

KORU RESEARCH INSTITUTE

Research Report No. 003

The Turnover Tax Hospitals Aren't Tracking

*A Closer Look at What Staffing Turnover Really Costs Healthcare Organizations, and
Why Most Reporting Misses It*

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A Note From the Author

Report No. 001 named staffing turnover as one of the four bottlenecks compounding quietly behind credentialing. Report No. 002 traced a single domino, credentialing, through ten dimensions of organizational performance most executives never measure. This report does the same thing to turnover, and what I found stopped me: healthcare organizations do not actually have a turnover cost problem. They have a turnover accounting problem. Every hospital I have worked with can produce a turnover rate on demand. Almost none of them can produce a turnover cost, not the real one, the one that includes the overtime it triggers, the agency staffing it necessitates, the productivity ramp of the replacement hire, and the additional departures it quietly causes down the hall.

I have started calling this the shadow ledger. It sits underneath the official one, it is enormous, and almost no one in a healthcare organization is assigned to look at it. This report brings it into view, with the same sourcing discipline as the first two reports in this series, so an executive can hold it up next to a budget conversation and be taken seriously.

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Abstract

Healthcare organizations track staffing turnover more consistently than almost any other operational metric, yet the figure they track, a turnover rate, and even the figure they occasionally cost out, a per departure replacement estimate, systematically understates what turnover actually costs. Drawing on data published by NSI Nursing Solutions, the American Hospital Association, the Association for Advancing Physician and Provider Recruitment, and healthcare staffing and financial research, this report finds that the average U.S. hospital loses between approximately \$4.2 million and \$6.2 million annually to the full cost of staffing turnover, a figure that includes overtime, contingent and agency labor, lost productivity, and quality impact, against a reported replacement cost per bedside registered nurse of approximately \$61,110.

The central finding of this report is that the gap between the reported cost of turnover and its actual cost is not primarily a measurement difficulty. It is a reporting design choice, the same choice documented in Koru Research Institute's first report, where most U.S. hospitals report administrative expense as a single undifferentiated line item rather than a set of measurable categories. Turnover suffers the same fate, quietly, at scale, inside nearly every hospital finance function in the country. This report introduces the Koru Turnover Exposure Matrix, a diagnostic framework for locating which categories of turnover cost an organization already manages and which remain invisible, and closes with the Koru Engagement Model for acting on that diagnosis.

Keywords: *staffing turnover, healthcare workforce, nurse retention, hospital financial reporting, overtime and contingent labor, healthcare operations, total cost of turnover*

A Note on Sources and Methodology

As in Koru Research Institute's first two reports, this report distinguishes between two tiers of evidence. The first tier consists of primary data published by NSI Nursing Solutions, the American Hospital Association, AAPPR, and the U.S. Bureau of Labor Statistics. The second tier consists of figures reported by healthcare staffing firms, workforce management platforms, and industry research publishers. These industry sourced figures are directionally consistent with one another and with the primary literature, but are not peer reviewed, and are identified in the text as industry estimates where they appear. Where figures differ across the 2025 and 2026 editions of the same primary source, for example the NSI National Health Care Retention and RN Staffing Report, this report generally presents the most recently published figure and notes the prior year's figure where it adds useful context.

1. Executive Summary

- The average U.S. hospital loses an estimated \$4.2 million to \$6.2 million annually to the full cost of staffing turnover, spanning overtime, contingent and agency labor, lost productivity, administrative burden, and patient care impact (industry estimates).
- The reported, budgeted cost most organizations actually track, the direct replacement cost of a single bedside registered nurse, averages \$61,110, against national RN turnover of 16.4 percent in the most recent reporting period (2025 NSI National Health Care Retention and RN Staffing Report).
- Turnover is not evenly distributed, and the roles with the highest turnover rates are frequently the ones receiving the least executive attention. Medical assistants and patient services representatives turn over at 20 percent and 30 percent or higher respectively, and home care agency staff turn over at approximately 79.2 percent annually, rates that rarely appear on a hospital wide staffing dashboard built around RN metrics (industry estimates).
- Each single percentage point change in RN turnover is estimated to cost or save the average hospital approximately \$289,000 to \$295,000 annually, a sensitivity few organizations model explicitly when evaluating retention investment (industry estimates).
- Physician turnover carries a materially larger footprint per departure, with industry analyses placing the fully loaded cost between \$500,000 and more than \$1 million once recruiting, sign on incentives, onboarding, and lost clinical revenue during vacancy and ramp up are included, consistent with the findings of Koru Research Institute's first report.
- Turnover is self reinforcing before it is anything else. Vacancies create overtime pressure, overtime pressure drives burnout, and burnout drives further departures, a loop documented across multiple independent industry sources and consistent with the compounding pattern this report traces throughout.
- The organizations best positioned to control this cost are not the ones with the lowest turnover rate. They are the ones that can see the full cost of the turnover they already have, using a tool like the Koru Turnover Exposure Matrix introduced in Section 11, and resource retention accordingly.

