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INTELLIGENT CARE

A CFO's Guide to Identifying Revenue Gaps

in Senior Living Billing

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Where Could Revenue Be Slipping Through the Cracks?

In senior living, revenue leakage rarely comes from one major breakdown. More often, it develops through smaller gaps between the services being delivered, the documentation being completed and the charges ultimately making their way into Billing.

A service is documented but never invoiced. A claim is returned because information is incomplete. An eligibility change isn't reflected quickly enough. A private-pay balance ages without follow-up.

Individually, these issues may appear relatively small. Across hundreds of residents, multiple communities and thousands of transactions, however, they can add up to meaningful revenue that was earned but never collected.

For financial leaders, the question isn't simply whether the organization has a Billing process.

The more important question is:
How much of what your organization delivers and documents is actually making it into the revenue cycle?

1. The Financial Margin for Error Is Getting Smaller

Senior living and skilled nursing operators are managing revenue in an environment where there is increasingly little room for leakage.

According to an American Health Care Association survey of 441 nursing home providers, 87% were operating at a loss or at a total margin of 3% or less—with 45% operating in the red and another 42% at margins between 0% and 3%.

Industry estimates cited by Residex® also suggest that long-term care providers may unknowingly lose 5–10% of net revenue through billing errors, denied claims and delayed follow-up.

For CFOs, this changes the revenue conversation. Growth matters, but so does protecting revenue associated with services the organization has already delivered.

Before looking for new revenue, it is worth making sure you're capturing the revenue you've already earned.

2. Five Places Revenue Can Slip Through the Cracks

Understanding potential revenue leakage requires looking beyond the final invoice and examining the entire path from service delivery through payment.

- **The Documentation-to-Billing Gap**
  Your teams may be accurately documenting resident services in the EHR. But when Billing operates through a separate system, that in formation still needs to move from one workflow to another. Every manual handoff introduces another opportunity for information to be delayed, entered incorrectly or missed. The challenge for Finance is that a service that never becomes a charge may never appear as an outstanding receivable or denied claim. The revenue can be absent from the financial workflow altogether.

CFO question: How do we verify that the bill able services documented in our EHR actually become charges?

- **Manual Entry and Reconciliation**
  Disconnected systems often require employees to re-enter information, compare records or reconcile reports to make sure documented services match Billing. That creates two costs: the potential financial cost of errors or omissions and the operational cost of using staff to manually bridge systems that don't communicate. Adding another spreadsheet, audit or reconciliation step may help catch discrepancies, but it doesn't eliminate the process that created them.

CFO question: How much staff time are we spending reconciling information that already exists elsewhere in the organization?

- **Claim Errors and Denials**
  Revenue isn't captured simply because a claim was created. Across healthcare broadly, 30–35% of claims are denied or rejected on first submission, and one analysis cited by Residex found that nearly 41% of long-term care providers see 10% or more of their claims denied. Industry reporting has also indicated that approximately 30% of denied claims are never resubmitted. For Finance, denial management is therefore about understanding the dollars represented by those denials, why they occurred and how much is ultimately recovered.

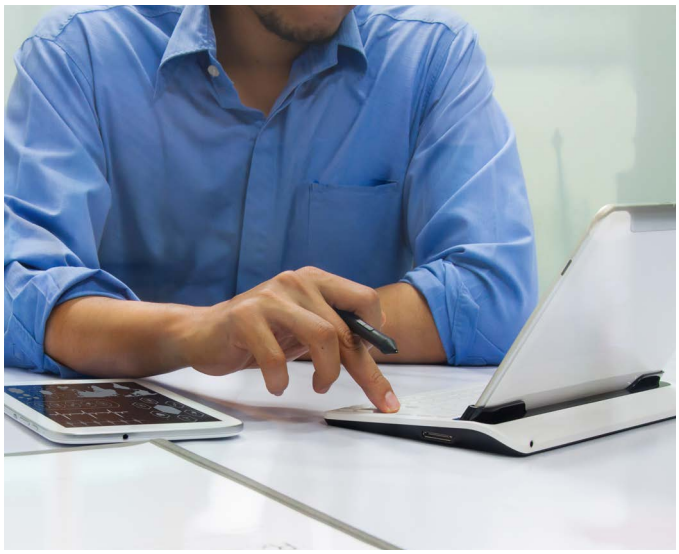
CFO question: Do we know the financial value of our denied claims—and what percentage of that revenue we ultimately recover?

- **Eligibility and Authorization Changes**
  Resident coverage can change over the course of a stay, including transitions among Medicare, Medicaid and managed care. When eligibility, payer or authorization information doesn't reach Billing quickly enough, the result can be delayed or denied reimbursement. The longer those discrepancies remain unresolved, the harder they may become to recover.

CFO question: How quickly does our Billing process reflect payer, eligibility and authorization changes—and how do we know when it doesn't?

- **Accounts Receivable Follow-Up**
  Generating an invoice or submitting a claim is only part of the revenue cycle. Private-pay balances, unpaid claims and aging receivables require visibility and consistent follow-up. Financial leaders need more than a total AR number. They need visibility into what is outstanding, why it is outstanding, how long it has been outstanding and what action is being taken.

CFO question: Can our team quickly identify which balances require attention before they become harder to collect?



