

8

Benchmarking Performance and Measuring ROI

Introduction

Chapter 8 presents two important components of practice management, tools that are invaluable when measuring the feasibility and performance of ancillary services: benchmarks and the return on investment analysis (ROI). The definition and historical use of each will be reviewed and some specific examples of their use in an ancillary services explored.

Several ratios will be presented that are common in benchmarking as well as an outline of the preparation and interpretation of a return on investment analysis. Although information alone doesn't do anything, it provides the primary tools for monitoring a practice's performance and diagnosing problems that impair productivity.¹ It also provides the information critical to deciding which ancillary services to offer, if any at all, and how best to proceed with expanding a medical practice. The trick is to learn what information to gather, how to interpret the information, and how to act on the interpretation. These three key components will be the focus of this chapter.

What Are Benchmarks?

Benchmarking Defined

“Benchmarking” is the process of defining a standard against which something can be measured or assessed.² It is the process of reviewing other practices (in this analysis), identifying the best and measuring performance against that standard.

This performance can include a review of the following areas:

- Total number of patients seen
- Total charges billed during a determined time period
- Net collections ratio
- Total physician productivity

The variables to compare can be endless, and it is important to determine the areas within a practice to be measured. Although the focus of this book is ancillary services, and the focus will be measuring their

performance, the general information in this chapter can be applied to almost any area of any practice or other business.

Benchmarking is a way to establish performance goals and is an excellent tool with which to monitor results. Like most methods of financial analysis, benchmarking allows for objective, measurable performance standards to be compared against actual performance as a way to identify trends and receive early signals that may be indications of either strength or weakness.

Using Benchmarks to Measure Performance

Benchmarks can be very advantageous when used in a comparative analysis. Generally, benchmarks should be used as comparisons against actual performance and are invaluable as a part of the financial statement comparison. Keep in mind that benchmarks are not always realistic for a practice and should be conservatively used, not as a resource for overreaction.³

There are nuances within every practice, and they should be taken into consideration when utilizing benchmarks. For example, if an insurance payer in an area pays a particularly high rate of reimbursement, it might be wise to set fees higher than other practitioners in the area or specialty to capture as much money as possible from this payer. This, in comparison to the other practitioners, will inflate the practice's gross charges. Thus, when comparing the collection ratio (gross payments ÷ gross charges) to other practices in the same specialty, performance will appear to be low, indicating the revenue cycle is lacking. Instead, the lower gross collection rate could simply be a result of the higher fee schedule.

Benchmarks will vary by several categories, including by specialty, number of providers, number of locations, geographic region, and ownership structure. Keep this in mind so that apples are being compared to apples. The utilization of benchmarking is an ongoing process that allows the use of an independent standard to compare areas such as productivity, expenses, staffing, and certain quality measures. By participating in benchmarking on a regular basis, (e.g., monthly, quarterly, or yearly), a practice can easily ascertain whether it is doing everything right or has areas that need improvement.

Essentially, there are the following four steps in the benchmarking process:

- Choose the areas to be measured.
- Collect and analyze data.
- Compare the data with corresponding data from similar organizations to determine top performers.
- Adopt the best practices of the top performers.

In the next sections, what data to gather, how to put the data in a format for analysis, and the resources from which to find the top performers will be discussed.

External vs. Internal Benchmarks

As performance is compared to that of the best practices, external sources are being used. For example, how do the physicians' productivity numbers compare to other physicians' productivity in the same specialty and in the same area of the country? Are they treating as many patients as other similar practices? For internal benchmarks, practices can typically turn to "ratios," methods of testing relationships with each other, (e.g., comparing one number to another).⁴ "Ratios typically are comparisons of performance measurements on the two primary financial statements, the income statement and balance sheet."⁵

Although it is important to measure performance against internal standards, such as the budget and the previous year's performance, it is also beneficial to use external standards. Otherwise, performance that seems beneficial may merely be acceptable. Even if performance is adequate, it is essential to consider external sources or standards for comparison in pursuit of experience and knowledge that can be applied to the business. For benchmarking to be credible, the data must be comparative, which is usually the greatest challenge: benchmarking comparisons within the medical field."⁶

Internal Sources for Benchmarks

Internal benchmarks compare current performance against past performance. For example, comparing this year's expenses to last year's expenses. Or by comparing the current year's charges to past performance. Typically, when comparing expenses, they are shown

as a percentage of revenue, which allows a manager to quickly see a potential problem or better yet, an area that has improved. Alternatively, the income statement can be shown as a comparison to a budget with a vari-

ance column illustrating whether or not the practice is under or over budget. Figure 8-1, “Physician’s Income Statement” (following), shows a typical profit and loss statement for a single-specialty ASC in this fashion..