2. Introduction: The Shadow Ledger

Consider a composite scenario, familiar to anyone who has run hospital operations at scale. A 220 bed community hospital's chief nursing officer presents the year's staffing report to the board. RN turnover held at 15 percent, slightly better than the national average. The slide gets a nod, and the meeting moves on. What the slide does not show, because no one on the finance or HR team was ever asked to build the report that would show it, is that those departures cost the hospital an estimated \$4.5 million once replacement, overtime coverage, agency staffing, and productivity loss are added together, and that number appears nowhere in the board packet, because no single department owns all four pieces of it.

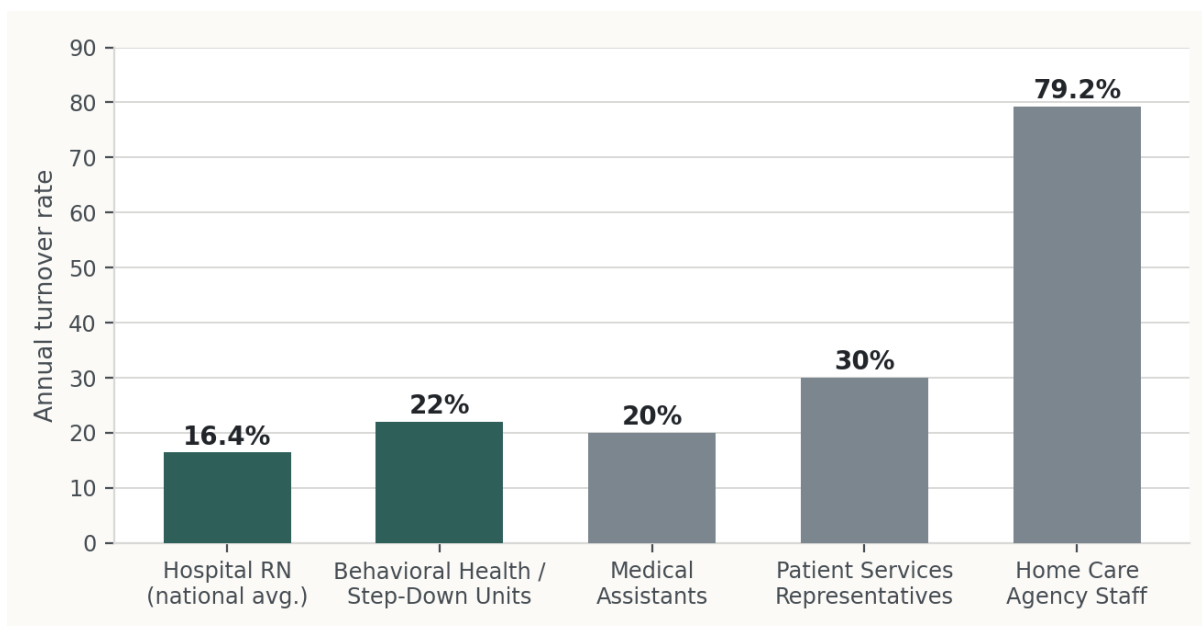
This is the pattern this report sets out to document. Healthcare organizations track staffing turnover more diligently than almost any other operational metric. Nursing leadership reviews it monthly. Human resources reports it quarterly. What almost no organization does is connect that rate to its full financial consequence: the overtime it triggers in the units left short staffed, the premium paid to agency and travel staff filling the gap, the months a replacement hire spends ramping to full productivity, and the second and third departures the first one quietly causes. A turnover rate is a symptom. The shadow ledger underneath it is the disease, and it is where this report spends most of its attention.

