,413)	(56,718)	57,120	(30,602)	28,440	(72,005)	43,274	15,701	(28,533)	(146,735)	(16,304)	(6,662)	(6,059)	32,557
Cataracts — Actual	194	156	182	190	177	213	181	201	179	1,673.0	185.9	173.9	159.6	152.3
Cataracts — Budgeted	182	182	182	182	182	182	182	182	182	1,634.3	181.6	175.0	156.0	150.0
Favorable (Unfavorable)	12	(26)	0	8	(5)	31	(1)	19	(3)	38.8	4.3	(1.1)	3.6	2.3
Number of Months (YTD)	9													
Number of Quarters (YTD)	3													

particular items that require additional research to explain variances and/or highlight potential problems.

The specific information contained in the one-page report is customized to each facility to meet identified information needs. However, typical sections within the report would include:

- Operational overview statistics detailing number of surgical days, total number of procedures performed, etc.
- Surgical procedures analysis breaking down the cases performed by type — for example, cataracts, cornea transplants, posterior segment procedures, oculoplastics, ophthalmic lasers, etc.
- Patient encounter information that reflects the number of patients treated, average collections and operating expenses per patient and other items of interest to the stakeholders
- Operating revenue detail
- Operating expense detail
- Accounts receivable analytics
- Accounts payable summary
- Payroll and personnel statistics
- Key budgeted items and comparisons to actual

Individual facilities, managers and ownership groups will, of course, identify other information needs that will require specific reports. I would urge financial managers to subject all such items to one simple test: Ask, “What strategic or operational decision will the information contained in this report guide?” If you can’t identify such a decision, you need to question the necessity of generating the report.

Although many of the facility’s stakeholders may be comfortable with quantitative financial reports, strongly consider presenting some of the key information in graphic formats. Visual presentation is extremely effective for financial elements that you want to track over an extended period of time — for example, total monthly charges and collections, key surgical case counts and, perhaps, projected collectible accounts receivable and accounts payable. These particular elements are usefully portrayed using line graphs or bar graphs. These tools quickly and effectively allow virtually all users to grasp the trends of these items and the favorable or unfavorable nature of the trend. Figure 3 illustrates this type of visual

portrayal of trends in monthly surgical procedures over a six-year period for a hypothetical ASC.

REPORTING TO STAFF MEMBERS

Staff members typically have limited access to the facility’s financial information, but in many of the operating expense categories, the staff has substantial influence on purchasing decisions. Thus, financial managers and the ownership group should strongly consider providing detailed information on surgical supplies expenses, labor costs and utilization and variable operating expenses to team leaders and other staff responsible for acquisition of these items and inventory control. The key element is to provide information in areas where the staff has not only responsibility but also authority to influence the business decisions being made. While monthly data are often subject to substantial fluctuations, particularly if the facility uses cash basis accounting, the data provide immediate feedback to the managers who are making these purchase decisions. Quarterly and annual data, information identifying trends in these categories, benchmarks and annual budgets should also be communicated and regularly reviewed with those responsible.

REPORTING TO LENDERS

Lenders’ interest is typically confined to one simple area: Is the facility sufficiently profitable to repay any borrowed funds that the lender has provided? Earlier in the module, we discussed loan covenants that must be met. Other common lender requirements include the periodic provision of facility tax returns and, perhaps, those of guarantors. Additionally, guarantors of loans are routinely required to provide personal or business financial statements on a scheduled basis, for example, quarterly or annually.

REPORTING TO REGULATORS

Regulators often require that the facility regularly complete and submit various reports that document compliance with federal, state and local laws and regulations. Examples are many and include income, payroll, unemployment and use tax returns.

Several states require ASCs to file reports summarizing detailed financial and operational data. These reports may set forth charges, collections, numbers of patients, numbers and types of surgeries performed and many other data points. Often, these states then compile this information by facility and publish reports that are available to the public. If your state publishes such information, I urge you to

