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first illinois chapter

February 2025

FIRST ILLINOIS SPEAKS

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Message From Our Chapter President

Dear Friends and Colleagues,

There never seems to be a dull moment in today's world and the healthcare industry is no different. We continue to face a variety of challenges, including economic pressures, regulatory changes, cyberattacks and recruitment shortages. Despite these countless challenges, I believe our industry is on the upswing. Fitch Ratings recently revised its U.S. Not-for-Profit Healthcare sector outlook to neutral from deteriorating, and S&P Global Ratings issued a stable outlook for 2025. I believe these are a testament to the incredible people we work with in this industry. It's also a reminder of how HFMA can be such a fulfilling organization as we receive firsthand education from these healthcare leaders.

As we near the end of the third quarter, this is a great time to reflect on the events our chapter hosted since the last newsletter in the fall.

- In September we held our second annual landscaping event at The Boulevard, an organization that provides medical respite care, holistic support, and housing services to help ill and injured homeless adults. Thank you to Harris & Harris for their strong attendance and sponsoring lunch afterwards!
- Our biennial Region 7 Midwest Conference was in October. This was a great opportunity to catch up with our fellow Region 7 chapters as well as meet new HFMA members. We saw a great lineup of speakers over the two-and-half days, as well as two very fun social events. Congratulations to the Greater Illinois Chapter for their trivia victory! Thank you again to all our sponsors and exhibitors for their support of Region 7. In addition, I'd like to thank the Region 7 planning committee who helped organize such a great event!
- Our Membership Committee made a goal to hold more social outings for our members throughout the year. We held two more Happy Hours since the fall, with Blue & Company and Wintrust each sponsoring. The first event had our attendees competing at putt-putt golf, while the second had groups competing in healthcare and HFMA trivia. Did you know there is a specific ICD-10 code for being struck by a duck!? Thank you to our sponsors as well as the Membership Committee for creating these networking opportunities! Please be on the lookout for more networking events as we explore new activities as well as different locations across the Chicagoland area.
- Lastly, the chapter's February 13 Provider & Payer Symposium at the University Club of Chicago showcased an amazing lineup of speakers and panelists. Thank you to the committee for their creativity and hard work!

We also have several upcoming events that will take us through our 2024-2025 fiscal year. Please check out our website or scan the QR code below for upcoming events.

- **Annual Strategic Planning Session & Volunteer Appreciation Event** (April 30 at the Plante Moran offices) – Interested in volunteering with the chapter, or would you like to see how chapter leaders plan for our upcoming fiscal year? Join us as we set the goals and initiatives for the next year. Stay afterwards for our volunteer appreciation event that immediately follows.
- **Spring Symposium** (May 21 at Northwestern Medicine Prentice Women's Hospital) – This year's Spring Symposium combines our annual Accounting & Reimbursement event with the Revenue Cycle conference. Join us for our first time hosting an event at Prentice Women's Hospital since before the pandemic!

I'd like to once again thank our board members, volunteers, annual partners and sponsors, and all of those who participated in events so far this chapter year! We would not be able to host the educational content and networking opportunities without each and every one of you.

Scan the QR code for upcoming event details

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Navigating the Cost Report Appeals Process: Appeal Types

The goal of this introductory discussion is to set up a decision framework for deciding how and when to appeal underpaid or denied Medicare Part A reimbursement claims finalized through the Medicare Cost Report settlement process. Appeals can be extremely profitable; in fact the 2008 Rural Floor Budget Neutrality Adjustment (RFBNA) factor appeal and subsequent litigation is estimated to have yielded over $ 3 billion of additional payment for 2,200 hospitals that had appealed this issue. Provider Reimbursement Review Board (PRRB) appeal settlement agreements, called Administrative Resolutions (ARs), usually result in additional payment to the provider beyond that allotted in the contested Notice of Program Reimbursement (NPR) and end the appeal process. Appeals also send a focused message to the Medicare Administrative Contractors (MACs) who audit Cost Reports, the federal agency administering Medicare, known as the Centers for Medicare and Medicaid Services (CMS) and ultimately to elected representatives in Congress regarding the providers' reimbursement related concerns.

The timeline and level of Return on Investment (ROI) for successfully appealing specific contested underpayments can differ greatly from issue to issue, e.g. Medicare Bad Debt, DSH, or Allied Health Sciences reimbursement appeals. So, when protesting appeals issues on a filed Cost Report, or later challenging audit adjustments on an NPR, a provider must carefully determine, on an issue-by-issue basis, what level of resources to invest in protecting appeal rights.

Decisions to engage outside expertise for appeals should factor in the probability of success, the dollar amount at stake, and the estimated timeline to resolution. Items protested on the filed Cost Report, prior to audit and the resulting NPR, require a written rationale for why the provider feels each protested item should be paid and a detailed calculation supporting the

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protested amount.

Importantly, to realize financial benefit from protecting appeal rights on the as-filed Cost Report, additional resources must be invested to properly file the appeal with the PRRB and to follow up with legal briefs and potentially participate in a hearing and further Federal Court litigation if the issue is not administratively resolved.

NPR appeals must be filed in a timely manner with the PRRB within 180 days of receipt of the NPR. The NPR is presumed to arrive by 5 days after the date on the NPR issuance, effectively allowing for a total of 185 days to file. (See: PPRB Rules Version 3.2, Rule 4.3.1, Commencement of Appeal Period).