This report is Koru Research Institute's third, and it follows directly from the first two. Report No. 001 named staffing turnover as one of four bottlenecks compounding behind credentialing. Report No. 002 traced a single one of those bottlenecks, credentialing, through ten dimensions of organizational performance. This report applies the same discipline to turnover: not the rate a hospital already reports, but the full cost it has not yet learned to see.

3. The Scale of the Problem

The headline figures on healthcare staffing turnover are, by now, well established, and they are larger than most finance committees realize. The 2025 NSI National Health Care Retention and RN Staffing Report, based on data from 450 hospitals across 37 states, found the average cost to replace a single bedside registered nurse at \$61,110, with national RN turnover at 16.4 percent. A separate industry compilation citing the 2026 edition of the same report places national RN turnover at 18.4 percent for the most recent reporting year and the average replacement cost at approximately \$56,300 to \$60,090, depending on publisher methodology, a modest year over year shift that does not change the underlying conclusion: replacing a single nurse is a five figure event that recurs, on average, once for every five to six nurses on staff every year.

Applied at the facility level, the median hospital in the NSI survey turned over 74 registered nurses in a single year. At approximately \$56,300 to \$61,110 per departure, that is between \$4.2 million and \$4.5 million in RN replacement cost alone, before a single dollar of physician turnover, non clinical staff turnover, overtime coverage, or agency premium is added to the total. U.S. hospitals collectively spent approximately \$6.6 billion on RN turnover in 2024 alone, and that figure counts only the piece everyone already agrees to measure.



Source: 2025 NSI National Health Care Retention and RN Staffing Report; industry compilations citing Rellevate (2025) and StealthAgents (2026) healthcare staffing research. Behavioral health and step down turnover reflects NSI's reported 4 to 8 percentage point premium over the hospital wide RN average; medical assistant, patient services representative, and home care agency figures are industry estimates.

The distribution above is, on its own, a finding worth sitting with. The roles with the highest turnover are not the roles that receive the most retention investment. Home care agency staff, turning over at an estimated 79.2 percent annually, and patient services representatives, turning over above 30 percent, rarely appear in the same staffing report that tracks RN turnover to the tenth of a percentage point, not because their turnover matters less, but because no one has been assigned to measure it with the same rigor.

4. What Standard Turnover Reporting Actually Measures

Most healthcare organizations that track a turnover cost at all track one number: a per departure replacement estimate, built from recruiting fees, advertising, sign on incentives, and basic onboarding expense. This is a real cost, and it is the correct starting point. It is also, on the evidence assembled for this report, a minority share of the total.

The \$61,110 NSI figure, and similar figures reported by other publishers, are themselves built from several distinct components: recruiting and advertising cost, agency or overtime coverage during the vacancy, onboarding and orientation expense, and the productivity shortfall while the new hire ramps to full competence. Even this relatively comprehensive per departure figure typically excludes several categories this report treats as material: the burnout driven turnover a single vacancy causes among remaining staff, the quality and patient safety cost of a short staffed unit, and the administrative burden turnover places on nurse managers who spend hours on scheduling and recruitment instead of clinical oversight, a cost that shows up nowhere in a staffing budget because it is absorbed as time, not a line item.

