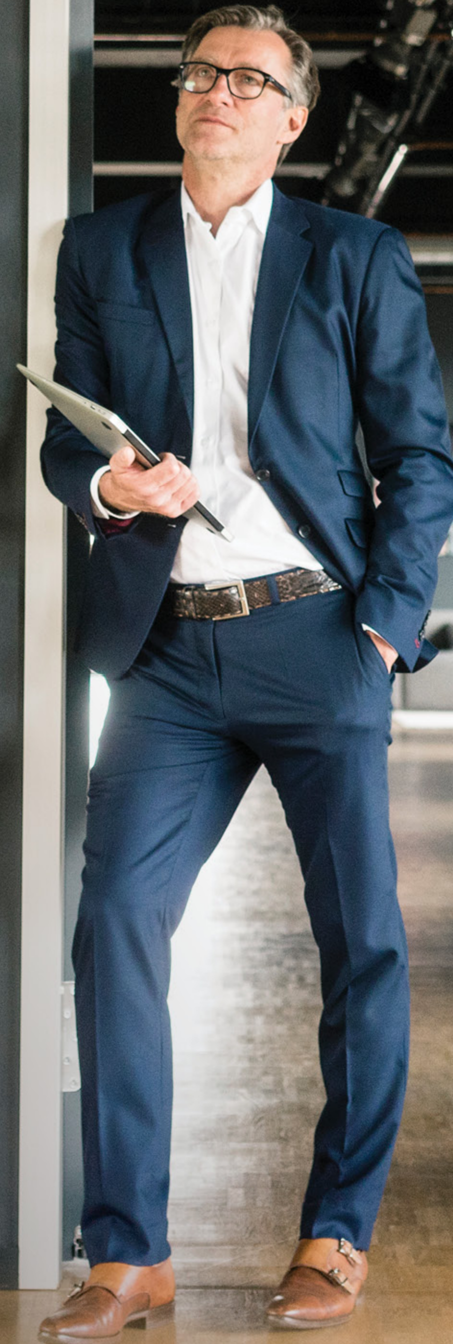
Smart decisions. Lasting value.™

Crowe Healthcare Summit 2019

Nurture Your Network
Upskill. Connect. Grow.

Worksheet S-10: Lessons Learned From Year-One Audits

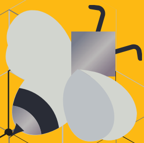


September 17

Presented by:
Nancy Gayle – Ascension Health
Ron Wolf – Crowe

Introducing Healthcare’s Trusted Community:

The Crowe Hive Network



Being successful in your role today looks different than it did even a few years ago. **Engage with a network of those who have been there before you:**

- Ask and answer community questions
- Seek validation and gain support through crowdsourcing
- Connect with peers and Crowe specialists
- Earn rewards for your engagement and shop the Hive store

Simplify your busy workday. Register today to continue the Healthcare Summit conversations: **crowehive.com**.

© 2019 Crowe LLP

Agenda

- Recent History of DSH/UC Reimbursement
- Worksheet S-10 Audit Experience FY15
- FY2020 IPPS Final Rule Excerpts
- FY17 S-10 Audit Update

© 2019 Crowe LLP

Crowe

Your presenters

Ron Wolf

Senior Manager
Crowe LLP

Nancy Gayle

Senior Director – Net Revenue Management
Ascension

© 2019 Crowe LLP

Recent History of DSH/UC Reimbursement

© 2019 Crowe LLP

Recent History

Effect of Healthcare Reform on the DSH Payment Adjustment

- Patient Protection & Affordable Care Act (“ACA”) – March 2010
  - Significant Changes to Medicare DSH Adjustment
  - New Formula for Calculating DSH Beginning FY 2014
  - For 2014, 2015, 2016, and 2017 CMS Used low-income insured days from filed cost reports
- Uncompensated Care Portion – Significant Reimbursement $$
  - FY 2015 - $7.65B
  - FY 2016 - $6.4B
  - FY 2017 - $6B
  - FY 2018 - $6.8B
  - FY 2019 - $8.27B
  - FY 2020 - $8.35B