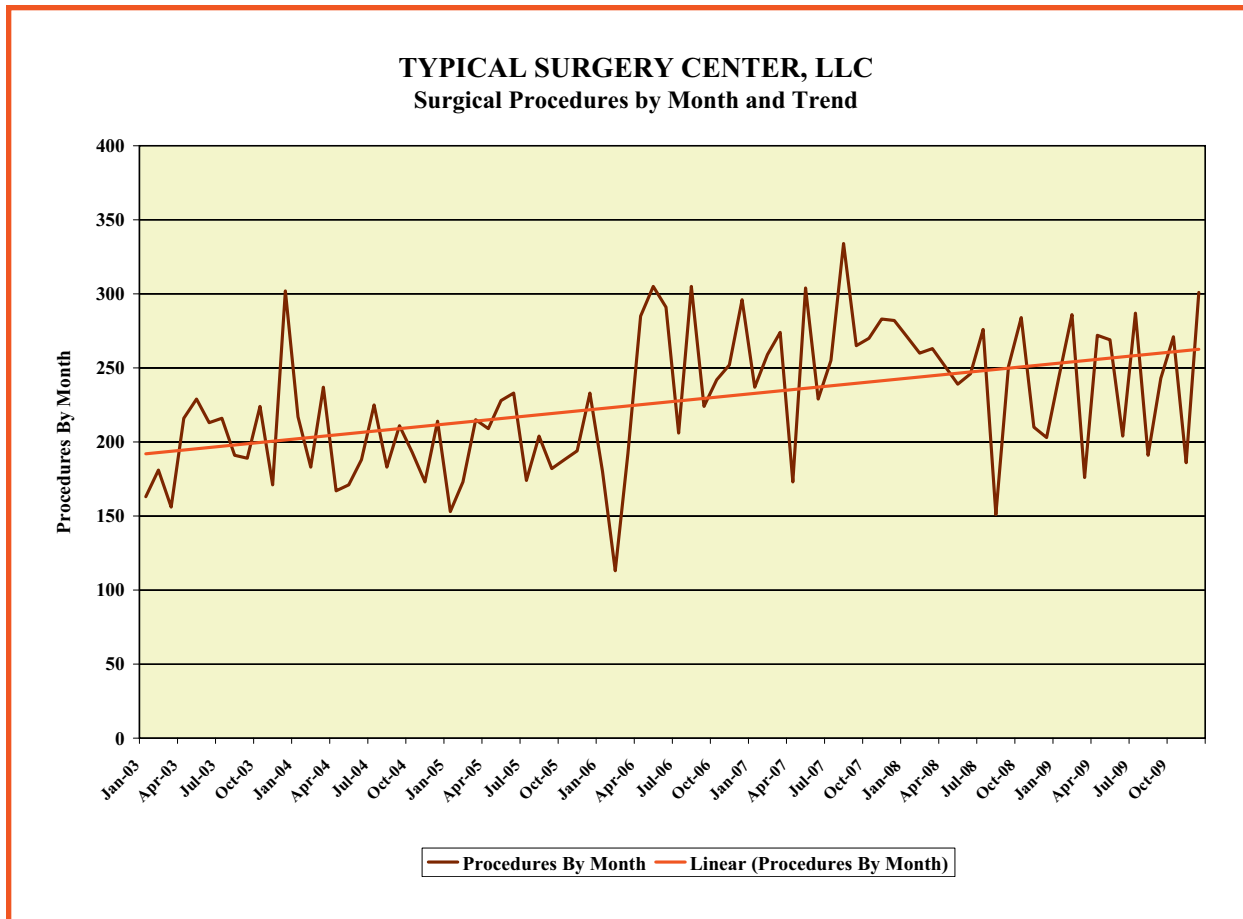


FIGURE 3: Monthly Surgical Procedures Comparison Report

obtain a copy of the publication. It will often provide very relevant external benchmark information, which we will discuss in detail later in the module.

Finally, approximately half of the states have “certificate of need” laws that restrict the development of ASCs. Often, when a certificate of need is granted allowing the development of a facility, conditions are attached that require periodic reports to be filed throughout the development process and on a continuing basis after operations commence. One area of particular emphasis is the requirement to provide charity care at a predefined level.

Delivering Financial Information to Stakeholders

Typically, financial reports are delivered to the various stakeholders in written form; however, it is my suggestion that the financial manager personally deliver information when possible and provide time for review, analysis and discussion of actions required in response to the data. This is particularly important when conveying financial information to

clinical staff members responsible for purchasing, inventory control and surgical scheduling.

Much of the financial information is presented to the facility owners during periodic meetings. Newer facilities often schedule monthly meetings until the operations and financial results have stabilized; at that point, the meetings may occur only quarterly. Many states’ corporate statutes and federal regulatory bodies require that these meetings be documented with minutes. One of these meetings is typically designated as an “annual” meeting during which officers are elected and various other official duties are discharged. During these meetings, it is important that the financial manager not only present data, but also interpret past results and provide his or her opinion as to future trends and factors, both positive and negative, that may materially impact the facility’s operations.

If some of the owners are unable to be present for the meetings, electronic communications including speakerphones or Web-based conferencing tools may be utilized to enable all to participate. Note that e-mail, while convenient, is not a “secure”

form of communication and should not routinely be used to transmit very sensitive or confidential information outside of the facility's internal network. In most situations, e-mail is not HIPAA compliant, so Protected Health Information should not be transmitted unless your network administrator has reviewed and approved the application.

As we've noted above, the financial manager should attempt to keep these discussions focused on material results that will impact the future profitability and/or operational efficiency of the ASC. If the results are unfavorable, less than budgeted or exhibit a worrisome long-term trend, be prepared to present a frank analysis of the difficulties and offer suggestions for improvement. By all means, avoid the tendency to mask or soften bad news; systemic problems rarely resolve themselves, and very few investors like unpleasant surprises.

Finally, as long as the facility has outstanding bank debt, I would urge that the financial manager and a representative of the ownership group meet at least annually with the primary banking contact to review financial results and outline expectations for future operations. The bank is subject to substantial regulatory oversight and will appreciate your efforts to keep the information in its files current and supportive of the loan.

Let's turn now to an examination of some very specific numeric tools that you will use to manage your facility on an ongoing basis.

Financial Benchmarks and Trend Analysis

In its raw form, financial information is of limited value to the manager. If I tell you that an ASC performed 125 surgeries last month, had nine full-time employees and generated revenue before income taxes of \$12,000, what can you tell me about the center's financial performance? Not much — other than, for at least this one month, it was profitable. Was facility utilization high or low? Is the staffing level appropriate or too high? How is the center doing in translating collections into distributable profits?

Single data points are rarely as useful as ratios and period-to-period comparisons that enable the financial manager to assess the performance of the facility against its historical record, its budget or industry norms. These analytical tools are commonly referred to as **benchmarks**. When fully

understood and implemented, benchmarks are powerful keys to drive financial decision making.

Benchmarking: External and Internal

There are two types of benchmarking: external and internal.

External benchmarking involves comparing your facility's financial and performance data with that for the industry as a whole so that you can see how your facility compares with others. Data are available from several sources. Be aware, however, that financial benchmarks can be materially different for surgical specialties other than ophthalmology. Information that doesn't break down the surgical case mix of the facilities contributing data should be used with great caution.

External benchmarking data should be used principally to identify a "healthy range" for each benchmark of interest, against which you can compare the performance of your center. Individual external benchmarks should not be viewed as specific numeric goals.

Perhaps the most useful external benchmark data for ophthalmic ASCs is the information available through the Outpatient Ophthalmic Surgery Society (www.ooss.org). These data are gathered and compiled for ophthalmic surgery centers or multi-specialty centers that have a substantial ophthalmic component.

Internal benchmarking is comparing your facility's current performance with its past performance over the same period of time — this could be a month, a quarter, a year or another measure. Each individual center has unique financial and operational characteristics — for example, geographic location, payer mix, local competition, surgeons' preferences for equipment and surgical supplies, case mix — that will produce variances from industry (external) benchmarks. Only by comparing your current performance with that for prior periods from which the data are well understood can you clearly identify problem areas or worrisome trends.

Over time, each center has the opportunity to compile observations on key benchmarks for various reporting periods. These internal benchmarks serve two important purposes. First, they provide the basis for comparison with external benchmarks to determine if your center is operating within the commonly defined industry healthy range. Second, they highlight positive or negative trends in the underlying data that allow the manager to assess the success of prior-period management tactics or focus

his or her analytical efforts on factors that may be hurting the center's profitability or productivity.