Figure 8-1 Physician ASC Income Statement			
	Actual 6 Months Ended 30-Jun-04 (\$)	Budgeted 6 Months Ended 30-Jun-04 (\$)	Variance \$
Income:			
Fee income	\$787,871.48	\$799,999.98	(\$12,128.50)
Less patient refunds	(4,030.35)	0.00	(4,030.35)
Total Income	783,841.13	799,999.98	(16,158.85)
Net Revenue	783,841.13	799,999.98	(16,158.85)
Staff Compensation:			
Office staff compensation	177,679.65	169,300.98	8,378.67
Payroll taxes	15,096.06	16,930.08	(1,834.02)
Automotive expense	700.00	1,050.00	(350.00)
Retirement plan contribution	6,538.68	16,930.08	(10,391.40)
Total Staff Compensation	200,014.39	204,211.14	(4,196.75)
Expenses:			
Accounting	3,828.75	4,300.02	(471.27)
Advertising and promotion	343.39	250.02	93.37
Bank charges	126.00	150.00	(24.00)
Contracted services	9,618.00	1,999.98	7,618.02
Depreciation	6,975.22	0.00	6,975.22
Dues and subscriptions	\$225.00	1,500.00	(1,275.00)
Interest	3,890.38	0.00	3,890.38
Insurance, general	4,527.00	7,500.00	(2,973.00)
Janitorial	7,108.97	6,000.00	1,108.97
Legal	6,801.76	0.00	6,801.76
Licenses & fees	2,815.00	1,000.02	1,814.98
Maintenance & repairs	433.30	7,500.00	(7,066.70)
Equipment maintenance	1,264.03	12,499.98	(11,235.95)
Medical supplies	54,764.58	49,999.98	4,764.60
Office expenses	920.66	2,500.02	(1,579.36)
Office supplies	498.58	0.00	498.58
Professional development	0.00	2,599.98	(2,599.98)
Printing costs	860.20	0.00	860.20
Rent	30,701.64	40,999.98	(10,298.34)
Uniforms	163.44	0.00	163.44
Utilities	4,965.07	2,200.02	2,765.05
Total Expenses	140,830.97	141,000.00	(169.03)
Net Profit (Loss)	\$442,995.77	\$454,788.84	(\$11,793.07)

FAs you can see in Figure 8-1, the practice is about \$12,000 under budget in profitability. By reviewing this statement regularly (in this case the month of June), managers and physicians can make the necessary changes to get the practice back on track before the end of the year. It may be that expenses are out of line or that collections are low. In this example, the practice did not budget for depreciation or legal fees. This lack of accurate budgeting becomes the primary reason for the lack of performance in profitability.

Another way of analyzing internal benchmarks is to compare past productivity performance along with past billing and collection performance. Figure 8-2 (following) illustrates a sample spreadsheet of a practice that is tracking performance over the past three years.

Common Ratios

Remember the old business adage, “You can’t manage what you can’t measure.” Neither should a practice implement changes or add services until it has accurate and relevant information to analyze and interpret. “Running your business without them is like driving at night with your lights off—you might arrive at your goal safely but, then again, you might drive over a cliff”.⁷

Ten common ratios are used in medical practices to manage the financial performance of the practice. These 10 ratios are by no means an exhaustive list, but rather highlight some of the more important ratios to consider. There are many other ratios that could be evaluated. Also, some of the following ratios could be evaluated in greater detail, or separated on a departmental

basis (i.e., the same ratio that is reviewed for the whole practice may be used for determining performance within an individual department, or in this case, to measure a particular ancillary service).⁸

The following 10 ratios can be routinely found in many industry benchmark data resources and are not listed in order of importance (the mathematical formula for each ratio is shown in Table 8-1).

Gross Collections Ratio

The “gross collection ratio” is a quick way to determine how much of what is being charged is actually being collected. It is derived by dividing total gross payments by total gross charges. By itself, it does not reveal much about performance, but when taken with the net collections ratio, it can determine whether fees are too high or too low. For example, consider an orthopedic practice with gross charges of \$1 million and gross payments of \$600,000:

$$\$600,000 / \$1,000,000 = 60\%$$

The gross collection ratio is 60%, or they are collecting only 60% of what is actually billed.