Fact vs Policy Appeals: Adapting Your Appeals Strategy to the Issue

Since each category differs in its handling by the provider and by CMS, it is helpful to make some high-level distinctions between the major genres of appeal issues before getting into the weeds about the scope of appealable adjustments, and relative cost benefit for individual issues.

Fact Based Appeals – Frequently the MAC's audit adjustments are due to perceived deficiencies in the accuracy and completeness of the provider's supporting Cost Report detail, particularly for those data elements that drive reimbursement. With documentation disputes, there may be no substantive disagreement between the provider and the MAC about the underlying reimbursement method or CMS policy. Rather, detail-based appeals typically involve a claim and counter claim regarding the quality, quantity, and timeliness of supporting data. The MAC's documentation related adjustments can address issues rooted in fact, such as proof of eligibility detail for traditional DSH, or billing records backing up claims for Medicare Bad Debt.

In terms of ROI considerations, it should be noted that the CMS appeals support contractor (ASC) for Medicare Part A Provider Appeals, Federal Specialized Services (FSS), does indeed settle a portion of well-presented and substantiated, fact-based appeal issues.

Policy Related Appeals – Certain contested payment practices with substantial financial impact reflect disputed CMS policy, relatively uniformly applied by MACs to all providers. Such was the case with the RFBNA $ 3 billion underpayment ultimately resolved in the providers' favor. Policy related appeals generally correspond to the interpretation and application of official CMS issuances such as annual IPPS Final rules, CMS Rulings , or Technical Direction Letters (TDLs). The CMS appeals contractor, FSS, tasked with handling appeals and negotiating AR's has virtually no discretion to settle cases pertaining to policy matters until that policy has been changed by CMS, possibly in response to a court decision or CMS reconsideration acceding to provider initiated push back.

Appeals of policy or regulatory driven Cost Report adjustments need to be initiated in the same manner as fact-based hospital specific issues. Policy oriented issues appealed at the individual hospital level can later be added to group appeals of the same issue. National policy issues are complex and usually not settled for several years, and even then, only after multiple appeals to higher courts including the Supreme Court. As such, challenges to CMS standing reimbursement practices are generally too expensive and risky for a single hospital to litigate. Group appeals present a united front to CMS and provide a much more economical avenue to profitable resolution because they divide the appeal cost among many providers. One strategy for appealing policy issues is to initially add the issue as a placeholder to the list of the hospital's appealed issues specifically to protect appeal rights in the shorter term. Once filed with the PRRB, the placeholder issue can later be transferred to a multi-provider group appeal.

Federal Register Appeals – Certain reimbursement issues with significant financial impact, such as the DRG Base year appeal, can, and arguably, should be appealed directly from CMS issuances published in the Federal Register. Federal Register appeals are prospective in nature and so do not require an NPR or even a filed Cost Report as prerequisites for filing with the PRRB. Note however, once the initial Federal Register appeal is filed, the same issue should be appealed yet again via the Cost Report NPR route when the Federal Register item appealed effectively reduces future Cost Report settlements. Federal Register appeals need to be filed 180 days from the date of publication in the Federal Register and do not have the 5-day mailing buffer that Cost Report appeals have from the NPR issuance date.

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Notes:

[1] "Medicare to settle hospital reimbursement dispute" L.A. Times, April 12, 2012

[2]"CMS Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, private health insurance, and related matters.

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Contact Blue & Co. about Cost Report Appeals

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The Top Accounting & Auditing Takeaways for Healthcare Entities

Explore key insights, including cybersecurity challenges and what to expect from Washington in 2025.

As healthcare organizations prepare for the new year, their concerns likely go beyond what is on their financial statements. In our webinar, "Year-End Accounting & Auditing Update for Healthcare Entities," Forvis Mazars examined several topics of interest in the healthcare industry, including cybersecurity and what to expect from Washington after last year's election. This article will offer some key insights for providers to keep in mind.

Risk-Sharing Arrangements

More entities are entering into risk-sharing arrangements, which involve contracts in which a healthcare entity receives payment in exchange for assuming an obligation to provide—and/or become financially responsible for—healthcare services to specified, qualified beneficiaries. It's important that organizations making contracts communicate with their accounting personnel so the arrangements are properly evaluated. When considering the accounting model to use, entities should refer to Accounting Standards Codification (ASC) 815, Derivatives and Hedging; ASC 460, Guarantees; or ASC 606, Revenue from Contracts with Customers.

Energy Service Agreements (ESAs)

Another arrangement gaining popularity among healthcare entities is the ESA, in which a special purpose entity (SPE) is created and debt remains with the SPE so the provider avoids putting debt on its books. The arrangements also are structured so the SPEs are not consolidated. These arrangements continue to evolve and accounting can vary among providers. Entities considering an ESA should ask questions such as:

Is there a lease component? In some cases, the provider will retain the underlying assets, but in other cases, they are leased to the SPE, which can trigger a difference in accounting.

Who gets the excess reserves? Does your organization retain those?

