PMM news

PRACTICE MANAGEMENT AND MARKETING NEWS IN PEDIATRIC DENTISTRY VOL. 10, NO. 1, February 2001

AMERICAN ACADEMY OF PEDIATRIC DENTISTRY

TO REVIEW

One more time: How do you block schedule for increased production and decreased stress? Answer: Read, study, brainstorm with your staff, and implement the block scheduling concepts and templates from the August and October 2000 *PMM News* issues. Block scheduling is one of the most positive changes you could experience in your practice in 2001.

In the December 2000 issue we completed a miscellaneous list of "pearls", valuable snippets to improve management, personnel administration, clinical efficiencies and so on. We examined the role of the Roving Dental Assistant, a boon to patient service and clinical staff productivity in any pedo office. The must-have protocol for emergencies, medical, fire or weather, was outlined with an actual example you can edit for your office. We concluded the issue with an anonymously written delightful piece about resigning from adulthood to once again enjoy life as an eight year old. If you missed that quote, retrieve the December issue, read it, close your eyes and imagine the world as an uncomplicated place seen through the eyes of some of your young patients. It will surely bring a smile…

EARN MORE, KEEP MORE?

The terse title for this section certainly makes sense, doesn't it? It seems obvious that if one earns more, the result should be keeping more—an increase in profits (income). Regrettably, however, the latter does not necessarily follow. Hence, the question mark in the title.

Dental practice profit margins have decreased slowly since the early 1970's, declining a little less that 1% per year. The profit loss is due to many factors: increase in the costs of dental supplies and materials; the cost of implementing OSHA regulations; the cost of processing third party claims, participation in managed care programs, and so on. While actual take home dollars may have increased during the same period, the percentage of profits have declined. Thereby, making dentists work harder for less gain.

Dentists are frequently concerned about marketing to attract more new patients, hiring another hygienist to see recares, scheduling more productively, working additional days, raising fees, adding to their service mix—on and on—all legitimate efforts to increase income. Please understand that such actions are necessary to increase dollars generated. However, they will not assure an increase in income (retained dollars). The other half of the formula that will result in increased income is to control, or better yet, decrease expenses.

SPENDING LESS

This concept is frequently overlooked as a way to increase income. Rather than concentrating only on generating more dollars from which overhead will have to be paid, focus on saving dollars from which overhead has already been deducted. Saved dollars flow directly to the bottom line and, thus, generate an increase in profits.

With lower profit margins a fact of life, control of spending becomes equally or more important as increasing production. The only answer to this problem is budgeting. A budget is a profit plan, a design to establish income, expense and profit goals. A budget, if properly structured and followed, can control spending. In my experience, consulting with scores of pedo offices, a practice that budgets simply spends proportionately less than a practice with no budget.

The budgeting process includes these steps:

1. Decide the income goal for the next year; i.e., how much is needed to cover practice expenses, retire debt, and compensate the doctor, including a return on his/her investment.
2. Set production and collection goals to make certain the annual income will be met.
3. Analyze line by line the Income and Expense statement from last year.
4. Make decisions about additional expenses (more staff members; capital expenditures for new equipment, new office, etc.), any increases in fixed expenses, and where savings are possible? Factor in the predicted inflation rate for the next year when making these calculations.
5. Determine fee increase.
6. Put the budget in writing and onto your computer system for easy monitoring.

Successful budgeting depends on three criteria: (1) setting and meeting production and collection goals; (2) consistency in naming and analyzing categories of expense; and (3) continuously involving staff members in the efforts, including savings projects. Another imperative is to monitor each category of expense by actual dollars spent AND by percent of gross collections.

SETTING PRODUCTION AND COLLECTION GOALS

The first step in the budgeting process is to determine the annual collection total; i.e., how much money is needed to pay office overhead, retire debt, and compensate the doctor so that he or she receives a fair return on investment.

Question: How can the annual collection goal be met? Answer: By setting a daily production goal based on the collection percentage rate.

If a practice must have annual collections of $650,000 and the office schedules patients 190 days per year, the following calculation determines a daily production goal: $650,000 ÷ 190 patient days = $3,421/day collection goal. If the collection percentage rate (calculated by dividing collections for a period by production for the same period) is 95%: $3,421 daily collection goal ÷ 95% collection rate = $3,600/day production goal. The difference between what is to be produced (production goal) and what is to be collected (collection goal) is an important concept in any practice that does not collect 100% of fees generated. In this example, there is a $179 per day difference between production and collections. The $179 per day multiplied by the number of days worked per year is a significant amount of money. In our example of 190 work days per year, $179 not collected daily equals $34,000 annually—significant? Yes! A realistic collection goal is 97% or better on private pay and "regular" insurance patients. Monitor separately the collection percentage rates on reduced-fee patients such as those enrolled in Medicaid, Delta Dental, Concordia, and other managed care organizations.