© 2019 Crowe LLP

Recent History

In the 2018 IPPS Rulemaking:

- Proposed Time Period for Calculating Factor 3 (Incorporating S-10 data)
  - FY 2018 (FY 2012 & 2013 Low-income insured days; ***FY 2014 S-10***)
  - FY 2019 (FY 2013 Low-income insured days; ***FY 2014 & 2015 S-10***)
  - FY 2020 (***FY 2014, 2015, and 2016 S-10***)
- Definition of Uncompensated Care
  - Cost of Charity Care (Line 23) plus Cost of non-Medicare bad debt expense (Line 29)
- Worksheet S-10 Audits
  - Instructions to MACs still under development
    - Expect cost reports beginning in FY 2017 will be first with S-10 subject to desk review
    - Cost reports beginning in FY 2014, FY 2015, and FY 2016 to be subject to further scrutiny after submission
    - **"Predictability is an important part of the process for reporting data on S-10"**

© 2019 Crowe LLP

Recent History

In the 2019 IPPS Final Rule:

- CMS intends to continue with and **further refine their efforts to review the Worksheet S-10 data submitted by hospitals based on what has been learned from the review process conducted for the FY 2019 rulemaking.**

- Relative to concerns expressed by commenters about MACs creating their own audit protocols for S-10 for EHR audits under HITECH without any guidance from CMS, CMS stated that **they strive to take lessons learned from these audits to improve audits for UC DSH.**

- **Instructions for the MACs are still under development and will be provided to the MACs as soon as possible in advance of any audit.**

- Due to the overwhelming feedback from commenters emphasizing the importance of audits, **CMS expects audits to begin in the Fall of 2018.**

© 2019 Crowe LLP

Recent History

In the 2019 IPPS Final Rule Cont’d:

- Effective for cost reporting periods beginning on or after October 1, 2018, in order for hospitals reporting charity care and/or uninsured discounts to have an acceptable cost report submission under § 413.24(f)(5)(D), **the provider must submit a detailed listing of charity care and/or uninsured discounts that contains information such as the patient name, dates of service, insurer (if applicable), and the amount of charity care and/or uninsured discount given that corresponds to the amount claimed in the hospital’s cost report as a supporting document** with the hospital’s cost report.

- In response to comments about use of a standardized format for these listings, CMS agreed… that requiring this information to be submitted in a standardized format would ensure consistency of the documentation and facilitate the contractor’s review and verification of the cost report and stated that **they will work toward developing a standard format to include in a subsequent Paperwork Reduction Act (PRA) notice to request public comment.**

© 2019 Crowe LLP

Worksheet S-10 Audit Experience FY15

© 2019 Crowe LLP

S-10 Audits FY15

MAC Audit Request Letters:

- The focus will be on the FY 2015 cost reports or those beginning on or after 10/1/2014.
- Each MAC has been tasked with 50 audits, which need to be completed/settled by January 31, 2019. Presumably, this is so the corresponding HCRIS data can be incorporated into the FY 2020 IPPS rulemaking process.
- The documentation request letters were all supposed to be issued by Friday August 31, 2018, with two to three weeks allowed for a response from providers. However we have learned that some clients were still receiving letters dated as late as Thursday, September 6th.
- Timelines for responsive documentation is 2 – 3 weeks
- Some MACs are utilizing the help of contractors to perform the audits

© 2019 Crowe LLP

S-10 Audits FY15

MAC Audit Request Letters Cont'd:

- The hospitals who have received the 3-4 page request letter describe it is onerous. Some key elements include the following:
  - Copy of the hospital's charity care policy and/or financial assistance policy along with explanation of how hospital personnel determine insurance status and charity care write-offs
  - Descriptions of the logic and process used when querying hospital records to obtain a detailed listing of accounts supporting charity care charges on S-10
  - Submission of the detailed listing of claimed charges and payments along with an explanation and reconciliation of any variance with reported amounts on S-10
  - Submission of the detailed listing of all bad debts for the hospital, including Medicare and Non-Medicare, along with reconciliation from financial accounting records to reported amounts on S-10