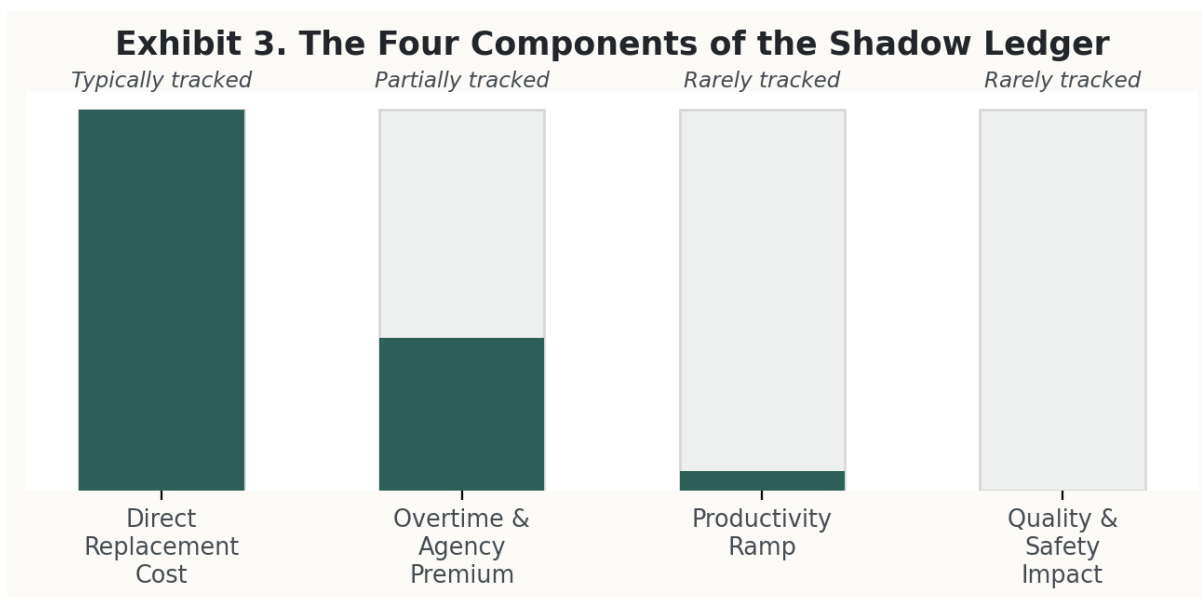
The result is a reporting structure that is internally consistent and quietly incomplete by design. An organization that tracks only the replacement estimate is measuring the down payment on turnover and presenting it, in every board meeting that follows, as the full price.

5. The Ledger Nobody Reconciles

Healthcare finance functions maintain, in effect, two sets of books. The official ledger tracks revenue, expense, and margin, and it is audited, reviewed, and presented to the board on a predictable cadence. Underneath it sits a second ledger that tracks the financial consequence of organizational dysfunction, turnover chief among it, and almost no one is assigned to reconcile it. Independent healthcare finance commentary has begun calling this the shadow ledger, and the description holds up against the evidence assembled in this report: it is enormous, it is real, and it collects with interest.

The components of that shadow ledger are individually well documented, even where they are collectively invisible. Overtime is the first and most immediate: vacancies routinely extend shifts and increase overtime expense in the units left short staffed, a cost that accelerates the burnout of remaining staff even as it inflates the labor line for the pay period. Agency and travel staffing is the second, and the most expensive on a per hour basis, with industry sources reporting that temporary staffing solutions can cost two to three times the rate of a comparable staff position, a premium organizations accept specifically because it is faster to deploy than a full hire and credentialing cycle, the same cycle documented at length in Koru Research Institute's second report.

Lost productivity is the third component, and the one most easily underestimated. National benchmarks consistently show that a newly hired registered nurse requires several months to reach full productivity, during which experienced staff absorb the resulting workload gap, a dynamic that compounds the same 90 to 120 day operational exposure documented in this report series' first installment. The fourth component, and the least frequently priced into any turnover estimate, is quality and patient safety impact. Independent research on care delivery consistently links understaffed units to delayed or missed care tasks, increased risk of adverse events, and longer lengths of stay, consequences that carry direct financial cost through readmission penalties and liability exposure, but which almost never appear on the same page as a turnover rate.