Environmental, Social, & Governance (ESG) Reporting

Even though they aren't likely SEC registrants, healthcare organizations should understand ESG, particularly what states may require. For example, California has greenhouse gas (GHG) emission and climate risk reporting for organizations that do business in the state that meet certain revenue criteria. In New York, hospitals can have workers' compensation claim expense reduced if they have

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The Top Accounting & Auditing Takeaways for Healthcare Entities (continued from page 6)

a program addressing GHG. By the fourth or fifth year of both programs, there will be reporting requirements that also require auditing.

Student Financial Aid & Related-Party Transactions

Providers that have nursing schools and receive student financial aid money should be aware of new rules that went into effect on July 1, 2024. Robust disclosures are required, such as major donors or board members affiliated with lenders. A Financial Responsibility Supplemental Schedule must be included with audited financial statements and contain information to calculate composite score ratios. If applicable, we recommend filing a separate report with an eZ-Audit filing containing the disclosures.

Employee Retention Credit (ERC)

The ERC, which was available for 2020 and most of 2021, offers a refundable tax credit to help businesses keep staff employed during the COVID-19 pandemic. In the past year, the IRS issued 28,000 disallowance letters for $5 billion in refund claims thought to be "a high risk of being incorrect." The IRS later indicated that up to 10% of the letters may have been in error. After a lengthy pause, the IRS has resumed issuing refunds for 400,000 low-risk claims. Some organizations may have applied in good faith without being certain that they met the criteria. In those situations, the entities may not want to bring ERC funds into income until they've gone through an audit or additional guidance is released.

Single Audit Updates

Providers should note that the annual federal expenditure threshold requiring a Single Audit rose from $750,000 to $1 million effective October 1, 2024. Organizations falling below that threshold won't be subject to the audit. In addition, the Type A program threshold for awards between $1 million and $34 million is rising to $1 million. Also, the indirect cost rate is increasing from 10% to 15%.

The Office of Inspector General and Health Resources and Services Administration have been auditing organizations that received Provider Relief Fund money, which aimed to support providers during the pandemic. We've seen random audits of various providers from across the country. Auditors are focused on lost revenue calculations, specifically how they were recorded, how bad debts and contractual allowances were determined, and controls over not "double-dipping."

In addition, some providers have received letters from the Homeland Security Operational Analysis Center reviewing FEMA benefits for duplication, particularly reimbursement from another source.

Cybersecurity

The healthcare industry has been the most victimized by cyberattacks for the past 14 consecutive years, with providers containing valuable data with personally identifiable information on patients and employees.1 Some malicious actors engage in blackmail and extortion by threatening to release medical records. Antiquated technology—caused by resource or financial restraints—can create vulnerabilities for healthcare entities.

With some cyberattack disruptions lasting at least 30 days, organizations should consider how they could circumvent a 30-day disruption while continuing to care for patients and access critical data. In addition to policies and procedures, providers should test their readiness by emulating a scenario and simulating what the response will be.

Outlook From Washington, D.C.

With President Donald Trump's administration now underway, it will likely reissue a lot of policies from Trump's first administration that were rescinded by President Joe Biden's administration, such as the return of short-term, limited-duration health plans to provide 12 months of coverage.

Also, expect CMS to give states much more flexibility in how they manage their Medicaid programs. Governors could take actions such as implement cost sharing and different eligibility and enrollment for the renewal processes.

With the Trump administration potentially using 10% or higher tariffs to raise revenue, healthcare items may be affected. Even if certain categories of healthcare products were excluded, supply chain costs may still be affected.

Questions?

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Patient access practices:
Positioning for value in ambulatory care

Patient access within our healthcare delivery system is a delicate balance between supply and demand. Supply is the time and resources available to care providers for provision of services, and demand is the population's need for care. Ambulatory care leaders know this balance is a tough one to hold, but today's healthcare environment with challenging labor conditions, rising costs, and regulatory shifts have made it feel unachievable.

To meet these challenges, the industry has accelerated its push toward value-based care models in the ambulatory enterprise that emphasize appropriate, safe, and coordinated care at lower cost. The success of these delivery models is predicated on efficient and effective patient access practices that support providers in maximizing patient throughput and capacity.

Efficiency begins with patient access. Understanding how to align and position your ambulatory care access operations is vital to the financial health and operational growth of your organization. Below are four things ambulatory leaders should consider to best position for a value-based world.

1. Establish access standards through a robust review of internal data

First, evaluate your organization's available data and identify critical measures that are necessary to achieve optimal accessibility. Your goal is to establish access standards around each of those identified areas.

Setting forth standard visit types and durations for visits by department is a key access standard. When providers utilize custom appointment specifications, there's often a learning curve for scheduling staff to understand all of the individual nuances and ultimately leads to scheduling errors, administrative rework, and delays in care. Creating access standards around appointment specifications, like visit types and durations, reduces variation among providers and creates a more streamlined process for patients to get on scheduling books.

These access standards will become the foundation for managing and monitoring performance across the enterprise.

2. Prepare to manage demand

Demand for outpatient services in healthcare has steadily increased and, according to Advisory Board, is expected to grow another 7% by

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Patient access practices: Positioning for value in ambulatory care (continued from page 9)

2026. This, alongside the proliferation of value-based arrangements, will force health systems to rethink their strategy around managing demand in the outpatient setting. The following are successful strategies to manage fluctuating demand:

- **Develop contact centers:** Clinic staff should focus on care delivery. Contact centers manage patient communication, ensuring optimal access and efficient scheduling. This frees clinic staff to work at their highest capacity and allows better performance and productivity measurement.
- **Optimize omnichannel strategy:** Maximize patient portals, texting, and other tech resources for efficient communication. Multiple channels improve patient satisfaction, reduce no-shows and cancellations, and enhance healthcare accessibility.
- **Monitor the market:** Demand fluctuations can create access bottlenecks. Coordinate with marketing to monitor demand and use request-for-care website functionality to prepare for current and future needs.

