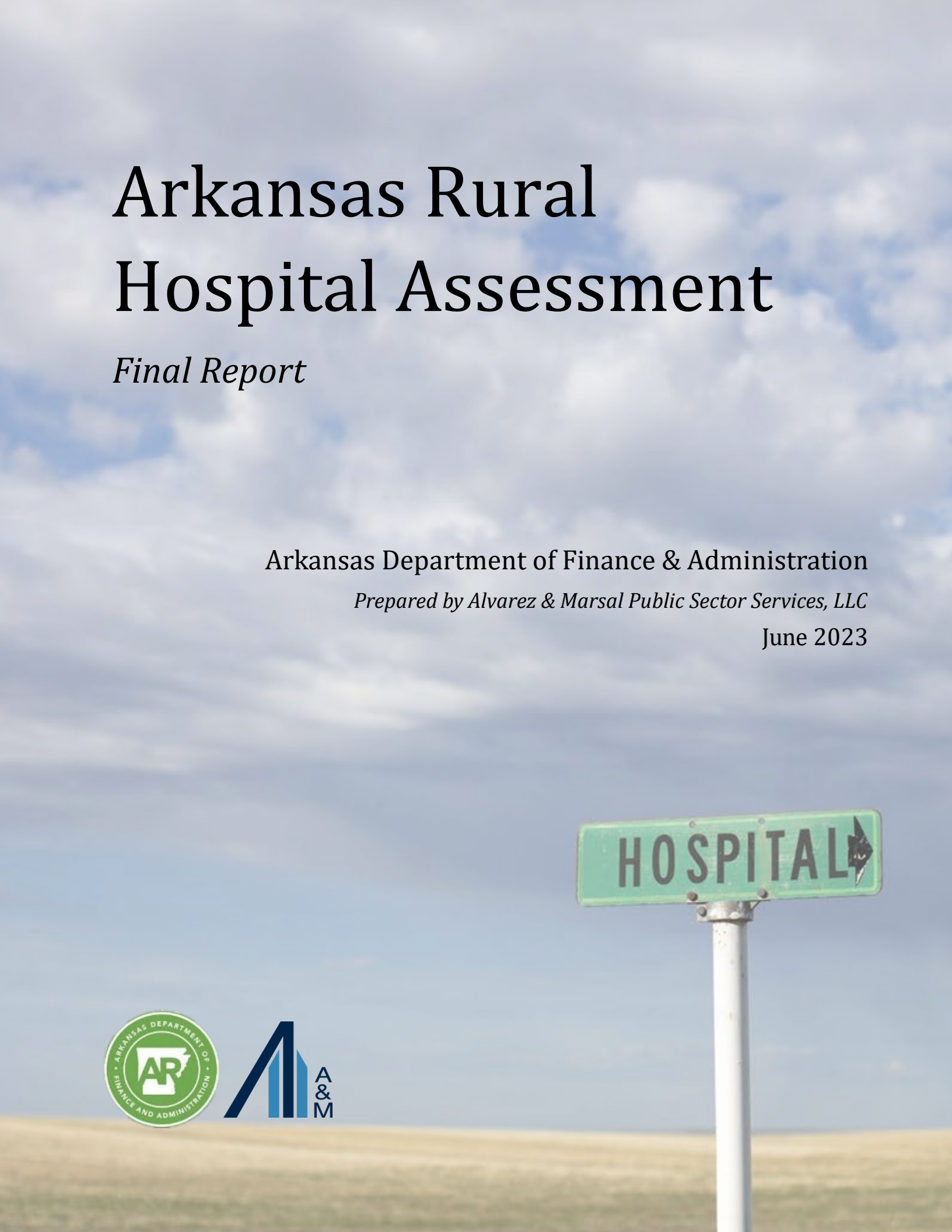
Arkansas Rural Hospital Assessment

Final Report

Arkansas Department of Finance & Administration

Prepared by Alvarez & Marsal Public Sector Services, LLC

June 2023



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Background

The State of Arkansas has approximately fifty rural hospitals, which may have been impacted significantly by the COVID-19 pandemic, increases in the cost of care, and/or reduced revenue. With well-publicized financial struggles threatening their viability, the Arkansas Department of Human Services (DHS) requested $60 million ($60M) in funding from the Arkansas American Rescue Plan Act (ARPA) Steering Committee in September of 2022.

Instead of approving the entire request, a decision was made to approve hospitals one at a time and an immediate infusion of $6M was made for one rural hospital (Ouachita County Medical Center). This decision was based in part on concerns about the long-term financial viability of these institutions and the need to prioritize this use of limited State Fiscal Recovery Funds (SFRF). Within this objective, the State sought a third party to conduct an independent review of the near- and medium-term financial condition and operating performance of Arkansas' rural hospitals to help inform the State's distribution of SFRF support. These hospitals were selected by DHS on the basis that they are either (1) Non-system CAHs (the "CAHs"); (2) non-system, non-Critical Access Hospitals located in counties with population of 50,000 or fewer (the "Non-CAH Rural Hospitals", collectively with CAHs, the "Assessment Group Hospitals"). While up to 26 hospitals were eligible to participate in this review, only 18 agreed to participate. These hospitals include the following:

CAHs under review include:

- Chicot Memorial Hospital
- Bradley County Medical Center
- Delta Memorial Hospital
- DeWitt Hospital
- Eureka Springs Medical Center
- Fulton County Hospital
- Howard Memorial Hospital
- Ozark Community Hospital
- Piggott Community Hospital
- South Mississippi County Regional Medical Center

Non-CAH (Rural) hospitals under review include:

- Arkansas Methodist Hospital
- Baxter Regional Medical Center
- Drew Memorial Hospital
- Great River Medical Center
- Magnolia Regional Medical Center
- Mena Regional Health System
- North Arkansas Regional Medical Center
- Ouachita County Medical Center

Grouping of Hospitals

These two facility types, CAH and Non-CAH, have been separated in subsequent reporting and analysis due to differences in publicly reported metrics, reimbursement, and other factors.

CAHs

The Critical Access Hospital (CAH) program was created as part of the Balanced Budget Act of 1997. The CAH program's goal is to aid small rural hospitals experiencing financial hardships due to dependence on Medicare, disproportionate shares of uninsured patients, declining and aging populations, stagnant economies, and escalating operating costs.[1] To qualify as a CAH under Federal regulations, a hospital must

[1] "Texas Critical Access Hospital Guide," Texas Department of Rural Affairs, 2022, pg. 5

be located more than a 35–mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15–mile drive) from another hospital; which makes them unique facilities in the healthcare industry. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 allowed for CAHs to establish psychiatric and rehabilitation units as distinct parts within a hospital, and the beds in those distinct parts are excluded from the bed count for the purposes of applying the 25-bed limitation.[2]

CAH reimbursement mechanisms also differ from those of a typical acute-care facility. CAHs receive cost-based reimbursement for Medicare services, meaning that for costs allocated to Medicare on the annual Medicare cost report submission, the hospital receives 101% of those costs as reimbursement. Hospitals are paid an estimate throughout the year for Medicare services, and a "true up" is performed once the annual cost report has been submitted and validated. Because CAH reimbursement for services provided to Medicare beneficiaries is primarily dependent on cost, most CAHs do not measure their Case Mix Index[3] (CMI), a measure that reflects the diversity, complexity, and severity of patient illnesses treated at a facility and which non-CAHs use to determine their service-based reimbursement. The lack of publicly available CMI data from CAHs prevents a comparison of the average acuity (severity of illness) for patients in a specific CAH during a defined period.

Arkansas also reimburses CAHs at higher median inpatient per diem and outpatient fee schedule Medicaid rates than non-CAH facilities due to the populations these facilities typically serve. Arkansas CAHs receive Medicaid reimbursement subject to a median per diem rate of $2,179, which is roughly 256% higher than the median per diem rate for Non-CAH Rural Hospitals.[4] CAH Medicaid outpatient reimbursements are generally based on a fixed outpatient fee schedule established in 1990 and are further subject to cost-based adjustments using standard Medicare cost reporting principles.

Non-CAH Rural Hospitals

Unlike CAHs, which receive cost-based reimbursement for inpatient and outpatient service delivered to Medicare beneficiaries, Non-CAH Rural Hospitals are paid for such services using the Medicare prospective payment system (PPS). PPS pays a fixed fee based on the diagnosis related group (DRG) of the patient rather than a variable fee based on the hospital's cost of providing the service.

There are also differences in Arkansas' Medicaid reimbursement policies for CAH and Non-CAH Rural Hospitals. Medicaid reimbursements to Non-CAH Rural Hospitals are generally subject to a lower standard median per diem rate of $850 for Medicaid inpatient services.[5] Medicaid outpatient reimbursements to Non-CAH Rural Hospitals are also generally based on the same fixed outpatient fee schedule that CAH reimbursements follow; however, Non-CAH Rural Hospital outpatient reimbursements do not receive the additional cost-based adjustments that CAHs receive for outpatient services.[6]

[2] "Texas Critical Access Hospital Guide," Texas Department of Rural Affairs, 2022, pg. 10–11
[3] The Case Mix Index (CMI) is the average relative DRG weight of a hospital's inpatient discharges, calculated by summing the Medicare Severity-Diagnosis Related Group (MS-DRG) weight for each discharge and dividing the total by the number of discharges.
[4] Medicaid Hospital Rate Study; Milliman, Inc., page 1.
[5] Ibid.
[6] Id., page 4.

Key Considerations for Assessment Group Hospitals

Potential Conversion to Rural Emergency Hospital Status

REH designation is a new provider type established by the Consolidated Appropriations Act, 2021 to address the growing concern over closures of rural hospitals and their financial stability. As of January 1, 2023, CAHs and certain Non-CAH Rural Hospitals have the option of converting to an REH. REHs are intended to maintain critical outpatient hospital services, such as 24-hour emergency services, laboratory, and diagnostic radiology services, and do not allow for inpatient beds/care. A facility will need to evaluate the financial implications carefully and thoughtfully and consider whether the areas they serve require inpatient care, before deciding to pursue such a conversion.

Potential Adoption of Life360 HOME Programs

On January 1, 2022, Arkansas Works was replaced by the Arkansas Health and Opportunity for Me program, or ARHOME. The ARHOME program uses Medicaid dollars to buy private health insurance for eligible Arkansas citizens. ARHOME focuses on improving individual health, not just simply providing reliable health care coverage. ARHOME also includes new Life360 HOMEs to focus on the health of certain key groups: High-risk pregnant and new moms, and babies (Maternal Life360); Arkansans living in rural communities (Rural Life 360); and young adults that are at greatest risk for poor health outcomes (Success Life 360).[7]

Maternal Life 360 providers will support women with a high-risk pregnancy diagnosis with evidence-based maternal and child home visiting services during pregnancy and for up to two (2) years after birth. To be eligible to serve as a Maternal Life360 provider, a hospital must be a birthing hospital that is a licensed general hospital either in the state of Arkansas or a border state and that also provides obstetrical services.[8]

Rural Life 360 participants will provide care coordination services to ARHOME individuals with a diagnosis of serious mental illness (SMI) or substance use disorder (SUD) who live in rural areas of the state. Services will include screening and referrals for all residents with a health-related social need, providing direct support and coordinating with behavioral health/social services providers to ensure clients remain healthy in the community and limit unnecessary hospitalization and ER.

To be eligible to serve as a Rural Life360 provider, a hospital must be a small rural hospital that is a licensed general or critical access hospital (CAH), has fifty (50) or fewer beds, and is located in a rural area. A rural area is defined as a county that has either a CAH or SHIP hospital or has less than 50,000 people.[9]

Success Life 360 will be contracted or provided directly by the hospital and will help with life skills and other health-related social needs for young adults at risk and were in foster care, incarcerated or involved with the juvenile justice system or are veterans. Clients will also need to be enrolled, or eligible for ARHOME. To be eligible to serve as a Success Life360 provider, a hospital must be an acute care hospital licensed by the Department of Health.[10]

[7] ARHOME - Arkansas Department of Human Services
[8] Life360 Providers - Arkansas Department of Human Services
[9] Ibid.
[10] Ibid.

Assessment Approach

The assessment of each Hospital's financial and operating viability was based on an objective, fact-based review of hospital-submitted data in conjunction with on-site visits and discussions between the A&M project team and hospital leadership and staff. The Hospitals under review were divided into two separate categories to ensure parity, as CAHs differ from non-CAH facilities in several key areas (*see Background section*). DHS requested data from eligible facilities in late January. The Assessment Group Hospitals opted-in to the Review by responding to that initial data request (*see Table 1*: Initial Data Request) by submitting their initial data starting on January 31 and concluding on February 28.

Table 1: Initial Data Request

Data Category	Requested Data	Time Period
General	Organizational Chart: Executive chart and business structure chart (highest-level outlining legal entities and ownership structure, include leadership names/titles, if available)	Current
Financial	Existing Monthly Management Reports (Financial and Operational): Financial data, which includes EBITDA, operating margin, cash on hand, accounts receivable, etc. Operational data, which includes avg daily census, avg length of stay, patient days and discharges, annual Emergency Department visits, Case Mix Index (CMI), etc.	Last six months
Financial	Audited Financial Statements (AFS): For the last 2 years, including any audit adjustments to reconcile with internal financials. If applicable, specific audited details on reconciliation to a consolidated AFS	Last two full years
Financial	Monthly Financial Statements: Balance sheet, income statement, and cash flow statement	Last six months
Financial	Quick Ratio	Current
Financial	Payer Mix: Medicare, Medicaid, private, uncompensated care, etc.	Current
Financial	Current CAPEX Budget and 3–5-Year Projected Expenses	Current
Labor	Actual Total FTEs: Breakdown between Non-Clinical FTEs and Clinical FTEs	Current
Labor	Physician Productivity Reports (Work RVUs)	Last 6–12 months
Operational	Plans for Achieving Sustainability: along with a statement of steps taken to date to improve the Hospital's business model and practices	Current
Physical Plant	Statement of Conditions or Average Age of the Plant / Facility	Current

Part One: Initial Data Analysis and Development of Hospital Profiles

Information received from each hospital through the data request was analyzed by the A&M team to prepare for the on-site reviews. Each hospital's data was reviewed across the following six core areas (general statistics, balance sheet metrics, payer breakdown, sustainability plan, income statement metrics, and quality indicators/other) and were organized into hospital-specific profiles (see Appendix A for additional detail).

Franklin BI Review

Additionally, during the initial data analysis, A&M reviewed several publicly available performance indicators by utilizing Franklin BI, a hospital business intelligence tool that A&M uses to perform high-level financial and operational performance analyses of hospitals and health systems. Franklin BI is primarily sourced by publicly available datasets that are housed by Centers for Medicare & Medicaid Services (CMS). These datasets include hospital-specific information, such as financial and operational data from Medicare Cost Report filings; National Plan and Provider Enumeration System (NPPES) identifiers (*i.e.*, NPI); and patient experience survey data and inpatient/outpatient volume statistics. Additionally, Franklin BI may be utilized to access census data to capture market share, growth opportunities, and trends.

For the purposes of this analysis, A&M relied on information from Medicare Cost Report filings and volume statistics. The information reflects data reported for 12-months in calendar year 2021, as that is the year with the widest range of available and complete information.

This exercise was designed to prepare the A&M team with a historical perspective of each hospital's financial and operational performance. A&M compared commonly reviewed hospital performance metrics and compared each to a standard benchmark to establish observations and questions in preparation for future discussions and on-site reviews. The charts in this section are based on 2021 hospital-submitted filings (*e.g.*, Medicare Cost Reports, audited financial statements etc.), unless otherwise noted.

Selected metrics included:

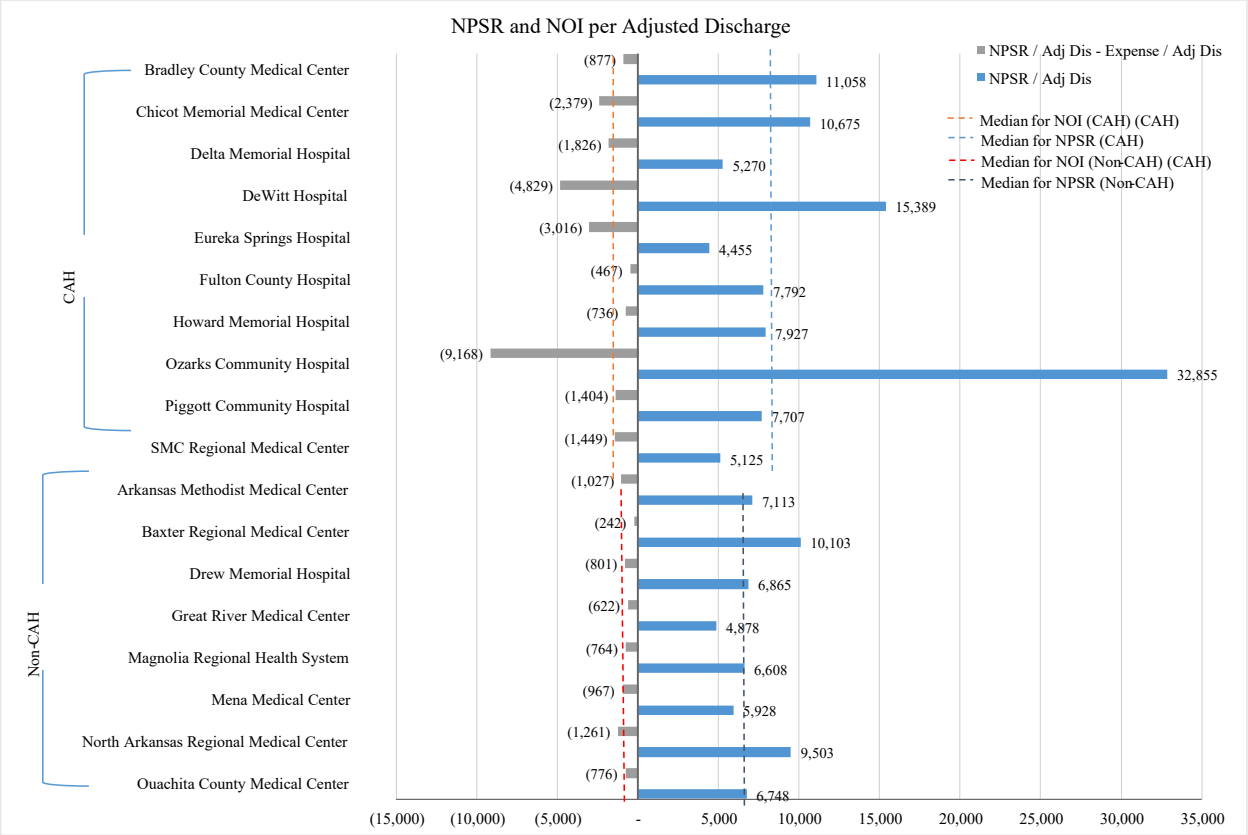
- Net Patient Revenue (NPR) and Net Operating Income (NOI) per Adjusted Discharge
- Average Length of Stay
- Labor Costs as a Percentage of Net Patient Revenue
- Full-Time Equivalents (FTEs) per Adjusted Average Daily Census (ADC) (or more commonly known as FTEs per Adjusted Occupied Bed)

Net Patient Revenue per Adjusted Discharge

Net Patient Revenue (NPR) per adjusted discharge is the quotient of net charges for services divided by adjusted discharges. It is one element of negotiated price per inpatient stay. NPR is a better equivalent unit of revenue than gross revenue, especially in value-based and bundled payment markets. Expenses per Adjusted Discharge measures the average cost incurred for each discharged patient, adjusted for outpatient revenues. The difference between NPR and Expense per Adjusted Discharge is the Net Operating Income (NOI) per Adjusted Discharge. A positive Net Operating Income (*i.e.*, a greater difference between NPR per adjust discharge and Expense per adjusted discharge) is usually a sign of a sustainable hospital operations.