3. The Hidden Cost Isn't Just Lost Revenue

Revenue leakage has an obvious financial impact. The less visible cost is the amount of organizational effort required to prevent or correct it.

When EHR and Billing information don't connect, people often become the integration. Employees re-enter information. Finance compares reports. Teams research discrepancies. Staff correct claims that might have been caught earlier. Managers create spreadsheets and additional controls to make sure information hasn't been missed.

For a single community, those activities consume time. Across a multi-community organization, the cost and complexity can multiply.

How much are you spending to compensate for disconnected processes?

A connected revenue cycle should not simply improve Billing efficiency. It should reduce the organization's dependence on manual intervention while giving Finance greater confidence that documented services are being reflected downstream.

4. What Should a Connected Revenue Cycle Look Like?

The objective isn't simply to replace one Billing system with another. It is to create a more reliable path:

Service Delivered → Service Documented → Charge Created → Claim or Invoice → Payment → Reconciliation

At each stage, Finance should be able to answer three questions:

Did the information move forward? The next step in the revenue cycle should receive the information it needs without unnecessary manual intervention.

Can we identify an exception? Missing information, errors or discrepancies should become visible early enough for someone to act.

Can we measure the outcome? Leadership should be able to understand what was billed, what was paid, what remains outstanding and where revenue is being delayed or lost.

For multi-community operators, that visibility also needs to extend beyond an individual location. Financial leadership should be able to identify patterns across the portfolio and determine whether an issue is isolated or systemic.

The goal is not simply faster Billing. It is greater confidence in the integrity of the revenue cycle.

5. CFO Revenue-Capture Checklist

Use the checklist below with Finance, Operations and care leadership. If the answer to a question isn't immediately clear—or requires pulling information from multiple systems, spreadsheets or departments—it may indicate an area worth examining more closely.

Documentation → Billing

- ☐ Can we verify that billable services documented in our EHR become charges?
- ☐ Can we identify documented billable activity that never reaches Billing?
- ☐ How many manual steps occur between documentation and charge creation?
- ☐ Where is information entered more than once?
- ☐ Do we have a consistent process for identifying missing charges before the billing cycle closes?

Claims & Denials

- ☐ What is our first-submission rejection or denial rate?
- ☐ What are our most common reasons for denials?
- ☐ What percentage of denied claims are successfully corrected and resubmitted?
- ☐ What is the dollar value of claims that ultimately go uncollected?
- ☐ Are we tracking denial trends to identify recurring process issues?

Eligibility & Payer Management

- ☐ How are payer, eligibility and authorization changes communicated to Billing?
- ☐ How quickly are those changes reflected?
- ☐ How do we identify an eligibility or authorization issue before it affects reimbursement?
- ☐ Who is accountable for resolving an issue once it's identified?

Accounts Receivable

- ☐ Can Finance easily see invoices, outstanding balances, payments and collections?
- ☐ How quickly are aging balances identified for action?
- ☐ Can leadership compare AR performance across communities?
- ☐ Can we quickly determine why a balance remains outstanding?

Operational Efficiency

- ☐ How much staff time is spent manually entering, comparing or reconciling information?
- ☐ What spreadsheets or workarounds have become part of the normal Billing process?
- ☐ Are employees routinely acting as the bridge between systems?
- ☐ What would happen to the process if the person who manages those workarounds wasn't available?

Executive Visibility

- ☐ Can we follow revenue from documented service through payment?
- ☐ Can we identify where revenue is being delayed?
- ☐ Can we identify revenue that never entered Billing at all?

- ☐ Can we quantify the financial impact of our current revenue-cycle gaps?
- ☐ Do we have the information needed to prioritize which gaps to address first?

If several of these questions are difficult to answer, the issue may not simply be Billing performance. It may be visibility into the entire path from care documentation to revenue.

6. Connecting the Revenue Cycle with Residex Billing

For organizations already using Residex to document resident care and services, Residex Billing extends that workflow into the financial side of the operation.

EHR-Integrated Billing — Charges can be generated directly from completed charting, helping reduce missed billable services and duplicate data entry.

Flexible Billing Options — Supports private pay, Medicaid, electronic claims, third-party billing, split billing and tiered pricing within the platform.

Built-In Claims Management — Medicaid and managed care organization claims can be validated before submission to identify information that could otherwise contribute to a denial.

Waystar Integration — Supports the exchange of claim, remittance and eligibility information across the claim lifecycle.

Accounts Receivable Management — Provides visibility into invoices, outstanding balances, payment activity and collections.

Online Payments and Recurring Autopay — Helps streamline payment processing and private-pay collections.

Multi-Community Capabilities — Supports organizations managing financial workflows and visibility across multiple communities.

The value of integration goes beyond eliminating duplicate entry.

It creates a more direct connection between the services your organization documents and the revenue cycle responsible for capturing their financial value.

One Question Worth Answering

Revenue-cycle performance is typically measured by what enters the financial system—charges, claims, receivables and payments.

But there is another question worth asking:

Did everything we should have billed actually make it to Billing?

If the answer isn't immediately clear, there may be an opportunity to take a closer look at what happens between documentation and revenue.

See how Residex Billing can help create a more connected path from documented services to Billing.

EXPLORE RESIDEX BILLING

Sources

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