Medicare Reimbursement and Effective Cost Reporting

Summer CPE Symposium – Session #1

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Introductions

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Effective Medicare Cost Reporting for PPS Hospitals

Wage Index Impacts

- Medicare certified short-term acute IPPS hospitals are required by CMS to complete the wage index worksheets in the Medicare cost report and occupation mix survey:
  - Worksheets S-3, Parts II through V
  - Completed every 3 years
- Wage index values are incorporated as an element of Medicare reimbursement to PPS hospitals:
  - As a result, the wage index value can have a significant impact on a hospital's Medicare reimbursement.
- The goal of the wage index is to adjust prospective payment rates to account for varying wage related costs for hospitals operating in different geographical areas:
  - For example, wages paid to employees in New York City are much higher than hiring the same employees in rural North Carolina.
  - Geographical areas are defined by the Office of Management & Budget and are called Core Based Statistical Areas (CBSA).

Wage Index Impacts

- Wage index worksheets are commonly reviewed in detail by the hospitals before CMS conducts annual wage index audits.
  - Federal Fiscal Year 2026 wage index values will utilize hospital cost reports beginning on or after 10/01/23.
  - Revisions to wage index worksheets are due to the MACs by September 3, 2024.
- It is recommended for hospitals to do a separate deep dive review or assessment of their wage index schedules each year to ensure appropriate dollars and hours are supported and ready for MAC audit.

Wage Index Impacts

- Why is the hospital wage index important?
  - **Data is used to adjust Medicare payments for differences in wage rates across geographic regions.**
    - **May have significant impact on health system revenue.**
  - Applied to the labor portion of the Medicare payments.
  - Hospital wage index rates trickle down to other types of providers, including skilled nursing, outpatient services, rehab, home health, and hospice services.
  - Providers in counties with few hospitals could be negatively affected by poor cost report data.

Expect COVID-19 to continue to influence wage index data through Federal Fiscal Year 2025.

Wage Index Impacts: Rural Floor

In rural wage index floor was initiated to protect small Core Based Statistical Area (CBSA) from having a lower calculated wage index below the state's rural wage index

Wage index values that are into the bottom quartile of the national wage index average with receive an increased wage index value of 50% of the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value

Urban hospital that are granted Medicare Geographic Classification Review Board (MGCRB) reclassification to rural will be included in the rural wage floor calculation in FY2024.

Per the FY 2025 Proposed Rule, CMS plans to update the CBSA delineations issued by the Office of Management and Budget (OMB) based on 2020 Census data.

Wage Index Impacts: Physician Data

- Highly recommended to keep track of Part A/B physician time through time studies or time sheets or directly stated in the contract with physician.
  - Appropriate support will be required at the time of audit.
- MACs may ask for the following information around the physician data.
  - Recommended to track of the type of personnel, description of services rendered, labor costs and related hours, trial balance number, and cost report grouping on worksheet A.

Wage Index Impacts: Contract Labor

- MACs typically request ALL contracts and in place during the cost report period to support dollars and/or hours included on the wage index; invoices may also be requested as support:
  - Recommended to keep track of these contracts throughout the year so it's not all on one department or group to retrieve all related contracts.
  - There are new software programs available to assist in organizing and tracking contracts for multiple reasons, one being wage index requests.
- Dietary contract labor has been under increased scrutiny over the last few years:
  - MACs are looking to see the costs and hours related to the full outsourcing of the dietary department (not small catering orders from external vendors, as an example).
- In addition to the contracts, be sure to track the vendor's name, description of services provided, and trial balance accounts.
- If no hours can be documented or supported, then the contract labor costs should be excluded from the wage index worksheets.

Wage Index Impacts: Wage-Related Costs

- If the provider is self-insured, the support for the amount claimed as health insurance costs.
- If using a third-party administrator, the TPA report may be requested by the MAC to support these costs.
- Support for wage-related costs that tie to the working trial balance.
- Additional costs may also be included, such as any services the hospital provides to employees are no costs or discounted costs.
  - Examples may include:
    - ✓ Physicals not covered under insurance
    - ✓ Vaccines not covered under insurance
    - ✓ Smoking/weight management programs

Wage Index Impacts: MAC Wage Index Audits

- Prior to the MAC Wage Index Audits, hospitals likely benefit from a second look at their wage index values.
- Suggested scope of review that can be done internally at the hospital or through hospital's third-party cost report preparer:
  - Comparison to other hospitals in same CBSA or surrounding areas
  - Review prior year adjustments to incorporate these prior to audit
  - 3 – 4-year comparison of hospital's key wage index values to identify trends or inconsistencies
  - Involve other hospital departments in the discussion, such as payroll, accounts payable, etc.