3. Evaluate capacity management standards

Managing capacity in the healthcare setting is how you manage time as a resource and is the offset to balancing fluctuating demand. High-performing organizations recognize that how they use time as a resource is the most important element of optimized patient access. Here are three key factors in managing capacity:

- **Template management:** This includes regular evaluation and maintenance of providers' schedules to ensure that they're built to support demand. It includes setting forth clinical FTE expectations and holding staff accountable to meeting them as a primary measure of productivity.
- **Slot utilization:** Once templates are created and a maintenance strategy determined, organizations should work to efficiently use appointment slots to prevent access delays. Waitlists, schedule blocks, and automatic releases are proven methods to avoid schedule gaps and maximize utility of electronic health records (EHR).
- **Online scheduling:** Ambulatory leaders shouldn't overlook the value of their virtual front door. This is just as important as focusing on access to your physical one. Enhanced EHR capabilities, such as ticket scheduling, allow patients direct access to schedule care while also defining appointment criteria to ensure appropriate scheduling and avoid any further delays in care.

4. Recognize the importance of continuous improvement

Building and maintaining a patient access strategy that ebbs and flows with both the market demand and provider supply (i.e., time and resources) is essential for long-term success. By focusing on not only managing demand and capacity but also sustaining and continuously improving efforts over time, you remain agile in a dynamic market. Below are three key components of continuous improvement in patient access:

- **Panel management:** Regular review and maintenance of patient panels by provider removes access limitations – by encouraging thoughtful care progression planning and promoting patient engagement and autonomy in their care. A panel maintenance strategy ensures that providers are able to see the right patients at the right cadence to promote good condition management and success in value-based agreements.
- **Transition of care coordination:** Continuity of care is more than just a buzzword in the healthcare space – it's an essential component of risk management. Continuity of care helps avoid unnecessary readmissions and promotes comprehensive disease management in a multidisciplinary team setting. Effective transition of care coordination between providers needs to be regularly evaluated due to constantly shifting clinical trends in the healthcare market.
- **Proactive peer reviews:** The key word here being "proactive." Peer reviews don't always have to be reactive to misses in clinical care. Establishing a cadence of proactive clinical reviews encourages physicians to provide accessible, safe, and high-quality care (all measures that are evaluated under value-based arrangements).

The bottom line

Patient access is a dynamic and challenging concept that comes with a unique set of complexities that make it difficult to achieve at an optimal level. While current industry trends such as labor shortages and cost instability have created additional barriers to access, ambulatory leaders can position their organizations to succeed both in meeting today's challenges as well as in a value-based future by establishing and evaluating access standards, developing strategies to manage demand, and embracing a culture of continuous improvement.

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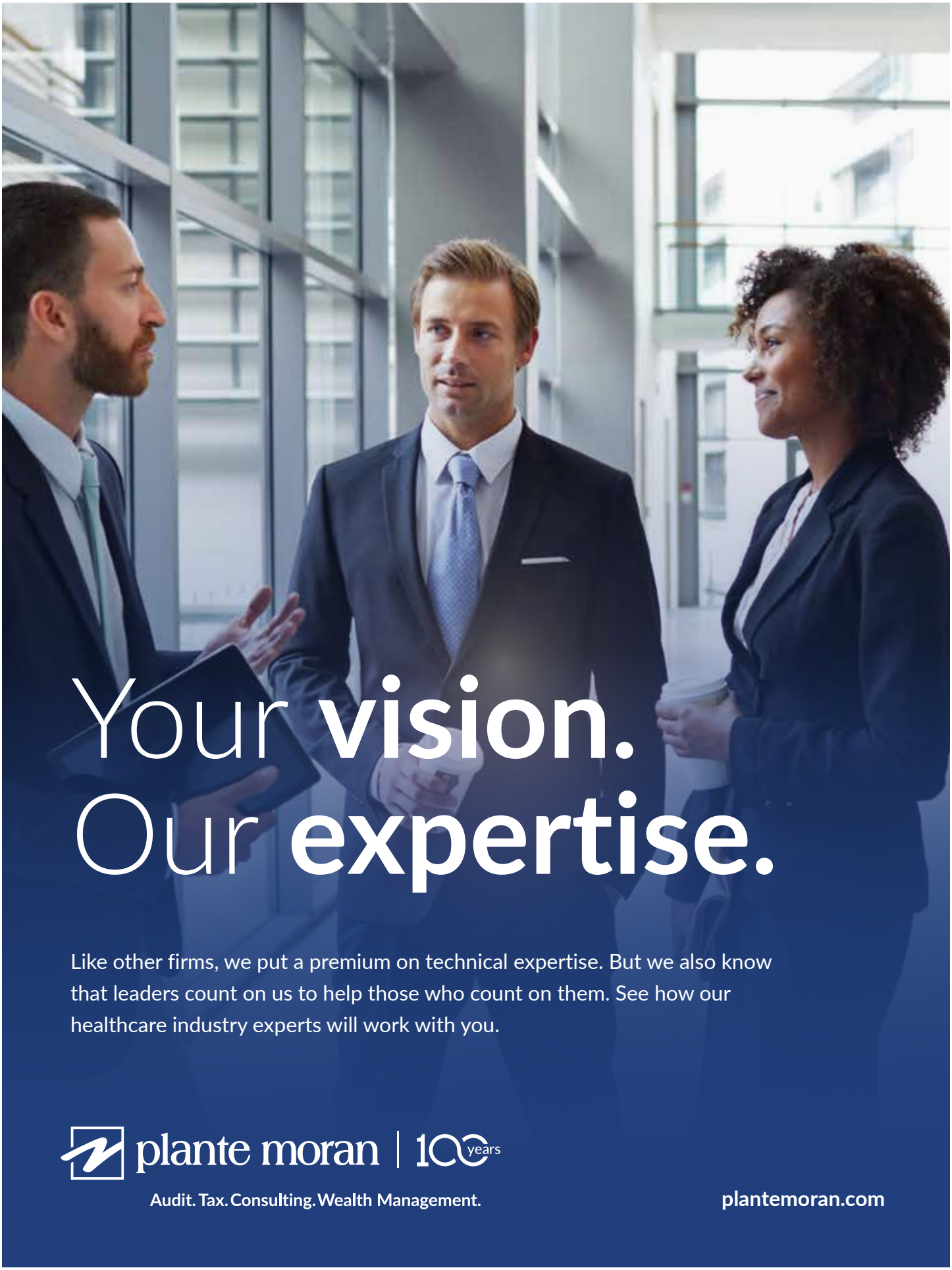
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Commitment and path required in change management to create a sustainable impact