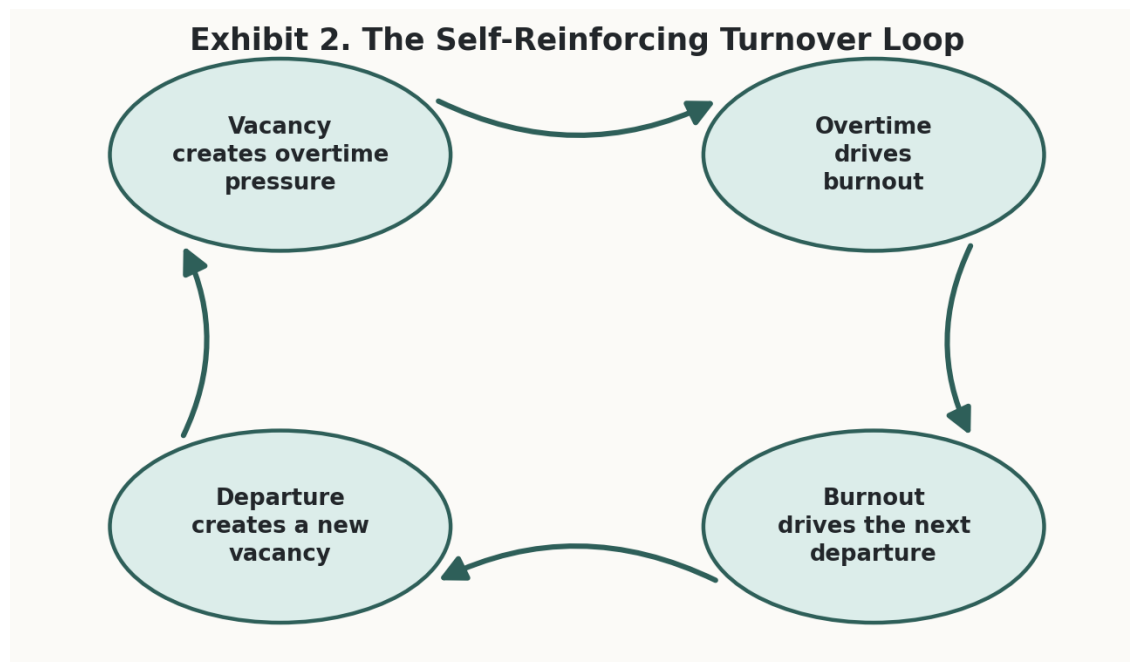


Illustrative allocation based on the tracking behavior documented across the industry sources cited in this report, not a precise proprietary measurement. The pattern, not the exact proportion, is the finding: severity and visibility move in opposite directions.

None of these four components are individually mysterious. Overtime shows up in a payroll report. Agency spend shows up in a vendor invoice. Productivity ramp is a well documented HR benchmark. Quality impact is tracked, if imperfectly, through patient safety reporting. What does not exist, in the large majority of healthcare organizations examined for this report, is a single owner assigned to add these four line items together and present the sum as what turnover actually costs. Each department reasonably reports its own piece. No one reports the total, and the total is the number that actually matters.

6. The Self Reinforcing Loop

Turnover in healthcare does not behave as an independent, one time event repeated at random. It behaves as a loop, and the loop is the real villain of this report, not any single vacancy. Vacancies create overtime pressure on remaining staff. Overtime pressure drives burnout. Burnout drives the next departure. The next departure creates a new vacancy, and the loop repeats, each cycle adding to the shadow ledger described in Section 5 without ever appearing as a single, named cost on any report.

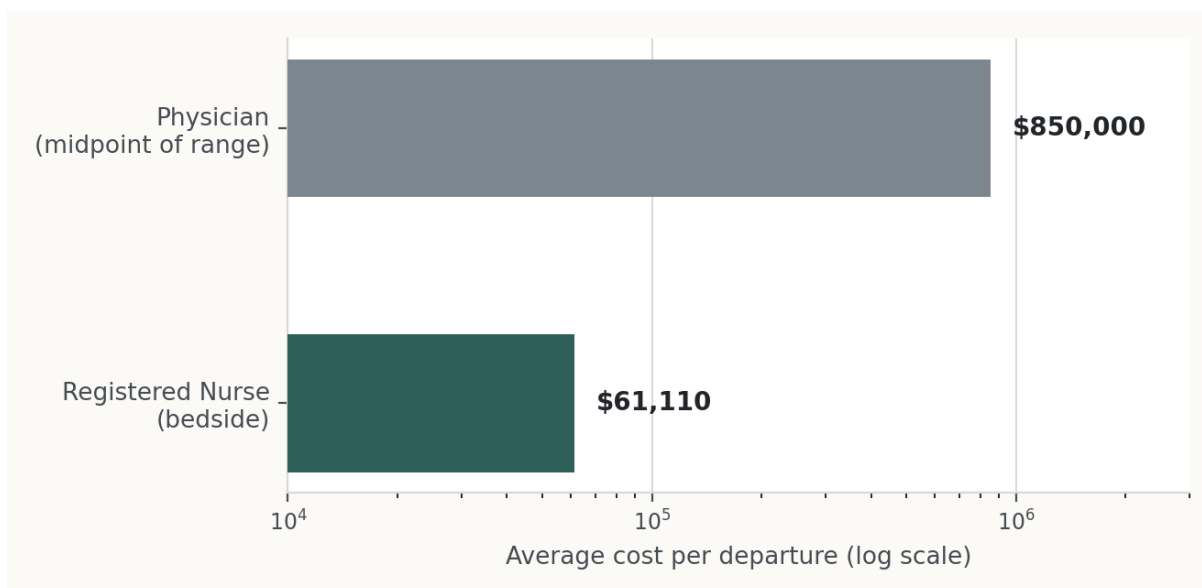


Independent healthcare workforce research confirms the mechanism directly: disengaged healthcare employees are reported to be 1.7 times more likely to leave than engaged peers, and employee engagement in the sector has been reported as slipping even as headline turnover rates modestly improved.