Wage Index Impacts: MAC Wage Index Audits

- Common issues that come up in audits to address during wage index review, prior to MAC audit:
  - Identifying the appropriate paid hours to include
    - On-call hours/shift differential hours should be excluded.
  - Physician Part A admin (best practice is to conduct frequent time studies to split time or have physicians complete time sheets on how they spend their time)
  - Contracted dollars and hours supporting documentation (full contracts with vendors required)
  - Accidental omission of dietary or housekeeping contract dollars and hours
  - Benefits buried in other trial balance accounts (artificially decreasing wage related costs)
  - Appropriate alignment of wages and hours (such as A-6 salary reclasses)
  - Reconcile trial balance wages to payroll reports

Wage Index Impacts: Occupational Mix Survey

- Occupational Mix Survey (OMS) is submitted every three years:
  - Most recent surveys were submitted by June 30, 2023 and will be applied to the FY 2025 – 2027 wage index.
  - Occupational mix adjusted national average hourly wage for FFY 2024 is $50.34.
  - Each hospital's salaries and wage related costs are adjusted by the occupational mix.
  - Categories included in the OMS:
    - RNs, LPNs, surgical technologists, nursing assistants, orderlies, medical assistants, surgical technologists, and all other occupations
    - Full time, part time, directly hired, and acquired under contract employees
  - Do **not** include any salaries or hours for physicians or APNs that are directly billable under Part A or B.

Other Wage Index Impacts: Rural Floor Wage Index

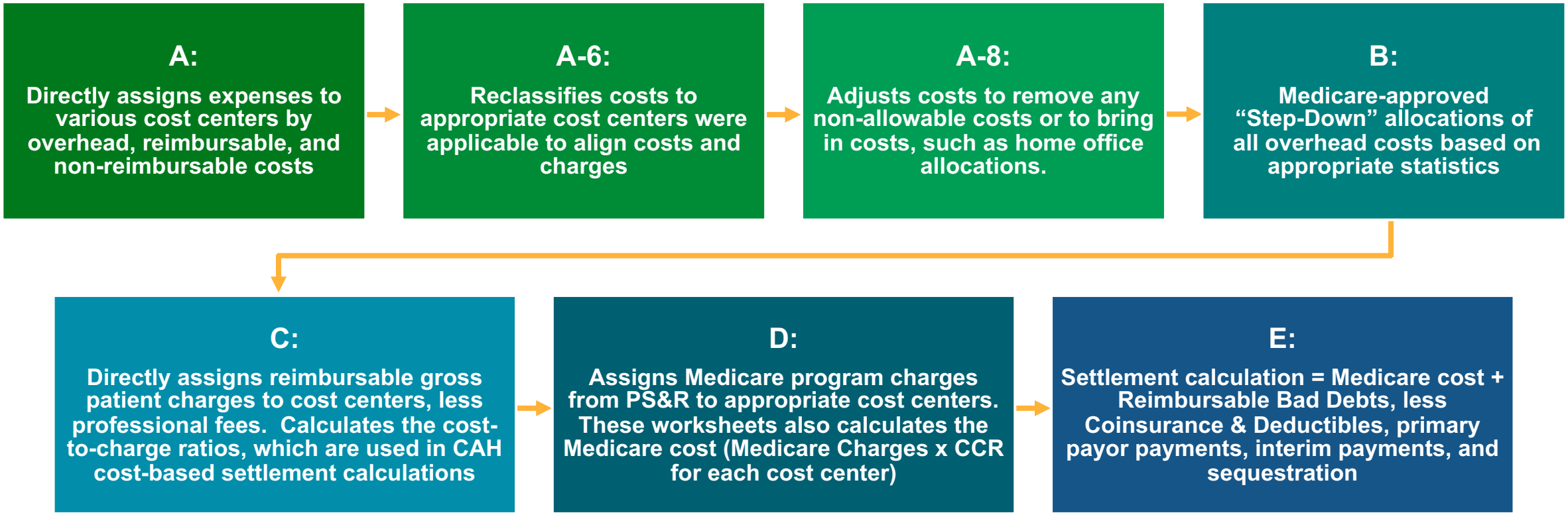
- Regulations ensure that the wage index for an urban CBSA can not be lower than the state's rural wage index.
- CMS estimates 646 hospitals will receive the rural floor in FY 2024.
- Rural floor must be applied in a budget neutral manner.

Other Wage Index Impacts: “Frontier States” Wage Index

- A frontier state is defined as a state with at least 50% of counties with a population per square mile of less than six.
- Wage index floor for “Frontier” hospitals is set at 1.00.
- Does ***NOT*** need to be applied in a budget neutral manner.
- *Excludes* Alaska and Hawaii.