In the comparison below, we've added a median benchmark reflective of the cohort in review.[11] The median results for total Net Patient Revenue were $7,927 and $6,807 for CAH and non-CAH facilities, respectively. The median results for Net Operating Income were ($1,449) and ($788) for CAH and non-CAH facilities, respectively. The graph indicates that the entire cohort of both CAHs and non-CAHs has experienced operational losses on a per adjusted discharge basis.

Figure 1: Comparison of Net Patient Revenue and Net Operating Income per Adjusted Discharge Across Hospitals, with NPR and NOI medians for each subset of facility (CAH and Non-CAH).



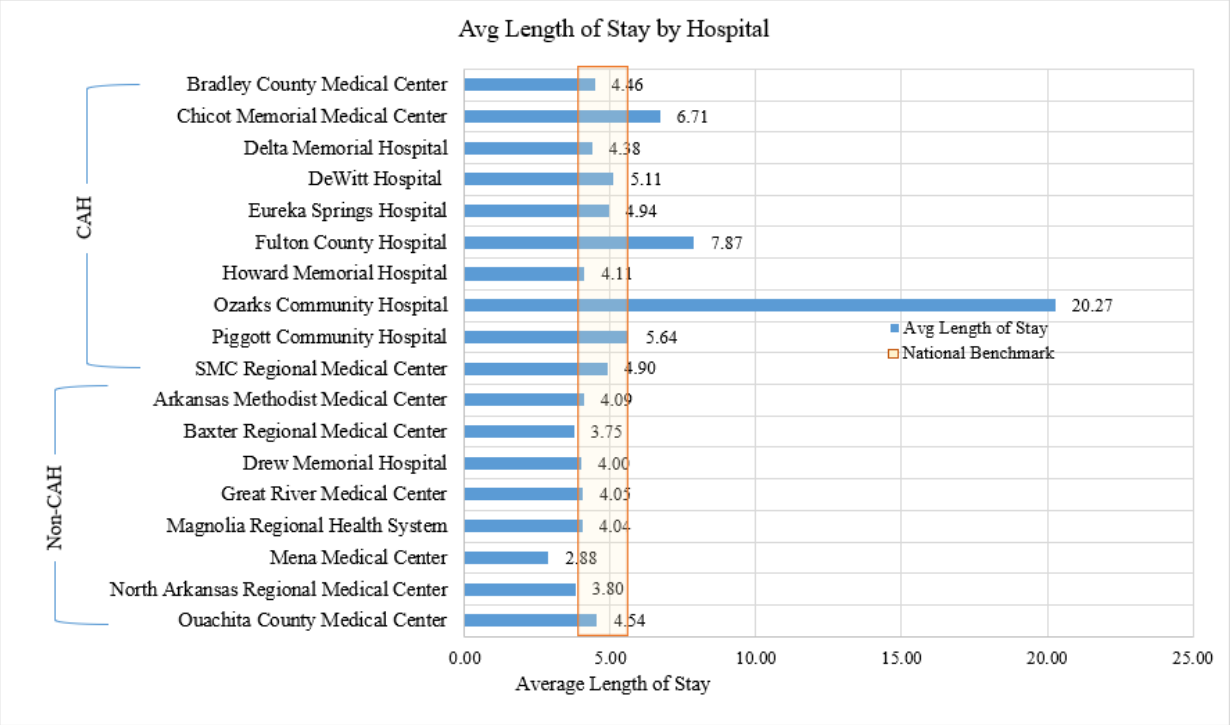
Average Length of Stay

The average length of stay (ALOS) refers to the average number of days that patients spend in a hospital. It is generally measured by dividing the total number of patient days stayed by all inpatients during a year by the number of discharges. Length of stay is a key measure of patient throughput at a facility and can greatly affect both revenues and costs. Managing towards a lower average length of stay within a facility has also been linked to improved clinical quality outcomes & a decreased risk of hospital acquired infection. Length of Stay benchmarks at the DRG level can be found utilizing the Centers for Medicare & Medicaid Services (CMS) Geometric Mean Length of Stay (GMLOS).[12] CMS uses each DRG's GMLOS to determine reimbursement for each discharge for those hospitals that use the DRG payment system. In the

[11] Based on 2021 data in Franklin BI (sourced from Medicare cost report data). Ozarks Community Hospital data from Franklin BI has been a consistent and significant outlier; further OSR analysis and data review is required.
[12] chap1.pdf (cms.gov)

comparison below,[13] we've compared each facilities' ALOS to a benchmark range reflective of national averages for CAH and non-CAH facilities (4 days for CAH[14] to 5.4 days for non-CAH[15]).

Figure 2: Comparison of Average Length of Stay Across Hospitals



[13] Based on 2021 data in Franklin BI (sourced from Medicare cost report data). Ozarks' average length of stay is skewed higher due to the large amount of swing bed volume at the facility – their 2022 provided statistics indicate that approximately 78% of all patient days are swing bed days. The Franklin BI data combines both acute and swing bed patient days, causing the length of stay it appear drastically higher.

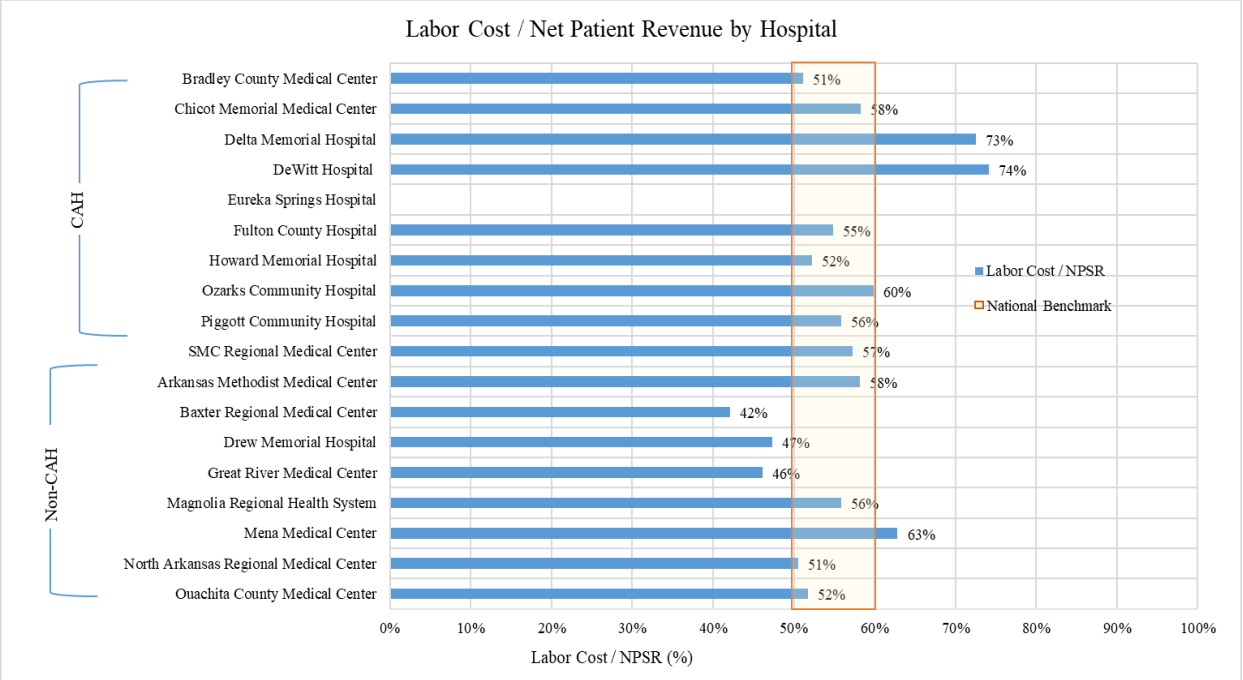
[14] Based on the 96-hour CAH designation criteria, per CMS.

[15] Based on American Hospital Association data for community hospitals, 2019.

Labor Costs as a Percentage of Net Patient Revenue[16]

Labor costs are typically a healthcare facility's largest expense category. Examining what percentage of Net Patient Revenue is consumed to pay for labor expenses provides insight into how efficiently (or inefficiently) that labor is being used. Based on the latest data available for CAH facilities, the median Labor Cost as a percent of Net Patient Revenue is approximately 47%.[17] Prior to the COVID-19 pandemic, industry trends supported a Labor Cost as a percent of Net Patient Revenue was between 45% to 50% for non-CAH facilities.[18] Post-COVID, that trend has increased due to high staffing and supply costs. To account for this increase, we've revised the comparison range to 50 to 60% for non-CAH facilities in the graph below.[19]

Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals

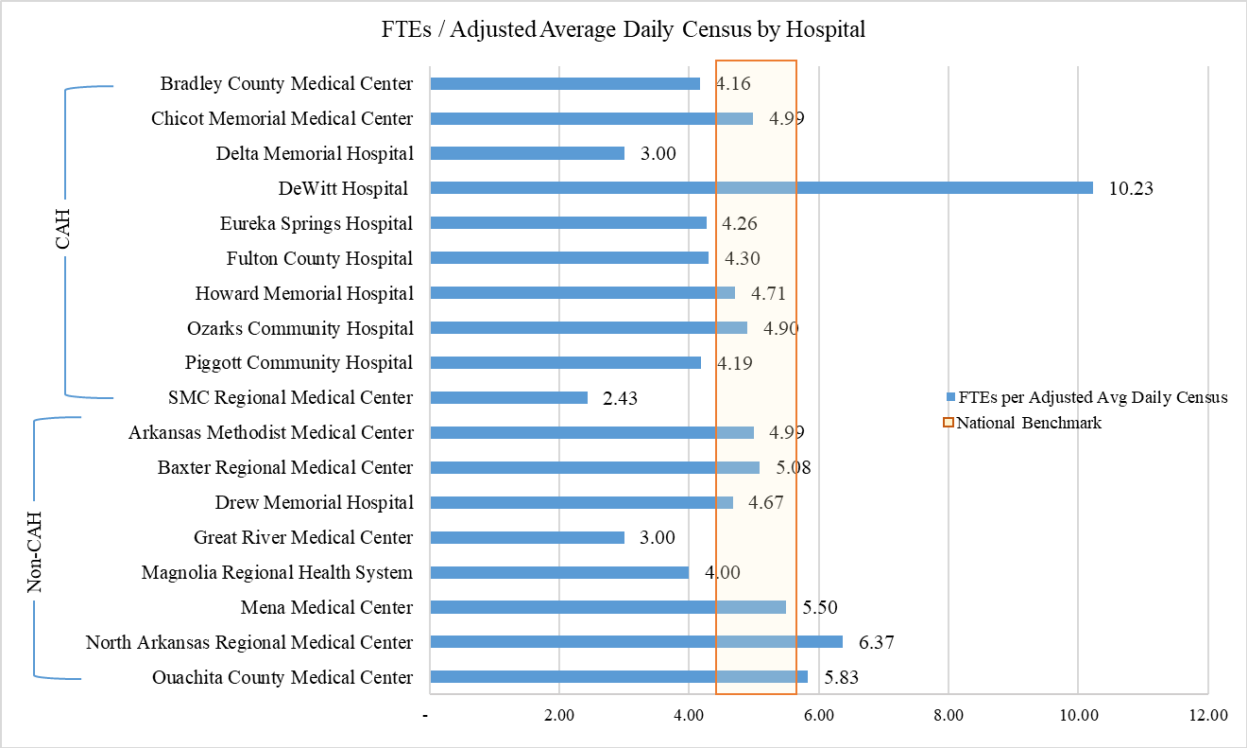


[16] Eureka Springs was excluded from this comparison because it does not report on select (*i.e.*, Other- Employee Benefits Dept) within Franklin BI.
[17] CAH Financial Indicators Report: Summary of 2020 Indicator Medians by State, May 2022.
[18] This range is dependent on bed size and hospital type and as such variation between Non-CAH Rural Hospitals and CAHs is common.
[19] Based on 2021 data in Franklin BI (sourced from Medicare cost report data).

Full Time Equivalents per Adjusted Average Daily Census

Full time Equivalents (FTEs) per adjusted average daily census (or FTEs per Adjusted Occupied Bed) is a commonly used, high level labor/productivity metric. The metric is calculated as the quotient of full-time equivalent personnel divided by adjusted average daily census, and measures staffing levels alternatively as a measure of labor inputs per output day of care. The Adjusted Average Daily Census is calculated by taking a hospital's average daily census and multiplying it by the facilities adjustment factor, which is calculated as total gross charges divided by gross inpatient charges. The adjustment factor is used to account for all the outpatient / other services that are ongoing at a facility and convert them to an equivalent inpatient basis (adjusted discharges, adjusted patient days, etc.). This in turn, gives us a view of the number of FTEs required to provide care daily for a facility's patient population. In the comparison below[20], a range of 4.6 - 5.72 FTEs per Adjusted Occupied Bed was provided by a 2020 State Median Report.

Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals



[20] Based on 2021 data in Franklin BI (sourced from Medicare cost report data).

Part Two: On-Site Review (OSR)

Following the initial data analysis, the A&M team completed on-site reviews for each participating hospital. This visit consisted of two to four members of the A&M team meeting with various Hospital staff. Over the course of each onsite visit, the team met with executive-level management, including but not limited to the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Operating Officer (COO), Chief Compliance Officer (CCO), Chief Information Officer (CIO), Chief Nursing Officer (CNO), Chief Medical Officer (CMO), Director of Human Resources (HR) and Chief Administrative Officer (CAO). The visit concluded with a complete facility tour with plant management.

These reviews proved critical to capturing context around the data collected, as well as assessing the physical plant in person for future infrastructure needs/vulnerabilities. See Appendix B for additional detail.

Metric Definitions

For consistent review of each hospital, A&M used the defined key metrics as follows:

- Quick Ratio = (Current Assets – Inventories – Prepaid Expenses) / Current Liabilities
- Current Ratio = Current Assets / Current Liabilities
- Days Cash on Hand = Cash & Cash Equivalents / Daily Expenditures
    - Daily Expenditures = (Total Operating Expenses + Interest Expense – Depreciation Expense) / 365
- Debt Service Coverage Ratio = Operating Income / Total Debt Service
    - Total Debt Service includes Principal & Interest
- Average Age of Plant = Accumulated Depreciation / Annual Depreciation Expense
- Days in Accounts Receivable, Net = (Accounts Receivable, Net * Days in the Period) / YTD Net Patient Revenue
    - Days in the Period should equal the number of days included in YTD Net Patient Revenue figure
    - Days in A/R can either been done at a net or gross level
        - Days in Accounts Receivable, Gross = Accounts Receivable, Gross * Days in the Period) / YTD Gross Patient Revenue
- Debt to Operating Revenue = Total Long-Term Debt / Total Operating Revenue
- EBITDA Margin = EBITDA / Total Operating Revenue
- Operating Margin = Operating Income / Total Operating Revenue
- NPR / Adj Discharge = Net Patient Revenue/Adjusted Discharges
- Expense / Adj Discharge = Total Operating Expense / Adjusted Discharges
- FTE / Adjust Occupied Bed = Total FTEs / Adjusted Average Daily Census
    - Adjust average daily census is calculated by taking a hospital's total ADC and multiplying it by their adjustment factor

High Level Assessment Results

Overall Results

For the purposes of summarizing each hospital and comparing performance across the entire cohort of participating hospitals, A&M developed a quad-chart to focus on two common performance areas: current financial condition and sustainability. Definitions for each are outlined below.

Current Financial Condition – Financial Viability is determined based on each hospital's annualized, trailing 6 month operating margin, calculated days cash on hand (see *Figure 6*: Quick Ratio, Days Cash on Hand, Operating Margin Comparison), and calculated quick ratio.

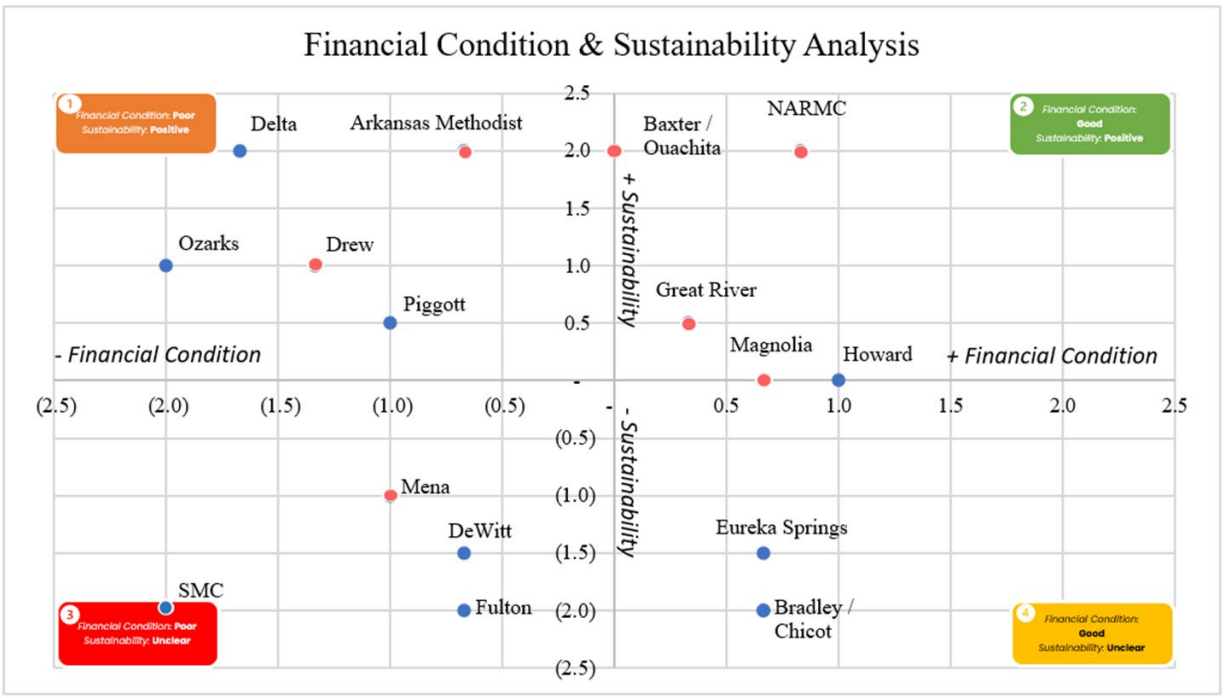
- **1=** Operating Margin <10%; <90 DCOH; Quick Ratio <1.0 – Poor Financial Condition
- **3=** Operating Margin =<5%; 90-100 DCOH; 3> Quick Ratio>=2 – Mixed Financial Condition
- **5=** Operating Margin >=0%; >120 DCOH; Quick Ratio>=4 – Good Financial Condition

Sustainability - Sustainability is scored based on A&M's qualitative assessment of each facility's submitted sustainability plans (SP), capital investment required, and financial outlook.