In my experience, careful study of internally developed benchmark data is critical to the long-term success of every ophthalmic ASC. In the coming sections, we will take a closer look at several of the key financial benchmarks every center should monitor.

Focusing on Controllable Costs

A characteristic of all ASCs is that they are high-fixed-cost businesses. This means that a great percentage of the operating costs of the business are not within the control of the manager within a relevant range of surgical case volume. For example, the ASC's rent, utilities, property taxes, insurance costs, equipment maintenance contracts and many other expenses are obligations that must be paid (fixed costs) regardless of its case counts.

The typical ophthalmic ASC's patient cohort is also usually heavily weighted to Medicare patients, functionally a single payer system. Thus, the ability of ophthalmic ASCs to increase revenues by adjusting charges is very limited. For centers with a preponderance of anterior segment procedures, it is common for 60 to 80 percent of the patients to have Medicare as their primary insurance; posterior segment practices typically have a somewhat lower percentage of Medicare patients, although the share usually does not fall below about 50 percent. Additionally, over the past few years, many of the commercial payers have adopted global fee schedule reimbursement models that reflect the Medicare fee schedule.

Lacking control over revenue generation, it is thus imperative that financial managers of ophthalmic ASCs focus on those expense areas where a majority of dollars are spent and over which they can exert some control. Two areas are always of particular concern:

- Labor costs
- Surgical supplies expense, including drugs and medications

Together, these two expense categories often comprise 65 to 80 percent of a facility's total expenses. Let's look at each category more closely.

Useful Labor Cost Benchmarks

In our earlier discussion of the chart of accounts, we pointed out that most labor cost benchmarks

use "fully burdened" labor costs rather than simply "wages" or "direct" labor costs. Fully burdened labor costs include not only wages and salaries but also other expenses for obligations and benefits provided to staff members. Those obligations and benefits include employer payroll taxes, health insurance premiums, retirement plan contributions and other benefit programs such as tuition reimbursement, dental, vision and staff training costs. These indirect costs are typically in the range of 22 to 28 percent of the facility's direct labor costs.

Numerous benchmarks are available to evaluate the efficiency and productivity of a facility's staff. Examples include:

- Labor cost ratio
- Labor hours expended per incisional surgery
- Collections per full-time-equivalent (FTE) employee
- Incisional cases per FTE employee

Of these, the labor cost ratio and labor hours expended per incisional surgery are the most commonly utilized and, in my view, provide the most valuable information.

LABOR COST RATIO

The **labor cost ratio** is a measure of the efficiency with which a facility utilizes its staff. It is computed by dividing fully burdened staff labor costs by the facility's net collections. It is essential to include the cost of salaried as well as hourly employees and all indirect labor costs as described above. "Net collections" refers to the total amount of reimbursements received by the facility less any refunds to patients and payers and adjusted for the net cost or revenue derived from the purchase and sale of pass-through items as discussed earlier in the module.

Ophthalmic ASCs should expect the labor cost ratio to be in the 20 to 30 percent range. Centers with a high proportion of cataract surgeries should be at the lower end of the range, whereas centers that undertake a significant number of posterior segment, pediatric, cornea transplant and oculoplastics cases would expect to be near the upper bound of the range.

LABOR HOURS EXPENDED PER INCISIONAL SURGERY

Labor hours expended per incisional surgery also measures the efficiency of both the staff and the facility staffing plan. To compute this ratio, divide the total hours paid during the period of

measurement by the number of incisional surgical cases performed during the period. I suggest that ophthalmic laser cases be excluded, for two reasons: (1) they require relatively limited staff time, and (2) their inclusion in calculating the ratio may hinder its comparability with both internal and external benchmarks because both the number of such cases and their proportion of the total cases can vary substantially from month to month and from center to center.

Most centers can expect the labor hours expended per incisional surgery ratio to remain in the 5.5 to 9.0 range. For centers where cataract surgery predominates, the ratio should be in the 5.5 to 7.0 range. Centers that perform a significant number of retina, pediatric, oculoplastics or transplant cases could generate ratios in the 7.0 to 9.0 range and still be operating efficiently.

COLLECTIONS PER FTE EMPLOYEE AND INCISIONAL CASES PER FTE EMPLOYEE

Computation of these two ratios — **collections per FTE employee** and **incisional cases per FTE employee** — is self-evident, with the exception of the use of “full-time-equivalent (FTE) employees” as the denominator in the calculation. Using the raw head count of ASC employees seldom produces meaningful, reproducible or comparable data due to wide variations in the use of part-time and as-needed (PRN) versus full-time employees. FTEs are considered to be employees who are paid for 2,080 hours in a calendar year — 52 weeks times 40 hours per week. Converting the labor hours you are analyzing to FTEs establishes a consistent and comparable basis for further calculations.

This example illustrates the conversion. Assume that during a specific month your facility pays staff members for 1,225 hours. This figure is derived from your payroll reports and includes not only hourly workers but also salaried staff at an assumed rate of 40 paid hours per week. To convert the hours paid to FTEs, simply multiply them by 12 to annualize the monthly paid hours; then divide the total (14,700) by 2,080. The resulting quotient, approximately 7.07, is the number of FTE employees paid during the month.

The industry benchmark range for ophthalmic ASCs for collections per FTE is \$250,000 to \$400,000, while the benchmark range for incisional cases per FTE is 275 to 350 cases. Your initial impression may be that these ranges are too wide to be useful, but remember that external benchmarks are best used simply to establish the boundaries of a healthy range. Read on to further understand the

relationship between internal and external benchmarks and their interpretation.

EFFECT OF STAFFING DECISIONS ON LABOR COST RATIOS

The ratios that utilize labor hours to compute benchmarks illustrate some of the pitfalls that financial managers must avoid. There are many ways to staff an ASC to achieve a desired result. Some facility managers believe that the best strategy is to hire a core staff of very experienced surgical personnel who, because of their experience level, can perform in a highly productive manner. Logically, these more experienced staff members will command higher wages and benefits.