A daily production goal provides a target for the scheduling coordinator. Some days the goal will be met, other days, surpassed, still other days, not met. However, with a definite goal toward which to schedule, production and collections will increase, thereby meeting the income portion of the budget plan.

CATEGORIES OF EXPENSE AND CHART OF ACCOUNTS

To meet and monitor the expense portion of the budget, various expenses must be assigned consistently and accurately to certain categories. The following *Chart of Accounts* provides code numbers that will assure each expense is assigned a proper category. For example, every account with a 5000 code number designates a personnel cost: wages, taxes, and benefits. Every account with a 6000 code number is spent on occupancy costs—lease or note, janitorial service, insurance, maintenance, repairs, and utilities, and so on. Omit those expense categories and code numbers which you prefer not be monitored separately in your office.

The *Chart of Accounts* places overhead items into seven major categories of expense and shows the typical percent of collections dedicated to each category. The dentist's (s') compensation is to be monitored separately, NOT counted as part of staff costs. Work with the practice accountant or bookkeeper to standardize the delineation of expense categories. Consistency of placing expenses in the same category month-to-month and year-to-year will make the budgeting process easier and more accurate each year.

While writing a budget may seem an onerous task for the first year, subsequent years' budgets are easier to write and more accurate. The practitioner who has never budgeted should consider setting a six month budget now for the first half of 2001. This exercise will "get your feet wet" and demonstrate the enormous positive results from the discipline of budgeting.

Categories of Expenses in Pediatric Dentistry Based on Gross Collections

Personnel — 5000's Chart of Accounts Codes
- *Salaries—23% - 26% including payroll taxes
- Benefits —approximately 2% - 4% additional, particularly if a retirement plan is funded

Occupancy —5% - 9% — 6000's Chart of Accounts Codes
- Lease or note payment
- Repairs and maintenance to facility
- Insurance on building and contents
- Utilities (except telephone)
- Janitor/grounds/security
- Depreciation, if applicable

Administrative —6%-9% —7000's Chart of Accounts Codes
- Accounting, legal —under 2%
- Advertising—for employees
- Answering machine or service
- Collection costs/bank charges
- Computer expenses
- Continuing education—staff, doctor (s)
- Dues and subscriptions
- Insurance
- Malpractice
  - Business overhead
  - Disability
- Laundry
- Licenses/Permits
- Meals for business
- Office supplies, printing—under 2% unless changing address, adding an associate or partner or some such that requires new letterhead, cards, etc.
- Postage
- Taxes
- Telephone—1-2%
- Miscellaneous

Equipment, furnishings, contingency —4%-6% — 8000's Chart of Accounts Codes
- Lease or note for purchase
- Repairs to equipment
- Depreciation, amortization
- Contingency fund - equal to 3 months' production

Clinical supplies—5%-8%—8500's Chart of Accounts Codes

Off-site laboratory—pedo under 2%; ortho under 3% to 4%—8800's Chart of Accounts Codes

Marketing/practice promotion—2%-5%—9000's Chart of Accounts Codes
- Advertising, yellow pages
- Practice brochures and other literature
- Giveaways
- % of Dental Health Educator/ Marketing Coordinator's salary

Doctor compensation—9500's Chart of Accounts Code

For years I imagined *Chart of Account* numbers were set in stone, decreed by some omnipotent council of accountants somewhere. Of course, I never owned up to such an imaginative error. The truth is the *Chart of Accounts*—those numbers used to designate/code your checks that pay your office bills for everything from payroll to cotton rolls—is YOURS to customize, change to meet your definition of expense categories, and modify from time to time as need dictates. Typically, the only things standing between your current *Chart of Accounts* that codes your checks the way someone else says and the way you want them categorized is YOU and YOUR ACCOUNTANT or BOOKKEEPER. Talk to your accountant. Insist your checks be coded so that at the end of each month the dollars spent on each expense are organized, categorized as you want them to be, preferably falling into the seven categories, plus doctor compensation listed above.

The following *Chart of Accounts* will make your expenses break into easily monitored categories. And consistency in analyzing each expense category—what is included, where savings can be made, where increases are unavoidable— is what makes control of overhead mean an increase in profit, that bottom line that one wants to be fat.