Net Collections Ratio

The “net collections ratio” is calculated by dividing total gross payments by total adjusted charges (total gross charges minus total adjustments). Because of contractual allowances imposed by insurance companies which are legal to take, the net collections ratio is

Figure 8-2 Physician ASC Income Statement					
	2004	2003 to 2004	2003	2002 to 2003	2002
	(\$)	(% change)	(\$)	(% change)	(\$)
Charges	\$5,937,188	23.22%	\$4,818,294	174.19%	\$1,757,253
Payments	\$1,672,239	11.96	\$1,493,600	122.13	\$672,409
Adjustments	\$3,773,410	43.12	\$2,636,516	198.10	\$884,449
Gross collection ratio	28.17%	-9.14	31.00%	-18.99	38.26%
Net collection ratio	77.28%	12.89	68.46%	-11.14	77.04%

*Annualized based upon data from January 1, 2004, to July 12, 2004

vital in ensuring a practice is collecting all the monies it is entitled to receive. The following equation refers to the preceding example and calculates the net collection ratio:

$$\$600,000 / (\$1,000,000 - \$350,000) = 92.3\%$$

Even though the net collections ratio is near 100%, there is almost 8% of total charges being left on the accounts receivable each month. This may be a result of contractual allowances not being written off correctly, or there may be claims that are being denied for various reasons. Either way, the accounts receivable will continue to grow if the reason is not determined and steps taken to correct the problem.

Days Outstanding in Accounts Receivable Ratio

“Days outstanding in accounts receivable” is calculated by dividing outstanding accounts receivable monies by the average adjusted charges for a particular time period, for example, three months:

$$\frac{\text{Adjusted charges for the past three months}}{\text{Total number of days for the same period}} \div \text{Average adjusted revenue per day}$$

$$\frac{\text{Outstanding accounts receivable}}{\text{Average adjusted revenue per day}} \div \text{Days in accounts receivable}$$

Tracking days in A/R helps monitor the billing cycle by illustrating how long money sits on the A/R before claims are paid. For example, if the days in A/R ratio is 90 days, the average claim billed takes three months before it is paid. In any practice, 90 days would be very high and would signify a problem with either claims transmission or the performance of its billing staff. Additionally, a ratio this high means that it takes 90 days to collect what is billed today and at least 90 days of working capital is needed to maintain the practice’s cash flow needs.

Expense to Earnings Ratio

Another meaningful ratio in the medical practice is that of overhead (expenses) relative to revenue, which can

yield different results depending upon how the revenue is calculated and defined. One way to calculate the expense to earnings ratio is to divide the total operating expenses (less provider benefits and salaries) by total revenue. “Total operating expenses” is generally defined as total overhead except for the physicians’ salaries and total benefits. It separates revenue less expenses prior to any physician compensation to derive a gross operating margin before considering any provider compensation, benefits, and other perks.

$$\frac{\text{Total operating expenses (less provider salary and benefits)}}{\text{Total revenue}} = \text{Expense to earnings ratio}$$

The expense to earnings ratio can also be calculated on a departmental basis or even by expense category. For example,

$$\frac{\text{Total medical supply expenses}}{\text{Total revenue}} = \text{Medical supply expense to revenue}$$

This is valuable as a quick determinant of practice performance and can be easily compared to industry benchmarks. When analyzing this ratio each month, a trend can be determined and variations from the norm can be easily spotted and thus corrected in a timely manner.

Average Revenue per Patient Ratio

In determining the number of patients that must be seen to achieve a predetermined amount of revenue, the “average revenue per patient ratio” is invaluable.

$$\frac{\text{Total monthly collections}}{\text{Total monthly patient visits}} = \text{Revenue per patient}$$

This ratio can be broken down by provider or department and can provide an early warning signal of the costs on a per patient basis. as a further indicator of practice performance,

Staffing Ratio

The “staffing ratio” is an excellent tool in analyzing practice performance but will not involve actual dollars.

Rather, this ratio determines the total number of employees in the practice per provider.