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In 2021, Carilion Clinic, a $2 billion revenue, eight-hospital integrated health system in Roanoke, Va., was facing a problem familiar to many health systems around the country: stubbornly high average length of stay (ALOS) that was hurting Carilion's efforts to serve its community.

The pandemic had exacerbated operational challenges and mitigated the effectiveness of previous interventions, driving key metrics in the wrong direction. Not only was inpatient ALOS a challenge, but Carilion also identified rising observation rates, suggesting an opportunity to improve how it classified patient status.

To tackle both issues at once, Carilion partnered with members of what was then known as Claro Healthcare, now part of Kaufman Hall, a Vizient company. Their joint implementation efforts – encompassing people, process and technology, with associated monitoring and oversight – produced results well-beyond initial projections.

Kaufman Hall and Carilion's partnership

Commenting regarding the partnership, Paul Davenport, system senior vice president for Carilion Clinic, summed up the requirements and expectations of such a partnership as follows:

> *"When a healthcare system collaborates with a consulting firm, it necessitates that system leaders adapt, adopt and integrate external expertise into their teams. Given the inherent complexity of healthcare systems, sophisticated approaches are essential, particularly when aiming to become a high-reliability organization. Leaders who lack professional experience with consulting projects might hesitate to engage, fearing that the project reflects on their abilities or that external help is unnecessary. They may not fully grasp that the challenges faced by intricate health systems surpass individual capabilities. These engagements temporarily augment resources for teams without necessitating permanent staff increases and further educate leaders to improvement strategies.*
>
> *Executives might also bring in consulting partners due to existing pressures on the leadership team, while recognizing the need for additional improvements. The demand for change management, along with increased resources, is substantial in health systems. Leaders might believe that continuing past practices will ensure future success, but consulting firms can facilitate change, focus resources on critical areas and introduce external best practices to enhance access and quality of care."*

Project parameters and approach

Kaufman Hall's engagement with Carilion began in March 2021 with an assessment of the challenges before them. Over the previous 2.5 years, inpatient ALOS and observation rates had increased. These troubling trends were reframed as opportunities for improvement that could reap significant benefits to Carilion, both financially and for their mission, if abated or reversed.

Implementation was a multilayered process covering the planning, designing and integrating of improvement initiatives. To turn these theoretical improvements into reality, Kaufman Hall and Carilion worked together to engage with and educate the staff, creating organizational awareness and buy-in. The team enhanced the current multidisciplinary forums and implemented additional workflow improvements. They also stood up dashboards that tracked key metrics, incorporating these tools into their educational efforts.

The monitoring and support phase involved monthly reporting on financial and operational progress, chart reviews and on-site visits for educational follow-up. Beginning with implementation, the executive steering committee met each month to exercise overall project responsibility, but its work during the monitoring phase shifted toward ensuring sustainability for the project by empowering the front-line staff and director-level process owners. While members of the Kaufman Hall team led the initial steering committee meetings, leaders at Carilion took increasing charge of the meetings over the course of the engagement.