Chart of Accounts (Categories of Income and Expense)

Income (Revenues)

3010	Professional fees
3500	Refunds—typically deducted from gross income so that net income is used to calculate percentage spent for each expense category.
4010	Interest income
4020	Other income

Expenses

7010	Accounting
7012	Advertising to find employees
9012	Advertising for marketing
8010	Amortization
7013	Answering service
9514	Auto expenses
7014	Banking charges
5018	Contract labor
7015	Collection expense
8015	Computer expense
8016	Contingency fund
7016	Continuing education
9518	Contributions
6011	Depreciation—building
8014	Depreciation—equipment
7020	Dues and subscriptions
8011	Equipment and small tools purchase
8012	Equipment lease
8510	Gases
5022	Insurance—staff
6014	Insurance —premises, equipment, etc.
9522	Insurance—disability - dentist(s)
9524	Insurance—health - dentist(s)
7024	Insurance —malpractice
6016	Interest on building loan
8013	Interest on equipment
6018	Janitorial service
8810	Lab work—outside
7026	Laundry
7030	Licenses and permits
7031	Marketing
5026	Meals—staff
7030	Meals —business
7031	Miscellaneous
7032	Office supplies
7033	Petty cash replenishment
7034	Postage
7035	Printing
7036	Profesional courtesy/gifts/entertainment
7037	Rent
6012	Repair & maintenance —building
8018	Repair & maintenance—equipment
8019	Retirement plan—staff
8020	Retirement plan—dentist(s)
5010	Salaries—business staff
5012	Salaries—dental assistant(s)
5013	Salaries—dental hygienist(s)
5014	Salaries—dentist(s)
5015	Supplies—clinical
5016	Supplies—sterilization
5017	Taxes—dentist(s) payroll
5016	Taxes—staff payroll
7042	Taxes—property
7043	Telephone
7044	Travel
7045	Uniforms—staff
9530	Uniforms—dentists(s)
6016	Utilities

ONE MORE WAY TO INCREASE INCOME

Raise fees. One of the management decisions that dentists most frequently worry about is fee increases. Many dentists are concerned that parents will complain, patients will leave, insurance carriers will tell clients that Dr. X's "fees are too high", insurance will not cover increases, and so on. I have seen clients struggle to pay the bills with income from a fee schedule that is four or five years old. In such a case, supply costs, staff wages, insurance premiums, taxes, etc., keep increasing year after year while the doctor eats these increases without raising fees.

Here's a rule of thumb: increase fees once a year by almost double the inflation rate or twice yearly at the inflation rate. The majority of doctors choose an annual increase. Also up for debate, the question of raising new patient examination fees and recare fees. Some consultants/speakers claim that if you want patients to value these two visits/services, you will let these fees keep pace with all other increases in your fees. Others say that patients are most likely to notice and compare costs on the new exam and hygiene appointment. I agree with the later opin-

American Academy of Pediatric Dentistry
211 E. Chicago Ave – Suite 700
Chicago, IL 60611-2663

Presort Std.
U.S. Postage
PAID
Permit No. 81
St. Joseph, MI
49085

ion and, therefore, recommend fees for first exams and recare being increased more slowly than others. Notice, I said increased more slowly. I did not say, "No increases." If, for example, as I am recommending for 2001, most fees are increased 5%, you might consider increasing those two services only 3%.

My friend, Dr. Charles Blair, has generously allowed me to distribute a grid he put together several years ago. Look what a 5% fee increase can do for a practice with 60% overhead that remains constant—increase net income by 12.5%.

Impact of Fee Changes on Practice Finances

Current Overhead	% Fee Increase			
	5%	10%	15%	20%
80%	25%	50%	75%	100%
75%	20%	40%	60%	80%
70%	16.6%	33%	50%	66.6%
65%	14.3%	28.6%	42.9%	57.2%
60%	12.5%	25%	37.5%	50%
55%	11.1%	22.2%	33.3%	44.4%
50%	10%	20%	30%	40%

Increase in Net Income

PREVIEW

In upcoming issues we will explore other monitors, numbers you must know and analyze to assure a well managed, profitable practice.

PMMNews

PRACTICE MANAGEMENT AND MARKETING NEWS IN PEDIATRIC DENTISTRY

Published six times a year as a direct membership benefit by the American Academy of Pediatric Dentistry, 211 E. Chicago Avenue–Suite 700, Chicago IL 60611–2663, 312-337-2169. Copyright©2001 by the American Academy of Pediatric Dentistry. All rights reserved. ISSN 1064-1203. aapdinfo@aapd.org, www.aapd.org

This publication is written by Ms. Ann Page Griffin, a nationally recognized author, lecturer, and consultant in dental practice management and marketing. Opinions and recommendations are those of the author and should not be considered AAPD policy.

Executive Director
Dr. John S. Rutkauskas
Communications Coordinator
Gina Sandoval
Communications Associate
Kelly Rizzo
Membership/Marketing Coordinator
Laura Scully
Graphic Designer
Cindy Hansen