Average Cost per Patient Ratio

As with the revenue per patient ratio, the “average cost per patient ratio” provides similar information regarding the total amount of dollars expended per patient. Used in conjunction with the revenue per patient ratio, productivity issues can be solved, purchase decisions can be made, and the ability to predict future revenues can be enhanced.

Total expenses per month (excluding provider salary and benefits) ÷ Total patient visits per month ÷ Average cost per patient

Departmental or Service Ratio

It can also be very beneficial to break costs down by department or by a particular service, such as ultrasounds, laboratory, X-rays, and so on. If an orthopedic practice offers X-ray service to its patients and would like to determine X-ray expense to X-ray revenue, the following ratio could result:

Total X2 ray expenses ÷ Total charges for all CPT codes related to X2 ray testing ÷ X2 ray expenses to X2 ray revenue

Average Adjusted Revenue per Day

Comparing “average adjusted revenue per day” to the daily charges will illustrate if daily productivity is above or below average. In other words, it illustrates how busy the practice is. Many things, such as scheduling, the number of physicians working in the office, hospital surgery blocks, and the number of patient rooms available can affect daily productivity numbers. Additionally, the manner in which charges are captured and the time frame in which they are entered can also skew the true picture of productivity. To calculate average adjusted revenue per day, apply the following formula:

Adjusted charges for the last three months ÷ Number of business days in the last three months ÷ Average adjusted revenue per day

Payer Mix Ratio

Not all insurance companies are of equal value to a practice in terms of total reimbursement. The payer mix ratio illustrates how valuable a particular health insurance plan is to the practice, in other words: how it contributes to the bottom line.

Individual insurance company payments ÷ Total payments ÷ Payer mix ratio

This ratio can help a practice decide the payers with which it wants to develop a particularly good relationship, and also those payers the practice is better off without.

Other Benchmark Indicators

Productivity Benchmarks

- Visits per full-time equivalent (FTE) provider
- Relative value units (RVUs) per FTE provider
- Hours worked per provider
- RVUs per visit
- Gross charges per visit
- Net charges per visit

Expense Indicators

- Staff FTEs per provider
- Staff payroll and benefits or total personnel cost to net charges
- Personnel hours worked per patient visit
- Provider compensation as a percentage of revenue and number of visits

Performance Indicators

- Amount of wait time per visit
- Wait time on the telephone
- Access wait time by appointment type
- Number of no-shows
- Transcription turnaround
- Accounts worked per collector FTE per day
- Words or lines transcribed per day
- Authorization turnaround time
- Return telephone call wait time

The preceding common financial ratios are summarized in Table 8-1 (following) for easy reference.

External Sources for Benchmarks

There are several excellent resources for industry benchmarks. Some of these sources are provided by the medical community, others are provided by standard business sources such as Dun & Bradstreet. The following is a list of medical industry benchmarking data sources:

- American Medical Association
- American Medical Group Association

- Center for Healthcare Industry Performance Studies
- Medical Economics
- Medical Group Management Association
- Practice Support Resources, Inc.
- Individual research initiatives via consulting firms

No matter what sources are chosen, the number of practices used to compile the data should be thoroughly documented and the manner in which the data was retrieved should be explained.

Table 8-1 Key Financial Ratios	
Gross Collection Ratio	
$\frac{\text{Total collections}}{\text{Total gross charges}} = \text{Gross (unadjusted) collection ratio}$	
$\frac{\$400,000}{\$1,000,000} = 40\%$	
Net Collection Ratio	
$\frac{\text{Total collections}}{\text{Total gross charges} - \text{total adjustments}} = \text{Net (adjusted) collection ratio}$	
$\frac{\$400,000}{\$1,000,000 - \$550,000} = 89\%$	
Days Outstanding in Accounts Receivable Ratio	
$\frac{\text{Adjusted charges for the last three months}}{\text{Total number of days (for the same time period)}} = \text{Average adjusted revenue per day}$	
$\frac{\$270,000}{90 \text{ days}} = \$3000 \text{ average adjusted revenue per day}$	
$\frac{\text{Outstanding net accounts receivable}^*}{\text{Average adjusted revenue per day}} = \text{Days in accounts receivable}$	
$\frac{\$300,000}{\$3000} = 100 \text{ days in accounts receivable}$	
*Apply a typical adjustment percentage to outstanding accounts receivable to derive net accounts receivable.	

