MCS Advisory

FRACTIONAL CFO · PRACTICE DIAGNOSTIC

Busy but *Broke*

Why a full schedule doesn't mean full bank accounts

The schedule is packed, the team is slammed, and the bank balance still won't grow. It's almost never a volume problem — it's a visibility problem. This is the diagnostic that separates activity from actual profit.

By provider
Who actually makes margin

By service line
What to do more & less of

By payer
Which contracts cost you money

Prepared by MCS Advisory · Med Consulting Solutions LLC · 2026

THE PARADOX · FULL SCHEDULE, EMPTY ACCOUNT

More patients, more stress, no more money

If your practice is busier than ever but your take-home hasn't moved, you're not imagining it — and you're not alone. It's the single most common financial complaint we hear from practice owners in 2026.

Here's the trap. A bookkeeper records what happened. Your accountant files what happened. Neither one tells you *why* a fully booked schedule isn't converting into cash. That gap — between activity and profit — is where practices quietly bleed money, and it's invisible on a standard P&L.

The uncomfortable truth: most practices look at **total revenue** and **total payroll**, then wonder why growth feels fragile. The answer is hiding one level down — in the margin each provider, service line, and payer actually produces.

The four things quietly draining a busy practice

1 · MARGIN BLINDNESS

You know total revenue. You don't know which providers, appointment types, or service lines produce margin versus just workload. Some of your busiest activity may be your least profitable.

2 · PAYER MIX DRIFT

More visits, but each one paying less as payer mix shifts and reimbursement rates fall. Volume rises while revenue-per-visit erodes — a treadmill that feels like growth.

3 · DENIAL & A/R LEAKAGE

Denials, downcoding, and slow follow-up leave 5–10% of revenue on the table. Cash you earned sits trapped in aged receivables instead of your account.

4 · COST CREEP

Salaries rise annually; operating costs climb; reimbursement stays flat. The spread between what you bring in and what it costs to run gets squeezed from both sides.

Source: MCS Advisory. Industry context per MGMA (2026 operating-cost and revenue data); healthcare finance practice observations. Educational use.

THE DIAGNOSTIC · MARGIN BY PROVIDER

Your busiest provider isn't always your most profitable

The first cut every practice needs but few have: contribution margin by provider. Total production hides the truth — two providers with identical revenue can contribute wildly different profit.

Illustrative example — a four-provider practice, monthly

Provider	Revenue	Direct cost	Contribution	Margin %
Dr. A — high volume, low-acuity	$92,000	$71,000	$21,000	**22.8%**
Dr. B — moderate volume, procedures	$88,000	$49,000	$39,000	**44.3%**
Dr. C — high volume, poor payer mix	$95,000	$78,000	$17,000	**17.9%**
Dr. D — lower volume, cash-pay	$61,000	$33,000	$28,000	**45.9%**
Total	**$336,000**	**$231,000**	**$105,000**	**31.3%**

Look at Dr. C: the **highest revenue** in the practice, and nearly the **lowest contribution**. A revenue-only view would call Dr. C your star. A margin view says the opposite — and points directly at the payer mix and case mix to fix.

WHAT THIS UNLOCKS

- Which providers to protect and grow
- Where scheduling or case mix needs to shift
- Which payer contracts drag a provider down
- Fair, data-based compensation conversations

WHY TOTAL PRODUCTION MISLEADS

Compensation and staffing built on gross production reward volume, not profit. A provider can be "productive" and margin-dilutive at the same time — and you'd never see it without this cut.

Illustrative figures for education only. Not a representation of any specific practice. MCS Advisory, 2026.

THE DIAGNOSTIC · MARGIN BY SERVICE LINE

Do more of what pays. Do less of what doesn't.

The second cut: contribution by service line. It answers the question growth depends on — which services should you build capacity around, and which are quietly subsidized by the rest of the practice?

Illustrative example — contribution by service line, monthly

Service line	Revenue	Margin %	Contribution	Read
In-office procedures	$104,000	**52%**	$54,080	Grow capacity
Ancillary / diagnostics	$68,000	**47%**	$31,960	Grow capacity
Established E/M visits	$112,000	29%	$32,480	Steady core
New-patient intake	$34,000	24%	$8,160	Feeds pipeline
Low-reimbursement visits	$18,000	**9%**	$1,620	Re-examine

A practice chasing volume adds more of what fills the schedule fastest — often the low-margin work. A practice managed on margin adds capacity where contribution is highest. **Same effort, very different bank balance.**

The profitability question, answered cleanly

Profitability improves when you can answer one question without guessing: **which providers, appointment types, and service lines produce margin — not just volume?** Once you can see it, the growth decisions get obvious: protect the high-contribution work, fix or reprice the low-contribution work, and stop letting a busy schedule disguise a thin margin.

Illustrative figures for education only. MCS Advisory, 2026.

THE FIX · FROM BLIND TO CLEAR

What a fractional CFO actually changes

The goal isn't a thicker report. It's a small set of numbers you watch weekly so growth stops being a source of stress and starts being deliberate.

WATCH WEEKLY

- Net collections (not just charges)
- Days in A/R
- Denial rate & top denial reasons
- Contribution margin by provider
- A rolling 13-week cash forecast

REVIEW MONTHLY & QUARTERLY

- Margin by service line & payer
- Payer-mix trend and rate realization
- Scenario-based growth planning
- Capacity & staffing vs. cash

The result is predictable collections, stable margins, and staffing decisions driven by cash and capacity — not stress. A CFO-led view makes it clear which growth moves are safe now, which should wait, and what to measure so payroll is never a cliffhanger.

Quick self-check: is your practice busy but broke?

- You can state total revenue, but not margin by provider or service line.
- Cash feels tight even in your busiest months.
- You've never modeled your payer contracts against your real cost to deliver.
- Compensation is built on production (volume), not contribution (profit).
- Payroll timing is a recurring source of anxiety.

Three or more? The problem almost certainly isn't volume — it's visibility. And visibility is fixable.

Stop running your practice on a hunch.

MCS Advisory provides senior fractional CFO/COO leadership for practices, ASCs, and healthcare ventures — the margin visibility, cash-flow discipline, and growth planning above, without a full-time hire. Book a free 30-minute financial clarity call.

medconsultingsolution.com/fractional-cfo.html · kays@medconsultingsolution.com