This loop matters most for how organizations evaluate the return on a retention investment. A staffing leader who models the value of reducing turnover by five percentage points, using only the direct replacement estimate, will understate the return by omitting the overtime, agency spend, and secondary departures that reduction would also prevent. Each single percentage point change in RN turnover is estimated to cost or save the average hospital approximately \$289,000 to \$295,000 annually, and the evidence assembled in this report suggests that figure is itself a conservative accounting once the self reinforcing loop is taken into account.

7. Not All Turnover Is Priced the Same

Turnover cost scales sharply with role, and a hospital wide average, however accurately reported, conceals more than it reveals. Registered nurse turnover, at approximately \$61,110 per departure, is the figure most healthcare finance teams are accustomed to citing. Physician turnover operates on an entirely different order of magnitude. Industry analyses of physician recruitment estimate the fully loaded cost of replacing a physician at between \$500,000 and more than \$1 million, once recruiting fees, sign on incentives, onboarding, and lost clinical revenue during vacancy and ramp up are included, consistent with the findings of Koru Research Institute's first report, with some analyses placing the fully loaded average closer to \$1.2 million per departure.



Source: 2025 NSI National Health Care Retention and RN Staffing Report; industry analyses of physician recruitment and turnover cost. Physician figure reflects the midpoint of the commonly reported \$500,000 to \$1.2 million range. The scale is logarithmic because the two figures differ by more than an order of magnitude, a gap worth sitting with on its own.

This gap has a direct operational implication for how retention investment should be prioritized. A hospital that prevents even one or two physician departures a year captures value on a scale that dwarfs a proportionally larger reduction in front line staff turnover, yet retention programs are frequently designed and resourced around the nursing population specifically, in part because nursing turnover is the most consistently measured and therefore the most visible line item available to a program designer. Physician retention, disconnected from a comparably rigorous cost model, tends to receive attention only after a high profile departure rather than as a continuously managed financial exposure.

Below the physician and RN level, the pattern repeats. Medical assistants and patient services representatives, the roles introduced in Section 3's chart, turn over at rates well above the hospital wide RN average, and while the dollar cost per departure is lower than a clinical role, the volume of departures across a multi clinic health system compounds quickly, particularly because these roles sit directly in the scheduling and front desk workflows documented as a source of revenue leakage in Koru Research Institute's first report.

8. Why Standard Reporting Misses It

The gap between reported and actual turnover cost is not, on the evidence assembled here, primarily a measurement difficulty. It is a reporting design choice, and it is the same choice Koru Research Institute's first report documented at the level of federal cost reporting. That report examined administrative expense reporting across 5,639 hospitals using Medicare Cost Report data and found that 78.3 percent of hospitals reported only a single, undifferentiated administrative and general expense line, offering no visibility into which specific functions were driving cost. Independent research on hospital financial transparency reaches a parallel conclusion at the policy level: because cost report data is self submitted, lags real time by a year or more, and is not subject to the same audit rigor as formal financial statements, it is structurally unable to support the kind of granular cost identification a turnover analysis would require.

Turnover cost suffers a version of the same structural gap, one level down, inside individual organizations. Overtime is owned by nursing operations. Agency and travel spend is owned by a staffing or supply chain function. Recruiting cost is owned by human resources. Productivity ramp is not owned by anyone in particular, because it does not generate an invoice. Quality and safety impact is owned by a clinical quality function that rarely communicates in financial terms with the departments tracking the other three. Each function can accurately report its own piece of the shadow ledger. No function is positioned, by its own reporting structure, to add the four together and present the sum as the total cost of turnover.

This is a solvable problem, and it does not require new data. Every component described in Section 5 already exists somewhere inside a healthcare organization's systems, in a payroll report, a vendor invoice, an HR benchmark, or a quality dashboard. What is missing is not the data. It is a single owner and a single report, and the organization willing to build both will know something its competitors do not.