- **1=** Plan is not quantified; implementation has not begun – Unclear Sustainability Plan
- **3=** Plan is partially quantified; implementation has begun – Mixed Sustainability Plan
- **5=** Plan is quantified; implementation is >75% complete – Positive Sustainability Plan

In the scatterplot below, the x-axis plots the current financial condition, and the y-axis is the sustainability analysis. Quadrant 1 and 3, on the left side of the y-axis capture hospitals with poor financial condition as measured by the aforementioned metrics; quadrant 2 and 4 designate good financial conditions. Hospitals above the y-axis have stronger sustainability plans than the hospitals below the y-axis. CAH sites are colored in blue, whereas non-CAH are in red.

Figure 5: Hospital Comparison by Sustainability (the x-axis) & Financial Condition (the y-axis)



Comparison of Hospitals by ARPA Funding Application Metrics

The State's application for ARPA funding includes the following eligibility criteria (the "Criteria"):

- The Hospital is licensed by the Arkansas Department of Health as a general hospital; and.

- The Hospital is currently enrolled with the Arkansas Medicaid program; and.
- The Hospital has insufficient assets to cover liabilities, as indicated by the Hospital's quick ratio of less than one (1); and/or.
- The Hospital has less than 90 days' cash on hand or is operating on a margin of less than -10% in Quarter 1 or Quarter 2 of Calendar Year 2022, as shown by the most recent quarter-end financial statements attached.

The Criteria's three key metrics are: 1) Quick Ratio; 2) Days Cash on Hand; and 3) Operating Margin (based on trailing six months annualized financials).

Figure 6: Key Metric Comparison below show each Hospital's performance on those three key metrics plus their Days in A/R, net and lists the Hospitals' average and median for each in bold at the bottom of the table.

Figure 6: Key Metric Comparison

Hospital	Hospital Designation	Quick Ratio	Days Cash on Hand	Days in A/R, Net	Operating Margin (Based on Trailing 6 Months Annualized)
Bradley County Medical Center	CAH	7.9	166.1	59.4	-20.6%
Chicot Memorial Medical Center	CAH	4.0	179.8	50.9	-30.8%
Delta Memorial Hospital	CAH	1.2	36.7	46.0	-21.7%
DeWitt Hospital and Nursing Home	CAH	2.6	52.3	46.2	-5.7%
Eureka Springs Medical Center	CAH	9.2	244.4	49.2	-25.0%
Fulton County Hospital	CAH	4.0	(0.4)	154.9	-3.7%
Howard Memorial Hospital	CAH	4.0	124.6	29.9	-9.0%
Ozarks Community Hospital	CAH	0.6	0.6	77.3	-12.3%
Piggott Community Hospital	CAH	3.3	18.7	74.0	-4.3%
SMC Regional Medical Center	CAH	(3.1)	49.8	72.9	-54.0%
Arkansas Methodist Medical Center	Non-CAH	6.9	68.5	60.0	-8.0%
Baxter Regional Medical Center	Non-CAH	2.4	82.8	34.1	3.8%
Drew Memorial Hospital	Non-CAH	2.4	11.3	72.0	-20.5%
Great River Medical Center	Non-CAH	3.3	123.2	121.4	-31.4%
Magnolia Regional	Non-CAH	5.5	120.7	57.7	-16.5%
Mena Regional Health System	Non-CAH	3.3	43.2	49.0	-9.8%
North Arkansas Regional Medical Center	Non-CAH	4.0	115.8	60.2	1.5%
Ouachita County Medical Center	Non-CAH	2.3	17.0	43.5	0.2%
Average:		**3.5**	**80.8**	**64.4**	**-14.9%**
Median:		**3.3**	**60.4**	**58.6**	**-11.1%**

12-Month and 18-Month Summary Breakeven Table

The table below summarizes the 12-month and 18-month breakeven amounts, based on the trailing 6 months of data. Each hospital's September 2022 through February 2023 monthly financial statements were aggregated and then annualized to develop the 12-month breakeven figures, and an additional 6 months of runout was then added to the 12-month figures to develop the 18-month breakeven. Where identified, one-time events were removed from any annualized figures, and then were added back into their respective line items after all other figures had been annualized. Negative figures represent a forecast loss based on the trailing 6 months of data.

Figure 7: 12- and 18-Month Break Even Summary

Hospital	Hospital Designation	12 Month Net Income Breakeven	18 Month Net Income Breakeven
Bradley County Medical Center	CAH	$ (3,470,413)	$ (5,205,619)
Chicot Memorial Medical Center	CAH	(1,066,190)	(1,599,285)
Delta Memorial Hospital	CAH	(313,306)	(469,959)
DeWitt Hospital and Nursing Home	CAH	645,204	967,807
Eureka Springs Medical Center	CAH	2,066,050	1,277,800
Fulton County Hospital	CAH	211,596	317,394
Howard Memorial Hospital	CAH	(1,262,338)	(1,893,507)
Ozarks Community Hospital	CAH	1,528,929	(2,464,621)
Piggott Community Hospital	CAH	(1,239,447)	(1,859,172)
SMC Regional Medical Center	CAH	(2,095,804)	(3,393,706)
Arkansas Methodist Medical Center	Non-CAH	(5,714,396)	(8,571,595)
Baxter Regional Medical Center	Non-CAH	7,113,956	6,755,753
Drew Memorial Hospital	Non-CAH	(7,728,798)	(11,593,197)
Great River Medical Center	Non-CAH	(3,349,396)	(6,109,094)
Magnolia Regional	Non-CAH	(1,765,323)	(3,481,206)
Mena Regional Health System	Non-CAH	(2,966,510)	(4,449,765)
North Arkansas Regional Medical Center	Non-CAH	(4,763,782)	(7,145,673)
Ouachita County Medical Center	Non-CAH	5,976,297	5,925,519
Total:		**$ (18,193,672)**	**$ (42,992,127)**
Total Only Losses:		$ (35,735,704)	$ (58,236,399)

Note: Breakeven amounts above are based on taking a facility's trailing 6 months (Sept. 2022 - Feb. 2023) of monthly income statements and annualizing the net income amounts

Hospital-Specific Analyses

Arkansas Methodist Medical Center

Quick Facts

- Classification: Non-CAH
- Licensed Beds: 129
- Closest Facility: 18.7 miles
- Average Age of Plant: 22.2 years
- Average Daily Patient Occupancy Rate: 31%
- Average length of stay (ALOS): 3.9
- Total full-time employees (FTEs): 674
- Corporate Structure: 501(c)3

Location: Paragould, Greene County
County Population: 46,317 (2021)

Table 2: Arkansas Methodist's Key Statistics

Operating Statistics		
C&C Equivalents	$	13.8 M
Current Assets	$	31.4 M
Net A/R	$	11.4 M
Total Assets	$	56.3 M
Days Cash on Hand		68.46
Quick Ratio		6.93
Current Ratio		7.65
Debt Service Coverage Ratio		-5.62
Days in Net AR		59.96
Average Age of Plant		22.20
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	68.7 M
Other Revenue	$	1.8 M
Total Revenue	$	70.6 M
Salaries, Wages & Benefits	$	40.1 M
EBITDA	$	(2.5 M)
Operating Income	$	(5.6 M)
Non-Operating Income/(Expense)	$	(0.1 M)
Net Income	$	(5.7 M)
Operating Margin %		-8%

Key Challenges

- Per hospital leadership, Arkansas Methodist is out of compliance with an affirmative debt service coverage ratio on two different notes held with a local bank totaling $13.8M
- The nearby (~18 miles) NEA Baptist facility that opened five years ago has contributed to a long-term decline in patient volumes

1 *Patient Volume Trends*

- St. Bernards Medical Center and the recently opened NEA Baptist facility in Jonesboro have been drawing patients that would have otherwise gone to Arkansas Methodist, resulting in an average daily census (ADC) that has decreased to ~40 for the fiscal year across all hospital areas as of December 2022. Through the same period in FY2022, the ADC was 46.5

2 *Financial Status*

- Cash & Reserves: Arkansas Methodist has roughly $13.8M of cash on hand, although $10M of that amount is internally designated and would require board approval to use for any other purpose. These funds are also allowing the hospital to maintain a days cash on hand requirement tied to their debt
- Debt: Per hospital leadership, Arkansas Methodist is out of compliance with an affirmative debt service coverage ratio on two different notes with a local bank totaling $13.8M. A $9.2M note matures August 2023 and a $4.6M note matures October 2024. The hospital does not have a contingency plan in place should the bank call the loans early or decline to refinance the remaining principle upon maturity. Along with the debt service coverage ratio requirement, there is a days cash on hand (DCOH) requirement of 60 days. The hospital has an "internally designated" line item on their balance sheet that is ideally reserved for capital improvements but is currently being kept so that the facility does not trip the 60 DCOH requirement (as noted in the table above, DCOH at Feb 28, 2023, was ~68.5 days when including internally designated funds)
- Accounts Receivable (A/R): Days in A/R is ~60 days. A primary driver is the growth of Medicare Advantage (MA) plans in their payer mix; leadership reported that MA plans tend to initially deny almost all claims, requiring significant time and expense of follow-up to ultimately receive reimbursement

3 *Labor Challenges*

- Arkansas Methodist has lost several employed providers recently, including multiple family practitioners, a urologist, an orthopedic surgeon, and a general surgeon. They have been struggling to fill these key roles
- The hospital has not been able to keep up with local competition on hourly wages for entry-level positions

4 *Technology Challenges*[21]

- Following a cybersecurity incident three years ago, the hospital has made significant investments in cybersecurity
- The Electronic Medical Record (EMR) used for inpatient services lacks the flexibility and range of function that hospital leadership would like to have

5 *Sustainability Plan*

[21] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- The hospital has identified numerous initiatives to decrease costs across the organization and is making progress on many of them. Absent from the sustainability plan are initiatives to grow the business or increase revenues; the plan is focused exclusively on cost-cutting

6

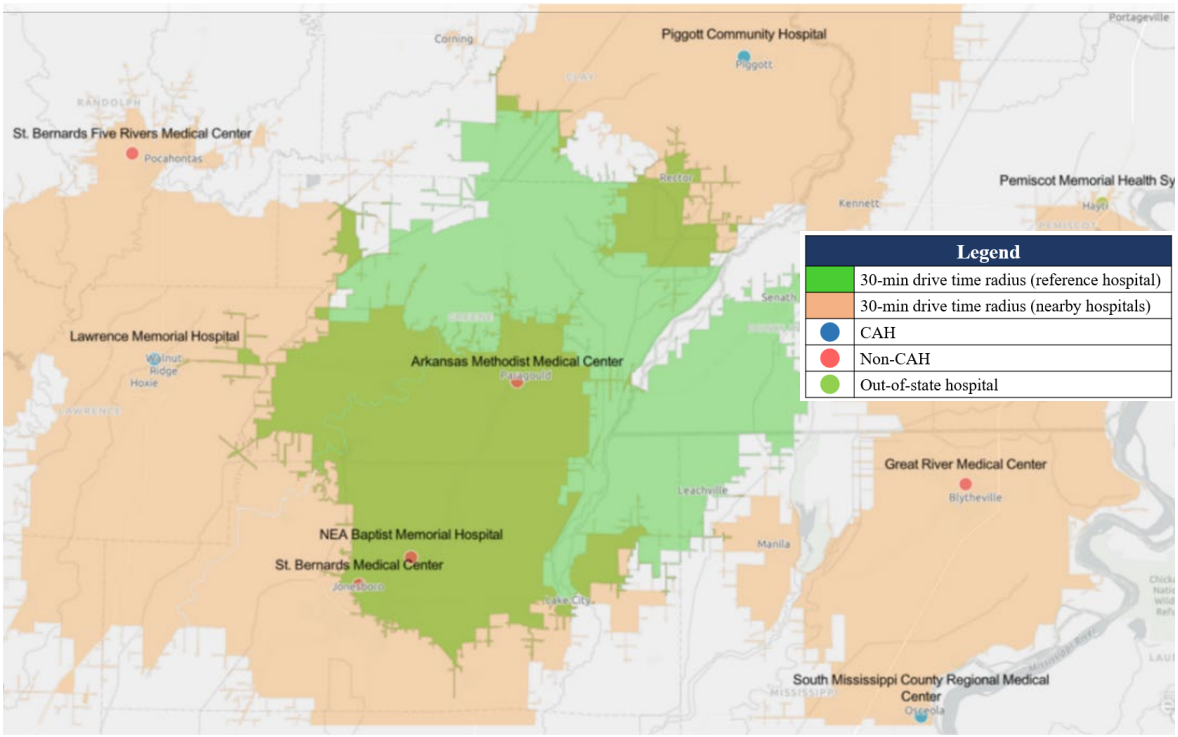
Physical Plant

- Several critical pieces of infrastructure need investment:
    - Roofs over the MRI/Cath Lab, ICU, and Med/Surg wings require replacement as soon as financially possible. The cost of continuously patching leaks and replacing water-damaged ceiling tiles has become a significant drain
    - The facility has two chillers and two chiller towers, both of which are required to cool the facility in peak heat; both chiller towers are leaking significant amounts of water and nearing end of life
    - The transfer switch for several important but non-Life Safety systems must be manually operated by hospital staff in the event of a power outage

Drive Time Assessment - Alternatives in the Surrounding Community

An estimated population of 200,258 is located within a 30-mile radius of Arkansas Methodist.[22] The three closest alternative hospitals are on average 21 miles away: St. Bernards Medical Center and NEA Baptist Memorial Hospital are 18.7 and 19.6 miles, respectively, to the southwest in neighboring Craighead County; and Lawrence Memorial is 26.3 miles to the west in Lawrence County. Additional alternatives which lie beyond a 30-minute drive include Piggott Community Hospital to the north and Great River Medical Center to the east.

Figure 8: Arkansas Methodist's Drive Time Assessment



Observations Related to Operational Outlook

The YTD acute average length of stay was 3.9 days, and the YTD acute average daily census was 28.8. Total average daily census (ADC) for the facility was 40.3 (inclusive of swing bed, rehab, and observation stays), while the occupancy rate for FY23 was 31%.

For comparison, the national benchmark average length of stay (ALOS) for non-CAH facilities is 5.4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%.[23]

[22] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.
[23] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

From Sept 2022 – Feb 2023, Arkansas Methodist reported 4,444 inpatient discharges[24] on an annualized basis, with a YTD adjustment factor of 3.00,[25] resulting in total adjusted discharges of 13,311.

Total inpatient days on an annualized basis were 14,892, with adjusted patient days of 44,604.

As of January 2023, Arkansas Methodist had 674 full-time employees (FTEs), of which 492 were clinically related. This leads to just over 5 FTEs for each adjusted occupied bed. The state benchmark for FTEs per adjusted occupied bed was 4.6-5.72.[26] Labor cost per net patient revenue was 58% for fiscal year 2023 to date, compared to the benchmark of 50% – 60% for rural non-CAHs.[27]

Table 3: Arkansas Methodist's Operational Indicators

Key Indicators - Operational Outlook	
(Sept 2022 - Feb 2023 Annualized; YTD Figures from July 2022 - Feb 2023)	
Total Inpatient Discharges	4,444
Adjustment Factor (YTD)	3.0
Total Adjusted Discharges	13,311
Hospital Patient Days	14,892
Adjusted Patient Days	44,604
Average Daily Census YTD	40.3
Acute Average Length of Stay	3.9
Emergency Department Visits	21,628
Occupancy Rate	31%
Total FTEs (Jan 2023)	674
Total CFTEs (Jan 2023)	492
Medicare Case Mix Index (YTD)	1.53
Labor Cost / Net Patient Revenue	58%
FTEs per each adjusted occupied bed	5.6

Observations Related to Current Fiscal Condition

The below assessment and observations related to the current fiscal condition are based on the latest data received from Arkansas Methodist leadership, which is as of February 2023. As of February 2023, the hospital's cash and cash equivalents was $13.8M, which includes $10.1M of internally restricted liquid assets. These restricted assets are helping Arkansas Methodist ensure they do not trip their remaining debt covenant, as outlined further below. Daily expenditures range for the most recent 6-month period were $202k, resulting in a calculated 68.5 days cash on hand (COH) as of February 2023.

Table 4: Arkansas Methodist's Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	13,831,957
Inventory and Prepaid Expenses	$	2,945,525
Current Assets	$	31,425,443
Total Assets	$	56,270,445
Current Liabilities	$	4,109,688
Total Long-Term Debt	$	13,636,800
Total Liabilities	$	17,746,488
Net Position	$	38,523,957
Daily Expenditures	$	202,035
Days Cash on Hand		68.5
Quick Ratio		6.9
Current Ratio		7.65
Debt Service Coverage Ratio		(5.62)
Average Age of Plant		22.20
Days in Net Accounts Receivable		60.00
Debt to Operating Revenue		19%

Cash Position

As discussed above, COH as of February 2023 is 68.5 days. The average period to collect patient accounts receivable (A/R) for the same period was 60 days. Arkansas Methodist does not regularly produce cash flow statements, and as such we do not have cash flow information for any period since the end of the hospital's 2022 fiscal year in June 2023.

[24] Arkansas Methodist provided only inpatient admissions and not discharge data. Admissions have been used as a proxy for discharges throughout this section.

[25] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue.

[26] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

[27] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Debt

Arkansas Methodist's current debt profile is primarily made up of two notes payable with a regional bank. The notes totaled roughly $13.8M as of June 2022 and both include covenants related to minimum debt service coverage ratios and cash on hand requirements. Per hospital leadership, the hospital has not tripped the 60 days cash on hand covenants but is out of compliance with the debt service coverage ratio requirements. While the hospital is out of compliance, the regional bank has the option to either accelerate repayments or recall the loans in whole. The bank has previously waived prior year breaches of the covenants but has declined to provide an ongoing waiver for future periods. The note payable that constitutes the majority of this debt matures in August 2023, and the remainder matures in October 2024, both with sizeable balloon payments (or the need to refinance the remaining principal) due at maturity. The bank has not made clear its willingness to refinance the remaining loan principle as these notes mature.

Revenue

Comparing the prior fiscal year results against numbers annualizing the six months of financials ending February 2023, Arkansas Methodist has had a slight 2% decrease in Net Patient Service Revenue (NPSR), and a more marked 24% decrease in other operating revenues. Supplemental funding is outlined in Table 5.