Other managers prefer to have a small number of key, experienced personnel and to meet their other staffing needs with less experienced — and, thus, less costly — employees. The use of part-time or PRN staff can be an effective strategy for reducing the cost of benefits.

I have seen both of these strategies employed effectively in ophthalmic ASCs that have been productive, profitable and stable over long periods of time, including two small, one-operating-room centers located less than 40 miles from each other on the eastern seaboard. One center uses the first approach; the other, the second. As a result, the number of FTEs at the first center is historically close to 5.0, while the corresponding number for the second center is historically close to 7.5.

The labor cost ratio — the percentage of collections spent on fully burdened labor — for these two centers is remarkably close and has been for several years. However, due to the different staffing strategies, the other three ratios (labor hours expended per incisional surgery, collections per FTE employee and incisional cases per FTE employee) differ quite a bit due to the second facility's using substantially more, albeit less costly, labor hours to achieve the same surgical productivity.

The take-home lesson here is the importance of internal benchmarking. Certainly, if your center falls outside the industry benchmark range, you should determine the causes for the deviation to ensure that your current structure is working acceptably for the owners and other stakeholders. But once you are satisfied that that is the case, use the internal benchmarks and their trends to monitor your performance. To be an effective manager, you must understand the data on a fundamental level. You must know *why* your benchmark for labor hours per incisional surgery is 7.5, not merely what the ratio is.

Surgical Supplies Expense Ratio

The cost of items consumed during surgical cases represents the other significant category of expenditures that are, at least somewhat, controllable. Analysis in this area starts with computation of the surgical supplies expense ratio.

A straightforward computation, the **surgical supplies expense ratio** is simply the cost of items used during surgical cases, including drugs and anesthetic medication, divided by net collections as defined earlier in the module. Most ophthalmic ASCs should exhibit a ratio in the 20 to 30 percent range, depending on case mix.

Percentages in cataract-intensive centers should be in the lower half of the range, while for facilities that perform a substantial number of posterior segment cases, the ratio may approach the 30 percent level.

Centers where non-cataract cases comprise a significant proportion of the case mix will likely have experienced some fluctuation in this ratio over the past few years. The reason is that the 2007 Medicare reimbursement restructuring has been phased in, and many procedures other than cataract have received material reimbursement increases, retina cases being a prime example.

Again, in the case of the surgical supplies benchmark, comparisons with the internal benchmarks your center has developed will be more instructive than comparison with external benchmarks because the center's owners have wide discretion over the type and cost of equipment and surgical supplies that are utilized in the facility. Choice of a vendor for intraocular lenses, viscoelastics and reusable versus single-use products will materially impact this ratio, given that owners and management have very limited control over anticipated revenue per case.

Periodically (I recommend doing this annually), you should supplement the surgical supplies expense benchmark by performing an analysis of the surgical case costs by physician for your major surgical procedures. The obvious place to start for most ophthalmic ASCs is with cataract surgery.

Prepare a template using a computer spreadsheet program to assist you in capturing the data. Don't simply identify the cost of the IOL, viscoelastics, custom tray and phacoemulsifier tubing and supplies. Break down in detail materials used in the admitting process; drugs and medications; individual items used intraoperatively, including solutions, blades, syringes, BSS, etc.; and recovery supplies.

The purpose of this exercise is to identify items that vary from surgeon to surgeon with significant

cost differences, items included in the custom packs or admitting protocols that aren't routinely used and individual items with high individual costs that may be "shopped" with alternative vendors.

Get the owners' agreement for you to share this information among the medical staff members so that the surgeons can compare their typical case costs and perhaps generate cost-saving suggestions.

Incisional Surgical Procedures Performed: Monitoring the Surgical Calendar

Surgical volume is the oxygen ASCs breathe to sustain life. A fundamental truth of ASC financial management is that *a sustained decline in surgical volume cannot be offset by becoming more efficient in managing expenses.*

For that reason, I can't stress strongly enough that the financial manager needs to keep a very close eye on the surgical calendar. I would suggest monitoring incisional surgical case volumes weekly and monthly, as well as maintaining a facility committed block time schedule a minimum of three months into the future. Anticipated unused operating room time should be offered to other medical staff members with sufficient notice to allow them to adjust their clinic schedules when necessary.

Surgical cases performed, cases scheduled in the near future and anticipated material changes in future volumes must be communicated regularly to the facility owners because their assistance is often required to recruit new staff surgeons, encourage current staff members to increase the case numbers that they bring to the facility and deal with other long-term changes in the medical staff membership.

Accounts Receivable and Revenue Cycle Management

With limited control over the pricing of our services, timely and effective billing and collection activities become extremely important to the financial health of an ophthalmic ASC. As a practical matter, the ability of the financial manager to impact the revenue cycle is limited to ensuring that this department functions efficiently.

In stable situations, the billing and collection function should be thought of as four distinct activities: precertification to determine patient eligibility for coverage, posting of charges and filing of claims following surgery, posting of payments from insurance and patients and, finally, collection efforts.

The first three functions are time-sensitive and are typically performed well by the local ASC staff or deficiencies in performance are noticed rapidly. Failure to determine eligibility results in denied claims, failure to post charges and file claims results in rapidly diminishing cash collections, and failure to post payments results in improperly prepared patient statements and follow-up phone calls inquiring about the errors.

Unfortunately, the collection function is not particularly time-sensitive. For that reason, it is the effort that gets deferred when labor hours are in short supply — as they frequently are in this era of stringent expense control. It is incumbent on the financial manager to develop tools that will quickly highlight breakdowns in performance in this department.

Although many benchmarks are available to keep the financial manager on top of this critical area, two deserve particular mention and discussion:

- Days collections in accounts receivable
- Accounts receivable aging

DAYS COLLECTIONS IN ACCOUNTS RECEIVABLE

The **days collections in accounts receivable** ratio measures the average length of time that a charge remains unpaid. The ratio is computed by dividing *collectible* accounts receivable by average daily collections. Collectible accounts receivable is estimated by reducing your gross charges by anticipated contractual discounts and bad debt write-offs. This discount factor is very facility-specific and is determined by the relationship of your charge schedule to payer allowables.