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Commitment and path required in change management to create a sustainable impact

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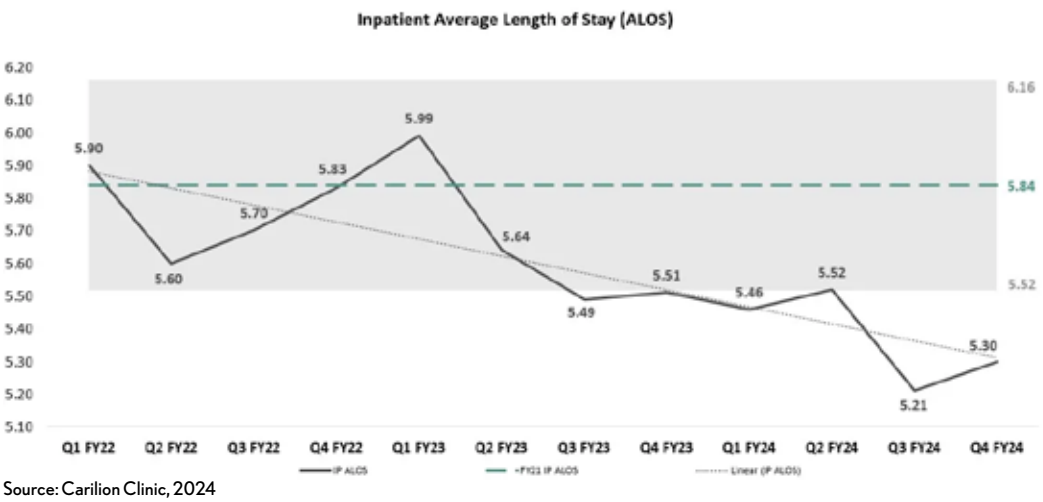
Results, challenges and keys to success

From FY2021 to FY2024, Carilion Roanoke Memorial Hospital (CRMH) saw its inpatient ALOS drop by 0.5 days, which translated to more than 8,000 additional inpatient admissions in that time relative to prior trends.

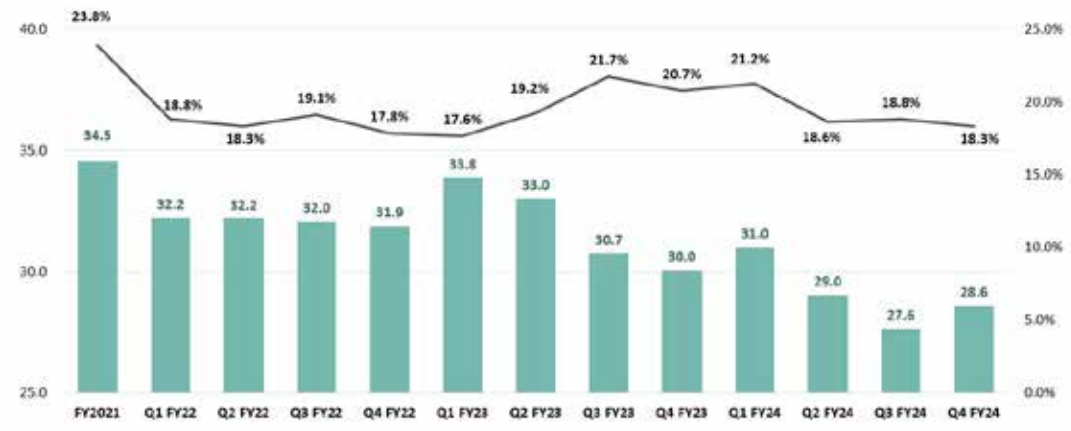
Carilion Roanoke Memorial Hospital inpatient ALOS over course of engagement



Source: Carilion Clinic, 2024

CRMH's observation ALOS was reduced by more than five hours, and its observation rate was lowered by 4.5 percentage points from the first to final year. All these figures met or exceeded initial projections established during the assessment phase.

Carilion Roanoke Memorial Hospital inpatient ALOS over course of engagement



Source: Kaufman, Hall & Associates, LLC, 2025

Progress was not always linear. The team overcame a variety of barriers to achieve these results. Like other health systems during the pandemic, Carilion experienced staffing challenges during the initial rollout, which slowed the progress of ALOS reductions in particular. CRMH also experienced bed closures during the engagement, increasing the importance of throughput improvements. In addition to these operational pressures, Carilion underwent key leadership changes during the engagement, which threatened its momentum.

However, these challenges were by and large overcome. The ultimate success of this project can be attributed to a number of factors, such as the following:

- Effective multi-disciplinary teams
- Bought-in physician leadership
- Skilled case management leadership
- Strong nursing and ancillary accountability
- Trusting relationship between the client and consultants
- Dedicated commitment to change management
- Educated, hand-in-hand support with regular meetings to build consensus

Conclusion and Carilion's path forward

This engagement owes its success to the hard work and adaptability of Carilion's leaders and team members, who carried an attitude of "How can we get this done?" rather than a "No-we- can't" mentality. Systemwide communication and awareness were areas of focus throughout the process, and the leadership growth of physicians and other front-line team members laid the foundation for the sustainability of these improvements.

Pairing throughput improvements with redesigns of the approach for determining patient status also paid off: More immediate progress on the latter helped generate buy-in for the former, amid external operational pressures. The emphasis on having a plan for each patient the moment they enter CRMH's doors was critical

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Commitment and path required in change management to create a sustainable impact

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to ensuring the proper patient status and advancing the patient toward a timely discharge.

Today, Carilion's focus remains set on sustained and continued improvement. Process changes and awareness efforts risk decay as organizational priorities shift elsewhere. Rather than resting on its laurels, Carilion is taking this new standard of care enterprisewide by applying it to its community facilities as well. Streamlining and standardizing these process changes, continuing to actively monitor and report out results and setting new, more ambitious goals across the organization will help Carilion stay on a growth trajectory.