Table 5: Arkansas Methodist's Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 70,236,885	$ 68,706,872	-2%
Other Revenue	$ 2,440,126	$ 1,846,883	-24%
Total Revenue	**$ 72,677,011**	**$ 70,553,755**	**-3%**
Salaries, Wages & Benefits (SWB) Expense	$ 45,396,991	$ 40,083,508	-12%
Supplies Expense	$ 11,363,237	$ 11,205,658	-1%
Other Operating Expense	$ 18,288,268	$ 21,798,768	19%
EBITDA	**$ (2,371,485)**	**$ (2,534,180)**	**-7%**
Depreciation Expense	$ 3,434,116	$ 3,108,539	-9%
Operating Income	**$ (5,805,601)**	**$ (5,642,718)**	**3%**
Non-Operating Income (Expense)	$ 3,617,474	$ (71,678)	-102%
Net Income	**$ (2,188,127)**	**$ (5,714,396)**	**-161%**
Operating Margin	-8%	-8%	0%
NPSR / Adj Discharge		$ 8,559	
Expense / Adj Discharge		$ 9,492	

**Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

Arkansas Methodist has reduced salaries, wages, and other benefits (SWB) moderately between the end of fiscal year 2022 and the months ending January 2023. Those savings are partially offset by increases in

other non-SWB expenses, resulting in a net 3% reduction in total operating expenses. The hospital's operating margin has held steady at -8% in both the prior and current period.

Supplemental Funding

Arkansas Methodist has previously received supplemental funding from federal sources totaling roughly $19M from FY2020 through FY2022. The amounts of those funds that were recognized in fiscal year 2021 and 2022 are broken out by source in the table below.

Table 6: Arkansas Methodist's Supplemental Funding

Supplemental Funding		
CARES Act Provider Relief Fund	$	12,226,000
CARES Act (CRF)		1,700,000
American Rescue Plan Act		5,162,000
Total	**$**	**19,088,000**

Break-Even Analysis

A break-even analysis was performed using a trailing six-month annualization of Arkansas Methodist's income statement. As flagged in *Table 7*, their annualized net income is ($5.7M), implying that the hospital will lose just under $8.6M of funds over the next 18 months. The currently quantified sustainability plan, if all anticipated dollars are achieved, has a potential impact of ~$5.4M.

Table 7: Arkansas Methodist's Break-even Analysis

Arkansas Methodist Income Statement	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Breakeven Over the Last 2 Quarters	12-Month Total	18-Month Total
Net patient service revenue	$ 5,172,610	$ 5,099,835	$ 5,422,968	$ 6,798,735	$ 5,888,939	$ 5,970,349	$ 34,353,436	$ 68,706,872	$ 103,060,308
Other Operating Revenues	153,240	155,966	133,669	146,115	184,329	150,123	923,441	1,846,883	2,770,324
Total Operating Revenue	5,325,850	5,255,801	5,556,637	6,944,850	6,073,268	6,120,471	35,276,877	70,553,755	105,830,632
Salaries, Wages, Benefits and Payroll Taxes	3,518,396	3,576,453	2,966,967	3,490,599	3,339,250	3,150,089	20,041,754	40,083,508	60,125,262
Supplies	904,131	690,242	912,491	1,171,870	1,034,560	889,535	5,602,829	11,205,658	16,808,487
Total Operating Expenses Less D&A	6,059,093	6,141,440	5,837,819	6,483,927	6,319,396	5,702,292	36,543,967	73,087,935	109,631,902
EBIDA	**$ (733,243)**	**$ (885,639)**	**$ (281,182)**	**$ 460,923**	**$ (246,128)**	**$ 418,179**	**$ (1,267,090)**	**$ (2,534,180)**	**$ (3,801,270)**
Depreciation	264,667	262,342	261,414	258,627	255,048	252,172	1,554,269	3,108,539	4,662,808
Total Operating Expenses	6,323,760	6,403,782	6,099,233	6,742,554	6,574,443	5,954,464	38,098,237	76,196,473	114,294,710
Operating Income (Loss)	**$ (997,910)**	**$ (1,147,981)**	**$ (542,596)**	**$ 202,296**	**$ (501,175)**	**$ 166,007**	**$ (2,821,359)**	**$ (5,642,718)**	**$ (8,464,077)**
Interest	55,961	53,855	55,327	53,261	54,703	54,380	327,487	654,974	982,461
Non-Operating Revenues (Expenses)	(520,828)	280,846	249,896	(272,534)	315,515	(88,734)	(35,839)	(71,678)	(107,517)
Net Income (Loss)	**$ (1,518,738)**	**$ (867,135)**	**$ (292,700)**	**$ (70,238)**	**$ (185,660)**	**$ 77,273**	**$ (2,857,198)**	**$ (5,714,396)**	**$ (8,571,595)**

Capital Considerations

The original building that Arkansas Methodist currently occupies was built in the 1940s and has been added to over time—most recently in 2000. The average age of the hospital's physical plant is 22.2 years, and many components need capital investment. Arkansas Methodist has three boilers, two of which are smaller than the third and all of which are required to keep the hospital warm during winter months, meaning the failure of any of the three during a cold spell would meaningfully disrupt hospital operations. In peak summertime heat, both of the hospital's two chillers are required to keep the hospital sufficiently cool, which poses a risk similar to that of the boilers—failure of either chiller would meaningfully disrupt operations. The two chiller towers on the roof are both leaking and in need of repair or replacement, and many of the air handlers across the facility need repair or maintenance. As a result of these environmental management issues, two of the hospital's six operating rooms are currently out of use because they cannot maintain adequate temperature and humidity levels. Several other areas of the hospital are also in disuse as a result of declining patient volumes, lack of staffing, and/or physical plant issues. The hospital has multiple

roofs in need of repair, including the roofs over the med/surg and ICU units. Hospital leadership is aware of these capital investment needs but does not currently have sufficient funds to address them.

Sustainability Plan

Arkansas Methodist has a multi-point sustainability plan with many initiatives either fully implemented or in process. Most of the initiatives are reductions in expense, such as reducing total FTEs and improving the efficiency of their staffing process. In total, the hospital forecasts roughly $5.4M in cost savings or revenue enhancements annually, $3.5M of which have been implemented over the past several months. This annual run rate of $5.4M is nearly enough to offset the $5.7M of annual losses described in the break-even analysis above.[28]

Table 8: Arkansas Methodist's Sustainability Plan Summary

Arkansas Methodist Sustainability Plan Summary	Financial Impact		
	Action Complete	Action Pending	Total
Revenue Enhancement:			
Rate increase for assisted living facility	$ -	$ 183,801	$ 183,801
Improve productivity and increase clinic revenues	-	303,673	303,673
Fixed investment earnings on internally restricted reserve funds	293,337	-	293,337
Reduce % of patients that leave without any treatment (LWAT) to 3%	$ 308,000	$ 22,000	330,000
TOTAL REVENUE ENHANCEMENTS IMPACT	**601,337**	**509,474**	**1,110,811**
Expense Reduction:			
Terminate badge tap contract	30,000	-	30,000
Eliminate 1 CRNA position	249,996	-	249,996
Reduce unnecessary overtime costs	193,200	646,800	840,000
Eliminate 40 FTEs	654,951	684,722	1,339,673
Change third-party hospitalist provider	240,000	-	240,000
Consolidate Wellness and Physical Therapy units	-	41,667	41,667
Eliminate travel spend	47,664	12,336	60,000
Terminate surgery locums	424,875	-	424,875
Terminate urology locums	613,767	-	613,767
Increase employee portion of monthly health insurance premium	120,000	-	120,000
Switch ERM provider	238,127	-	238,127
Reduce physician expenses	80,000	-	80,000
TOTAL EXPENSE REDUCTION IMPACT	**2,892,580**	**1,385,524**	**4,278,104**
TOTAL IMPACT	**3,493,917**	**1,894,998**	**5,388,915**

Revenue Enhancements

- Rate increase for assisted living facility:
  - Arkansas Methodist operates an assisted living facility and is considering increasing rates by 10%. This item is not yet implemented in part because the hospital is uncertain whether a rate increase would cause attrition and drive down net revenues
- Improve productivity and increase clinic revenues:
  - This item is not yet implemented. Arkansas Methodist hopes it can increase clinic productivity and revenues by, among other items, reducing the time physicians spend away from the clinic and ensuring more prompt and accurate chart completions
- Fixed investment earnings on internally restricted reserve funds:
  - Arkansas Methodist has moved some of its liquid assets – those that are not currently being used to fund operations – into conservative bond and equity investments, resulting in an increase in revenues as dividends and bond payments are received

[28] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

- Reduce the portion of patients who leave without any treatment (LWAT):
    - Patients who go the hospital and leave without receiving any treatment whatsoever represent poor outcomes for those patients who elect to not be treated, as well as unrealized potential revenues. By decreasing the share of such patients the hospital can increase its annual revenue. This item is partially implemented—LWATs have moved from 6% to 3.8%. The figures in the sustainability plan summary table above represent the expected revenue from further decreasing this figure to 3.0%, and hospital leadership believes it may be possible to get it as low as 2.0%

Expense Reductions

- Terminate badge tap contract:
    - Arkansas Methodist has cancelled its contract with the vendor that was providing badge tap functionality to staff
- Eliminate one certified registered nurse anesthetist (CRNA) position:
    - The hospital has opted to not fill a CRNA position that became vacant in November 2022. Hospital leadership stated that there were sufficient CRNAs remaining to cover the volume of patients the hospital is currently experiencing
- Reduce unnecessary overtime costs:
    - Although it is still less expensive than using travel nurses, overtime costs impact sustainability. Arkansas Methodist has implemented a system that requires written justification of overtime hours and subjects overtime requests to a higher level of scrutiny. To date, the hospital has achieved roughly 30% of its goal in this area
- Eliminate 40 FTEs:
    - Arkansas Methodist plans to reduce costs by eliminating 40 FTEs across both clinical and non-clinical staff. The hospital hopes to achieve this goal through attrition and has eliminated 13 FTEs by that mechanism so far
- Change third-party hospitalist provider:
    - The hospital has begun working with a new hospitalist provider at a lower cost than their current provider. Hospital leadership believes the new hospitalist will also be able to increase admissions volume and revenues
- Consolidate wellness and physical therapy units:
    - Arkansas Methodist's wellness services have seen reduced volume as other providers have come to the area. Through the early 2000s there were generally 1,500 members in the program—a number that has since dwindled to about 400. The hospital plans to fold wellness into existing physical therapy services
- Eliminate travel spend:
    - The hospital has halted all non-essential travel, such as attending conferences
- Terminate surgery locum tenens:
    - Arkansas Methodist has eliminated the surgery locum tenens position that it was previously maintaining. Hospital leadership anticipates that the two remaining surgeons will be able to absorb the patient volume that was being handled by the locum tenens
- Terminate urology locum tenens:

    - Urology has been an area where the revenues received cannot make up for the cost of providing services. As a result, the hospital has let go of the urology locum tenens position
- Increase employee portion of monthly health insurance premium:
    - Arkansas Methodist is shifting a portion of health insurance costs to employees by increasing the monthly employee health insurance premium by $25
- Switch Electronic Medical Record (EMR) providers:
    - The hospital has decided to change its EMR to a provider with lower costs than the current EMR provider. The contract has been signed but net savings will not begin to be realized until August of 2023 in the best-case scenario (in the worst-case scenario, net savings realization timeline is significantly pushed out by collections delays precipitated by the EMR transition)
- Reduce physician expenses:
    - Arkansas Methodist is working to reduce its spend on physicians through contract changes or terminations

Baxter Regional Medical Center

Quick Facts

- Classification: Non-CAH
- Licensed Beds: 268
- Closest Facility: 21.06 miles
- Average Age of Plant: 15.6 years
- Average Daily Patient Occupancy Rate: 48.8%
- Average length of stay (ALOS): 3.7 days
- Total full-time employees (FTEs): 1,601

Location: Mountain Home, Baxter County
County Population: 42,144 (2021)

Table 9: Baxter's Summary Statistics

Operating Statistics		
C&C Equivalents	$	64.3 M
Current Assets	$	107.9 M
Net A/R	$	27.2 M
Total Assets	$	189.4 M
Days Cash on Hand		82.85
Quick Ratio		2.41
Current Ratio		2.75
Debt Service Coverage Ratio		1.83
Days in Net AR		34.12
Average Age of Plant		15.60
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	289.0 M
Other Revenue	$	15.6 M
Total Revenue	$	304.5 M
Salaries, Wages & Benefits	$	149.8 M
EBITDA	$	22.9 M
Operating Income	$	11.6 M
Non-Operating Income/(Expense)	$	(4.5 M)
Net Income	$	7.1 M
Operating Margin %		4%

Key Challenges

- Baxter Regional has faced significant labor challenges during the pandemic, although in recent months the hospital has made progress in mitigating those challenges.

1 *Patient Volume Trends*

- Baxter Regional has an acute average daily census (ADC) of 100, a total ADC of 130.9, and did not report issues with decreasing patient volumes during our review

2 *Financial Status*

- As of February 2023, Baxter Regional has $6.0M of cash-on-hand and a restricted $58.3M "funded depreciation" account that is held in liquid assets but would require board approval to use for any purpose other than capital expenditures. Excluding the restricted account, days-cash-on-hand is 7.7 and quick ratio is .93. Including the restricted account, the figures are 82.8 days and a quick ratio of 2.4

3 *Labor Challenges*

- Baxter Regional's use of travel nurses during the pandemic peaked at 60 nurses in March 2022. As of end of January 2023 that number is down to 15 and hospital leadership hopes to further reduce it below ten. The prevailing hourly rate for travel nurses has also come down from a peak of $160 per hour to $120 per hour. The hospital has raised entry-level wages through the pandemic in order to remain competitive with other businesses in the area

4 *Technology Challenges*[29]

- Baxter Regional did not report any major IT challenges

5 *Sustainability Plan*

- Baxter Regional has 40 locations serving residents from 11 counties and is intent on continuing to grow its footprint. A new building to house oncology services was recently completed and the hospital will begin using it once the back-ordered linear accelerator is delivered in several months
- In the last two years, the hospital has added 26 new providers and intends to add three more before the end of their FY in June. The hospital has numerous other initiatives that are planned or in process to decrease costs and increase revenues/footprint

6 *Physical Plant*

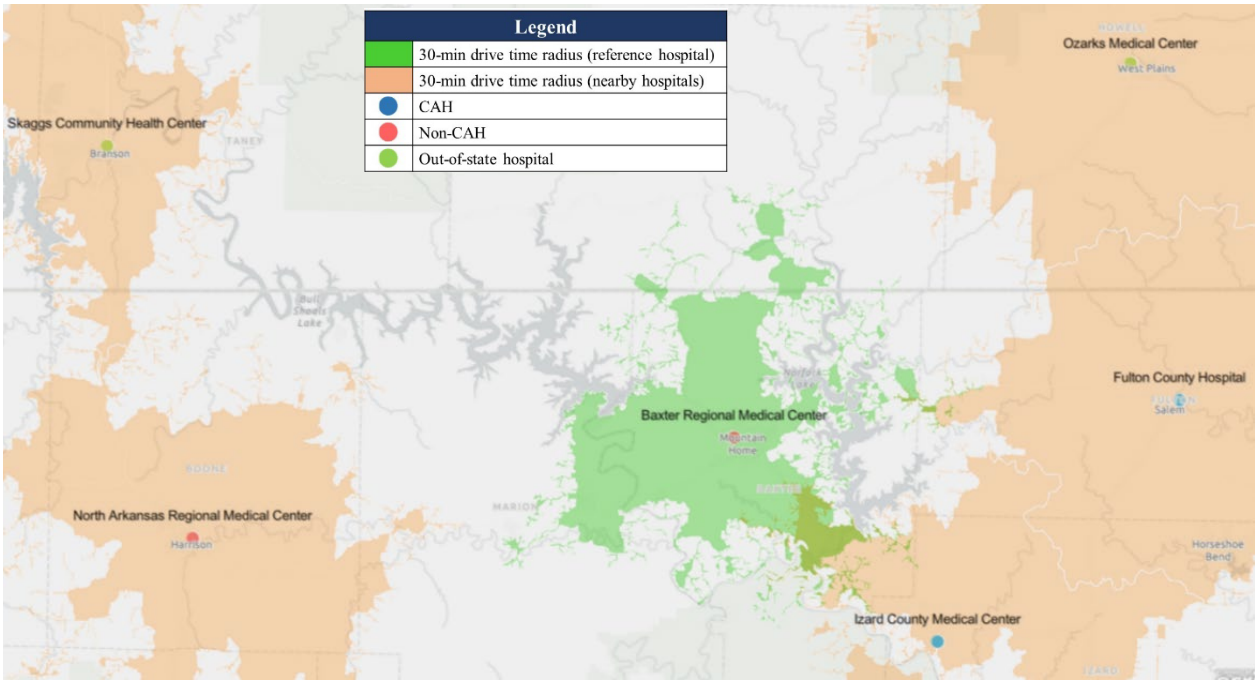
- Overall, the hospital's facilities are in average shape, and the hospital has maintained the restricted "funded depreciation" account in order to finance needed capital expenditures. One issue is that the hospital's chillers are not currently connected to the emergency power system, and the hospital is in the process of replacing several older generators with new, larger generators that will be able to also support the chillers in the event of a power outage

[29] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

Drive Time Assessment - Alternatives in the Surrounding Community

A population estimated at 67,915 is located within a 30-mile radius of Baxter Regional.[30] The three closest alternative hospitals to Baxter Regional are on average 21 miles away: Izard County Medical Center is 34 miles to the southeast in neighboring Izard County; Ozarks Medical Center is 40 miles to the northeast in the State of Missouri; and North Arkansas Regional Medical Center is 41 miles to the west in Boone County. Izard County is a CAH, and Ozarks Medical and North Arkansas Regional are more than an hour by car.

Figure 9: Baxter's Drive Time Assessment



Observations Related to Operational Outlook

The FY22 acute average length of stay (ALOS) was 3.7 days and the average daily census (ADC) for acute care was 100, up from 93 in FY21.[31] The occupancy rate for the FY22 was 48.8%.

For comparison, the national benchmark average LOS for non-CAH facilities is 5.4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals

[30] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.
[31] Baxter Regional also provides rehabilitation and adult behavioral health inpatient services. The FY22 ADCs of those areas were 17.4 and 9.5, respectively.

in Arkansas, in 2016, average occupancy rates hovered around 30%.[32] Baxter had both a lower ALOS than the benchmark and a higher occupancy rate than most Arkansas hospitals did in 2016.

In fiscal year 2022, Baxter Regional reported 9,859 inpatient discharges with an adjustment factor of 3.0 resulting in total adjusted discharges of 29,352. Total acute care patient days in that year were 36,517, beating the hospital's forecast by just under 3,000 and indicating an increase of 7.7% over the prior year's results.

As of December 2022, Baxter Regional employed 1,601 full time employees (FTEs), of which 1,301 were direct patient care related ("clinical" FTEs or CFTEs). FTEs per each adjusted occupied bed (also called "FTEs per adjusted ADC") was 4.1, just under the state benchmark of 4.6–5.72 FTEs per adjusted ADC.[33] Labor cost as a percent of net patient revenue was ~52% compared to the benchmark of 50% - 60% for rural non-CAHs.[34] That Baxter is on the low-end of labor cost as a percent of net patient revenues and below the benchmark for FTEs per adjusted occupied bed indicates that the hospital is deploying its staff resources efficiently.