To ensure year-to-year consistency, my suggestion is to use a discount factor that is a moving average of collections divided by gross charges for two or three prior years and the current year-to-date. Average daily collections are determined by dividing the year-to-date collections by the number of days in the collection period, using a 365-day year.

As we've noted previously, benchmarks are most useful for tracking a trend over several time periods. Days collections in accounts receivable is no exception, in that it can be materially affected in the short run by fluctuating surgical volumes or by failure to enter charges on a timely basis, particularly at the end of a measurement period.

As a diagnostic tool over a period of time, days collections in accounts receivable can tip you off, among other issues, to declining performance by the collection staff, an inappropriate pattern of charge-offs or a payment problem with a major payer.

For ophthalmic ASCs, 35 to 45 days is a healthy range for this index; however, understanding month-to-month fluctuations often requires some detective work.

ACCOUNTS RECEIVABLE AGING

Virtually every computerized practice management system produces an **accounts receivable aging** report, which categorizes gross accounts receivable into various "buckets" based on the length of time since their date of service. The buckets are typically in 30-day increments.

There are numerous sources of benchmark data for this tool, but a reasonable distribution of accounts for an ophthalmic ASC would be 50 to 70 percent of the total as current (less than 30 days old), 10 to 20 percent from 31 to 60 days old, 5 to 10 percent 61 to 90 days from date of service, and 10 to 20 percent at 91 days or older.

Two specific possible problems exist with these data, and the financial manager must determine that appropriate adjustments have been made when necessary. First, some software programs have a setting that recomputes the aging based on the date of the most recent transaction. For example, when an insurance payment is posted, the software may consider the account again current and move it to the under-30-day bucket. This has the effect of making the aging appear much more current than if it were computed based on the date of service.

Health care accounts receivable are unique because there are often two parties responsible for payment of the claim. First, the insurance payers are responsible for the initial processing of the claim and payment of a portion of the costs pursuant to their policy contract with the patient. This has the unfortunate effect of delaying the billing to the second payer, the patient, for the net amount he or she owes. It is a commonly accepted axiom of billing and collections that the longer the delay in billing the patient from the date of service, the greater the risk of incurring a bad debt for some or all of the balance for which the patient is responsible. An aging analysis based on the date of the most recent transaction is very likely to lead the financial manager to overestimate the collectible amount of the gross accounts receivable.

A second problem is that most practice management software for ASCs is not designed to handle "time payment" accounts, that is, accounts in which the patient has arranged with the facility to pay off the balance over some period of time. Aged on date of service, these accounts will slip further and further into the undesirable aging buckets even though

the patient may be meeting his or her agreed-upon obligations. In these cases, the aging will appear worse than the underlying economic reality.

One possible solution, when your software allows, is to run a separate aging on patient-responsible accounts based on transaction date. Accounts on payment plans that are making agreed-upon payments will be aged as current; those that have no posted transactions will continue to move to the higher-aging buckets. Although not a precise fix, this approach may allow the financial manager to develop more accurate data without the effort of maintaining a separate subsidiary accounts receivable subledger for those accounts on payment plans.

The accounts receivable aging report is best used to identify specific collection problems such as individual unpaid claims, problem payers or breakdowns in the collections staff's performance, rather than to analyze the performance of the organization as a whole. In particular, the manager needs to review in detail the trends of the over-60-day and over-90-day buckets. Well-managed centers address problem accounts before they reach the 90-day mark.

Ironically, these two tools (days collections in accounts receivable and accounts receivable aging) may frequently provide conflicting indications of performance. For example, a busy surgical month will create a large dollar volume of current claims, reducing the percentages of claims in the older-aged buckets. But, because additional cases increase the total dollar amount of collectible accounts receivable, the "days collections" ratio may deteriorate significantly.

These tools are important and useful because they are sensitive to short-term fluctuations in the volume of surgical activity. Because of their volatility, they require the financial manager to develop a deep understanding of their relationship to each other and to other revenue cycle benchmarks that may be tracked. They also require that the financial manager evaluate significant swings in the ratios in a timely manner.

Many other data points can be benchmarked, and in particular circumstances, financial managers and other stakeholders may find them informative and useful. As I've suggested previously, it's vital to evaluate the development of management tools and reports in light of their ease of computation, influence on decision making, financial importance and the extent of control that the manager can exert on the underlying variables. It makes little sense to spend time on the analysis of small dollar fluctuations or expenses that are essentially fixed in nature.

Cash Flow Management and Long-Term Planning

To this point, we've focused on the major revenue generating and operating expense elements that impact the profitability, efficiency and productivity of the ophthalmic ASC. A further goal of the financial manager is to ensure the long-term stability of the enterprise. Thus, the manager must consider and plan for demands on the resources of the business from nonoperational needs.

Potential sources of cash for an ASC include cash generated from operations, borrowed funds and capital contributions from the owners. After the initial development period, successful facilities rely on positive cash flow from operations to fund their usual obligations and provide for their future needs. Exceptions may occur for the purchase of costly new or replacement technology or extensive remodeling of the physical plant that requires new borrowing or a capital infusion from the ownership, but these unusual events occur very infrequently.

In addition to normal trade accounts payable and other operating expenses, there are four other major claims on the cash of the organization:

- Repayment of long-term debt
- Reserves established for capital purchases
- Reserves for unanticipated operating needs
- Distributions or dividends paid to owners

The financial manager must anticipate these needs and the timing of required payments, plan accordingly and keep affected stakeholders informed of how these obligations will be addressed.

In my experience, these nonoperating uses of cash often cause great confusion to less experienced financial managers and frequently also to owners who rely primarily on the income statement for their understanding of the economic performance of the facility.

Repayment of Long-Term Debt

Typical debt obligations managed within an ASC have fixed monthly payments, due the same time each month. In the case of amortizing loans, such as those for equipment purchases, leasehold improvement construction or real estate mortgages, a portion

of each payment is allocable to interest and a portion reduces the outstanding principal balance.

As we discussed earlier, the interest expense is captured on the facility's income statement; however, the principal reduction also requires cash but is not reflected as an element of operating income. Thus, the financial manager must reserve cash for the total debt service payments and ensure that the owners understand how this cash is to be used. A primary function of the statement of changes in cash is to highlight such uses of cash in an easily understood format.