Prospective Payment System & Critical Access Hospitals

Overview of Medicare Cost Report Reimbursement



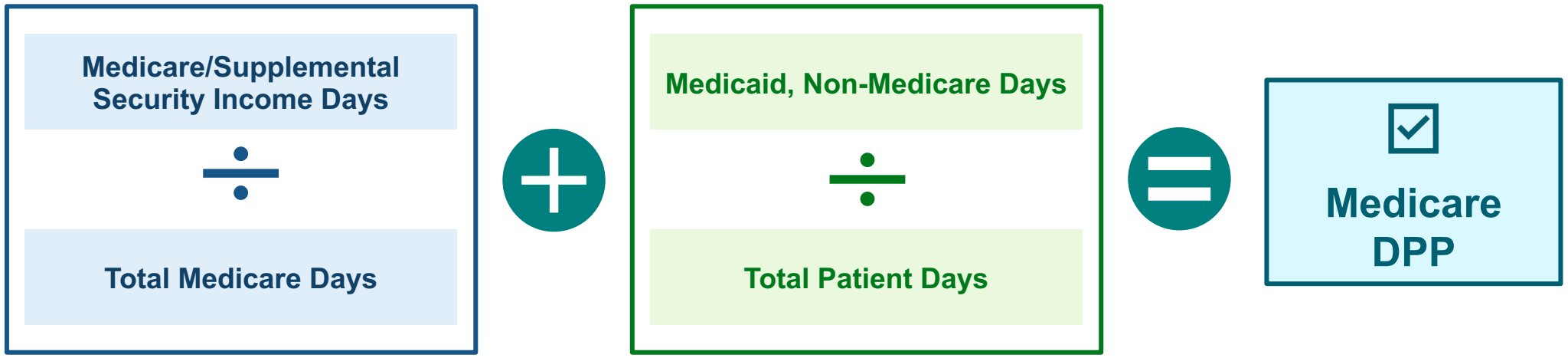
DSH Uncompensated Care Payment

- DSH program was established in 1986 to provide additional reimbursement for hospitals that serve a disproportionate share of Medicaid eligible and uninsured patients:
  - Prior to 2014 it was 100% Empirically Justified DSH
  - In 2014 the breakout changed to 25% Empirically Justified DSH and 75% Uncompensated Care Payment
- Uncompensated care payment is the product of 3 factors:
  - 75% of the total payments other made under Section1886(d)(5)(F) of the Social Security Act
  - 1 minus the percent change in the percent of individuals uninsured
  - A hospital's uncompensated care amount relative to the uncompensated care amount of all DSH hospitals expressed as a percentage
- Eligibility for 340B is directly linked to hospital's allowable DSH percentage:
  - Greater than 11.75% allowable DSH
  - Sole Community Hospitals (SCH) are 340B eligible with greater than 8.00% allowable DSH

DSH Uncompensated Care Payment

Primary Method of Qualifying for Medicare DSH payments

If the hospital's Medicare Disproportionate Percentage (DPP) equals or exceeds a specified threshold, the hospital will qualify for DSH adjustments:



Disproportionate Share Hospital (DSH): Recent Updates

- 2024 IPPS Final Rule: Section 1115 Waiver Days
  - CMS has limited how Medicaid 1115 days count for the purposes of Medicare DSH calculations.
  - The final policy will only count the days of patients who receive from the state's section 1115 Demonstration:
    - Health insurance that covers inpatient hospitals services; ***or***
    - Premium assistance that covers 100% of the premium cost to the patient, which the patient uses to buy health insurance that covers IP hospital services.

- Transmittal 12513: Treatment of Medicare Part C Days in the Calculation of a provider's DSH adjustment
  - Hospitals with cost reports on hold where no original NPR has been issued or hospitals with pending appeals related to the treatment of Medicare part C days in DSH adjustment are affected.
  - With this being issued recently, recommended steps at this time are to review and understand the policy changes and reach out to your MAC for next steps.

Medicare Bad Debts

For both PPS and CAHs, Medicare bad debts can be claimed for reimbursement at 65%

Allowable bad debts

- Debt must be related to covered services and derived from deductible or coinsurance amounts
- Provider must be able to establish that reasonable collection efforts were made
- Debt has been deemed uncollectible and claimed as worthless and;
- Sound business judgment established that there was no likelihood of recovery at any time in the future

Non-allowable bad debts

- Deductibles and coinsurance amounts from patients enrolled in Medicare Advantage plans, professional fees billed separately (fee schedules or on 1500), or for services not covered by Medicare
- Unpaid amounts written off to charity care or contractual allowance account

Medicare Bad Debts

Types of Medicare Bad Debt

Traditional (Regular)

- Not eligible for Medicaid
- Reasonable collection efforts performed
- All collection efforts ceased; returned from final collections
- Not charity/uncompensated patient

Medicaid Crossover

- Beneficiary eligible for both Medicare and Medicaid
- CMS “Must-Bill” policy

Indigent (Charity)

- Not eligible for Medicaid
- Indigence determined by provider
- Total resources taken into account
- Supporting documentation
- Presumptive charity reimbursement/allowability debatable and varies by MAC

Medicare Bad Debts

- Medicare Bad Debts may go through an audit process by the MACs
  - MACs may review recoveries, which can be challenging to support on the provider side
  - Keep copies of your bad debt policies handy, they will be requested during the audit
  - Audit will have a process to identify any dissimilar treatment of Medicare and non-Medicare accounts
  - Overall lack of documentation in the process

- Beginning with cost reports beginning on or after October 1, 2022 a new format must be used to submit Medicare bad debts: Exhibit 2A
  - Increases required columns from 10 to 24
  - Recommended (if not already) to get your internal team on the same page before the deadline to ensure there is adequate time to pull all the fields.

