



Perspectives on Medical Practice Management

Volume 6, Issue 3

Summer 2008

Can We Help?

Our firm provides a broad range of services to medical practitioners, including:

- Accounting & Financial Management
- Tax Services
- Internal Accounting Controls
- Government & Third-Party Payer Regulations
- Practice Management Consulting
- Practice Development
- Office Automation Consulting
- Personal Financial & Estate Planning
- Practice Valuations
- Finance Consulting

Inside this issue:

Stimulus Act Tax Opportunities For Your Practice 1

Good Reasons To Create A Budget 2

Fixing Scheduling Problems 3

How Secure Is Your Office Data 3

Medical Briefs 4

Stimulus Act Tax Opportunities For Your Practice

This year's Economic Stimulus Act does more than send individual taxpayers federal income-tax rebates. The law also presents opportunities for reducing the taxes your medical practice will owe for 2008.

Higher Section 179 Expensing Limit

Section 179 of the tax code now may allow your practice to immediately deduct as an expense -- rather than depreciate over a period of years -- up to \$250,000 of the cost of new or used medical equipment and other eligible business assets that you purchase and start using during the 2008 tax year. Before the law change, the expensing limit for 2008 was \$128,000.

Note that an overall investment limit of \$800,000 -- increased from \$510,000 -- applies for 2008. Purchases exceeding \$800,000 generally reduce the Section 179 deduction dollar for dollar, so that the deduction is fully phased out when a taxpayer's total investment in assets eligible for Section 179 expensing reaches \$1,050,000. A taxable income limitation also applies.

50% Bonus Depreciation

The Stimulus Act also greatly increases the total regular first-year depreciation deduction allowed on new equipment purchased and placed in service during 2008. This "bonus" depreciation deduction is generally equal to 50% of the asset's cost. In addition to equipment, bonus depreciation is available for furniture, leasehold improvements, computer software, and other qualified property (but not for buildings).

Bonus depreciation is claimed on top of the

regular first-year depreciation deduction and can be used in conjunction with Section 179 expensing. For example, if you invest \$650,000 in medical equipment this year, you potentially could deduct 75% of your total cost in 2008:

- \$250,000 -- Section 179 expensing maximum
- 200,000 -- 50% bonus depreciation*
- + 40,000 -- regular first-year depreciation**
- \$490,000 -- total 2008 deduction

Extra Depreciation For Vehicles

The Stimulus Act also increases by \$8,000 the first-year maximum depreciation deduction allowed for a new automobile acquired and first used in 2008. The depreciation increase is \$8,000 if the vehicle is used entirely for business. So, the maximum first-year depreciation allowance becomes \$10,960 -- the 2008 \$2,960 maximum plus \$8,000. With business use between 50% and 100%, the maximum depreciation deduction is reduced proportionally. There's no depreciation increase unless the vehicle is used more than 50% for business purposes.

The Stimulus Act's incentives may make investing in fixed assets this year a smart financial decision for your practice. Please call us if you want to discuss your effective cost of acquiring equipment.

* 50% of \$400,000, the remaining cost after accounting for the Section 179 deduction

** Assumes the equipment is five-year property and that the half-year convention applies.

Good Reasons To Create A Budget

For any size medical practice, a budget is a useful financial control tool because it can help you improve financial performance and ensure ongoing profitability.

An annual budget makes it easy to track your practice's expenditures and collected income, as well as evaluate your profitability by comparing actual spending and income generated to anticipated amounts.

Budget variance reporting prevents unpleasant financial surprises by letting you identify issues that need to be addressed before they develop into major problems. Moreover, a budget can become a mini business plan for the coming year and beyond. Working with a realistic projection of your costs and revenue can facilitate making business decisions, such as whether to add (or eliminate) procedures, equipment, or staff.

Categorizing Current Spending

Budget creation typically begins with a list of expense categories specific to the spending history of your practice. The categories you decide to track might include, for example: owners' draws/wages, owners' benefits, other physicians' wages, other physicians' benefits, staff wages, staff benefits, rent, utilities, malpractice insurance, business insurance, supplies, marketing, capital purchases, and repairs and maintenance.

Consider splitting certain categories for more exact tracking, such as breaking down "supplies" into "clinical" and "office." Such sub-categories can make spending analysis easier. You also may want to use expense categories that allow for meaningful comparisons of your spending with benchmark cost statistics for similar practices, if available.

Baseline Budget

With your tracking categories established, you'll need a corresponding 12-month expenditure history drawn from your accounting system's records. These figures can be used as the baseline for projecting the next 12-months' expenditures. However, each category should be adjusted as needed to reflect any changes you anticipate.

You might consider, for example:

- The degree to which anticipated changes in patient volume will affect your variable expenses for staffing and supplies
- The amount of any increase or decrease in salaries and benefits because of staffing changes or adjustments in your benefits package
- The cost and continuing support expenses for equipment to be acquired or new services you are planning
- Other anticipated changes in overhead expenses, such as insurance costs

You'll need to follow a similar process to create the income side of your budget. Be sure to include any anticipated additional revenues from the growth of your patient list or price changes for medical services.