It is also important that the financial manager read and understand all of the underlying loan documents and the structure of each loan. We previously reviewed reporting obligations that may be imposed as conditions of loans, as well as noting that the facility and guarantors of the debt may be required to furnish financial information periodically to the lender. Typically, the financial manager is responsible for obtaining all of the required information or, at least, for arranging for the guarantors to submit everything required in a timely manner.

Be aware that many amortizing loans specify an amortization period that is longer than the term of the underlying note. This is particularly true when the lender is a commercial bank; historically, commercial banks are not long-term lenders. For example, your facility may be leasing space in an office building, but you borrowed the funds to complete the leasehold improvements to make the space functional as an ASC. A common loan structure would amortize the principal of the loan over the initial term of the lease, say 10 years, but the note may contain a "balloon" repayment provision making the entire unpaid balance due at the end of three or five years.

In this case, the financial manager needs to begin to plan to refinance the loan many months in advance of the note due date. Assuming that you have made all of the required payments on a timely basis, been in compliance with the debt covenants and your center is operating profitably, it is likely that your current lender will offer to negotiate a renewal or extension.

Be cognizant that the renewal offer may propose changes in the interest rate and, perhaps, the term of the note to reflect current conditions in the financial markets. In some cases, depending on the degree of leverage in your initial loan, the bank may require the owner(s) to contribute additional capital.

In short, don't assume that everything will automatically renew on favorable terms with your

current lender. The financial markets have been very volatile for the past few years, and I anticipate that they will remain so for several more. Be prepared to solicit competing proposals from other lenders. To do so, you will need to be able to supply each lender with sufficient documentation to allow them to underwrite the loan and issue either a non-binding term sheet or a formal commitment letter outlining their proposed loan terms.

Allow enough time, at least 60 days after receiving all of the loan proposals, for the ownership group to select and notify the successful lender, have formal loan documents prepared and complete the closing and funding of the loan.

Capital Purchases Reserves and the Nature of Depreciation

Depreciation expense is an accounting convention that represents the exhaustion of the "store of value" contained in capital assets, where capital assets are defined as those things with a useful life in excess of one year. As a cash management issue, depreciation presents a problem that is the precise reverse of that created by the principal repayment of long-term debt.

That is, depreciation expense is a reduction of income before taxes captured on the income statement that does not use cash. Unfortunately, this often leads to the temptation to view the resultant unspent cash as available for other current needs, including distributions or dividends paid to owners.

The financial manager needs to understand, and convey to other stakeholders, that depreciation expense is, when viewed over the long run, an actual expense that must be managed, or there will be serious negative consequences for the enterprise.

For example, when you purchase a car, you are acquiring an asset that will provide you with several years of service, but one that has a finite life. As you drive the car, you reduce its inherent store of value. We can estimate the rate at which you are consuming the asset. Say the new car costs \$30,000 and you believe that its useful life is 100,000 miles. Further, assume that you drive 20,000 miles per year. It is easily understood that for each mile you drive you are using 30 cents of the initial store of value; thus, for each year in which you drive 20,000 miles, you are using up \$6,000 of the value and 20 percent of the useful life of the car. This is, in essence, depreciation expense. You don't feel any immediate cash impact, but you are using up a valuable asset that you purchased at some time in the past.

Of course, you must supply gasoline, oil and other maintenance items, but those are operating

expenses, equivalent to the rent, utilities, surgical supplies and labor costs of the ASC. For your personal financial health, however, you need a plan to replace the car at the end of its useful life.

Among your options are obtaining a loan to finance the new car purchase (bank debt), selling some of your other assets to finance the purchase (something akin to a capital contribution) or allocating some of your operating income over the 100,000-mile life of the old car to a reserve fund to replace the car when it becomes obsolete.

Over a several-year period of time, your ASC faces similar issues. Your surgical equipment will wear out or become technologically obsolete, as will such things as patient transport equipment, monitors, computers and information processing equipment. Eventually, you will need to repaint and to replace the carpet, reception room furniture and the facility's major environmental systems. To fund these changes, the ASC has the same three options: bank debt, capital contributions or a regular protocol that uses current cash produced from operations to replace materials on a regular basis as their store of value is exhausted.

At its heart, this is a strategic decision that must be made by the ASC ownership group and implemented by the financial manager. The financial manager will usually need to initiate this discussion and explain the alternatives.

My suggestion is to establish an annual capital budget based on anticipated replacement needs and an additional increment to provide for unforeseen events — for example, addition of a new surgeon who requires specialized instruments, or failure of a device or piece of equipment. While the amount of the capital budget will vary by facility, it is reasonable to assume that most medical equipment, furniture and fixtures will have a useful life of five to ten years. Thus, the financial manager may anticipate cash needs equal to 10 to 20 percent of the initial cost of these assets on an annual basis.

As we will see later, attempting to retain large amounts of cash to provide for major renovations or acquisition of costly new technology is often viewed as undesirable by the ownership group and may under certain circumstances have undesirable tax consequences. These major expenditures, often for particularly long-lived assets such as the heat, air conditioning and ventilation system, are most often financed by bank debt.

In any event, sound financial management requires the development and implementation of a long-term plan to ensure that the capital assets of the facility remain functional, reliable and available to allow the center to meet its organizational goals.

Operating Reserves

We've all experienced situations where a major payer — for example, Medicare — withheld payments for a period of time, the clearinghouse was unable to process claims or there was another interruption to incoming cash flow. Certain recurring expenses are crucial to the continued operation of the facility, and cash should be held on a current basis to ensure that these short-term needs can be met if our collections drop unexpectedly. Examples of these recurring expenses include payroll costs, rent, utilities and monthly debt service payments.

I suggest that my clients establish a policy to maintain a general ledger cash balance at a level equal to or greater than 15 days' average operating expenses, plus any known major expenditures that are due in the next 30 to 45 days. Specific items for which you may wish to reserve cash include professional liability insurance (if paid annually), business property taxes and anticipated principal payments on your working capital line of credit.

Again, the financial manager will want to obtain the agreement of the owners of the facility because this policy will defer the payment of cash distributions or dividends.