9. How Turnover Compounds the Rest of the Operational Stack

Staffing turnover does not operate in isolation from the other bottlenecks documented across this report series, and treating it as a standalone HR metric understates its reach into the rest of the operational stack. A departed provider who must be replaced re enters the same 90 to 120 day credentialing and enrollment window documented in Koru Research Institute's first two reports, meaning a single turnover event does not simply cost the organization a replacement, it re triggers the full revenue gap those reports quantify in detail. A short staffed front desk team, a direct consequence of the elevated turnover among patient services representatives documented in Section 3, is less able to correct the scheduling data issues identified in Report No. 001 as a driver of patient no show rates, compounding a second bottleneck on top of the first.

The interaction runs in the other direction as well. Organizations already stretched thin on administrative staff are the same organizations least able to absorb the roughly 13 hours per week of prior authorization work documented in Report No. 001, which increases the administrative burden that Section 6 of this report identifies as a direct contributor to the burnout driven turnover loop. Staffing turnover is not a fifth, separate bottleneck alongside credentialing, onboarding, scheduling, and workflow. It is the mechanism that connects the other four, and an organization that treats it as an isolated human resources concern will consistently underestimate its total exposure.

10. Toward a Total Cost of Turnover Metric

The evidence assembled in this report points toward a specific, actionable recommendation: healthcare organizations should track a Total Cost of Turnover figure, built from the same four components identified in Section 5, direct replacement cost, overtime and contingent labor coverage, productivity ramp, and quality and safety impact, rather than the single replacement estimate most currently report. None of the four components require new data collection. All four already exist inside separate systems. What they require is a single reporting owner willing to assemble them into one number and present that number with the same regularity currently reserved for the turnover rate alone.

This is not primarily a technology recommendation, though workforce management platforms increasingly offer the integration layer to make it easier. It is an organizational design recommendation. The evidence in Section 8 suggests the reporting gap persists not because the data is unavailable, but because no one's job description includes assembling it. Closing that gap is a matter of assigning ownership, not acquiring new capability, and it is one of the least expensive strategic moves available to a healthcare finance function this year.

11. The Koru Turnover Exposure Matrix™

Every organization examined in this report exhibits a version of the same diagnostic pattern documented in Koru Research Institute's first two reports: financial attention flows to whichever cost is most visible, not whichever cost is most expensive. The Koru Turnover Exposure Matrix applies the same two axis diagnostic introduced in Report No. 001, financial severity against organizational visibility, specifically to the components of turnover cost identified in Section 5.

Severity vs. Visibility	Low Organizational Visibility	High Organizational Visibility
High Financial Severity	Blind Spots Productivity ramp, burnout driven secondary departures, and quality/safety impact. High cost, rarely priced, and distributed across departments with no single owner.	Known Fires Direct replacement cost and agency/travel premium. Reported consistently because an invoice or a benchmark makes the cost impossible to ignore.
Low Financial Severity	Background Noise Minor scheduling friction from short term vacancies. Worth monitoring, not worth resourcing ahead of the categories above.	Distractions Individual exit interviews and anecdotal complaints about staffing. Visible and discussed, but rarely the organization's most expensive turnover problem.

Table 1. The Koru Turnover Exposure Matrix

The diagnostic value of the matrix, as in the two reports that precede it, sits in the quadrant most organizations never think to examine: blind spots. Known fires, the direct replacement cost and agency premium documented in Sections 3 and 5, are resourced because an invoice or an oft cited benchmark makes them impossible to ignore. Blind spots, the productivity ramp, the secondary departures driven by

the self reinforcing loop documented in Section 6, and the quality impact of a short staffed unit, receive the least attention of any quadrant despite carrying, in aggregate, the larger share of the \$4.2 million to \$6.2 million total this report identifies. Used as a diagnostic exercise, the matrix asks a healthcare executive to plot their own organization's turnover related costs honestly against both axes before deciding where the next retention dollar should go.