Medicare Bad Debts Exhibit 2A: Considerations

1. Bad debt amounts include professional or fee schedule amounts

2. Payments were not netted against accounts

3. Including amounts that were previously claimed

4. Duplicate accounts on the listing – use formulas to double check for duplicates

5. Not including all required data on the Exhibit 2A

Updated Cost Report Exhibits

- Now effective (beginning with cost report periods beginning on or after 10/1/22) for hospital cost reports, the following exhibits are required at the time of filing:
  - ✓ Exhibit 2A: Medicare Bad Debts listing
  - ✓ Exhibit 3A: Medicaid Eligible Days for hospitals claiming DSH or Low-Income Payments (LIP)
  - ✓ Exhibit 3B: Charity Care Listing to support S-10
  - ✓ Exhibit 3C: Total Bad Debts Listing to support S-10

Exhibit detail totals must match exactly to what is reported in the cost report, or the provider risks cost report rejection and temporary suspension of Medicare payments.

Medicare Dependent Hospitals & Low Volume Adjustments

- **Medicare Dependent Hospital (MDH) provide additional payments to hospital**
  - Program has been extended through December 31, 2024
  - MDHs are located in rural areas, less than 100 beds, and not classified as a Sole Community Hospital
- **Low volume adjustment**
  - FY19-FY24 hospital must have fewer than 3,800 total discharges, which includes Medicare and non-Medicare discharges and located no more than 15 road miles from the nearest hospital
    - Low Volume Hospital (LVH) with **fewer than 500 discharges**, the adjustment is additional 25% for each Medicare discharge
    - LVH with **more than 500 and less than 3,800 discharges**, the additional percent calculated using the formula [(95/330)-(number of total discharges/13,200)]
  - FY25 hospital must have fewer than 200 total discharges, which includes Medicare and non-Medicare discharges and located no more than 25 road miles from the nearest hospital


Effective Medicare Cost Reporting
for Critical Access Hospitals

Critical Access Hospitals

- Located in a rural area and more than 35 miles from the nearest hospital or CAH
  - Or more than 15 miles in areas with mountainous terrain or only secondary roads
- Average length of stay during fiscal year <4 days
- Furnish 24-hours emergency services
- No more than 25 beds
- Prior to 12/31/2005, a hospital could qualify if it was certified by the state as a necessary provider of healthcare services
- Medicare reimburses at 101% of hospitals allowable costs for inpatient and outpatient services (uses CCRs for this calculation)
- Professional fees paid via Medicare Physician Fee Schedule are not cost-reimbursed

Critical Access Hospitals

- Enhanced reimbursement opportunity for professional services, if provider reassigns benefit.
  - Optional all-inclusive “Method II” billing could enhance reimbursement for some CAHs.
  - Billing professional charges on UB-04 instead of 1500, which allows the following splits:

Professional services paid at 115% of the Physician Fee Schedule

Facility/technical services reimbursed at 101% of allowable cost

Prospective Payment System and Critical Access Hospitals

- **Recap of Medicare Cost Report reimbursement:**
  - ✓ **A:** Directly assigns expenses to various cost centers by overhead, reimbursable, and non-reimbursable costs
  - ✓ **A-6:** Reclassifies costs to appropriate cost centers were applicable to align costs and charges
  - ✓ **A-8:** Adjusts costs to remove any non-allowable costs or to bring in costs, such as home office allocations.
  - ✓ **B:** Medicare-approved "Step-Down" allocations of all overhead costs based on appropriate statistics
  - ✓ **C:** Directly assigns reimbursable gross patient charges to cost centers, less professional fees. Calculates the cost-to-charge ratios, which are used in CAH cost-based settlement calculations
  - ✓ **D:** Assigns Medicare program charges from PS&R to appropriate cost centers. These worksheets also calculate the Medicare cost (Medicare Charges x CCR for each cost center)
  - ✓ **E:** Settlement calculation = Medicare cost + Reimbursable Bad Debts, less Coinsurance & Deductibles, primary payor payments, interim payments, and sequestration

Critical Access Hospitals: Expenses

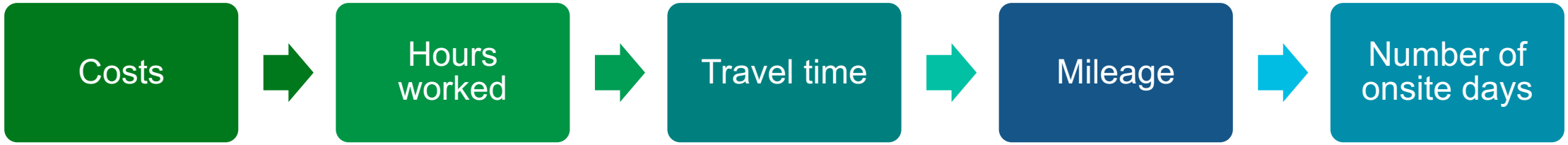
- Expenses should be pulled from the facility trial balance (Worksheet A)
- Split by salaries and “all other” expenses

General Service Cost Centers	Reimbursable Cost Centers	Non-Reimbursable Cost Centers
• “Overhead” type expenses	• Typically, patient-driven such as operating room, radiology, therapy, etc.	• Expenses that Medicare deems non-allowable through normal course of business

Appropriate classification of expenses is **critical** for CAHs to ensure the correct Cost-to-Charge Ratios (CCR) are calculated.