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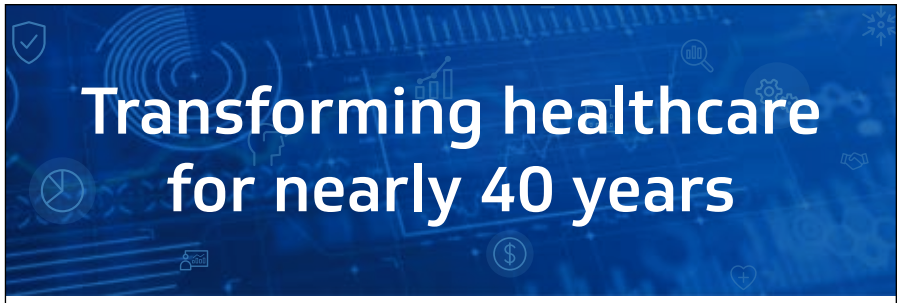

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Or simply drop us an email at education@firstillinoishfma.org.

First Illinois Chapter HFMA News & Events

Thank you to HFMA Volunteers Who Made "The Boulevard" Workday for the Homeless a Great Success

Saturday, September 28, 2024

Our First Illinois HFMA Membership/Engagement Committee recently hosted a Volunteer Event at The Boulevard.

Thirty years ago, The Boulevard founders witnessed thousands of people with medical injuries entering shelters across Chicago with nowhere else to go. To break the cycle of homelessness, these individuals needed a place to recover and the opportunity to move on to stable housing. The Boulevard was founded in 1994 to answer this critical need. Today, The Boulevard is one of the original medical respite care facilities in Illinois serving men and women experiencing homelessness with a full range of resources for holistic human healing. Through a continuum of programs and services, The Boulevard helps their clients gain the stability they need to restore their health and rebuild their lives.

In 2-hour or 4-hour shifts, either 8 to 10AM and/or 10am – 12pm, our HFMA volunteers provided:

- Gardening (primary volunteer activity)
- Organizing and sorting the clothing closet
- Creating a Breast Cancer Awareness Month poster

The Boulevard is located at:
3456 West Franklin Boulevard, Chicago, IL 60624
https://blvd.org/ | phone: 773-533-6013

Thank you

We would like to thank the following individuals for donating their time that helped to make this event successful:

- Meagan Appleby
- Jennifer Atilano
- Matthew Aumick
- Kassandra Blorke
- Dawn Jackson
- Cayden Jones
- Ashton Jones
- Jamaal Jones Sr.
- Victoria Levitske
- Melissa Meyers
- Kirsten O'Neal
- Jennifer Radloff
- Melissa Rodriguez
- Priya Verghese

In addition, we would like to extend a special thank you to Melissa Meyers at Harris & Harris for sponsoring a lunch for the volunteer participants after the event concluded.

First Illinois scores big with new event

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Since 2006, HFMA's First Illinois Chapter has provided more than $150,000 in scholarship funds to members and their children seeking higher education. The primary source of funding for the scholarships is the Chapter's annual golf outing. When it came time to plan the 2024 event, however, they decided to switch things up a bit.

What was different

Previously, the event took the form of a scramble on a traditional 18-hole golf course. Foursomes were a mix of business partners and providers. In 2024, the Chapter hosted a Topgolf tournament instead. It took place August 23 in Naperville, Ill. Business partners and providers had separate foursomes, with providers competing for the Chapter's first golf championship trophy.

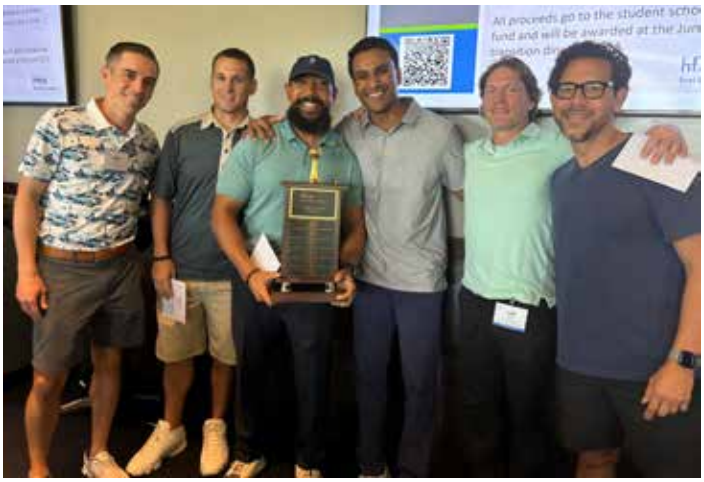
Why the change

Matt Aumick, CHFP, CPA, controller for US Acute Care Solutions in Chicago and the 2024-25 president of First Illinois, said the Chapter felt the change would be beneRicial for two main reasons. The fiirst was allowing for more networking time.

"On an 18-hole course you're really limited to your own foursome while golRing, so networking is limited to a short time before and after the event," said Aumick. "With the Topgolf setup, however, attendees were able to mingle throughout the entire afternoon – both while golfing and during the networking sessions."

The second reason was that an 18-hole course can be intimidating for non-golfers.

"We thought the Topgolf format would appeal to more of our members who might enjoy a more laid-back atmosphere," Aumick said.