Table 8-1 continued	
Expense to Earnings Ratio	
$\frac{\text{Total operating expenses (less provider salaries and benefits)}}{\text{Total collections}} = \text{Expenses to earnings ratio (practice overhead percentage)}$	$\frac{\$50,000}{\$85,000} = 58.82\%$
Average Revenue Per Patient Ratio	
$\frac{\text{Total monthly collections}}{\text{Total patient visit}} = \text{Average revenue per patient}$	$\frac{\$15,000}{250} = \60.00
Staffing Ratio	
$\frac{\text{Total number of FTE employees}}{\text{Total number of FTE providers}} = \text{Staffing ratio}$	$\frac{25.3 \text{ FTE employees}}{5 \text{ FTE providers}} = 5.06\%$
Average Cost per Patient Ratio (Two Methods)	
$\frac{\text{Expenses per month (excluding physician salaries & benefits)}}{\text{Total patient visits}} = \text{Average cost per patient}$	$\frac{\$50,000}{250} = \200.00
$\frac{\text{Expenses per month (including physician salaries & benefits)}}{\text{Total patient visits}} = \text{Average cost per patient}$	$\frac{\$100,000}{250} = \400.00
Departmental or Service Ratio	
$\frac{\text{Total expenses for ancillary service for period}}{\text{Total net charges for all CPT codes related to ancillary service}} = \text{Ancillary service expense ratio}$	$\frac{\$15,000}{\$50,000} = 30.00\%$

Table 8-1 continued	
Average Adjusted Revenue per Day	
$\frac{\text{Adjusted charges for the last three months}}{\text{Number of business days in the last 3 months}} = \text{Average adjusted revenue per day}$	
$\frac{\$25,000}{86} = \290.70	
Payer Mix Ratio	
$\frac{\text{Each payer's net charges}}{\text{Total net charges}} = \text{Payer mix ratio}$	
$\frac{\$45,000}{\$350,000} = 12.86\%$	

Measuring Return on Investment (ROI)

The Importance of Measuring ROI

“Return on investment” (ROI) analysis is way of evaluating an investment’s potential by comparing its expected gains to the investment costs. Return on investment is frequently calculated as the “return” from a purchase divided by the cost of that purchase; the total is usually expressed as a percentage.

$$\frac{\text{(Total revenue – Total costs)} \div \text{Total costs}}{5} \text{ ROI}$$

For example, a urology practice is considering purchasing laser equipment to treat prostate conditions. Based on the patient base that suffers from these conditions, how many patients would have to be treated by laser before the actual equipment is paid for? This simple example works well in situations where both the revenue generated and the costs of an investment are easily known. But what if the same urology practice instead wanted to invest in a lithotripsy machine to treat kidney stones? Other things being equal, when considering alternatives, the investment with the higher ROI is the better investment. However, the numeric ROI figure derived from the

analysis will not factor in extenuating circumstances or risk. For instance, what if Medicare doesn’t pay for this type of laser procedure? How much space is needed to perform this procedure? What is the risk, and will mal-practice insurance cover it at no additional cost to the premium? All of these issues are difficult to quantify and difficult to factor into an ROI equation. For illustration purposes, assume that Medicare will reimburse \$500 for each procedure. There is no additional risk to the patient and there is an extra procedure room in which to perform the procedure. Also assume the laser machine cost is \$10,000 and that 10% of current total patients with prostate problems will benefit from this type of procedure. The following is a formula for calculating the total revenue generated in one year.

Reimbursement of procedure	\$500
Total number of patients eligible	500 × 10% = 50 total eligible patients
Total number of procedures performed in one year	45

The total revenue generated in one year is \$22,500.

$$\text{Total revenue} = \$500 \times 45 \text{ patients or } \$22,500$$

Thus, total ROI is calculated as follows:

$$\frac{(\text{Total revenue} - \text{Total costs})}{\text{Total costs}} = \text{ROI}$$

$$\frac{(\$22,500 - \$10,000)}{\$10,000} = 125\%$$

Health care today has become a very complex business. As such, it is not always easy to match specific returns (such as increased profits) with the specific costs that led to them, and this makes ROI less trustworthy as a guide for decision making. ROI also becomes less trustworthy as a useful number when the cost figures include allocated or indirect costs, which are probably not caused directly by the investment. Business investments typically involve financial consequences extending several years or more. In such cases, the ROI number has meaning only when the time period is clearly defined. Shorter or longer time periods may produce quite different ROI figures for the same investment. Moreover, when financial impacts extend across several years, the analyst must decide whether to use discounted (net present value) figures or nondiscounted values.⁹ Given these shortcomings, many business advisors are advocating a move away from the ROI as the “be all, end all” tool for investment decisions. Put in its proper perspective, however, it still remains a valuable tool for analyzing the investment in ancillary services.