Critical Access Hospitals: Worksheet A-8-3

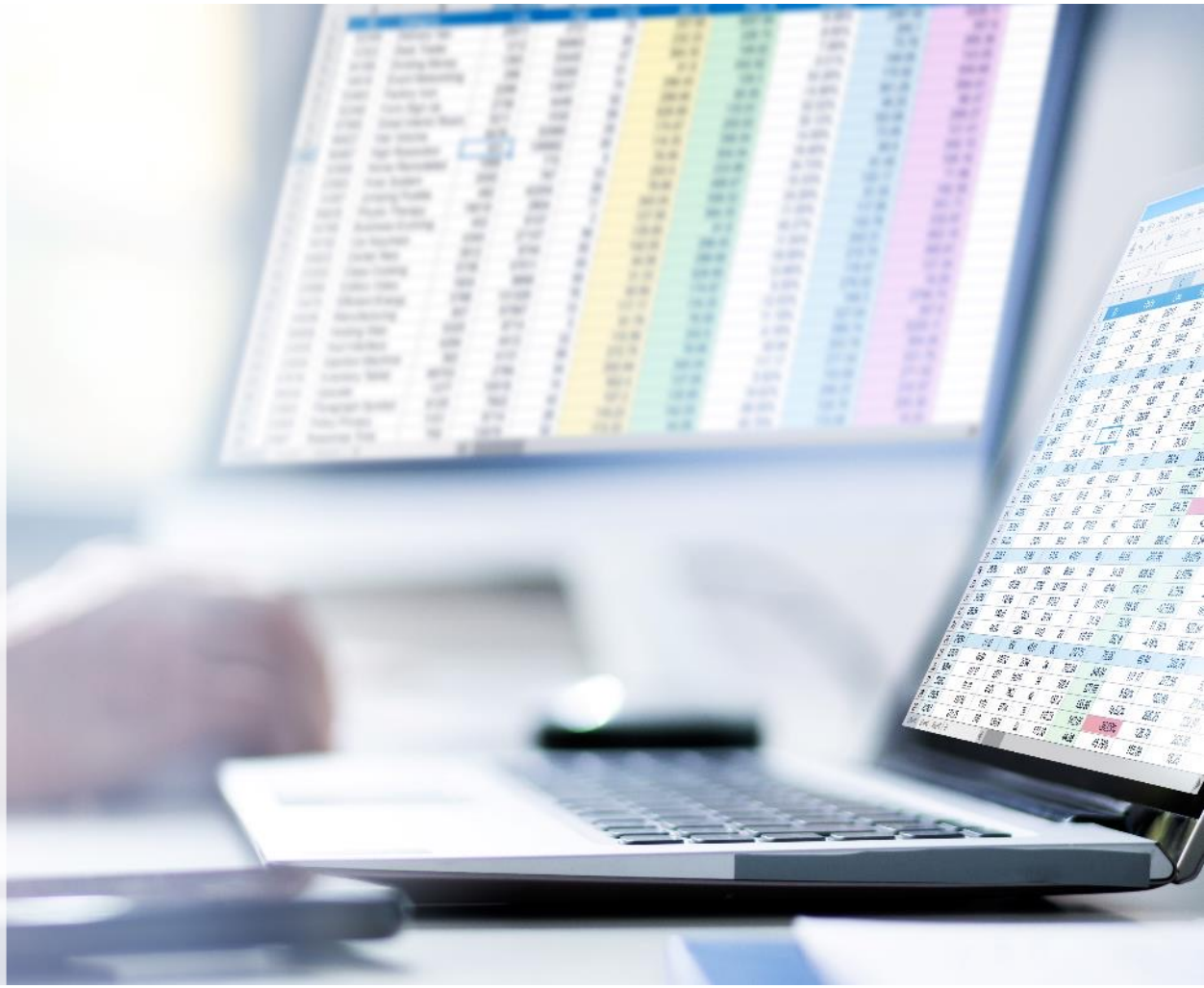
- For CAHs, there is a limitation on therapy services provided by an outside vendor.
- Recommended to track and accumulate invoices throughout the year and ensure the following details are included:



- There are additional allowance for travel, overtime, supplies, and equipment to help avoid an adjustment.