Golfers on the KSB Hospital team got the top score. Pictured with the trophy from the left are Drew Clement, FinThrive; Nick Emmole, KSB Hospital; Austin Frazier, KSB Hospital; Aaqil Khan, KSB Hospital; Luke Kline KSB Hospital; and Rich Franco, Northwestern Medicine

How it turned out

The changes paid off. According to Aumick, the Chapter met its three goals for the event: increased attendance, an even mix of providers and business partners and a positive net income to donate to the scholarship fund.

There were 103 attendees – roughly double the previous year's attendance. About $15,000 was raised for the Chapter's scholarship fund, meeting the annual goal. Funds were raised via general donations from attendees and via business partners' purchases of hitting bays and other sponsorship opportunities, such as the registration table, lunch and donated baskets that were raffled off during the event. Providers also paid a small fee to enter a foursome.

Post-event survey feedback was positive, with a consensus to host another Topgolf event in 2025. In fact, it's already scheduled for August 22. Aumick encourages other chapters looking for a new networking event to give the Topgolf format a try.

"We found the Topgolf setup an excellent opportunity to have a fun outing for all golf skill levels," he said. "One of our favorite aspects was seeing how many new faces, and how many people in general, felt comfortable enough to come out and participate."

About the Author

Crystal Milazzo is a senior editor and writer at HFMA, based in Beaverton, Oregon.

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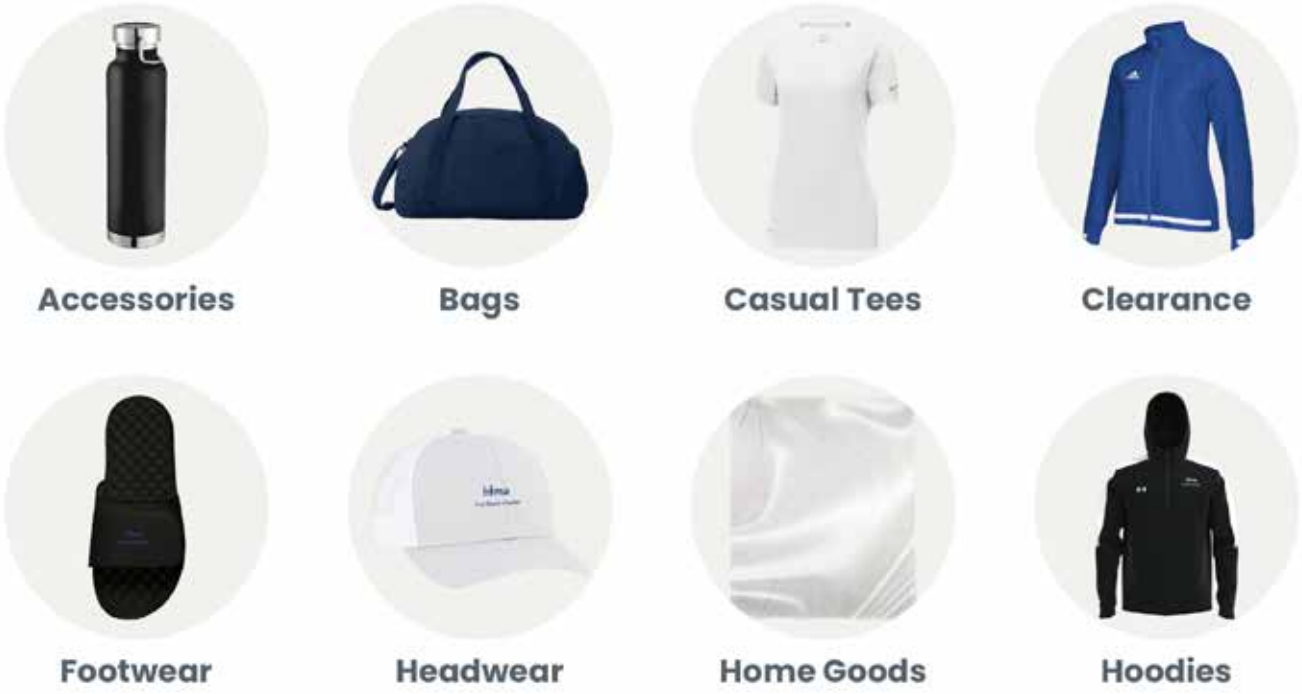

First Illinois Chapter HFMA Events

2025 Events

2025 Event Calendar At-A-Glance

May 21	**Spring Symposium** Northwestern Medicine Prentice Women's Hospital, Chicago, IL
June 1	**Kane County Cougars Baseball Family Outing** Geneva, IL
June 12	**Women in Leadership (WIL) Retreat** Cantigny Park Campus, Wheaton, IL
July 17	**Transition Dinner** Carlucci's Restaurant, Rosemont, IL
August 22	**Topgolf & Scholarship Event** Topgolf, Naperville, IL
October 28 – 29	**Fall Summit** Sheraton Lisle Naperville Hotel, Lisle, IL

Scan the QR code for event details

Interested in Sponsorship Opportunities at any of these events?
Contact ecrow@firstillinoishfma.org

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FIRST ILLINOIS SPEAKS

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Publication Scheduling

Publication Date	Articles Received By
June 2025	May 1, 2025
October 2025	September 1, 2025
February 2026	January 6, 2026