© 2019 Crowe LLP

S-10 Audits FY15

MAC Audit Request Letters Cont'd:

- The letter further indicates that the MAC will be selecting samples of charges/payments and bad debts from the aforementioned listings and will request patient documentation. It is our understanding that similar to EHR audits, the supporting documentation will include the following:
  - Charity care applications and supporting documentation such as pay stubs, bank statements, which evidence the determination that patient qualifies for charity care **(*Note: Please be aware of potential adjustments of presumptive charity care accounts based on past experience with EHR and MBD audits re: lack of supporting documentation associated with predictive analytical tools)**
  - UB Billing and EOB
  - Medicaid RAs if applicable

© 2019 Crowe LLP

S-10 Audits FY15

Reasonable Collection Effort (CMS Pub. 15-1, §310) :

- It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also Includes other actions such as:
  - Subsequent billings
  - Collection letters
  - Telephone calls or personal contacts
- **Documentation required**
  - The provider's collection effort should be documented in the patient's file by:
    - **Copies of the bill(s)**
    - **Follow-up letters**
    - **Reports of telephone and personal contact, etc.**

© 2019 Crowe LLP

S-10 Audits FY15

Indigent or Medically Indigent Patients (CMS Pub. 15-1, §312) :

- Sometimes provider establishes before discharge or within a reasonable time before the current admission that the patient is indigent or medically indigent
- Providers can deem Medicare beneficiaries indigent or medically indigent when they have also been determined eligible for Medicaid as either categorically needy or medically needy
- Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of a Medicare beneficiary under the following guidelines:
  - The patient's indigence must be determined by the provider, not by the patient (i.e. a patient's signed declaration of inability to pay medical bills cannot be considered proof)
  - The provider should take into account a patient's total resources, which includes, but not limited to, an analyses of assets (only those convertible to cash and unnecessary for daily living), liabilities, and income and expenses
  - The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill (e.g. Title XIX, local welfare agency, and guardian)
  - **The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination**

© 2019 Crowe LLP

S-10 Audits FY15

Common Themes:

- Condensed timeframe imposed on providers and MACs/contractors from outset
- Inconsistent application of audit program/scope by MACs/contractors
  - Sampling techniques/size
  - Documentation requirements
  - Error rate extrapolation
- Not auditing to the FAP
- Extremely short response times for supporting documentation
- No established process to challenge/correct MAC audit adjustment/errors

© 2019 Crowe LLP

S-10 Audits FY15

Examples - St. Vincent Anderson Regional (15-0888):

- Audited by WPS, which employed a combination of statistical sampling and judgmental sampling. In either case, the auditors, who acknowledged their inexperience in reviewing such data (as evidenced by the numerous pleas to CMS for answers and clarification), routinely made judgments regarding the sufficiency of information/documentation with heavy reliance on the notes in the PAS. These are historically abbreviated and difficult to interpret, with wide variation from hospital to hospital due to the frequent turnover experienced in PFS departments. Furthermore, there was not sufficient time to allow providers to effectively respond to questions and provide additional documentation.

© 2019 Crowe LLP

S-10 Audits FY15

Examples - St. Vincent Anderson Regional (15-0888) Cont'd:

- As a result of the audit, this hospital's cost of uncompensated care reported on Line 30 of Worksheet S-10, was reduced by 37.10% or <$3,993,946>, from $10,766,248 to $6,772,302. Of the total amount adjusted, <$2,439,612> was for "lack of documentation" or "missing information" and an additional <$570,901> due to an arbitrary distinction made regarding "co-pays" versus "coinsurance & deductibles", all of which are considered "patient responsibility" throughout the healthcare industry.
- Missing information cited included: charity care applications, income support, estate checks, remittance advices.