Critical Access Hospitals: Worksheet B

- Review **each year**!
  - Small changes could impact reimbursement.
  - Track quarterly or monthly to ensure documentation.
- Keying errors could have impacts if a stat is put on the incorrect line.
- Stats must be current, accurate, and capable of being audited.
- Direct costing in many cases is preferred versus cost allocations.



Critical Access Hospitals: Worksheet B

- Changes to the allocation basis (e.g., square feet, nursing hours, etc.) can be requested.
  - MAC must approve, in writing, the change in allocation basis at least 90 days prior to the close of your fiscal year
  - Consider and demonstrate the impact of the allocation basis change, such as ease of tracking or collecting the data for an allocation change or just an overall better way to allocate expenses for your organization.

Critical Access Hospitals: Worksheet C

Start with your mapped trial balance, then determine if any charge reclassifications are needed and if any professional charges should be removed…

- Reclassifications and removal of professional charges typically utilize a detailed revenue and usage report that breaks out the following:
  - ✓ Patient status (inpatient, outpatient, clinic, etc.)
  - ✓ UB Revenue Code that categorizes each type of service billed and professional fees that should be removed
  - ✓ Department mapping to where charges are posted in TB – have a reconciliation ready for the MAC audit.

Critical Access Hospitals: Worksheet C

1.

Cost to Charge Ratios (CCR) are calculated on Schedule C.

2.

Always review CCRs for reasonableness and compare to the prior year. Be able to explain any significant variances between years, such as new service or winding down a department.

3.

Inpatient and Outpatient CCRs are used to determine outlier reconciliations. Monitor any significant changes in CCR (more than 10% change) between years if your outlier payments are over $500,000.

4.

CCRs are used in settlement calculations for CAHs

Critical Access Hospitals: Cost to Charge Ratios (CCR)

- **CCR Greater than 1.0**
  - Means costs are greater than charges
  - Review Expenses on Wkst. A
    - Inconsistent department mapping
    - Missing professional cost adjustment
  - Review Allocations on Wkst. B, Part I
  - Is this naturally a higher cost service? Or lower volume this year?

- **CCR Less than 1.0 (or close to 0)**
  - Means charges are greater than costs
  - Review cost structure of service
    - Costs properly matched with charges?
  - Review charges by revenue code
    - Is a reclassification needed to align charges?
  - Is this naturally a low-cost service? Or unusually high volume this year?

Critical Access Hospitals: PS&R Input

Run the PS&R as late as possible to ensure you have enough lage time for claims processing

- Medicare will run a new PS&R at the time of tentative settlement and at the time of Audit.

Map PS&R charges to the same cost centers as gross charges from schedule C

- Small movements can have significant impact on CAH reimbursement.

Provider-Based Rural Health Clinics

Many CAHs have Provider-Based Clinics

Advantages

- Potential higher reimbursement compared to freestanding physician practices
- Reimbursement for Medicare Bad Debts
- Have typically increased hospital physician/mid-level provider coordination and integration
- Additional cost-sharing with the clinic of IT, finance, HR, or billing resources from the parent hospital
- 340B Drug Discount Program

Disadvantages

- Perceived billing confusion – split billing for patients
- Decreased accountability, physician control, or productivity
- Increased costs due to proximity to hospital facilities, salaries, with less effective cost management

Provider-Based Rural Health Clinics

- All “new” RHCs are subject to the new per-visit cap (exception for RHCs grandfathered) as set in the H.R. Consolidated Appropriations Act of 2021 (COVID Relief Package) passed in December 2020.

- “Grandfathered” RHC will not be subject to the new per-visit cap:
  - Must be enrolled in Medicare as of 12/31/20
  - Owned by hospitals with fewer than 50 beds as of 12/31/20 and continued to have less than 50 beds

Provider-Based Rural Health Clinics: Considerations for Effective Reporting

1. Review for duplicate allocations of overhead costs to RHC.
    - Overhead costs from the hospital's worksheet B should be considered and reviewed to ensure there are no duplicate costs coming down to the RHC cost center (e.g., capital costs, administrative, housekeeping, utilities, etc.). In some cases, costs kept at the hospital level will increase hospital cost-based reimbursement.
2. Review wages by job code and consider if employees "float" between the RHC and the hospital. Some time/wages may need to be reclassed to the hospital for appropriate wage cost split.
3. Ensure RHC is tracking visits by provider type, which can be challenging for some clinics.
    - RHC visits are defined as medically-necessary medical or mental health visits or qualified preventative health visit (exclude nursing only visits, IP/OP hospital department, etc.)
4. Reclassify RCH costs for services not included in All-Inclusive Rate (AIR), such as Chronic Care Management.