Using Variances

Once your annual spending and revenue plan is complete, you'll be ready to start tracking results and using variance analysis -- periodic comparisons of your actual results with budgeted amounts -- to uncover differences from the plan that have occurred. It's a good idea to review the variance data monthly or quarterly.

Variance reporting should simplify the identification of any significant departures from budgeted amounts and the percentage differences. As you learn of significant items needing your attention and the dollar impact on your profitability, you can determine why each variance has occurred and decide whether and what remedial action is necessary.

Let Us Help

We can advise you about setting up an easy-to-work-with budget system that fits your practice's financial situation and needs. Please contact us about it.

The general information in this publication is not intended to be nor should it be treated as tax, legal, or accounting advice.

Additional issues could exist that would affect the tax treatment of a specific transaction and, therefore, taxpayers should seek advice from an independent tax advisor based on their particular circumstances before acting on any information presented.

This information is not intended to be nor can it be used by any taxpayer for the purpose of avoiding tax penalties.

Fixing Scheduling Problems

Is your practice experiencing too many no-shows and backups? Do new patients wait too long for appointments? If so, you may want to reconsider your scheduling methods.

Conventional scheduling in uniform segments, for example, creates physician downtime whenever patients don't appear or are late. Double-booking some periods during the day offers insurance against downtime, but risks backups on days when few patients are no-shows.

Countering No-Shows

“Wave” scheduling – slotting all of each hour's patients together at the start of the hour -- is one possibility for working around no-shows. Backups and downtime are minimized, but if you overschedule some time slots, many patients will experience long waits. And others won't be seen for almost an hour after their scheduled appointment time, or even longer if the day's schedule backs up.

To reduce the waiting, you might schedule just a few patients at

the start of each hour and fill out the hour with standard-length appointments.

Open-Access Variations

If fitting acute-need patients into your schedule causes backups, or new patients wait many weeks before being seen, some form of open-access scheduling may help. You might simply reserve some appointments each day for patients needing acute care and for new patients, varying the number of slots as experience dictates. Or eliminate advance appointments and schedule all patients to be seen on the day they call or the following day, using a uniform segment or wave method.

Many offices with open-access scheduling hold back a portion of each day (or certain days each week) for advance appointments. This facilitates handling follow-ups and physicals.

No one scheduling method is best for every practice. But analyzing your situation and, perhaps, testing some variations may lead to a more efficient use of your physicians' office time.

How Secure Is Your Office Data?

Privacy concerns make data security a requirement for medical practices. Protecting your patient and business information includes periodically checking the security of your electronic and non-electronic records.

Electronic Data

Safeguarding information stored on your office systems and handheld electronic devices depends on utilizing their built-in protective features. Therefore, confirm that physicians and staff consistently use:

- Unique user IDs and passwords for all computers
- Encryption and passwords for all laptops and add-on memory
- Automatic locking for all temporarily idle computers

Also, keep both operating systems and anti-spyware software updated.

Paper Records

A typical medical office generates a large volume of physical data, including charts and other paper patient records, that needs to be protected against unauthorized viewing as well as loss. Limiting access to the chart storage area during office hours is basic. But are charts also piled on desks before updating or filing? And, if physicians or others remove charts from the office, is there a record of the removal, and are the charts still being safeguarded?

Most likely, your office handles many reports and other documents each day that include patient information. Preventing unauthorized viewing calls for shredding any such items that are not filed, rather than adding them to the general trash.

Securing your offices at closing creates a corresponding need to limit key and alarm code access -- and to change both promptly if a key is lost or someone with access leaves the practice.

Protection of your data will not be complete unless you also create and distribute written security standards that each member of your practice is expected to follow.



200 East Buffalo Street
Suite 402
Ithaca, New York 14850
Phone: 607-272-5550
Fax: 607-273-6357

28 North Main Street
Cortland, New York 13045
Phone: 607-756-0073
Fax: 607-756-0052

Email: info@sciarabbawalker.com

The Active Professionals



SciArabba Walker & Co., LLP

200 East Buffalo Street
Suite 402
Ithaca, New York 14850

Medical Briefs

Payers' RBRVS Use Grows

A recent AMA study of 127 public and private payers found that 77% use Medicare's Resource-Based Relative Value Scale (RBRVS) as input when determining physician pay. Usage was 74% in 2001 and 63% in 1998.

Sales Reps' Access to Physicians

A recent telephone survey of 180,000 physicians -- by SK&A Information Services, Inc. -- found that 19% of office-based physicians do not meet with drug industry sales representatives and another 22.7% require an appointment before meeting. Some physicians (about 5%) restrict meetings with reps to certain weekdays or a certain time of the day (3.2%).

Movement to Mid-sized Practices

A national study last year by the Center for Studying Health System Change found that the share of physicians in solo or two-person practices fell by about eight percentage points from 40.7% to 32.5% between 1996-97 and 2004-05. Yet the share of physicians in multi-specialty practices also dropped -- to 27.5% in 2004-05 from 30.9% in 1998-99.

Return Service Requested