Observations Related to Current Fiscal Condition

The assessment and observations below are based on analysis of the latest financial data received from Baxter Regional's leadership, which is as of February 2023.

Table 10: Baxter's Operational Indicators

Key Indicators - Operational Outlook	
(Sep. 2022 - Feb. 2023 Annualized)	
Total Acute Discharges	9,859
Adjustment Factor	3.0
Total Acute Adjusted Discharges	29,352
Acute Hospital Patient Days	36,517
Acute Adjusted Patient Days	108,716
Acute Average Daily Census	100.0
Total Average Daily Census	130.9
Average Length of Stay (YTD)	3.7
Emergency Department Visits	33783
Occupancy Rate	48.8%
Total FTEs	1,601
Total CFTEs	1,301
Case Mix Index (if available)	N/A
Labor Cost / Net Patient Revenue	52%
FTEs per each Adjusted Occupied Bed	4.1

Table 11: Baxter's Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	64,303,184
Inventory and Prepaid Expenses	$	13,215,199
Current Assets	$	107,900,312
Total Assets	$	189,368,745
Current Liabilities	$	39,223,653
Total Long-Term Debt	$	40,315,721
Total Liabilities	$	81,539,159
Net Position	$	107,829,586
Daily Expenditures	$	776,148
Days Cash on Hand		82.9
Quick Ratio		2.4
Current Ratio		2.75
Debt Service Coverage Ratio		1.83
Average Age of Plant		15.60
Days in Net Accounts Receivable		34.12
Debt to Operating Revenue		13%

[32] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

[33] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

[34] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Cash Position

As of February 2023, the hospital's cash and cash equivalents was $64.3M including $58.3M of liquid funds internally designated as "funded depreciation" to be used for investment in the hospital's physical plant. Daily expenditures for the 6-month period ending in February 2023 were, on average, $776k, indicating that Baxter Regional had roughly 83 days of cash on hand at the end of February. The average days in net accounts receivable for the time period was 34.1, indicating robust revenue cycle management (RCM). A cash flow runout analysis was conducted based on data received from September 2022 through February 2023. As seen in the table below**,** cash flows vary month to month, with certain months showing high outflows and other showing inflows. It is also important to note that the $58M in funded depreciation does not flow through the facility's cash flow statements.

Table 12: Baxter's Cash Flow Runout

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Beginning Balance	$ 6,589,749	$ 8,918,474	$ 6,516,792	$ 5,245,274	$ 7,664,885	$ 3,051,572
Patient Receipts[1]	24,873,003	22,228,010	22,907,281	25,898,751	20,650,209	23,879,048
Other	1,457,389	1,427,691	3,385,104	2,038,271	4,346,385	1,460,558
Total Receipts	26,330,392	23,655,701	26,292,385	27,937,022	24,996,594	25,339,606
Total Disbursements	24,001,667	26,057,383	27,563,904	25,517,411	29,609,907	22,390,398
Net Increase (Decrease)	2,328,725	(2,401,682)	(1,271,519)	2,419,611	(4,613,313)	2,949,208
Ending Balance	$ 8,918,474	$ 6,516,792	$ 5,245,274	$ 7,664,885	$ 3,051,572	$ 6,000,780

Notes:
(1) December patient receipts have been adjusted from the initial data submission to reflect more recent figures

Debt

The primary component of Baxter Regional's current debt profile consists of hospital revenue bonds originated in 2016 in an original amount of $45M. The remaining portion of the hospital's $40.3M of long-term debt as February 2023 is composed of various notes and lines of credit that were used to fund capital investments. Baxter Regional has a debt to operating ratio of 13% and a debt service coverage ratio of 3.07 as of February 2023.

Revenue

For the sixth-month period from September 2022 through February 2023, Baxter Regional achieved an annualized net patient service revenue (NPSR) of almost $289M and other revenues of $15.6M. These figures — 6% and 27% growth over FY 2021,[35] respectively — represent Baxter Regional's growing footprint: The hospital added nine new physicians in 2022 and six new providers in the first months of 2023. The gains in NPSR and non-NPSR operating income drove a 156% increase in operating income from fiscal year 2021 to the annualized six-month period ending February 2023. An important note is that Baxter Regional has recognized all COVID-19 related stimulus funding as part of "other operating revenues," and so fluctuations in this category may be due to differences in recognized amounts year-over-year.

[35]Baxter Regional's fiscal year ends December 31st and the hospital's fiscal 2022 results were not yet available as of the time of this report. As such, the prior fiscal year results used in this section are based on fiscal 2021 data.

Table 13: Baxter's Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 273,408,457	$ 288,974,450	6%
Other Revenue	$ 12,247,758	$ 15,563,912	27%
Total Revenue	**$ 285,656,215**	**$ 304,538,362**	**7%**
Salaries, Wages & Benefits (SWB) Expense	$ 145,832,172	$ 149,838,064	3%
Supplies Expense	$ 104,719,656	$ 73,938,024	-29%
Other Operating Expense	$ 17,973,423	$ 57,905,226	222%
EBITDA	**$ 17,130,964**	**$ 22,857,048**	**33%**
Depreciation Expense	$ 12,598,615	$ 11,245,690	-11%
Operating Income	**$ 4,532,349**	**$ 11,611,358**	**156%**
Non-Operating Income (Expense)	$ 10,318,580	$ (4,497,402)	-144%
Net Income	**$ 14,850,929**	**$ 7,113,956**	**-52%**
Operating Margin	2%	4%	140%
NPSR / Adj Discharge		$ 9,845	
Expense / Adj Discharge		$ 9,980	

**Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

Baxter Regional's spend related to salaries, wages, and benefits (SWB) grew modestly from fiscal 2021 to the six months ending February 2023. Two factors contributing to that modest growth were offsetting developments: A decrease in the use of travel nurses, which are more expensive than directly employed staff, and increases in staff wages to keep pace with rising wages in the local market.

Supplemental Funding

Baxter Regional has previously received supplemental funding during the pandemic in the form of both federal dollars and state dollars. The table below summarizes the significant supplemental funding that was received.

Table 14: Baxter's Supplemental Funding

Supplemental Funding	Total Amount Received
Federal Sources	$ 31,480,027
State of Arkansas Cares Support	$ 6,501,005
FEMA (Received 2022)	$ 1,413,225
Arkansas Economic Development	$ 600,000
Arkansas Direct Worker Grant	$ 991,650
Other	$ 141,001
Total	**$ 41,126,908**

Break-Even Analysis

Based on the trailing six months of financial data, the break-even analysis table below shows that Baxter Regional is now on track to break-even over the annualized period of Sept. 2022 through Feb. 2023. This achievement is a testament to the organization's recognition halfway through 2022 that the current operating picture was not sustainable, and that they needed to begin to move in a different direction. Since July 2022, Baxter Regional has taken numerous steps to shore up their financial position and looks to continue to find ways to improve and better serve the community.

Table 15: Baxter's Break-even Analysis

Baxter Income Statement	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Breakeven Over the Last 2 Quarters	12-Month Total	18-Month Total
Net patient service revenue	$ 25,246,938	$ 24,393,700	$ 23,293,976	$ 26,003,586	$ 23,158,107	$ 22,390,918	$ 144,487,225	$ 288,974,450	$ 433,461,675
Other Operating Revenues	1,490,977	1,750,370	2,894,699	4,269,655	614,086	677,350	11,697,137	15,563,912	19,430,687
Total Operating Revenue	26,737,915	26,144,070	26,188,675	30,273,241	23,772,193	23,068,268	156,184,362	304,538,362	452,892,362
Salaries, Wages, Benefits and Payroll Taxes	12,103,462	13,277,348	12,013,061	13,189,378	12,672,170	11,663,613	74,919,032	149,838,064	224,757,096
Supplies	6,246,842	6,696,681	6,660,082	5,621,465	5,519,056	6,224,886	36,969,012	73,938,024	110,907,036
Total Operating Expenses Less D&A	23,209,878	24,460,481	23,500,118	23,870,893	23,107,344	22,691,943	140,840,657	281,681,314	422,521,971
EBIDA	**$ 3,528,037**	**$ 1,683,589**	**$ 2,688,557**	**$ 6,402,348**	**$ 664,849**	**$ 376,325**	**$ 15,343,705**	**$ 22,857,048**	**$ 30,370,391**
Depreciation	955,856	948,057	941,274	924,621	931,063	921,974	5,622,845	11,245,690	16,868,535
Total Operating Expenses	24,165,734	25,408,538	24,441,392	24,795,514	24,038,407	23,613,917	146,463,502	292,927,004	439,390,506
Operating Income (Loss)	**$ 2,572,181**	**$ 735,532**	**$ 1,747,283**	**$ 5,477,727**	**$ (266,214)**	**$ (545,649)**	**$ 9,720,860**	**$ 11,611,358**	**$ 13,501,856**
Interest	140,239	138,500	138,920	137,187	126,090	125,415	806,351	1,612,702	2,419,053
Non-Operating Revenues (Expenses)	(5,097,654)	2,620,939	1,971,748	(2,059,396)	2,375,082	(2,059,420)	(2,248,701)	(4,497,402)	(6,746,103)
Net Income (Loss)	**$ (2,525,473)**	**$ 3,356,471**	**$ 3,719,031**	**$ 3,418,331**	**$ 2,108,868**	**$ (2,605,069)**	**$ 7,472,159**	**$ 7,113,956**	**$ 6,755,753**

Capital Considerations

Baxter Regional has an average age of physical plant of 15.6 years. The hospital's facilities and equipment are relatively well-maintained but there are several areas that need or could benefit from ~$6M of additional capital investment within the current fiscal year. A top item on the list is upgrading the facility's emergency generators. Currently some of the equipment responsible for cooling the hospital during hot weather are not connected to the generators, meaning that in the event there is a power outage on a hot summer day the hospital would not be able to keep the indoor environment sufficiently cool. Baxter Regional has budgeted $1.7M for generator upgrades that will be made during the 2023 and 2024 fiscal years. Other capital investment items budgeted for fiscal 2023 include $2M for remodeling and updating the emergency department, $600k for installing a new fire panel in the boiler area, and $1M for updating or replacing some parts of the hospital's IT infrastructure and servers.

There are a number of other capital investments planned over a 12 to 24-month timeframe depending on availability of funds. These include updating and maintaining air handlers and the roofs of several of the hospital's buildings, renovation and expansion of the women's clinic, radiology equipment upgrades or replacements, and renovations to the cardiovascular intensive care unit (CVICU). In total the 12 to 24-month capital items total $29.5M. There are roughly 20 bigger ticket investments that Baxter Regional will eventually need to make in the two to five-year time horizon. Those longer-term purchases include maintenance of the hospital's helipad, equipment for multiple areas such as endoscopy and central sterile, and replacement of six ambulances that are nearing end of life. In total these longer timeframe items are estimated to cost Baxter Regional a total of $50.5M.

Upcoming Obligations

Outside of the items discussed above in "*Debt*" and "*Capital Considerations*", Baxter Regional has no major upcoming obligations.

Sustainability Plan

Baxter Regional has identified several opportunities to increase revenues and cut costs. A majority of these initiatives had been implemented by early March 2023, although many of the changes will take time for their full effect to flow through to the hospital's bottom line.[36] *Table 16* is a breakdown of many of Baxter Regional's sustainability initiatives.

Table 16: Baxter's Sustainability Plan

Baxter Regional Medical Center Sustainability Plan	Financial Impact		
	Action Complete	Action Pending	Total
Revenue Enhancement:			
Invest in hospital growth (various, see narrative below)	$ 2,300,000	$ 2,300,000	$ 4,600,000
Use 340(b) program for home infusion contract pharmacy		850,000	850,000
Increase reimbursement rates (various, see narrative below)	4,114,000		4,114,000
Continue growth in population health management	1,398,000		1,398,000
RCM improvements in hospital and clinics	1,158,000		1,158,000
TOTAL REVENUE ENHANCEMENTS IMPACT	**8,970,000**	**3,150,000**	**12,120,000**
Expense Reduction:			
Reduce travelers from high of 60 to fewer than 10	$ 6,000,000	$ 666,667	$ 6,666,667
Discontinue the Community Paramedic Program	256,000		256,000
Curtail non-critical capital expenditures	9,000,000		9,000,000
Changes and reductions to employee benefits	325,000		325,000
Expand use of 340(b) pharmacy discount program	300,000		300,000
Improve department processes for flexing staff hours	*Impact Unknown*		*Impact Unknown*
Change RN/LPN mix to a higher LPN ratio	275,000		275,000
Change EMT/Paramedic mix to higher EMT ratio	120,000		120,000
Reduce staff turnover rates	*Impact Unknown*		*Impact Unknown*
Reduce supply costs (various, see narrative below)	1,245,000		1,245,000
Start new, more efficient LPN and CAN residency program	145,000		145,000
Expand LPN program so students start in high school	*Impact Unknown*		*Impact Unknown*
TOTAL EXPENSE REDUCTION IMPACT	**17,666,000**	**666,667**	**18,332,667**
TOTAL IMPACT	**26,636,000**	**3,816,667**	**30,452,667**

Revenue Enhancements

- Invest in hospital growth:
  - Baxter Regional aims to grow service volume by signing new providers and broadening the range of services provided
  - The hospital added 20 providers during FY 2021 and 2022. To date in 2023, Baxter Regional has added six providers and intends to hire three more by the end of the year
  - The hospital intends to grow its cardiac catheterization lab and cardiovascular surgery volume through signing a new cardiologist, having existing cardiologists assist more with clinic work, and expanding the range of existing service lines to include additional procedures (TAVR [percutaneous aortic valve replacement] and Watchman procedures)
  - Baxter Regional is expanding its diagnostic capabilities with the addition of two nuclear cameras and a new echo echocardiography machine

[36] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

    - Hospital leadership is also considering the addition of a second suboxone clinic and broadening its pain management program
    - Depending upon the availability of funds, hospital leadership would like to expand the emergency department to accommodate patient growth in that area
- Expand 340B program capabilities:
    - In addition to using 340B to reduce the cost of employee prescriptions, Baxter Regional plans to broaden revenues using 340B by performing home infusions, growing hepatitis-C testing, and adding a new clinic and physician
- Higher reimbursement rates:
    - Baxter Regional expects to realize increased reimbursements from both Medicare and commercial payer services in 2023. Hospital leadership expects both inpatient and outpatient Medicare services to have increased reimbursements of approximately $2.9M in total. Renegotiated contracts with two commercial payers are forecast to increase commercial payer reimbursements by an additional $1.2M
- Continue growth in population health management:
    - Baxter Regional's growing population health management program is anticipated to bring in an additional $1.4M of annual revenue
    - Working on additional growth of Population Health Teams in Family Practice Enterprise
    - Switched from an independent Medicare Shared Savings Plan (MSSP) to Caravan which has over 200,000 covered lives
    - Partnered with Main Street Health in late 2022
    - Partnered with Trilogy Care Connect
- Revenue cycle management (RCM) improvements in hospital and clinics:
    - The hospital is working to improve RCM processes in both the hospital and the clinics, with a specific focus on services for patients covered by Medicare Advantage plans. These RCM updates are estimated to result in $1.2M in increased annual revenue once fully implemented

Expense Reductions

- Reduce travel nurses from high of 60 to fewer than ten:
    - Baxter Regional's use of travel nurses peaked at 60 nurses in March 2022. The hospital has since brough its utilization of travel nurses down to 15 as of March 2023 and intends to further reduce the number to fewer than ten. Elimination of the 45 travel positions to date will save roughly $6M of annual labor expense, with another $667k of cost savings anticipated for moving from the current 15 positions to the target of ten or fewer
- Discontinue the Community Paramedic Program:
    - Baxter Regional closed the community paramedic program that it previously ran in 2022. The program historically generated approximately $350k in net annual losses. The hospital hopes to fill the gap left by the closure of the community paramedic program with its chronic care management, remote patient monitoring, and transitional care services
- Curtail non-critical capital expenditures:

    - Historically, capital expenditures to maintain and update the facility and equipment ran at roughly $15M annually. As discussed in the "Capital Considerations" section above, the hospital has reduced annual capital expenditures to $6M and plans to continue the curtailment until the hospital is on more stable financial footing
- Changes and reductions to employee benefits:
    - Baxter Regional has implemented several changes to the benefits that it provides to employees, including changes to the formulary/drug plans
- Expand use of 340B pharmacy discount program:
    - Baxter Regional has begun to leverage its 340B program to provide pharmacy services to employees at a reduced cost, resulting in a $95k savings over the course of the two months that the changes have been in place. This indicates annualized likely savings for $300k going forward
- Improve department processes for flexing staff hours:
    - The hospital is working to improve the efficiency of its staffing model by making it more dynamic and responsive to real-time hospital needs to save labor costs associated with unnecessary hours or overtime
- Change mix of Registered Nurses (RNs) and Licensed Practical Nurses (LPNs):
    - By leveraging less-expensive LPNs instead of RNs for the types of work that both are qualified to perform, hospital leadership expects to save approximately $275k annually
- Change mix of Emergency Medical Technicians (EMTs) and Paramedics:
    - Similar to the previous item, the hospital anticipates an annual savings of $120k from prioritizing the use of less-expensive EMTs rather than paramedics for work that both positions are qualified to do
- Reduce staff turnover rates
    - Decreasing staff turnover rates will reduce the cost of hiring and training replacement staff. They aim to do this via a combination of having adjusted wages upwards to more competitive levels and by fostering a collaborative and positive work environment. This piece of the sustainability plan did not yet have a quantified savings associated with it
- Reduce supply costs
    - Baxter Regional is a member of the purchasing coalition TPC and expects to save approximately $800k annually through TPC rebates on purchases
    - The hospital recently renegotiated the terms for its purchases of supplies for spinal procedures for a go-forward annual savings of $300k
    - There is an additional $145k of annual savings that will be realized from changes to the vendor terms that Baxter Regional uses for its RN residency program

Bradley County Medical Center

Quick Facts

- Classification: CAH
- Licensed Beds: 33
- Closest Facility: 17.5 miles
- Average Age of Plant: 21.11
- Average Daily Patient Occupancy Rate: 38.4%
- Average Length of Stay (ALOS): 3.28 days
- Total full-time employees (FTEs): 154
- 501(c)(3) non-profit that reports to a county judge-appointed board of directors

Location: Warren, Bradley County
County Population: 10,408 (2021)

Table 17: Bradley's Summary Statistics

Operating Statistics		
C&C Equivalents	$	10.7 M
Current Assets	$	17.1 M
Net A/R	$	3.3 M
Total Assets	$	24.7 M
Days Cash on Hand		166.10
Quick Ratio		7.91
Current Ratio		8.27
Debt Service Coverage Ratio		N/A
Days in Net AR		59.45
Average Age of Plant		21.11
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	20.1 M
Other Revenue	$	0.3 M
Total Revenue	$	20.4 M
Salaries, Wages & Benefits	$	13.0 M
EBITDA	$	(3.1 M)
Operating Income	$	(4.2 M)
Non-Operating Income/(Expense)	$	0.7 M
Net Income	$	(3.5 M)
Operating Margin %		-21%