Provider-Based Rural Health Clinics: Considerations for Effective Reporting

- Focus on on-campus expansion, which must be withing 250 yards of main provider
- Evaluate locations of current provider-based rural health clinics
- Expansion of services in existing provider-based rural health clinics
- Consider the benefits of utilizing 340B drug discounts through additional provider-based clinics

Utilizing Cost Report Data for Reimbursement Analysis

Medicare Reimbursement Analysis

- The Medicare cost report data can be used as a source of data for calculating various statistical, operating, and financial metrics
- Medicare cost report data for all providers can be utilized to run key benchmarks
- Considerations using Medicare cost report data:
  - Medicare cost report groupings will vary from financial statement presentation
  - Prepare comparative analysis to identify trends or areas requiring further analysis
  - Use business intelligence capabilities to automate metric analysis and competitive analysis across multiple facilities
  - Medicare cost report data is publicly available

Medicare Reimbursement Analysis: Examples

Average Length of Stay (ALOS)

Total Patient Days

÷

Total Discharges

- ✓ ALOS when compared with the Case Mix Index (CMI) could be an indicator of potential opportunities
- ✓ **Low ALOS with a high CMI** could indicate upcoding compliance risk
- ✓ **High ALOS with a low CMI** could indicate a documentation, charge capture, or case management improvement opportunities

Hospital Occupancy

Total Acute Patient Days

÷

Total Acute Bed Days Available

Average Hourly Wage (AHW)

Gross Salaries

÷

Total Hours

- ✓ Significant decrease or increase could indicate incorrect payroll data is incorporated, such as including shift differentials or not including all appropriate paid hours

Medicare Reimbursement Analysis: Examples

Effectively capturing DSH eligible days helps offset operation losses on Medicaid patients

- Also, ensuring all eligible days are captured will help keep the hospital above the required threshold to participate in the 340B program

Current year to prior year comparisons

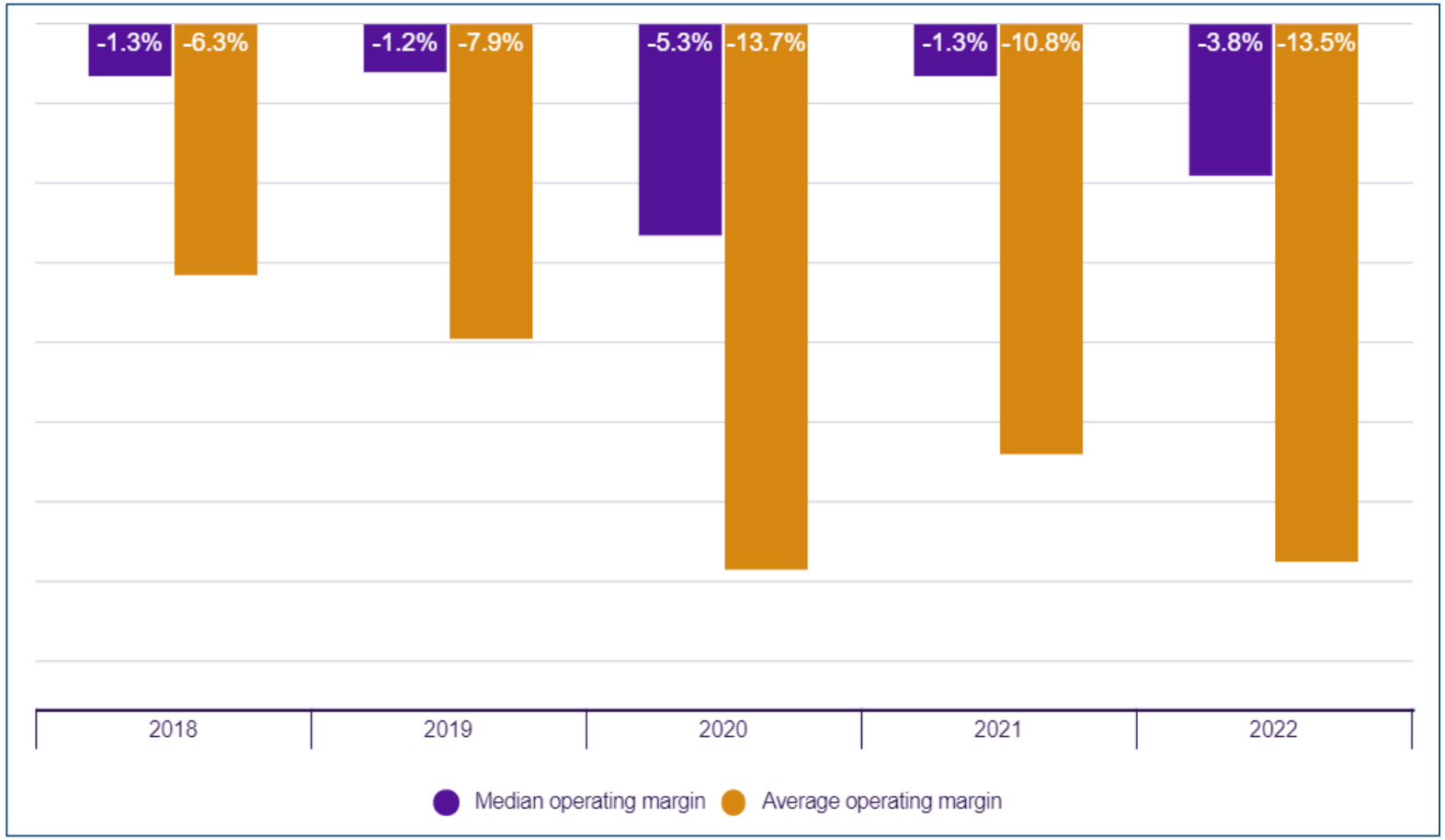
- Helps visualize trends between years and identifies inconsistencies between years for a deeper dive
- Used drafted cost report before filing in this comparison as part of the review process

Medicare margin over 3 – 4 years

Margin Hospital, Inc.