© 2019 Crowe LLP

S-10 Audits FY15

Examples - St. Vincent Anderson Regional (15-0888) Cont'd:

Auditor Comments:

- Cannot verify write off date (account notes are shown for 8/20/15 only). Missing remittance advice. Charity care amount not allowable. <$18,123.66> (Judgmental)

- Total charge per UB04 $15,549.65. Patient is not eligible for Medicaid on 8/23/15 - 8/24/15 per Medicaid eligibility. Missing patient account notes. Patient is not eligible for Medicaid per eligibility. Missing charity care determination and support (income support, etc). <$18,479.65> (Judgmental)

- Copay of $75 not allowable. Patient qualified based upon Experian report: household of 4, payment advisor score of 354, income of 17,000, income <138% of FPL. 100% charity care. Charity care amount not allowable as co-pays are not allowable. <$75>

© 2019 Crowe LLP

S-10 Audits FY15

Examples - St. Vincent Anderson Regional (15-0888) Cont’d:

Auditor Comments Cont’d:

- Missing remittance advice and patient account notes. Received Anthem Midwest Eligibility show patient is presumptively eligible. <$11,094.70> (Judgmental)
- Missing remittance advice and patient account notes. <$23,463.19> (Judgmental)
- Missing support for income or proof of HIP eligibility at or around the time of write off. <$236,007.81> (Judgmental)
- Missing patient account notes and charity care determination and support (pay stubs, W-2, tax returns, bank statements and or Experian report (as applicable)). <$249,297.42> (Judgmental)

© 2019 Crowe LLP

S-10 Audits FY15

Examples - St. Vincent Anderson Regional (15-0888) Cont’d:

Auditor Comments Cont’d:

- UB04 charges $1,139,552.58. Admit date 12/1/15 per RA. Total charges billed to Medicaid $1,090,490.20. Charity care amount not allowable. Unable to determine what $34,349.06 is claimed for. <$34,249.06> (Judgmental)

- Missing patient account notes (account notes submitted start 1/1/16) & proof of income (pay stubs, W-2, bank statement, Experian report, tax returns (as applicable). Account notes do not support presumptive eligibility. <$23,384.89> (Strata 5)

- Missing eligibility for Mdwise/HIP (8/1/16) to support charity care determination. <$61,189.52> (Strata 5)

© 2019 Crowe LLP

S-10 Audits FY15

Examples - Borgess Medical Center (23-0117) :

- Also audited by WPS which employed a combination of statistical sampling and judgmental sampling…
- As a result of the audit, this hospital’s cost of uncompensated care reported on Line 30 of Worksheet S-10, was reduced by 28.64% or <$2,077,539>, from $7,253,846 to $5,176,307. Of the total amount adjusted, <$1,577,212> was for “lack of documentation” or “missing information” and an additional <$114,615> due to an arbitrary distinction made regarding “co-pays” versus “coinsurance & deductibles”, all of which are considered “patient responsibility” throughout the healthcare industry.
- Missing information cited included: charity care applications, income support, estate checks, remittance advices

© 2019 Crowe LLP

S-10 Audits FY15

Examples - Borgess Medical Center (23-0117) Cont'd:

Auditor Comments:

- Missing support for income. Patient approved for 85% charity care. Proof of income submitted per Borgess financial application results-for patient record dated 10/25/16) <$35,099.41> (Strata 6)

- Section 1011 candidate (not a citizen). No eligible for Medicaid (not a michigan resident). Income of $3,024/year per charity care application. Signed 8/22/15. Missing denial for section 1011 coverage. Missing income support. Charity care amount not allowable. <$84,618.54> (Strata 6)

- Per charity care form patient has income of $0. Patient is supported by family. Income < 100% of FPL. 100% charity care. Charity care application dated 11/3/15. Requested correspondence indicating no coverage from employer and progressive insurance. No support received. Total charges claimed. Charity care not allowable due to missing support. <$115,994.60> (Judgmental)

© 2019 Crowe LLP

S-10 Audits FY15

Examples - Borgess Medical Center (23-0117) Cont'd:

Auditor Comments Cont'd:

- UB04 charges \$71,484.46. Total charges claimed. Per remittance advice, insurer denied claim due to pre-existing condition. Death certificate submitted. Date of death 7/10/15 (rec 12/6/18). Estate check completed on 6/13/17. No probate found per patient account notes. Charity care amount is not allowable as there are \$0 deductible/coinsurance amount. <\$71,484.46> (Judgmental)