Distributions and Dividends

The final claim on the positive cash flow of the organization is that of the owners as a return for the assumption of entrepreneurial risk. Depending on the legal form of the business, these payments are made either as distributions to the shareholders or as dividend payments.

In order to facilitate proper cash management, the financial manager and the owners need to agree on the timing of such payments and the method by which the amount to be paid out is determined. I typically suggest quarterly to minimize the time spent on check writing and processing.

Cash Management and Entity Structure: Considerations for Financial Managers

While most ophthalmic ASCs organize as some form of corporation, infrequently the owners may elect to organize as a partnership or sole proprietorship. The form of organization is usually dictated by federal or state tax implications and is often determined by the owners' legal and tax advisors. The financial manager needs to understand the form of organization because it often has direct implications on the cash management activities of the center.

For the purposes of this module, we will concentrate on the two major categories of ownership: regular corporations, sometimes referred to as "C" corporations, and "pass-through" entities that are usually taxed as if they are partnerships. These pass-through entities include limited liability companies, subchapter S corporations, limited liability partnerships and regular partnerships.

Regular, or "C," Corporations

The regular corporation form has not been commonly chosen for many years due to the problem of "double taxation." This form of corporation is a federal tax-paying entity, subject to corporate income taxes in years when it shows a profit. As a result, most closely held corporations attempt to pay wages or dividends near the end of their fiscal year to minimize their corporate tax liability.

To the extent that cash remains in the entity and income taxes are paid, the cash is effectively "trapped" in the corporation. The only way to get the cash to the owners is via compensation or dividend payments, both of which are taxable as income to the recipient. Thus, the earnings of the corporation are taxed twice, once at the corporate level and again on receipt by the owner as dividends. Note that the ASC would likely have to elect to pay out the cash as dividends in order to reflect payment to the owners based on their ownership percentage, a legal requirement for surgery centers.

For the financial manager, the implication of this form of legal organization is that it is very difficult to accumulate cash in the corporation to fund debt principal payments, capital replacement reserves and the short-term operating reserve. Depleting the cash balance at the end of the fiscal

year will require that the organization maintain a working capital line of credit to ensure that it will have cash available to meet its requirements during the first month or two of the new fiscal year. Additionally, all of the distributions to the shareholders must be made in a taxable form, dividends, for an ASC. This restricts the tax-planning ability of the individual owners in that they cannot influence the nature of the cash they receive.

Pass-Through Entities

Organization as a pass-through entity makes cash management more flexible because these entities usually elect to be taxed as partnerships. Partnership income is not taxable at the federal level and is distributed to the individual owners on a Schedule K-1 at the end of the ASC's fiscal year. During the year, cash payments may be made to the owners as nontaxable distributions.

Since the pass-through entity is not separately taxable, the problem of double taxation is avoided, and the financial manager, with the approval of the owners, can accumulate cash in the organization to meet continuing and anticipated cash needs. Note that this does not mean that the ASC's profits are not taxed. Rather, they are distributed to the individual owners and reported on their individual tax returns, for example, Form 1040 for individuals.

Although it is rare, a limited liability company can elect to be taxed as a regular corporation. The financial manager needs to check with the ASC's tax advisor to confirm which election has been made.

"Phantom" Income and Pass-Through Entities

One consideration for the financial manager of an entity that has elected pass-through status involves the disassociation of cash distributions and allocated taxable income. This situation is commonly known as the "phantom" income problem. Under certain circumstances it is possible that an owner would be allocated taxable income via Form K-1 after a profitable year of ASC operations but would not have received sufficient cash distributions to pay the resulting personal tax liability.

It is more likely that this problem will occur in the first year or two of operations of a new ASC, but certain cash management policies can produce the same result in a mature center as well. Ironically, phantom income can result from a fiscally conservative or risk-adverse ownership group attempting to avoid or to retire bank debt.

Remember that the principal portion of a debt service payment impacts only the balance sheet and is not an expense that reduces accounting, or taxable, income. Assume that your center earns an accounting profit of \$300,000 in a given fiscal year and that depreciation and amortization (expenses that don't use cash) equal the scheduled debt principal reduction (payments that use cash but don't reduce income). In that case, your center would generate \$300,000 of positive cash flow that can be used for operating or capital reserves, debt reduction or distributions to the owners.

Now assume that the owners are worried about the outstanding bank debt, which they have personally guaranteed. They make a decision to reserve \$50,000 of the \$300,000 accounting profit for capital purchases, to reserve \$50,000 for operating expense issues and to prepay the bank debt with the remaining \$200,000. This decision is a seemingly prudent use of the distributable cash, which substantially reduces business risk and provides for the future stability of the ASC.

The phantom income problem is that the entire \$300,000 will flow through to the owners as personally taxable income on Form K-1. If their individual marginal tax rates are, say, 40 percent, as a group they will have a tax liability of \$120,000 and no cash to pay the taxes when due. As long as this result is anticipated and planned for, the owners may elect to go ahead with the debt payoff as described above. Suffice it to say, however, that the financial manager may face some relationship issues with the owners if this tax liability comes as a surprise after the money has been used to pay down the debt.

For many financial managers the anticipation of a phantom income issue is beyond the scope of their expertise. I would urge that financial managers consult with the ASC's independent accounting and tax advisor at least annually to ensure that this concern is avoided or, at a minimum, recognized well in advance.

Budgeting: Road Map for the Future

To this point, we have concentrated on the goals and objectives of financial reporting and financial management, as well as on constructing a financial infrastructure through the general ledger and basic financial statements. We've also emphasized that it is crucial for the financial manager to allocate his

or her time principally to those areas and issues that will impact the organization's financial well-being and decisions.

Much of this discussion has concentrated on elements that summarize economic events that have already occurred or that occur concurrently with the analytical activities. Although all of these activities are necessary to the successful financial management of an ophthalmic ASC, using them to generate a comprehensive budget document can substantially enhance their value.

For mature centers, projecting the results of operations for the coming year is relatively straightforward. The task begins with the current-year income statement. Typically, operating expenses are relatively stable from year to year, unless there has been a material change in the scope of the business or the ASC has renegotiated a major vendor contract.