Quantifiable Areas

Many times, calculating ROI reveals a return in the form of opportunity costs, those “costs” that if reduced won’t realize an effect on the total bottom line. There are many quantifiable areas when calculating ROI, but this fact is actually one of the fallacies of calculating ROI and using it as a tool to make decisions. Typically, many of the numeric values used to calculate ROI are imprecise and left to one’s judgment. There is an absence of consistency, making ROI a conceptually elegant tool used by economists to describe an idea that makes sense possibly only in theory.¹⁰

Assume the practice is going to purchase an EMR (electronic medical record) which will make available the square footage space currently occupied by paper charts. That space is now free to be utilized in several different ways. Additional administrative office space can be created, or more patient rooms added. Either

way, one could make the argument that the total square footage of this “new” space multiplied by the total cost per square foot would represent a dollar amount to be used in the calculation of return on investment. But utilizing this space for administrative office space would not realize any change to the bottom line. The rental amount is still the same as it was before the implementation of EMR. Therefore, including this figure in the total ROI of EMR investment is misleading. Conversely, if the “new” space is used for additional patient treatment rooms or procedure rooms that begin to generate additional revenue, this revenue would be used in the calculation of the overall ROI.

Estimating expenses can also be tricky. There’s a tendency to think that a practice’s current staff can take on a larger workload with the addition of an ancillary service. That is oftentimes an illusion. In this example of seasonal services, the busier times can put a strain on staff that they won’t be able to handle efficiently. If the waiting room becomes full during this season and patients have to wait long periods of time, the practice will soon find itself losing patients.¹¹

Another area difficult to measure is the amount of space required. Even simple ancillary services require additional square footage and if they are squeezed into the existing office space, the practice may wind up squeezing out another service that is more profitable.¹²

Weighing Costs Against Benefits

In many cases, performing an ROI in-house will keep costs to a minimum. Analyzing whether or not to offer a particular ancillary service is relatively straightforward and can be analyzed in less than a day. In the case of determining whether or not to open an ASC, for example, the analysis becomes much more complicated and all the more crucial. This type of analysis often does, and should, include an outside consulting firm, accountants, and lawyers to weigh all the factors associated with a venture of this magnitude and risk. In this case, the fees to perform an in-depth ROI can be quite high, but the potential revenue can also be very high. In most cases, the greater the venture being considered, the greater will be the risk and potential reward—and the greater the cost to analyze the potential return on investment. What an ROI analysis can offer is a road

map to success, identify the potential pitfalls (areas where money will not be saved, or even lost), and the areas where return will be the greatest. It can offer a great tool with which to move forward (or not) with any venture and determine whether or not the proposed investment will increase the bottom line and provide patients with a valuable service.

Interpreting the Results

As with benchmarking, the ROI analysis is not usually a cause for overreaction. In fact, this analysis should be done before any money is spent on the proposed service and should offer an answer as to whether or not the partners should move forward with the ancillary service. Done correctly, the ROI analysis should be fairly straightforward in that it should offer a bottom line return and identify whether money will be made on a venture or not. However, increasing the bottom line is not the only factor to be considered. Consider in-house labs in physician offices as an example. Oftentimes they are break-even ventures but represent a marketing strategy to offer a service and convenience to the patients who will ultimately earn the practice more referrals and more money from outside sources.

A practice might even want to offer some marginal or money-losing services along with money-making ventures. Both combined can make a stronger showing to patient and referral sources. Further a practice may want to judge the feasibility of an ancillary service by how much money the service saves, rather than how much revenue it generates. Whichever avenue or combination of avenues is chosen, every ancillary service is unique and several factors will determine its revenue-generating capability.¹³

Conclusion

Before an ancillary service is invested in and launched, it should be considered carefully. Aside from the revenue implications, there can be administrative headaches to consider. Planning ahead, as reviewed in this book, and carefully considering the impact on the bottom line, whether in real costs or additional patients, will aid in the decision-making process, minimize risk, and offer

a plan with which to move forward.

Endnotes

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