- Received eligibility for Medicare for 4/17/17. Per eligibility patient passed away on 2/7/17. The claim was paid by Medicare for GME/IME per the remittance advice and patient account notes. \$0 deductible/coinsurance amounts. Missing remittance advice from Health Choice (Medicare HMO?). Missing estate check. Charity care amount is not allowable.<\$41,909.30> (Judgmental)

© 2019 Crowe LLP

S-10 Audits FY15

Questions for the group:

- What were some of the hurdles your teams faced last fall?
- Difficult time working with MAC/contractor?
- Were you able to resolve all differences/disagreements?
- Are you pursuing appeals via NPRs or Final Rule?

© 2019 Crowe LLP

FY2020 IPPS Final Rule Excerpts

© 2019 Crowe LLP

FY2020 IPPS Final Rule

General:

- CMS is using only 1 year of S10 data rather than a blended 3 years of data for factor 3 calculation
- Will use a single year from Worksheet S-10 FY 2015 data to determine the Factor 3 for FY 2020
- FY 2020 Uncompensated care payments to increase ~1.01% to $8,350,599,096 up from $8,272,872,447 in FY 2019
- FY 2020 Proposed rule indicated using data available in HCRIS as of 3/31/2019 for final rule making, but changed to 6/30/2019 HCRIS in actual final rule.

© 2019 Crowe LLP

FY2020 IPPS Final Rule

Audit Process:

- CMS chose to audit 1 year of data (that is, FY 2015) in order to maximize the available audit resources and not spread over multiple years potentially diluting the effectiveness of their considerable auditing efforts.
- FY 2015 was focus primarily because this was most recent year of data CMS had broadly allowed to be resubmitted by hospitals and because the data had been previously subject to public comment and scrutiny (FY2019 rulemaking)
- The proposed UC payments to hospitals whose FY2015 data were audited represent approximately half of total proposed UC payments for FY2020.
- For the aforementioned reasons, FY2015 data are, on balance, the best available to use for calculating Factor 3 for FY2020.

© 2019 Crowe LLP

FY2020 IPPS Final Rule

Audit Process Comments:

- Many commenters opposed using 1 year of FY2015 S-10 data… instructions unclear/confusing; selective and inconsistent audits less reliable; mixing audited and unaudited data creates uneven playing field; harms those that were audited to the benefit of those that were not; substantial time lag in compensating hospitals for charity care provided in prior years…

- Moving away from 3-year average increases potential for anomalies and undue fluctuations in uncompensated care payments… is this a permanent decision by CMS?... 3-year average offers stop-loss approach by providing transition… variability in the amount of per-discharge uncompensated care payments, so should require a limit regardless of Factor 3… because of dilution of audited data in a 3-year average, CMS should strive to average three years of audited data…

© 2019 Crowe LLP

FY2020 IPPS Final Rule

Audit Process Comments Cont'd:

- Commenters asserted that auditing process for FY 2015 was subjective, lacked standardization… inconsistent review of adjustments, variation across MACs relative to documentation requirements… also the cost report instructions still need to be clarified… data elements for audits need to be spelled out

- Assertions that adjustments made under tight deadlines with no opportunity to review or appeal MAC decisions… made adjustments based on their own interpretation of language in FAPs… result of a lack of training/understanding of charity care process… sizeable adjustments based on extrapolations from small samples

- CMS should develop a review process similar to wage index, so by FY 2023, three years of fully audited data (FY 2017, FY 2018, and FY 2019) could be utilized… audit all hospitals and utilize single auditor… standardize timelines with adequate lead times and documentation required… reduce scope to minimize burden

© 2019 Crowe LLP

FY2020 IPPS Final Rule

Audit Process Responses:

- At the time CMS began auditing FY 2015 data in Fall of 2018, the FY 2017 data were incomplete as some hospitals were still submitting their cost reports.
- CMS does not agree that all hospitals' data needs to be audited to create a "level playing field… it was not feasible to audit all FY2015 data for the FY2020 rulemaking.
- The selection of hospitals for the FY 2015 audits was based on a risk-based assessment process, which CMS believes is effective and appropriate.
- CMS will consider further the concerns regarding data lag in future rulemaking in the determination of the best available data to calculate Factor 3 for future years.