Ophthalmic ASCs are fortunate in that revenues are also relatively predictable. CMS annually publishes its reimbursement schedule, and contracted rates with major commercial payers are usually well-defined. After obtaining input from the staff surgeons about any anticipated changes in their surgical volumes, preparation of budgeted revenues is straightforward.

Debt service requirements are known in advance, and estimates of depreciation and amortization can be readily obtained from your independent accountant. These elements then form the operating budget for the coming year.

Add to this document an estimate of capital equipment needs for the coming year and the financial manager now has a powerful tool to present for approval to the ownership group. This exercise is an excellent way to clearly define and obtain agreement on the important financial goals of the organization and to ensure that everyone is on the same page.

Final Thoughts

Although each organization is unique and faces individual challenges, there are many common threads in the operation and financial management of ophthalmic ASCs. Depending on your center's current status, it may take several weeks or months to organize or reorganize your accounting and reporting structures. Further, the environment we are operating in is very dynamic, and you may continually need to refine your reports and analytical tools. Following the principles outlined in this module

should allow you to develop clear and concise information that will make you a more effective manager, clarify communications with the ASC's owners and staff and promote the long-term success of your center.

Resources

BENCHMARKING FOR ASCs

The OOSS Benchmarking Survey measures the business and clinical performance of ophthalmic ASCs. Visit the OOSS website (www.oooss.org), and click on "ASC Quality & Efficiency" for more information about the survey. Your membership in the Academy, AAOE or OOSS qualifies you to participate in the OOSS Benchmarking Survey.

www.oooss.org

ORGANIZATION RESOURCES

AAOE: The practice management arm of the American Academy of Ophthalmology, providing resources across a broad range of topics. www.aao.org/aaoe

OOSS: A membership organization devoted to improving the performance of ophthalmic ASCs. www.oooss.org

Appendix Guide

Visit www.aao.org/ascfinancial for the following appendixes, which contain customizable templates for three common ASC financial reports.

- Appendix A: Typical ASC Balance Sheet
- Appendix B: Typical ASC Income Statement
- Appendix C: Typical ASC Statement of Changes in Cash

Also see the appendix that follows for summaries of the financial ratios, benchmarks, and reports explained in this module.

Appendix

Figure A-1: **Important Financial Ratios and External Benchmarks**

RATIO OR OTHER MEASURE	COMPUTATION	USE	BENCHMARK
COMPLIANCE-RELATED RATIOS			
CURRENT RATIO	Current assets/Current liabilities	Measures the enterprise's ability to meet its short-term cash needs to satisfy its creditors	2:1
DEBT SERVICE COVERAGE RATIO	Varies from financial institution to financial institution; is precisely defined in the loan documents supporting the loan	Measures whether the cash flow from facility operations is sufficient to cover the principal and interest payments required by its debt instruments and to provide a suitable safety margin after all other operating cash needs have been met	1.00–1.50
LABOR RATIOS			
LABOR COST RATIO	Fully burdened staff labor costs/Net collections	Measures efficiency of staff and staffing plan	20–30 percent
LABOR HOURS EXPENDED PER INCISIONAL SURGERY RATIO	Total hours paid during period/Incisional surgical cases performed	Measures efficiency of staff and staffing plan	5.5–9.0
COLLECTIONS PER FTE EMPLOYEE	Net collections/Number of FTE employees (requires conversion of staff, hourly and part-time workers to FTE employees)	Measures efficiency of staff and staffing plan	\$250,000–\$400,000
INCISIONAL CASES PER FTE EMPLOYEE	Number of cases/Number of FTE employees (requires conversion of staff, hourly and part-time workers to FTE employees)	Measures efficiency of staff and staffing plan	275–350 cases
SURGICAL SUPPLIES RATIO			
SURGICAL SUPPLIES EXPENSE RATIO	Total cost of surgical supplies (including drugs and anesthetics)/Net collections	Measures whether supply expenditures are in line with revenues	20–30 percent
ACCOUNTS RECEIVABLE			
COLLECTIBLE ACCOUNTS RECEIVABLE BALANCE	Gross receivables reduced by anticipated contractual discounts and bad debt write-offs	Supports the enterprise's working-capital line of credit; may be a compliance item required by lender	Facility specific
DAYS COLLECTIONS IN ACCOUNTS RECEIVABLE	Collectible accounts receivable/Average daily collections	Identifies whether the collections department is operating efficiently; can highlight an inappropriate pattern of charge-offs or a payment problem with a major payer	35–45 days
ACCOUNTS RECEIVABLE AGING DISTRIBUTION	Places gross accounts receivable into 30-day "buckets" based on length of time since date of service	Helps identify specific collection problems such as individual unpaid claims, problem payers or breakdowns in the collections staff's performance	Current (<30 days old): 50–70 percent of total 31–60 days old: 10–20 percent 61–90 days old: 5–10 percent ≥91 days: 10–20 percent

Figure A-2: Suggested Financial Reports and Frequency of Distribution

MONTHLY	ANNUALLY
Key Financial Indicators (one page)	Charges by Payer
Balance Sheet	Collections by Payer
Income Statement	Surgical Case Costs by Physician
Statement of Changes in Cash	Operating Expenses, Income and Non-cash Charges as a Percentage of Collections

Figure A-3: Report Content by Stakeholder Group

RECIPIENT	INFORMATION TO INCLUDE
OWNERS	Operational overview statistics: number of surgical days, total number of procedures performed, etc. Surgical procedures analysis: cases performed by type, e.g., cataracts, cornea transplants, posterior segment procedures, oculoplastics, ophthalmic lasers, etc. Patient encounter information: number of patients treated, average collections and operating expenses per patient, other items of interest to managers Operating revenue detail Operating expenses detail Accounts receivable analytics Accounts payable summary Payroll and personnel statistics Key budgeted items and comparisons to actual
STAFF	Surgical supplies expenses Labor costs and utilization Variable operating expenses
REGULATORS (FEDERAL, STATE AND LOCAL)	Tax returns Periodic reports required by state regulations Conditions pertaining to certificate of need in states where applicable
LENDERS	Any reports specified in the loan documents, such as basic financial statements, federal and state tax returns and compliance computations, e.g., debt service coverage ratio