12. The Koru Engagement Model, Applied to Turnover

Koru Research Institute's first report introduced the Koru Engagement Model, a three stage methodology moving from diagnosis to execution to sustained performance. Applied specifically to turnover, Insight™ means running the Turnover Exposure Matrix against an organization's actual data, department by department, to determine which of the four cost components identified in Section 5 are already tracked and which remain genuinely invisible. Execute™ means building the reporting infrastructure to consolidate those four components into a single Total Cost of Turnover metric, assigning a specific owner, and establishing the cadence at which it is reviewed. Optimize™ means using that consolidated view to model the return on specific retention investments, by role and by unit, rather than pursuing retention improvement as an undifferentiated, organization wide initiative.

Stage	Name	Focus	Outcome
01	Insight™	Diagnose true turnover exposure using the Koru Turnover Exposure Matrix, by role and by unit.	A quantified Total Cost of Turnover figure with a defensible return on investment case for retention spend.
02	Execute™	Build the reporting infrastructure connecting overtime, agency spend, productivity, and quality data into one metric.	A single, owned Total Cost of Turnover report reviewed on a defined cadence.
03	Optimize™	Sustain performance: retention program design, targeted by role and unit, under ongoing advisory.	Retention investment prioritized by actual financial exposure, not by which cost happens to be visible.

Table 2. The Koru Engagement Model, Applied to Turnover

Organizations typically enter this model at Stage One, Insight, regardless of how well managed their reported turnover rate already appears, for the same reason documented in Report No. 001: without a clear, quantified view of the full cost across all four components in Section 5, retention resources are allocated on the basis of which cost is loudest rather than which cost is largest. Organizations with an already functioning Total Cost of Turnover report, an uncommon but not unheard of position, may enter directly at Stage Three, Optimize. The model is sequential in logic, not rigid in application.

13. Limitations of This Report

This report synthesizes published data rather than presenting new primary research, and that synthesis has specific limits worth stating plainly. First, the Total Cost of Turnover range of \$4.2 million to \$6.2 million per average hospital, discussed in Sections 3 and 5, is drawn from industry publishers rather than a single controlled study isolating all four cost components simultaneously. Readers applying this range to a specific organization should treat it as directional rather than precise, and should expect meaningful variation by facility size, region, and specialty mix.

Second, several figures cited in this report, including the physician turnover cost range, the agency staffing cost premium, and the productivity ramp benchmarks, originate from industry publishers rather than peer reviewed research, as disclosed in the methodology note above. Where NSI, AAPPR, or Bureau of Labor Statistics data exists alongside an industry estimate, both are presented, and the primary source figures should be weighted more heavily.

Third, this report is authored by the founder of a healthcare operations firm. The Koru Turnover Exposure Matrix and the Koru Engagement Model presented in Sections 11 and 12 reflect the diagnostic and operating approach of that firm. Readers should evaluate the underlying data independently of the frameworks offered to interpret it, and the author has structured this report, including the sourcing methodology disclosed above, to make that evaluation possible.

Future research from Koru Research Institute will continue to examine specific components of this operational stack in greater depth.

14. Conclusion: The Organization That Sees the Whole Ledger

Every healthcare organization examined in the research underlying this report already tracks turnover. That was never the missing piece. What is missing is the willingness to add together the four components, direct replacement cost, overtime and contingent labor, productivity ramp, and quality impact, that together constitute what turnover actually costs, and to assign a single owner to that sum. The villain in this story is not any single nurse manager, staffing vendor, or HR department. It is the shadow ledger itself, the accumulated, uncoordinated cost of overtime, agency premium, ramp up productivity loss, and quality exposure, compounding quietly until it shows up as a margin the finance team cannot fully explain.

The organizations that win are not the ones that eliminate turnover, an unrealistic standard in an industry with the workforce dynamics documented throughout this report. They are the ones that stop treating a turnover rate as a complete answer, plot their own organization honestly across the matrix in Section 11, known fires against blind spots, and resource retention with the same financial discipline they would apply to any other multi million dollar line item, because on the evidence assembled here, that is precisely what turnover already is, whether or not it is currently reported that way.

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Koru Health works with medical groups, behavioral health organizations, urgent care networks, Federally Qualified Health Centers, and private equity portfolio companies to diagnose and rebuild the operational systems that determine whether healthcare organizations can scale.

Koru Research Institute is the research and publishing arm of Koru Health, based in New York, NY. Its mission is to bring rigorously sourced, transparently cited analysis to questions that healthcare executives are otherwise left to answer with vendor marketing or internal anecdote. This is the third report in an ongoing series.

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