© 2019 Crowe LLP

FY2020 IPPS Final Rule

Audit Process Responses Cont'd:

- Primary reason CMS used 3-year average in the past was to assure uncompensated care payments would remain stable and predictable… but now believe that for FY 2020, mixing audited and unaudited data for individual hospitals by averaging multiple years could potentially lead to a "less smooth result"… Still, given concerns raised, CMS may consider returning to use of 3-year average in future rulemakings… when more years of audited data are available
- With respect to adoption of stop-loss policy, the statute at 1886(r) does not give CMS the authority to implement such a policy
- Regarding a cap on the amount of per-discharge uncompensated care payments, CMS may consider the issue in future rulemaking, including modification of amount of interim payments

© 2019 Crowe LLP

FY2020 IPPS Final Rule

Audit Process Responses Cont'd:

- CMS has more confidence in the accuracy of the FY 2015 data, as a whole, from the combined efforts from hospitals, who may not have been selected but resubmitted cost reports, as well as the results of the audits
- Relative to concerns regarding timeframes of audits, it is not generally possible for providers to have extensions for additional time because of excessive administrative inefficiencies and delay completion… CMS strives for increased standardization as MACs continue to gain experience
- Regarding adjustments reflecting no or insufficient documentation, the MAC must adjust to reflect what can be documented… necessary in order to be equitable to others that did maintain adequate documentation

© 2019 Crowe LLP

FY2020 IPPS Final Rule

Audit Process Responses Cont’d:

- CMS strives to use the lessons learned from the FY 2015 audits to improve the instructions and audits in the future… for example in recognition of the importance of additional audits and to allow for more lead time… FY 2017 audits have already begun

- Cannot make the MACs review protocol public as all CMS desk review and audit protocols are confidential… however they will continue to work with stakeholders to address their concerns regarding the accuracy and consistency of data reported… through provider education and further refinements to the instructions as appropriate

- Regarding the requests for an appeal process… CMS has confidence in the FY 2015 reviews and believe the audit process will continue to improve… they do not believe creation of a process justifies a delay in the use of this data… may consider topic further in future as they gain more experience…

© 2019 Crowe LLP

FY17 S-10 Audit Update

© 2019 Crowe LLP

S-10 Audits FY17

Audit Request Letters (Figliozzi/MACs):

- The focus is on the FY 2017 cost reports or those beginning on or after 10/1/2016.
- Each MAC has been tasked with similar number of audits, which need to be completed/settled by December 31, 2019, so the corresponding HCRIS data can be incorporated into the FY 2021 IPPS rulemaking process.
- The documentation request letters were sent by June 30, 2019, with two to three weeks allowed for a response from providers. However we have learned that some clients were still receiving letters dated as late as Thursday.
- Timelines for responsive documentation is 2 – 3 weeks.
- Similar to last year, some MACs are utilizing the help of contractors to perform the audits.
- Letters indicate an audit entrance conference call will be scheduled.

© 2019 Crowe LLP

S-10 Audits FY17

Audit Request Letters (Figliozzi/MACs) Cont'd:

- This year's letters are 2-3 pages and consistent across MACs and designated subcontractors. Some key elements include the following:
  - Copy of the hospital's charity care policy and/or financial assistance policy in effect for cost report period under review
  - Reconciliation of the bad debts claimed on S-10 to audited financials/wtb
  - Descriptions of the logic and process used when querying hospital records to obtain a detailed listing of accounts supporting charity care charges, payments, and bad debts on S-10
  - Submission of the detailed listing of claimed charges and payments reported amounts on S-10 (Excel template of required fields furnished)
  - Submission of the detailed listing of all bad debts for the hospital reported on S-10 (Excel template of required fields furnished)