	6/30/2020	6/30/2021	6/30/2022	6/30/2023
Medicare Charges				
Inpatient Acute	10,081,988	10,283,627	10,386,464	10,182,807
Swing Beds: SNF	85,288	86,993	87,863	86,140
Outpatient	18,329,773	18,696,368	18,883,332	18,513,070
Total Medicare Charges	**28,497,048**	**29,066,988**	**29,357,658**	**28,782,018**
Contractual Allowances				
Inpatient Acute	5,740,900	5,855,718	5,914,275	5,798,309
Medicare Bad Debts	(9,016)	(9,197)	(9,289)	(9,106)
Swing Beds: SNF	37,981	38,741	39,128	38,361
Outpatient	14,914,849	15,213,146	15,365,277	15,063,997
Total Medicare CA	**20,684,714**	**21,098,408**	**21,309,392**	**20,891,561**
Reimbursement				
IP PPS Operating Payments	2,677,378	2,730,925	2,758,234	2,704,151
IP PPS Capital Payments	207,188	211,331	213,445	209,259
DSH & Uncompensated Care	623,089	635,551	641,906	629,320
Low Volume Adjustment	833,434	850,102	858,603	841,768
HAC Adjustment	45,360	46,267	46,730	45,814
Swing Beds: SNF	47,306	48,252	48,735	47,779
Outpatient	3,414,924	3,483,222	3,518,054	3,449,073
Adjusted Reimb. Medicare Bad Debts	9,016	9,197	9,289	9,106
Total Medicare Reimbursement	**7,857,694**	**8,014,848**	**8,094,996**	**7,936,271**
Medicare Cost				
Inpatient Acute	3,804,533	3,880,623	3,919,429	3,842,578
Swing Beds: SNF	20,211	20,615	20,822	20,413
Outpatient	4,580,424	4,672,032	4,718,753	4,626,228
Medicare Bad Debts	13,871	14,149	14,290	14,010
Total Medicare Costs	**8,419,039**	**8,587,419**	**8,673,294**	**8,503,229**
Medicare Margin				
Inpatient Acute	581,915	593,553	599,489	587,734
Swing Beds: SNF	27,095	27,637	27,913	27,366
Outpatient	(1,165,500)	(1,188,810)	(1,200,698)	(1,177,155)
Medicare Bad Debts	(4,855)	(4,952)	(5,002)	(4,903)
Total Medicare Margin	**(561,345)**	**(572,572)**	**(578,298)**	**(566,958)**

Operating Margin Trends: U.S. Hospitals



- In FY22, U.S. hospitals' **median** operating margin was **negative 3.8%**
- The **average** operating margin was **negative 13.5%**
  - *To remain financially viable, the average hospital must rely on non-operating income to close gap between revenue and expenses.*

Source: https://www.definitivehc.com/resources/healthcare-insights/hospital-operating-margins-united-states

A national healthcare advisory services firm providing consulting, audit, and tax services

PYA by the Numbers

40% FEMALE OWNERSHIP

Over 2x the average of similarly sized firms

- Inside Public Accounting

Consistently ranked TOP 20 HEALTHCARE CONSULTING firm in the U.S. by Modern Healthcare

TOP 15 LARGEST AUDITOR of AHA's Top U.S. Multi-Hospital Systems - Ames Research Group

INSIDE public accounting BEST OF THE BEST FIRMS 2023

Clients in ALL 50 STATES

USA TODAY MOST RECOMMENDED TAX & ACCOUNTING FIRMS 2024 IN COOPERATION WITH statista

MORE THAN **3400** HEALTHCARE CLIENTS

Academic Medical Centers | Accountable Care Organizations Ambulatory Surgery Centers | Blood Centers | Clinically Integrated Networks | County Owned Hospitals | Critical Access Hospitals Diagnostic Centers | Dialysis Centers | Health Plans | Health Systems | Home Health Agencies | Hospices | Hospitals Independent Practice Associations | Maternity Centers | Medical Groups | Mental Health Centers | Nursing Homes Physician-Hospital Organizations | Physician Practices | Physical Therapy Centers | Psychiatric Hospitals | Rural Health Centers Safety Net Hospitals | Surgery Centers | Urgent Care Centers

Vision Beyond the Numbers®

We measure our success based on the success of our clients.

Our culture of HELP and helpfulness is an intrinsic daily philosophy.

RESPONSIVE

ACCESSIBLE

COMMITTED

How can we help?