Key Challenges

- Increased Medicare and Medicaid audits resulting in significant paybacks (~$240k from 2015). Revenue cycle management (RCM)-vendor relationship-management challenges and average accounts receivable (A/R) days is relatively high (generally runs at an average of 64 days)

1 *Patient Volume Trends*[37]

- Recent drop in patient census volume likely reflected in drop in net patient service revenue in annualized trailing 6 months (Sept.-February 2023) as compared to FY22

2 *Financial Status*

- Strong financial position with 166.1 Days Cash on Hand, 59.45 days in net accounts receivable (A/R), and a Quick Ratio of 7.91 as of Feb. 2023
- Reserve amount of approximately ~$8M as of Feb. 2023
- No long-term debt reported

3 *Labor Challenges*

- Noted difficulties with certain provider coverage in Obstetrics and Gynecology (OB/GYN); potential future loss of more senior providers could result in lapses in service coverage / involuntary service changes

4 *Technology Challenges*[38]

- There is no CIO – position is currently posted for candidates with preferences for bachelor's in computer information services
- Current electronic medical record (EMR) and RCM software: CPSI – True Bridge
- An EMR conversion (to a new vendor) is scheduled in December 2023, which will increase monthly costs from $30-$32k per month to $43k per month

5 *Sustainability Plan*

- Leadership is partnering with Delta Region Community Health Systems Development in a three-year program to assess operations, implement best practices, and sustain changes. The focus of that program will be on financial performance, operational efficiencies, increasing telehealth utilization, ensuring access to emergency medical services, addressing workforce recruitment, and retention needs
- Initiatives include improving physician documentation, improving provider coverage with local hospital partnerships, and renegotiation of services

6 *Physical Plant*

- Original plant built in 1949 needs material investment. Bradley County's Master Facilities Plan projects an estimated budget of $8-$15M in core infrastructure *improvements* (and additional $5M for cosmetic changes) vs $30M for new hospital *build*; hospital leadership favors building a new facility

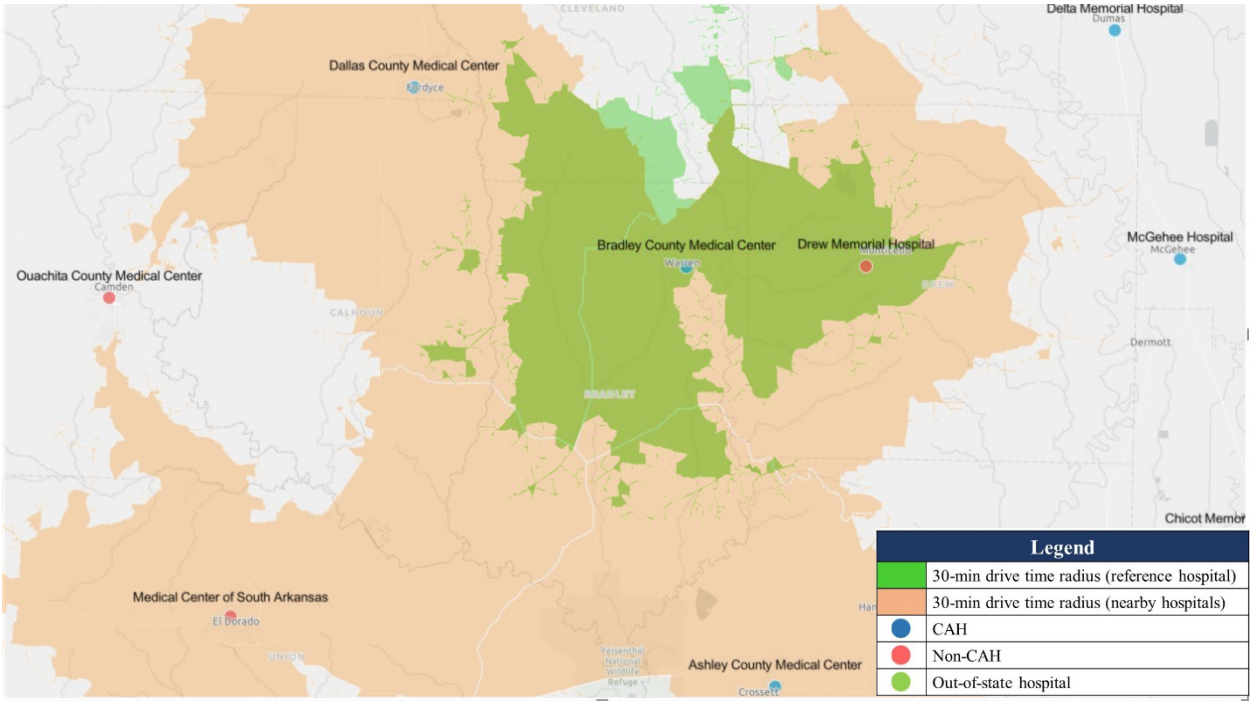
[37] Annualized Aug. 2022 to Jan. 2023 stats versus FY22 stats.

[38] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

Drive Time Assessment - Alternatives in the Surrounding Community

A population estimated at 39,773 is located within a 30-mile radius of Bradley.[39] Bradley County Medical Center is the only hospital within Bradley County, a county in south Arkansas with a population of roughly 10,408. Bradley leadership confirmed that the Hospital main service population is the ~5,000 people from the county. The two closest alternative hospitals to Bradley are on average 23 miles away: Drew Memorial Hospital is 17.5 miles to the east in neighboring city of Monticello, and Dallas County Medical Center is 28.1 miles to the northwest in Fordyce. Additional alternatives lie beyond a 35-mile or 45-minute drive. People living to the south or southwest of Bradley may find that their closest alternative is about 42 miles from Bradley at Ashley County Medical Center or 51 miles away Medical Center of South Arkansas, respectively.

Figure 10: Bradley's Drive Time Analysis



Observations Related to Operational Outlook

The YTD acute care average length of stay (ALOS) was 3.3 days, and the acute average daily census (ADC) was also 3.3. Total ADC is 12.7, while the occupancy rate for the year was approximately 38.4%.

For comparison, the national benchmark ALOS for CAH facilities is 4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%.[40] The Arkansas State benchmark for ADC Beds is

[39] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.
[40] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/
[40]CAH Financial Indicators Report: Summary of Indicator Medians by State. May 2022 State Medians Report 2022 (FLEX)

2.98. ALOS falls below the benchmark, ADC is above the benchmark for acute inpatients, and occupancy is below the national benchmark average range for occupancy rate, but above Arkansas average for rural hospitals. This combined with the total ADC of 12.7 suggests that acute inpatients are not the primary makeup of the census.

As of Feb. 2023, Bradley has reported 372 annualized inpatient discharges with an adjustment factor of 4.77 resulting in total annualized adjusted discharges of 1,774. Annualized acute adjusted patient days for the current year (5,826) were 9% lower than FY22 stats (6,536). Conversely, annualized ER visits for the current year (5,730) were 8% greater than FY22 stats (5,272).

Total FTEs were 154. The total clinical FTEs count was 108. FTEs per each adjusted occupied bed (also called "FTEs per adjusted ADC") was 2.6. The state benchmark for FTEs per adjusted ADC was 4.6-5.72.[41] Labor cost per net patient revenue was at 65% compared to the benchmark of 50% - 60% for CAHs.[42] Staffing at Bradley has been relatively consistent throughout the pandemic and labor costs have increased 4.6% in the current year (~$13.0M) vs prior year (~$12.4M). Thus, staffing appears efficient but expensive due to the increase in labor costs.

Table 18: Bradley's Operational Outlook

Key Indicators - Operational Outlook	
(Oct 2022 - Feb 2023 Annualized)	
Total Inpatient Discharges	372
Adjustment Factor	4.77
Total Adjusted Discharges	1,774
Hospital Patient Days	1,222
Adjusted Patient Days	5,826
Acute Average Daily Census	3.3
Total Average Daily Census	12.7
Acute Average Length of Stay (YTD)	3.3
Emergency Department Visits	5,730
Occupancy Rate	38.4%
Total FTEs	154
Total CFTEs	108
Case Mix Index	N/A
Labor Cost / Net Patient Revenue	65%
FTEs per Adjusted Occupied Bed	2.6

Table 19: Bradley's Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	10,706,352
Inventory and Prepaid Expenses	$	759,977
Current Assets	$	17,106,408
Total Assets	$	24,699,524
Current Liabilities	$	2,067,549
Total Long-Term Debt		N/A
Total Liabilities	$	2,067,549
Net Position	$	22,631,975
Daily Expenditures	$	64,456
Days Cash on Hand		166.1
Quick Ratio		7.9
Current Ratio		8.27
Debt Service Coverage Ratio		N/A
Average Age of Plant		21.11
Days in Net Accounts Receivable		59.45
Debt to Operating Revenue		N/A

Observations related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (Dec. 2022, Jan. 2023, or Feb. 2023). Based on the initial data received, A&M's on-site review, and 2023 data, Bradley County's cash position is relatively stable with Feb. 2023 cash and cash equivalents at $10.7M. Daily expenditures have dropped during this same period from $66k in FY22 (Sept. 2022) to $64k in annualized FY23. As of Feb. 2023, there are 166.1 days cash on hand. The stability of these figures combined with the Quick Ratio of 7.91 evince a stable outlook for Bradley County's financial condition.

[41] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.
[42] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Cash Position

Days cash on hand (COH) is 166.1 days as of Feb. 2023. The days COH, combined with a positive cash flow runout balance at the end of Feb. 2023 (seen in the below table), is consistent with a healthy financial picture. This view does not include $8M in reserves. Bradley County leadership has identified revenue cycle management (RCM) as a key area of concern, and it is important to note that delays in claims processing and collections pose a risk of decline in cash and cash reserves given the current ($3.47M) net income. Days cash on hand (COH) declined slightly from ~174.8 days in September 2022 to ~166 days in February 2023. Additionally, days in accounts receivable (A/R) has remained fairly constant at ~60 days in September 2022 to 59.5 in February 2023. The steadiness in financial metrics can likely be attributed in part to the promotion of the controller to CFO in May 2022. The CFO also serves as the CEO and has a detailed understanding of Bradley County's financial conditions and risks.

Bradley County outsources revenue cycle management to a third party. When asked about A/R days, hospital leadership noted that an opaque working relationship with their RCM vendor may have contributed to their relatively high average A/R days (generally runs at approximately 64 days on average). Bradley County's quick ratio has decreased from ~9.1 at Dec. 2022 to 7.91 at Feb. 2023.

Table 20: Bradley's Cash Flow Runout

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Beginning Balance	**3,116,434**	**2,921,459**	**2,951,779**	**2,413,938**	**2,250,237**
Cash Flows from Operating Activities: Change in Net Assets	$ (216,836)	$ (453,310)	$ (385,369)	$ (185,240)	$ (83,032)
Net Cash (Used in) Provided by Operating Activities	103,426	605,169	16,807	137,690	466,093
Net Cash (used in) Provided by Investing Activities	(81,565)	(121,539)	(169,279)	(116,151)	(168,963)
Net Cash (used in) Provided by Financing Activities	-	-	-	-	-
Net Increase (Decrease) in Cash & Cash Equivalents	(194,975)	30,320	(537,841)	(163,701)	214,099
Cash & Cash Equivalents at the End of the Period	**2,921,459**	**2,951,779**	**2,413,938**	**2,250,237**	**2,464,336**

Debt

Bradley County's does not have long term liabilities, however, short-term liabilities increased by $766k from September 2022 ($1.30M) to February 2023 ($2.07M), caused by normal operations. Hospital leadership relaxed its "use it or lose it" accrued leave policy at the end of 2022 that contributed to this increase. Accounts payable (A/P) accounts also grew from $460,145 in September 2022 to $880,786 in February 2023. Bradley County does not currently hold any long-term debt or bonds, but hospital leadership said that short-term loans could be accessed if needed.

Revenue

Using annualized FY23 financials from Sept.-February 2023 data, Bradley County could see a 6% decrease in net patient revenue (NPSR) from the prior year. This seems consistent with the hospital's reported recent service volume decreases, which hospital leadership attributed to the recent leave of a rural health clinic physician. Hospital leadership shared that laboratory and radiology services are the most profitable contributors to net patient service revenue, while L&D and the rural health clinic (which also serves as the women's clinic) incur revenue losses driven by low volume.

Table 21: Bradley's Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 21,300,607	$ 20,126,854	-6%
Other Revenue	$ 385,148	$ 297,332	-23%
Total Revenue	**$ 21,685,755**	**$ 20,424,186**	**-6%**
Salaries, Wages & Benefits (SWB) Expense	$ 12,421,548	$ 12,987,381	5%
Supplies Expense	$ 2,243,929	$ 2,026,769	-10%
Other Operating Expense	$ 9,535,896	$ 8,512,276	-11%
EBITDA	**$ (2,515,618)**	**$ (3,102,240)**	**-23%**
Depreciation Expense	$ 993,621	$ 1,114,205	12%
Operating Income	**$ (3,509,239)**	**$ (4,216,445)**	**-20%**
Non-Operating Income (Expense)	$ 2,819,966	$ 746,032	-74%
Net Income	**$ (689,273)**	**$ (3,470,413)**	**-403%**
Operating Margin	-16%	-21%	-28%
NPSR / Adj Discharge		$ 11,345	
Expense / Adj Discharge		$ 13,890	

**Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

Bradley County's reduction in patient volumes is consistent with a 10% decrease in supply cost from FY22 ($2.2M) to annualized FY23 ($2.0M). However, salaries, wages, benefits, and payroll taxes (SWB), increased by five percent compared to the prior year. This increase is primarily due to an increase in nurse wages ($28-38 per hour). According to leadership, the greatest factor for consideration of expenses is the high likelihood physical plant maintenance challenges (due in part to the advanced age of the physical plant) and capital expenses in addition to costs associated with aged equipment.

Outside of these physical plant related challenges, total operating expenses have reduced 2% compared to prior year, but net income has reduced by (403%). This is largely due to a 74% reduction in non-operating income(expense) which includes sales tax revenue that is only booked when funds are requested from the county and spent.

Supplemental Funding

Bradley County received supplemental funding in the amount of $4.5M through various relief funds and grants from the U.S. Departments of Health and Human Services ($4.2M) and the U.S. Department of Housing and Urban Development ($0.3M). The table below summarizes the funding amounts and their sources.

Table 22: Bradley's Supplemental Funding

Supplemental Funding	Total Amount Received
Provider Relief Funds and American Rescue Plan Rural Distribution	$ 4,114,129
COVID19 Testing and Mitigation for Rural Health Clinics	49,461
COVID19 Testing for the Uninsured	21,158
COVID19 Community Development Block Grant	330,000
Total	**$ 4,514,748**

Break-Even Analysis

A break-even analysis was performed on a trailing six-month annualization of Bradley County's income statements to better visualize month-on-month revenue and expense trends. As seen in the table below, both revenue and expenses exhibit some variance month on month. Fluctuations in non-operating expenses are due to realization of Sales Tax revenue being posted after request and use of funds from the county. Based on annualization of Sept. 2022 – Feb. 2023 data, there exists a 12-month annualized operating loss of ($4.2M) and net income loss of ($3.5M). Although Bradley County has healthy cash reserves, this trend indicates a need to implement sustainability measures to mitigate the loss.

Table 23: Bradley's Break-even Analysis

Bradley Regional	September	October	November	December	January 2023	February 2023	Breakeven over the last 2 Quarters	12 Month (Annualized)	18 Month Total
Net patient service revenue	$ 1,551,356	$ 1,669,744	$ 1,404,346	$ 1,831,520	$ 1,780,385	$ 1,826,076	$ 10,063,427	$ 20,126,854	$ 30,190,280.85
Other Revenue	31,661	(16,645)	78,290	21,121	38,212	(3,974)	148,666	297,332	445,998
Total Revenue	1,583,017	1,653,099	1,482,636	1,852,641	1,818,597	1,822,102	10,212,093	20,424,186	30,636,279
Payroll Taxes	1,211,051	1,107,855	1,013,612	1,150,564	1,049,321	961,287	6,493,690	12,987,381	12,987,381
Supplies	207,793	157,435	107,928	135,634	154,344	250,250	1,013,384	2,026,769	3,040,153
Total Expenses Less D&A	2,066,637	1,871,638	1,752,632	2,155,274	1,995,074	1,921,959	11,763,213	23,526,426	35,289,638
EBITDA	**(483,620)**	**(218,538)**	**(269,996)**	**(302,632)**	**(176,477)**	**(99,857)**	**(1,551,120)**	**(3,102,240)**	**(4,653,360)**
Depreciation	88,611	93,172	93,469	93,622	93,802	94,426	557,102	1,114,205	1,671,307
Total Operating Expenses	2,155,248	1,964,810	1,846,101	2,248,896	2,088,876	2,016,385	12,320,315	24,640,630	36,960,946
Operating Income (Loss)	**(572,231)**	**(311,710)**	**(363,465)**	**(396,254)**	**(270,278)**	**(194,283)**	**(2,108,222)**	**(4,216,445)**	**(6,324,667)**
Interest	-	-	-	-	-	-	-	-	-
Non-Operating Expenses	160,811	16,645	(11,615)	10,885	85,039	111,251	373,016	746,032	1,119,048
Net Income (Loss)	**$ (411,420)**	**$ (295,065)**	**$ (375,080)**	**$ (385,369)**	**$ (185,240)**	**$ (83,032)**	**$ (1,735,206)**	**$ (3,470,413)**	**$ (5,205,619)**

Capital Considerations

There is an extensive deferred maintenance/update list from 2013 with over $4.2M of identified updates. The hospital requires certain roof repairs and cosmetic updates. Equipment in the facility is aged but functioning due to a competent plant operations team and regular preventative maintenance. Some equipment, such as an updated nurse call system, may be required soon since it has reach end of life and is no longer serviceable. Other pain points include mechanical, electrical, and plumbing (MEP) related challenges, HVAC system update/repairs, aged generators, and transfer switch. There is currently sufficient back up for these areas, however, they pose a capital risk incase preventative maintenance cannot repair the equipment. There is a new chiller and new boiler.

Upcoming Obligations

The Hospital has looming and overdue facility maintenance and repair expenses that leadership has noted in its Master Facilities Plan developed in early 2023 (the "Plan"). The Plan documents several critical maintenance and repair items with a total projected budget of $8-15M in core infrastructure changes (and an additional $5M for supplemental cosmetic improvements). Hospital leadership is also debating whether

to abandon the current facility and to build an entirely new facility on a nearby plot of land for approximately $30M. This topic is discussed in more detail in the *Sustainability Plan* section below.

Bradley County is also planning for a technology update with an associated ~$11k-$13k increase in monthly expenses. Earlier operational assessments had identified the need for more reliable data as Bradley County's experience with a current technology vendor is troubled by limited tracking and reporting capabilities.