© 2019 Crowe LLP

S-10 Audits FY17

Audit Request Letters (Figliozzi/MACs) Cont'd:

- The letter notes that if the hospital tracks professional fees/physician charges in a separate system from hospital charges, no revenue code detail is required
- The letter further indicates that additional information may be requested at a later time, based on initial review and may include additional sample documentation and/or patient level detail

© 2019 Crowe LLP

S-10 Audits FY17

Entrance Conference (Figliozzi):

- They expect to sample 5-10 accounts (“Pilot” samples) from each of the 3 tabs that asked for, charity, payments and bad debts.
- For the charity accounts they are testing to see that the accounts are documented appropriately for the financial screening, billing, financial assistance documentation, etc.
- For the bad debt accounts they are testing to ensure the amounts are net of recoveries, they are related to patient balances and that they were written off during the cost reporting period.
- Not a lot of time for providers to pull the information for the sample, roughly 1 week to provide the supporting documentation for the sample requested.

© 2019 Crowe LLP

S-10 Audits FY17

Entrance Conference (Figliozzi) Cont'd:

- They expect to have all adjustments from the samples prepared by the end of October - 1st week of November.
- They intend to give providers 2 weeks to review/dispute any adjustments before scheduling the exit conference calls.
- Internal completion date of first week of December expressed.
- Based on this timing we are estimating that we should see account samples pulled by the middle of September.

© 2019 Crowe LLP

S-10 Audits FY17

Sample Selections (Figliozzi):

- They expect to sample 5-10 accounts (“Pilot” samples) from each of the 3 tabs that asked for, charity, payments and bad debts…

© 2019 Crowe LLP

S-10 Audits FY17

Entrance Conference (MACs):

- They expect to sample as many as 19 accounts from each of the 3 tabs that asked for, charity, payments and bad debts
- Will furnish samples by the end of August
- They are giving the providers more time to pull the information/documentation for the sample, because they acknowledged having to drop to work on wage index
- They expect to have all adjustments from the samples prepared by early_November
- They intend to schedule the exit calls mid- to late November.
- Hard deadline for completion for CMS is December 31st

© 2019 Crowe LLP

S-10 Audits FY17

Sample Selections (MACs):

- They expect to sample 19 accounts from each of the 3 tabs that asked for, charity, payments and bad debts…

© 2019 Crowe LLP

S-10 Audits FY17

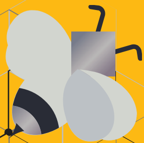
Questions for the group:

- What has been your experience thus far with the current FY17 audits?
- Have you received all sample selections at this point?
- What are the relative sizes of the sample selections between Figliozzi and MACs?
- What are the deadlines for submission of documentation responsive to the sample selections?
- What is timing for the review of audit adjustments and exit conferences?

© 2019 Crowe LLP

Introducing Healthcare's Trusted Community:

The Crowe Hive Network



Being successful in your role today looks different than it did even a few years ago. **Engage with a network of those who have been there before you:**

- Ask and answer community questions
- Seek validation and gain support through crowdsourcing
- Connect with peers and Crowe specialists
- Earn rewards for your engagement and shop the Hive store

Simplify your busy workday. Register today to continue the Healthcare Summit conversations: **crowehive.com**.

© 2019 Crowe LLP

Crowe

Thank you

Nancy Gayle – Ascension
+1 317 583 3727
nancy.gayle@ascension.org

Ron Wolf – Crowe LLP
+1 636 346 9871
ron.wolf@crowe.com

© 2019 Crowe LLP

The information in this document is not – and is not intended to be – audit, tax, accounting, advisory, risk, performance, consulting, business, financial, investment, legal, or other professional advice. Some firm services may not be available to attest clients. The information is general in nature, based on existing authorities, and is subject to change. The information is not a substitute for professional advice or services, and you should consult a qualified professional adviser before taking any action based on the information. Crowe is not responsible for any loss incurred by any person who relies on the information discussed in this document. Visit www.crowe.com/disclosure for more information about Crowe LLP, its subsidiaries, and Crowe Global. © 2019 Crowe LLP.