



Making Sense of Your Financials

By Matthew Hallgren



What's the first thing you look at when you get your homecare agency's Profit and Loss statement (P&L) each month? If you're like most people, it's the bottom line. You want to know how much money your agency made or lost. Maybe you even glance at revenue or salary expenses. But if the results aren't good, do you know how to improve them?

Imagine if you visited a patient whose primary complaint was that he "just didn't feel good." How would you know how to treat him? You would probably ask him questions and perform an examination. In other words, you would diagnose him so that you could develop a plan of care.

Think of the P&L as a tool for diagnosing the financial health of your agency. You might know that your agency "just doesn't feel good" based on its bottom line, but you need to know what questions to ask and what examinations to perform to manage its financial outcomes.

Let's take a look at the major categories on the P&L, also known as the income statement.

Start at the Beginning

The first item on the P&L is revenue. Revenue is the income the agency earns by providing services to patients. Revenue can be influenced by a number of factors, the most obvious being patient volumes like admissions or census. Generally speaking, a higher census results in higher revenue. But there are a number of other important factors impacting revenue that your agency should be measuring, reporting, and managing on a regular basis.

Home Health Revenue

Many home health payers, particularly Medicaid and Commercial Insurance, reimburse home health agencies in a straightforward manner. Payments are based on the number of visits or the hours of care provided to each patient. If clinically appropriate, additional visits and hours can result in additional revenue.

Things get more complicated when we start talking about Medicare reimbursement. Medicare pays agencies under the Prospective Payment System (PPS). PPS reimbursement is a predetermined amount that is based on each patient's condition and service use during a 60-day episode of care. A number of Commercial Insurers have adopted the PPS reimbursement methodology over the last several years.

There are three wonderful things about PPS payers. One, reimbursement from these payers typically makes up the majority of an agency's home health revenue. Two, PPS payers are more profitable than other home health payers. And three, each agency actually has the ability to influence its PPS reimbursement on a patient-by-patient basis. How?

Agencies perform an evaluation of each PPS patient known as the Outcome and Assessment Information Set (OASIS). The OASIS reflects the patient's condition and service needs, which in turn determines the agency's reimbursement for providing care for that patient. In other words, the agency's reimbursement depends on how acute the patient is, and how well the agency reflects that acuity in its OASIS documentation. Remember, Medicare and other PPS payers *want* to reimburse you more for caring for sicker patients.

For expert homecare advice, consult the experts

If your agency's PPS revenue is low, there's a good chance your caregivers and staff aren't properly educated on how to maximize appropriate PPS reimbursement. Poor revenue results may also be caused by a failure to closely monitor LUPA, PEP, and Therapy Adjustments, which can be devastating to PPS reimbursement. Both caregivers and management need to understand what causes PPS adjustments and how to minimize their frequency. The cost of an OASIS training and education program can pay for itself many times over through revenue improvements and long-term financial sustainability.

Hospice Revenue

Hospice revenue is based primarily on patient days, which are the collective number of days patients are under the agency's care. For example, if a hospice agency had 20 patients under its care for a full 30-day month, we would say that the agency had 600 patient days that month (20 patients x 30 days).

The key to improving hospice revenue is increasing patients' lengths of stay in a clinically appropriate manner. This can often be achieved by proactively identifying hospice candidates further "upstream" rather than waiting for referrals to come to you. If your hospice agency's average length of stay is short compared to industry averages – currently about 70 days nationally – consider working with your referral sources to educate them about the benefits of hospice care when dealing with end-stage illness.

Where Does the Money Go?

The remainder of the P&L deals with the agency's expenses. Expenses are the costs required to operate the agency.

It's extremely important that your agency's P&L separates direct expenses from administrative expenses. Let's look at what that means and why it's so critical.

Direct (Caregiver) Expenses

Direct expenses are the costs directly associated with providing hands-on care for patients. They're sometimes referred to as caregiver expenses since it's the caregivers who provide patient care. Direct expenses include caregiver salaries, caregiver benefits, contracted caregivers, caregiver mileage, and medical supplies. Hospice direct expenses go a step further to include the costs of pharmaceuticals, DME, imaging, labs, diagnostics, and all other ancillary services involved in providing patient care.

As a rule of thumb, total direct expenses for a hospital-based agency should be between 60% and 70% of revenue. The number varies from agency to agency, but lower percentages are always better. So for example, let's say your agency had \$100,000 in revenue and \$75,000 in direct expenses in January. That means direct expenses were 75% of revenue ($\$75,000 \div \$100,000$) for the month.

Based on our criteria, direct expenses as a percent of revenue are too high in the example above. Your next step would be figuring out why. Excess caregiver utilization and low caregiver productivity are two common causes of excessive direct expenses. A professional review of your agency's utilization and productivity might be beneficial if your direct expenses are too high.

Does your current P&L display separate salary amounts for caregivers and office staff? Or are all agency salaries reported as a single dollar amount? What about benefits? If these expenses aren't itemized, you obviously can't perform the recommended calculation. Work with your accounting department to improve your P&L so that it lends itself to more straightforward analysis. Only then can you evaluate the appropriateness of your agency's expenses.

Administrative Expenses

Administrative expenses are the agency expenses not related to patient care. The list of administrative expenses is long but typically includes management and clerical salaries; management and clerical benefits; building lease and maintenance; utilities; office supplies and equipment; telephones, cell phones, and pagers; insurance; conferences and training; licenses and certifications; advertising, recruitment, and community relations; and everything else!

Administrative expenses may also include overhead allocations from an affiliated hospital or corporate office. Overhead allocations are simply a way of assigning costs shared by the whole organization to each department of the organization. Common examples of shared costs include human resources, information technology, payroll, accounting, and marketing.

As a rule of thumb, total administrative expenses for a hospital-based agency should be about 30% of revenue. Again, the number varies from agency to agency, but lower percentages are always better. So for example, let's say your agency had \$100,000 in revenue and \$35,000 in administrative expenses in January. That means administrative expenses were 35% of revenue ($\$35,000 \div \$100,000$) for the month.

Based on our criteria, administrative expenses as a percent of revenue are too high in the example above. Like before, your next step would be figuring out why. Excessive administrative expenses can be caused by a number of factors including inefficient office processes, more office FTEs than the agency's patient census calls for, or excessive line-item expenses. A professional assessment of these areas might be beneficial if your agency's administrative expenses are too high.

The Bottom Line

Revenue minus total expenses is called net income. If revenue is more than total expenses, the result is a positive number called a profit. If revenue is less than total expenses, the result is a negative number called a loss.

Many healthcare systems view homecare as part of the organization's larger mission and don't expect the agency to be profitable. But you should expect better. Even if you're a non-profit agency, profits can be reinvested so that the agency can continue to provide the most efficient and effective care to your patients. If your agency isn't profitable, now you know how to use the P&L as a starting point to diagnose its financial health.

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