Sustainability Plan

Bradley County's sustainability plan is composed of four main items: Service line optimization/alliances, use the Delta Regional Community Health Systems Development (DRCHSD) Grant Program's funded consultants to identify areas for operational improvement; transition to a new software platform in December 2023; and lastly, to implement its Master Facilities Plan.

Bradley County has strategic insight into sustainability plans; however, these options have not been quantified.[43]

Service line Optimization/Alliances:

- Bradley County has investigated the possibility of expanding services and has identified a strong community need for a medical detox program, chemical dependency services, and adolescent psychiatry services. However, the hospital is challenged to find the appropriate resources to standup these new offerings
- The Hospital is also currently scoping out possible partnerships with neighboring facilities to share providers. Bradley County is exploring a partnership with a nearby federally qualified health center (FQHC) to share call coverage with OB physicians. This program, however, may not include deliveries at Bradley County and may pose a downstream risk of outmigration of deliveries away from Bradley County
- To enhance its swing bed program, which has been serving increasing patient volumes and has generated higher revenues over time, Bradley County has brought on a consultant using grants from the Arkansas Rural Health Partnership to provide training, technical assistance, and support

Revenue Cycle Management / IT infrastructure:

- Bradley County is also planning for an EMR technology update with an associated ~$11k-$13k increase in monthly expense. Earlier operational assessments had identified the need for more reliable data as Bradley's experience with its current electronic record provider is troubled by a limited tracking and reporting capabilities. Hospital leadership stated that it was still too early to project the long-run savings associated with the conversion but hopes to address the operational limitations experienced through the current vendor

DRCHSD Grant Program:

- Bradley County is participating in the Delta Regional Community Health Systems Development (DRCHSD) Program, which provides participants a $250k grant for external consultants to perform

[43] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

an operations assessment which will include feasibility studies to help leadership identify which existing service lines are not sustainable and which new services lines should be added to promote sustainability. The program will take place during the next three years, and Bradley County plans to focus sustainability efforts on the outcome of that assessment (recommendations, likely)

Master Facilities Plan:

- During on-site reviews, Bradley County leadership emphasized that the Hospital's facilities are in critical condition and in dire need of upgrades, repairs, and maintenance documented in its Master Facilities Plan (the "Plan"). The Plan was completed in early 2023 by an external architecture firm (Polk, Stanley, & Wilcox) to provide Bradley County with a better understanding go the conditions of its current facilities and identify necessary improvements. The Plan projects an estimated budget of $8-15M in core infrastructure improvements, with an additional $5M needed for cosmetic upgrades. Some of most critical items include: a new electrical system and generator ($2.5M), roof replacement ($930k), boilers ($540k), air handlers ($458k), chillers ($417k), plumbing ($350k), and fire sprinklers ($300k)

Chicot Memorial Medical Center

Quick Facts

- Classification: CAH
- Licensed Beds: 25
- Closest Facility: 20.7 miles
- Average Age of Plant: 30.59
- Average Daily Patient Occupancy Rate: 26%
- Average length of stay (ALOS): 2.92 days
- Total full-time employees (FTEs): 123.07

Location: Lake Village, Chicot County
County Population: 10,019 (2021)

Table 24: Chicot's Key Statistics

Operating Statistics		
C&C Equivalents	$	8.9 M
Current Assets	$	12.0 M
Net A/R	$	2.1 M
Total Assets	$	16.9 M
Days Cash on Hand		179.8
Quick Ratio		4.03
Current Ratio		4.12
Debt Service Coverage Ratio		-11.12
Days in Net AR		50.9
Average Age of Plant		30.6
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	14.2 M
Other Revenue	$	0.2 M
Total Revenue	$	14.4 M
Salaries, Wages & Benefits	$	10.8 M
EBITDA	$	(3.6 M)
Operating Income	$	(4.4 M)
Non-Operating Income/(Expense)	$	3.4 M
Net Income	$	(1.1 M)
Operating Margin %		-31%

Key Challenges

- Continued population decline in the surrounding community has resulted in decreasing patient volumes and workforce recruiting challenges

1 *Patient Volume Trends*[44]**:**

- Volume reduced from prior year:
- Annualized acute adjusted discharges FY23 (1,573) were 20% less than FY22 (1,973)
- Annualized acute adjusted patient days FY23 (4,587) were 29% less than FY22 (6,469)
- Swing bed patient days YTD for FY23 were 1,067, up from 718 for the same time period in FY22
- Swing bed admissions were 164 YTD for FY23, up from 69 for the same time period in FY22

2 *Financial Status*[45]**:**

- Days cash on hand (COH): ~179 days
- Quick Ratio: 4.03
  - Both the quick ratio and DCOH calculation include ~$2.3M in Board Designated Funds
- Annualized net income is a net loss of ($1.1M)

3

- Generally healthy with accounts receivable (A/R) days of 51 days
- Minimal debt

Labor Challenges

- Demographic trends limit potential local workforce: 65% of hospital staff are not local
- Chicot Memorial has offered sign-on bonuses and increased base wages in recent years
- Hospital leadership is looking into provider resource collaborations with neighboring hospital systems

4 *Technology Challenges*[46]

- IT system is aged. Would like to move IT system to cloud, equipment would cost $300K
- Hospital leadership is considering updating electronic medical record platform
- Cybersecurity insurance is costly, at around $23-24k per year following a cyber security incident

5 *Sustainability Plan*

- Hospital leadership is not currently considering major revenue enhancement or expense reduction plans
- Chicot Memorial is looking to expand OB/GYN services by partnering with a nearby FQHC and looking to begin ophthalmology and urology services

6 *Physical Plant*

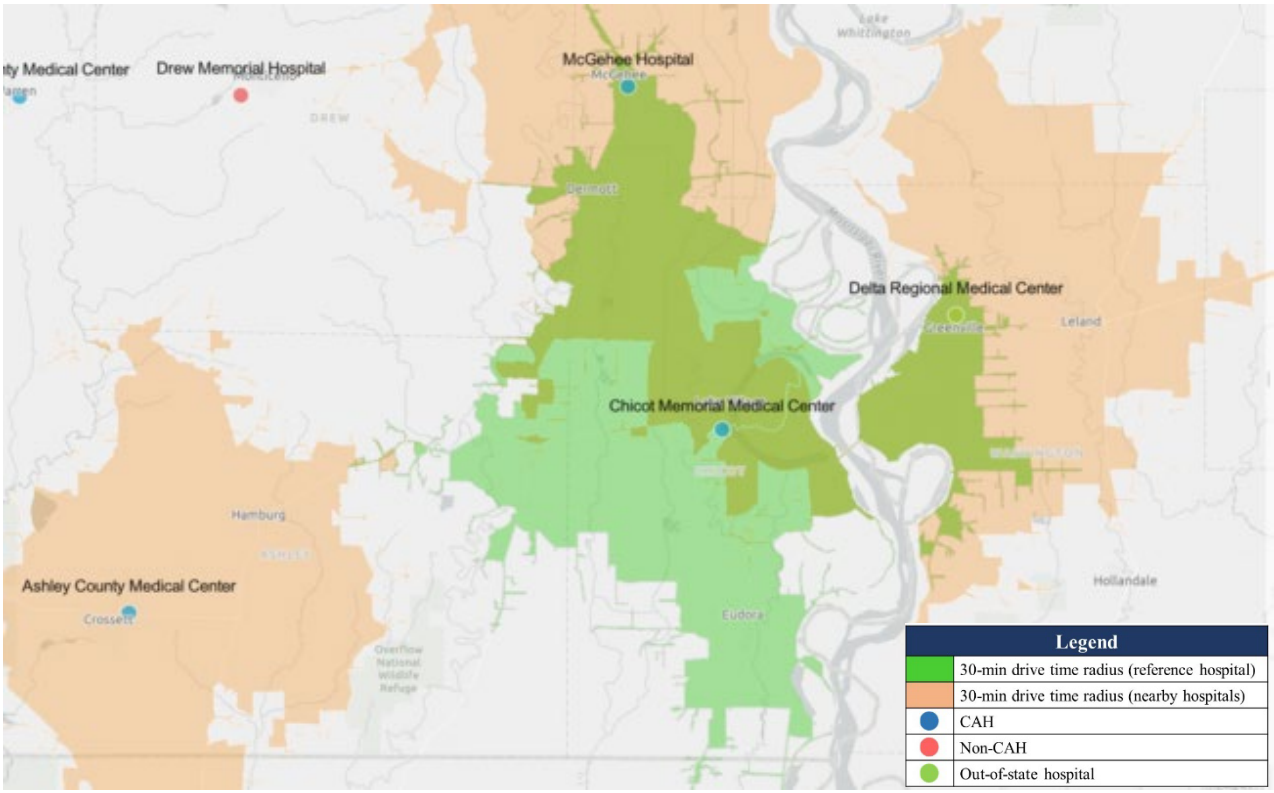
- The physical plant needs an estimated ~$1.45M for parking lot surface pavement, roof repairs, and generator upgrades

[44] Annualized Feb. 2022 (FY22) versus to annualized Feb. 2023 (FY23) stats.
[45] Financials as of Feb. 2023 and are based on Annualized Sept. 2022 – Feb. 2023 financials and prior year based on the Mar. 2022 Fiscal Year financials.
[46] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

Drive Time Assessment - Alternatives in the Surrounding Community

A population estimated at 72,380 (of which 43,687 is from Mississippi) is located within a 30-mile radius of Chicot County.[47] Chicot Memorial Medical Center is the only hospital within Chicot County, located in the southeast corner of Arkansas with a population of roughly 10,019. The two closest alternative hospitals to Chicot Memorial are on average 22 miles away: the closest is Delta Regional Medical Center in Greenville, Mississippi across the state border at 20.7 miles away to the east; McGehee Hospital is 23 miles to the north in McGehee. Additional alternatives lie beyond a 35-mile or 45-minute drive. People living to the west of Chicot Memorial may find that their closest alternative is about 47 miles from Chicot Memorial at Ashley County Medical Center in Crossett.

Figure 11: Chicot's Drive Time Assessment



Observations Related to Operational Outlook

The YTD acute average length of stay (ALOS) was 2.9 days, and the acute average daily census (ADC) was 1.98. Total ADC was 6.56 YTD and the occupancy rate for the year was 26%. For comparison, the national benchmark average LOS for CAH facilities is 4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%.[48] The Arkansas State benchmark for ADC Beds is 2.98. Compared to benchmarks, ALOS is below, acute ADC is below, and occupancy is below. This would suggest that

[47] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.
[48] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/
[40]CAH Financial Indicators Report: Summary of Indicator Medians by State. May 2022 State Medians Report 2022 (FLEX)

there is an overall low volume trend. The higher total ADC of 6.56 as compared to the acute ADC of 1.98 suggests that the daily census is largely made up of non-acute inpatients. This trend is consistent with what is observed at Chicot Memorial.

As of Feb. 2023, Chicot Memorial reported 248 annualized inpatient discharges with an adjustment factor of 6.35 resulting in total adjusted discharges of 1,573. Annualized adjusted patient days for the current year (4,587) were 29% lower than FY22 stats (6,469). Conversely, annualized ER visits for the current year (4,919) had relatively no change as compared to FY22 stats (4,942). This suggests a trend of reduced volumes on the inpatient side with roughly no change through the ER.

Table 26: Chicot's Operational Outlook

Key Indicators - Operational Outlook	
(Jul 2022 - Dec 2022 Annualized)	
Total Inpatient Discharges	248
Adjustment Factor	6.35
Total Adjusted Discharges	1,573
Hospital Patient Days	722
Adjusted Patient Days	4,587
Acute Average Daily Census	2.0
Total Average Daily Census	6.6
Average Length of Stay	2.9
Emergency Department Visits	4,919
Occupancy Rate	26.2%
Total FTEs	123
Total CFTEs	N/A
Case Mix Index	N/A
Labor Cost / Net Patient Revenue	76.2%
FTEs per Adjusted Occupied Bed	3.0

Total FTEs were 123. FTEs per each adjusted occupied bed (also called "FTEs per adjusted ADC") was 2.95. The state benchmark for FTEs per adjusted ADC was 4.6-5.72.[49] Labor cost per net patient revenue was at 76% compared to the benchmark of 47% for CAHs.[50] Staffing and attracting skilled workforce to Chicot Memorial has been a challenge. This aligns with a lower than benchmark FTE per adjusted ADC and higher than benchmark costs, because attracting staff has been expensive and difficult at Chicot Memorial.

Table 27: Chicot's Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	8,885,142
Inventory and Prepaid Expenses	$	263,852
Current Assets	$	11,970,891
Total Assets	$	16,915,587
Current Liabilities	$	2,905,384
Total Long-Term Debt	$	1,185,796
Total Liabilities	$	4,091,180
Net Position	$	12,824,407
Daily Expenditures	$	49,428
Days Cash on Hand		179.8
Quick Ratio		4.03
Current Ratio		4.12
Debt Service Coverage Ratio		(11.12)
Average Age of Plant		30.6
Days in Net Accounts Receivable		50.9
Debt to Operating Revenue		0.08

Observations Related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (Feb. 2023). Based on the initial data received, A&M's on-site review, and 2023 data, Chicot Memorial's cash position is relatively stable with Feb. 2023 cash and cash equivalents at $8.9M, which is inclusive of ~$2.3M in Board Designated Funds. Daily expenditures are $49k and days cash on hand are ~179.8 days as of Feb. 2023. The stability of these figures combined with the quick ratio of 4.03 (also inclusive of ~$2.3M in Board Designated Funds) represent a stable outlook for Chicot Memorial's current financial condition.

[49] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.
[50] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Cash Position

Days cash on hand (COH) in Feb. 2023 was 179.8 days. Chicot Memorial maintains only the registration process in-house and outsourced its coding, billing, and posting processes to an RCM vendor. In 2022. Leadership noted that they had an "excellent relationship" with the RCM vendor – built upon good communication and strong reporting capabilities. Leadership also credited the vendor for lowering the hospital's average days in A/R from 90-100 days, where it was before their arrival. Bad debt is sent to a third party that has achieved a collection rate of over 9%.

Chicot Memorial cash was previously bolstered by PPP loans and continuously bolstered by sales tax revenue. The hospital receives a county millage tax of about $3k per month and a sales tax of about $100k per month that may only be used for facility maintenance needs. Chicot Memorial's quick ratio fell from 5.05 in September 2022 to now 4.03 in Feb. 2023 after the hospital repaid its approximately $5M COVID-19 Accelerated and Advance Payment, which Chicot Memorial mostly abstained from using for operating costs per hospital leadership.

Debt

Chicot Memorial does not currently hold any debt except in the form of capital leases for equipment that have been booked as "Notes payable" of $406k. The Hospital's capital leases include items such as a new CT machine, laboratory equipment, x-rays, monitors, etc. In 2017, the Hospital issued a $780k revenue bond.

Revenue Bond Payable – Series 2017: The Revenue Bond Payable – Series 2017 is of the amount of $750,000 dated January 3, 2017, which bears interest at 3.8% and is payable in monthly installments of $43,664, with any remaining outstanding balance maturing on October 1, 2025. The Series 2017 Bond is secured by a mortgage lien on the Medical Center properties and by a security interest in the Medical Center's equipment and personal property.

Revenue

Key revenue drivers of the hospital include the home health, swing bed, wound care (particularly procedures utilizing artificial skin), and dental clinic services. Using annualized FY23 financials from Sept. 2022 to Feb. 2023 data, Chicot Memorial may potentially see a 14% decrease in net patient revenue (NPSR) from the prior year. The drop in revenue in recent months (Nov. 2022 – Feb 2023) can be partially attributed to a partial closure of the dental clinic when the only dentist was out on maternity leave, but hospital leadership expects revenue to pick back up in coming months now that the dentist has returned. Other drivers may include a decrease in inpatient admissions from Sept. 2022 (29) to Feb. 2023 (14). There were also some outlier months, namely May 2022 and July 2022, where certain large wound care reimbursements resulted in a 73% and 44% increase in net patient service revenue compared to the previous month, respectively. Local population reports show that the Chicot County population has decreased by 1,700 or approximately 10% in the last ten years, which poses a material threat to the hospital's long-term stability.

Table 28: Chicot's Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 16,447,051	$ 14,198,832	-14%
Other Revenue	$ 633,117	$ 168,074	-73%
Total Revenue	**$ 17,080,168**	**$ 14,366,906**	**-16%**
Salaries, Wages & Benefits (SWB) Expense	$ 8,685,080	$ 10,821,024	25%
Supplies Expense	$ 4,229,039	$ 2,539,684	-40%
Other Operating Expense	$ 4,817,334	$ 4,608,404	-4%
EBITDA	**$ (651,285)**	**$ (3,602,206)**	**-453%**
Depreciation Expense	$ 765,589	$ 823,204	8%
Operating Income	**$ (1,416,874)**	**$ (4,425,410)**	**-212%**
Non-Operating Income (Expense)	$ 3,661,303	$ 3,359,220	-8%
Net Income	**$ 2,244,429**	**$ (1,066,190)**	**-148%**
Operating Margin	-8%	-31%	-271%
NPSR / Adj Discharge		$ 9,028	
Expense / Adj Discharge		$ 11,948	

**Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

With most of its workforce coming from outside of the city, Chicot Memorial has had to make substantial investments in maintaining and attracting staff. This is often accompanied by sign on bonuses, increased pay scales, etc. and is a contributing factor to the 25% increase in salaries, wages, benefits, and payroll taxes. Overall supply costs are down 40% but supply costs often vary due to invoice costs for the artificial skin supply used for the wound care program. Other expenses at Chicot Memorial have remained relatively stable with only a 4% change.

According to leadership, costs related to the potential of physical plant maintenance challenges and capital expenses are looming. Outside of these physical plant related challenges, total operating expenses have increased 2% compared to prior year, but net income has reduced by 148%. This is largely due to a 16% reduction in total revenue.

Supplemental Funding

Chicot Memorial received $5.4M of supplemental funding. This cash added to the already strong financial health of the hospital and funding sources are outlined in the supplemental funding table. [51]

[51] Coronavirus Air, Relief and Economic Security Act (CARES Act). Arkansas Economic Development Commissions (AEDC). Arkansas American Rescue Plan Act Proposal (AARPA)

Table 29: Chicot's Supplemental Funding

Supplmental Funding	Total Amount Received
CARES Act Provider Relief	4,770,349
Rural Health Clinic related COVID-19 support	149,460
AEDC funding	228,000
AARPA	250,000
Total	**$ 5,397,809**

Notes: Data obtained from 2022 Audited financials

Break-Even Analysis

A break-even analysis was performed based on a trailing six-month annualization of Chicot Memorial's income statements to better visualize month-on-month revenue and expense trends. As seen in Table 30, both revenue and expenses remain relatively consistent month on month, with fluctuations based on a decrease in dental revenue during a leave by the only dentist, and certain months with low inpatient census. There is also some degree of fluctuation to expenses related to high-cost invoices for artificial skin wound care product, and a drop in SWB expense in Feb. 2023, that coincides with a rise in other expenses at the same time. The 12-month (Annualized) break-even analysis suggests a ($1.1M) loss.

