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Bookkeeping for a Medical or Dental Practice: What Standard Books Get Wrong

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The short answer

Most practice books are built like a retail shop: one revenue line, a pile of expenses, and a number at the bottom nobody trusts. A practice needs more than that, because what you produce, what you are allowed to collect, and what actually reaches the bank are three different numbers. Set the books up so those three reconcile every month, group expenses the way practice overhead is actually measured, and you get a profit and loss statement that answers questions instead of raising them.

Production, adjustments, collections

Your practice management software reports production: the full fee for everything done that month. You will never collect that. Contractual adjustments are the difference between your fee and what each payer has agreed to pay, and they are not a discount you chose, they are the price of being in network.

Line	What it means
Gross production	Full fee value of work performed
Contractual adjustments	The write-down required by each payer contract
Other adjustments and write-offs	Courtesy discounts, uncollectible accounts, refunds
Net production	What you are actually entitled to collect
Collections	What reached the bank this month, including payment on older work

Recording only the deposit hides all of this. Once adjustments are a visible line, you can see the cost of each payer contract, and whether a plan you are considering dropping is worth what it brings in.

> If your books show revenue equal to deposits, you cannot see your adjustment rate, which for most insurance-heavy practices is the single largest number on the statement after payroll.

A chart of accounts that fits a practice

The default chart of accounts in any accounting software is built for a generic business. A practice needs its expenses grouped the way practice overhead is measured, so the percentages mean something when you compare them to anything.

- Revenue by provider and by location, so you can see who produces what and whether a second site carries itself
- Clinical supplies separate from office supplies, and dental lab fees on their own line
- Staff wages, payroll taxes and benefits grouped together, with owner and associate compensation held apart from them
- Facility costs grouped: rent, utilities, repairs, property insurance, common area charges
- Marketing separated from patient relations, so the money that buys new patients is distinguishable
- Merchant fees and patient financing fees on their own line, not buried in bank charges
- Equipment purchases to the balance sheet, not to expenses, with the loan split between principal and interest

The last one matters more than it sounds. A practice that expenses a 90,000 dollar scanner and shows the whole loan payment as a cost has a profit and loss statement that is wrong twice over and a tax return that will need rebuilding.

The monthly close

A practice close is done when four things agree: the bank statement, the merchant deposits, the practice management software, and the payroll reports. Each one catches a different problem.

- Reconcile every bank, card and loan account to its statement
- Tie each merchant deposit to the batch it came from, including the fee taken out, so card income is gross rather than net
- Compare collections in the books to the collections report from the practice software, and explain the difference
- Post payroll from the provider reports, with employer taxes and retirement match in the right periods
- Review patient accounts receivable aged by payer, not as one total
- Book the month on the same basis every month, so the statements can be compared to each other

Most practices run their books on a cash basis for tax and look at an accrual view for management. That is a reasonable setup, but it only works if someone maintains both deliberately, rather than drifting between them.

The numbers worth watching

Number	How to read it
Collections as a percent of net production	Below the high 90s over several months means a collections process problem, not a billing accident
Adjustment rate	The real cost of your payer mix. Track it per payer before renegotiating or dropping a plan
Accounts receivable over 90 days	Old claims are the ones that die. Aged by payer, it shows which contract is the problem
Total staff cost as a percent of collections	Wages plus taxes plus benefits, excluding owner pay. The most common place a practice quietly loses margin
Clinical supplies and lab as a percent of collections	Moves with case mix, so watch the trend rather than any single month
Facility cost as a percent of collections	Fixed, so it improves only with volume or a renegotiated lease
Owner compensation and profit as a percent of collections	What is left for you. This is the number the others explain

Benchmarks vary widely by specialty, payer mix and region, so the useful comparison is your own practice over the last 24 months. A ratio moving two points in the wrong direction for three months in a row is a finding. A single month is weather.

Where practice books usually break

- Personal spending run through the practice account, which inflates expenses and makes every ratio meaningless
- Owner compensation mixed in with staff wages, so overhead looks catastrophic
- Card income booked net of fees, hiding a cost that often runs into five figures a year
- Equipment loans expensed in full, overstating costs and understating assets
- Retirement plan contributions posted to the wrong year, which can cost a deduction
- A second location with no separate class or location tagging, so nobody can tell whether it is profitable

None of these are exotic. They are what happens when a practice is bookkept by someone who has never seen a practice, and they are the reason the statements get ignored.

Frequently asked questions

Should a practice use cash or accrual accounting?

Most practices file taxes on the cash basis and review an accrual view for management, because accrual shows the work done and the money owed. Running both deliberately is fine. Drifting between them is what causes trouble.

How should insurance write-offs be recorded?

As a contra-revenue line, so the statement shows gross production, adjustments and net production separately. Recording only the net deposit hides the cost of your payer mix.

What should staff costs be as a percent of collections?

It varies by specialty, payer mix and whether providers are employed. Track your own trend over 24 months, and treat a sustained move of a couple of points as the signal rather than any single month.

Does the practice need its own chart of accounts?

Yes. Default software charts do not separate clinical supplies, lab, merchant fees, provider compensation or location, and those are the lines that make practice overhead readable.

How often should the books be closed?

Monthly, with bank, merchant, practice software and payroll reports reconciled to each other. A practice closed once a year at tax time cannot be managed.

General information based on federal law for tax year 2026, not tax advice for your situation. State rules vary.

Want this applied to your situation? Book a free 30-minute call with Akanchya Acharya, CPA at acharyacpa.com/contact or email akansha@acharyacpa.com.

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