Table 30: Chicot's Break-even Analysis

Chicot Memorial Medical Center	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	Breakeven over the last 2 Quarters	12 Months (Annualized)	18 Month Total
Net patient service revenue	$ 1,043,467	$ 1,261,356	$ 993,974	$ 1,295,444	$ 1,509,573	$ 995,602	$ 7,099,416	$ 14,198,832	$ 21,298,248
Other Revenue	21,801	24,405	13,533	15,922	(6,852)	15,228	84,037	168,074	$ 252,111
Total Revenue	1,065,269	1,285,761	1,007,507	1,311,366	1,502,721	1,010,830	7,183,453	14,366,906	$ 21,550,359
Salaries, Wages, Benefits and Payroll Taxes	944,447	1,004,418	899,151	969,525	850,408	742,563	5,410,512	10,821,024	$ 16,231,536
Supplies	193,320	258,662	194,586	193,967	224,443	204,864	1,269,842	2,539,684	$ 3,809,526
Other Expenses	235,922	303,707	329,276	313,797	574,235	547,265	2,304,202	4,608,404	$ 6,912,606
Total Expenses Less D&A	1,373,689	1,566,787	1,423,013	1,477,289	1,649,086	1,494,692	8,984,556	17,969,112	$ 26,953,668
EBITDA	**$ (308,420)**	**$ (281,026)**	**$ (415,505)**	**$ (165,923)**	**$ (146,364)**	**$ (483,862)**	**$ (1,801,103)**	**$ (3,602,206)**	**$ (5,403,309)**
Depreciation	63,233	64,619	67,739	72,739	71,659	71,613	411,602	823,204	$ 1,234,806
Total Operating Expenses	1,436,922	1,631,406	1,490,752	1,550,028	1,720,745	1,566,305	9,396,158	18,792,316	$ 28,188,474
Operating Income (Loss)	**$ (371,653)**	**$ (345,645)**	**$ (483,245)**	**$ (238,662)**	**$ (218,024)**	**$ (555,475)**	**$ (2,212,705)**	**$ (4,425,410)**	**$ (6,638,115)**
Interest	(5,631)	(4,553)	(2,863)	(13,568)	(4,405)	(5,108)	(36,128)	(72,256)	$ (108,384)
Non-Operating Expenses	210,735	153,855	157,798	823,974	224,962	144,414	1,715,738	3,431,476	$ 5,147,214
Net Income (Loss)	**$ (166,550)**	**$ (196,343)**	**$ (328,309)**	**$ 571,743**	**$ 2,533**	**$ (416,170)**	**$ (533,095)**	**$ (1,066,190)**	**$ (1,599,285)**

Capital Considerations

Chicot Memorial's original facility was built in 1967, and part of the facility received an upgrade in 2006, but the facility now requires an estimated $1.75M in additional renovations to a few key items: IT system upgrades from on-site to cloud ($300k), broken parking lot surface re-pavement ($500k), roof repairs ($500k), and a generator upgrade ($740k). Hospital leadership has not yet decided when these upgrades will be made.

Chicot Memorial is also considering upgrading their electronic medical record (EMR) system to a more streamlined system that allows for better reporting capabilities and that unifies its hospital, home health, and dental services, whose systems are not currently connected to each other. Chicot Memorial has not begun the formal vendor selection process but has identified a few preferred options.

Upcoming Obligations

The Hospital has looming and overdue facility maintenance and repair expenses that leadership has noted and is outlined above.

Chicot Memorial has in recent years directed more attention to cybersecurity. In 2020, Chicot Memorial was the victim of a cyberattack and was forced to pay a $30k ransom. Since then, Chicot Memorial has begun using identity authenticators, conducted phishing campaigns, and strengthened its cybersecurity insurance.

A key challenge to Chicot Memorial's stability is the declining county population, which (as discussed above) has fallen by 1,700, or approximately 10%, in the last ten years. Currently, a majority of hospital staff commute to work from outside of Lake Village. As a result, Chicot Memorial has experienced a talent shortage and has struggled to find in-town talent in areas such as finance, IT, nursing, OB/GYN, and other medical specialties. To address staffing issues during COVID, Chicot Memorial restructured its pay scale by adding $5-6 per hour to the bottom line, offered sign-on bonuses of $7,500 to travelers, and began a college recruitment program in Monticello. Chicot Memorial is maintaining these efforts as the demographic challenge it faces is long-term.

Sustainability Plan

Although Chicot Memorial did not provide a sustainability plan, the hospital does intend on expanding its surgery department through outpatient surgeries by relying on out-of-town surgeons.[52] In early March 2023, Chicot Memorial signed a partnership contract with a nearby FQHC to bring in an OB/GYN provider and nurse practitioners to run a clinic and conduct wellness visits starting in June 2023. This will be a critical addition to Chicot Memorial's services and to the local community, as there is currently no OB/GYN service available to women in the local area, who need to drive more than an hour away to find a women's health provider in the state. The hospital would also like to add ophthalmology and urology services but have not had early success finding the providers necessary to standup those potential new service lines.

[52] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

Delta Memorial Hospital

Quick Facts

- Classification: CAH
- Licensed Beds: 25
- Closest Facility: 19 miles
- Average Age of Plant: 7.86 years
- Average Daily Patient Occupancy Rate: 31%
- Average length of stay (ALOS): 4.8
- Total full-time employees (FTEs): 149.24 FTEs; 105.18 CTEs
- 501(c)(3) component of City of Dumas
- 25-year lease agreement for the building for $25 annually

Location: Dumas, Desha County
County Population: 11,090 (2021)

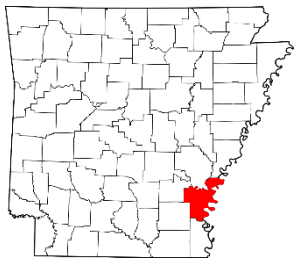


Table 31: Delta's Key Statistics

Operating Statistics		
C&C Equivalents	$	1.9 M
Current Assets	$	5.9 M
Net A/R	$	2.0 M
Total Assets	$	13.7 M
Days Cash on Hand		36.70
Quick Ratio		1.18
Current Ratio		1.41
Debt Service Coverage Ratio		-38.65
Days in Net AR		45.97
Average Age of Plant		12.43
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	16.1 M
Other Revenue	$	0.1 M
Total Revenue	$	16.2 M
Salaries, Wages & Benefits	$	11.4 M
EBITDA	$	(2.4 M)
Operating Income	$	(3.5 M)
Non-Operating Income/(Expense)	$	3.2 M
Net Income	$	(0.3 M)
Operating Margin %		-22%

Key Challenges

- Delta Memorial loses staff to a nearby FQHC primarily due to higher wages. The hospital continues to face nurse staffing issues, which hospital leadership has responded with increased retention incentives. Claims submitted to Medicare Advantage (MA) plans have consistently high rates of denials relative to other payers.

1 *Patient Volume Trends*

- General decreasing trend in patient volume correlated with the recent cancer center closure (March 6th)

Financial Status

2

- Based on the initial data received, A&M's on-site review, and 2023 data, Delta Memorial appears to be in a weak and declining financial condition with potential to financially improve if more sustainably managed
  - Delta Memorial's current CEO started in October 2022
- Cash flow has improved over the past few months due to collections from previous accounts receivable (A/R)
- Delta Memorial is currently using CPSI – TruBridge, along with Trilogy Revenue Solutions for A/R and RCM management. Days in net accounts receivable (days in net A/R) is ~46 days

Labor Challenges

3

- Delta Memorial is facing significant competition for staff from Mainline FQHC, which offers higher hourly wages
- To combat "nurse hopping", hospital leadership has historically enacted a deferral rule from hiring nurses that have left and attempt to re-enter the Delta Memorial workforce within the same year
- Competing against local hospitals (that typically have higher hourly wages) is difficult as management is also actively working to drive down nurse contract hourly rate from $67.50 (employed with no benefits) to $55 hourly (savings of 300k annualized)
- Currently, Delta Memorial does not have travel agency contracts which had previously been a financial challenge

Technology Challenges[53]

4

- Delta Memorial does not employ a Chief Information Officer (CIO) – consequently a discussion of IT/Technology challenges during the on-site review (regarding upcoming projects/conversions, cybersecurity, data, and interoperability) was unable to be completed
- Management noted select hardware is nearing end of life, putting forth an estimated budget of $136k to replace faulty equipment. There is also an identified need for scanners near bedside that integrate with Pyxis MedStation

Sustainability Plan

5

- Cost reduction efforts include reduction in nursing contract rates, reduction in consultant costs, renegotiation of contracts and renegotiation of in-network contracts. Select service lines (*i.e.*, Breakthru and NS100) are expected to expand and increase revenue

Physical Plant

6

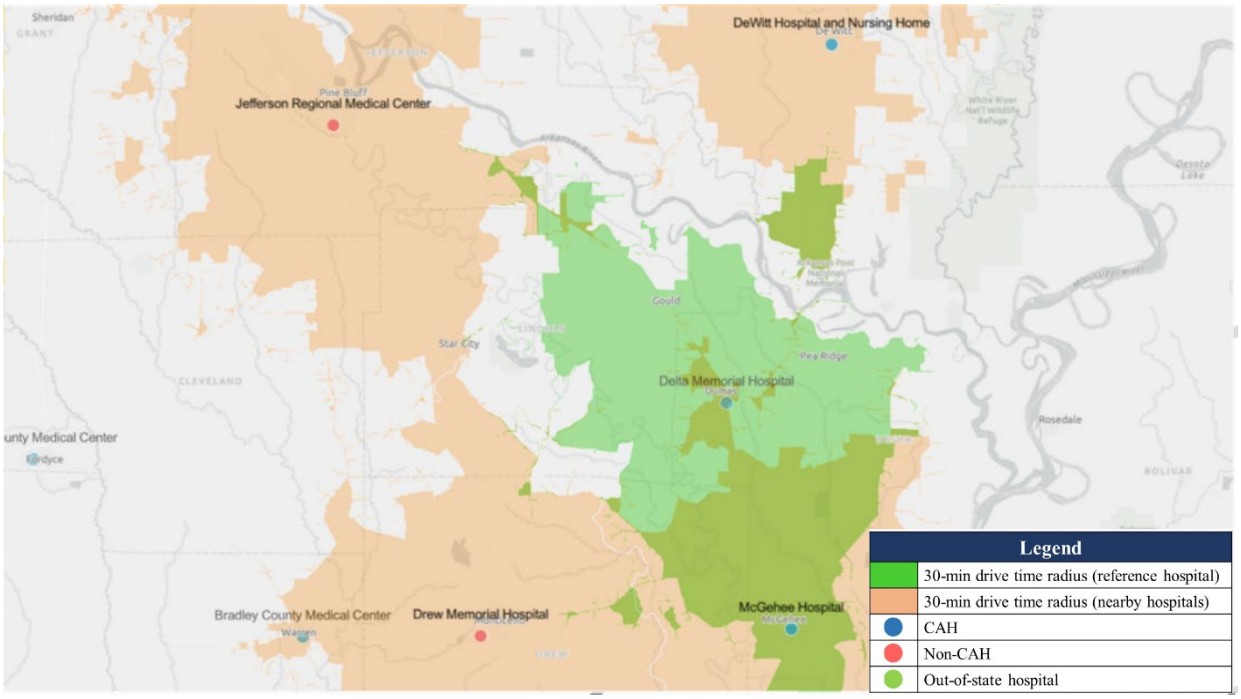
[53] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- In June 2006, Delta Memorial Hospital relocated to a new healthcare facility; per plant management, the facility is well maintained

Drive Time Assessment - Alternatives in the Surrounding Community

The population surrounding Delta Memorial within a 30-mile radius is estimated at 50,471.[54] The three closest alternative hospitals to Delta Memorial are on average 29 miles away: McGehee Hospital (also a CAH) is the nearest alternative, at approximately 20 miles Southwest of Delta Memorial – this hospital offers a Level Four Trauma Center, lab, radiology, specialty clinics, chronic care management and other core service offerings; Drew Memorial Hospital (non-CAH/general hospital) and DeWitt Hospital and Nursing Home (CAH) are both ~34 miles away from Delta Memorial in opposite directions. Distance between Delta Memorial and Jefferson Regional Hospital (non-CAH/general hospital) is approximately 44 miles.

Figure 12: Delta's Drive Time Assessment



Observations Related to Operational Outlook

The hospital is licensed for up to 25 beds. The average length of stay (ALOS) from July to December 2022 was 4.8 days, with a high of seven days and low of four days. ALOS is an indicator of efficiency – if all other things are equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. Delta Memorial's ALOS is consistent with the national average of approximately 4-5.4 days.

The average daily census (ADC) was 10 in December 2022, higher than the calculated annual ADC of 7.86 (calculated by total annual adjusted discharges divided by 365). Delta Memorial's occupancy rate is 31.5%,

[54] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

consistent with rural hospitals in Arkansas. In 2016, average occupancy rates hovered around 30%[55], ranging widely from 40 to 60% depending on location (*i.e.*, rural vs urban).

In 2022, Delta Memorial reported 594 annual inpatient discharges with an adjustment factor of 5.72,[56] resulting in total adjusted discharges of 3,397. Annual ER departmental visits totaled 3,880. Month-on-month volumes during the year remained relatively consistent with slight variation.

The hospital employs a total of 149 full-time employees (FTEs). Of those, 105 are clinical FTEs. FTEs per adjusted occupied bed (also called "FTEs per adjusted ADC") is 3.32. The state benchmark for FTEs per adjusted ADC was 4.6-5.72.[57] Labor cost per net patient revenue was at ~70% compared to the benchmark of 50% - 60% for rural non-CAHs.[58] Staffing and attracting skilled workforce to Delta Memorial has been a management challenge, as evidenced by a lower than benchmark FTE per adjusted ADC and higher than benchmark costs.

Table 32: Delta's Operational Outlook

Key Indicators - Operational Outlook	
(Jul 2022 - Dec 2022 Annualized)	
Total Inpatient Discharges	594
Adjustment Factor	5.72
Total Adjusted Discharges	3,397
Hospital Patient Days	2,870
Adjusted Patient Days	16,412
Average Daily Census	7.9
Average Length of Stay	4.8
Emergency Department Visits	3,880
Occupancy Rate	31.5%
Total FTEs	149
Total CFTEs	105
Case Mix Index	N/A
Labor Cost / Net Patient Revenue	70.5%
FTEs per Adjusted Occupied Bed	3.3

Table 33: Delta's Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	1,878,318
Inventory and Prepaid Expenses	$	982,853
Current Assets	$	5,889,716
Total Assets	$	13,687,543
Current Liabilities	$	4,164,853
Total Long-Term Debt	$	542,441
Total Liabilities	$	4,707,294
Net Position	$	8,980,248
Daily Expenditures	$	51,181
Days Cash on Hand		36.7
Quick Ratio		1.2
Current Ratio		1.41
Debt Service Coverage Ratio		(38.65)
Average Age of Plant		12.43
Days in Net Accounts Receivable		45.97
Debt to Operating Revenue		0.03

Observations Related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (through February 2023). Based on the initial data received, A&M's on-site review, and 2023 data, Delta Memorial appears to be in a weak and declining financial condition with potential to financially improve if more sustainably managed. Days of cash on hand (COH) has dropped from 83 days in July 2021 to 36 days in February 2023. Similarly, current assets have decreased by ~1M from last year, noting 5.9M in January of 2023 compared to ~7M in January of 2022; this is due to a decrease in unrestricted cash (~1.5M), decrease in gross patient receivables and an increase in inventories and prepaid expenses. Daily expenditures are approximately $51k per day,

[55] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

[56] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue.

[57] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

[58] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

with 36.7 days COH as of February 2023. The deteriorating cash position has highlighted the necessity of the sustainability plan's breadth of expense reduction efforts for short-term impact.

Cash Position

Days cash on hand is 36 days as of Feb. 2023. The cash flow runout table below shows Delta Memorial's cash flow trend, which supports a weak financial picture with negative cash and cash equivalents at the end of December 2022. Understanding the days of COH in conjunction with trends in accounts receivable (A/R) will give insight into potential revenue cycle management (RCM) inadequacies. When asked about A/R days and cash position, hospital leadership reported previous complications with TruBridge collections. Delta Memorial uses third-party vendor, Trilogy Revenue Cycle Solutions, to code for the inpatient and emergency department, A/R and denials management, payer contracts and revenue cycle KPI trending/monitoring. With the assistance of Trilogy, Delta Memorial identified inaccurate configuration of financial tables built within their billing platform, leading to bad debt. Since this discovery and subsequent remediation, cleaner claims are being submitted to payers to reimbursement. Hospital leadership attributes these improvements to Trilogy's staff training and education efforts across self-pay patients and up-front collections. Leadership confirmed days in A/R has improved through the partnership with Trilogy, noting 80 days in 2021 to an improved days of A/R of ~58 days, as of February 2023. Weekly management touchpoints are an effort to ensure collaborative revenue cycle operations across unbilled management, A/R, root-cause analysis of recurring edits/issues, ongoing education, and performance improvement initiatives.

Table 34: Delta's Cash Flow Runout Forecast

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Beginning Balance	$ 2,519,469	$ 1,678,551	$ 1,286,019	$ 1,700,223	$ 1,601,000	$ 1,659,184
Total Receipts	1,081,920	1,197,193	2,063,591	1,501,646	1,502,562	2,113,140
Cash Paid to Employees	(861,687)	(578,977)	(551,523)	(559,493)	(555,139)	(855,745)
Cash Paid to Suppliers	(702,182)	(736,645)	(851,631)	(787,146)	(646,432)	(977,481)
Total Disbursements	(1,922,838)	(1,589,725)	(1,649,387)	(1,600,869)	(1,444,378)	(2,178,938)
Net Change in Cash / Cash Equivalents	$ (840,918)	$ (392,532)	$ 414,204	$ (99,223)	$ 58,184	$ (65,798)
Ending Cash Balance	$ 1,678,551	$ 1,286,019	$ 1,700,223	$ 1,601,000	$ 1,659,184	$ 1,593,386

Table 35: Delta's Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 14,736,480	$ 16,111,944	9%
Other Revenue	1,858,236	107,324	-94%
Total Revenue	**16,594,716**	**16,219,268**	**-2%**
Salaries, Wages & Benefits (SWB) Expense	10,578,779	11,356,826	7%
Supplies Expense	3,660,489	1,632,480	-55%
Other Operating Expense	4,200,841	5,653,436	35%
EBITDA	**(1,845,393)**	**(2,423,474)**	**-31%**
Depreciation Expense	993,759	1,100,694	11%
Operating Income	**(2,839,152)**	**(3,524,168)**	**-24%**
Non-Operating Income (Expense)	7,273,314	3,210,862	-56%
Net Income	**4,434,162**	**(313,306)**	**-107%**
Operating Margin	-17%	-22%	-27%
NPSR / Adj Discharge		$ 4,743	
Expense / Adj Discharge		$ 5,813	

**Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Debt

Debt to operating revenue is low, with current debt mostly stemming from equipment purchases. Per management, Delta Memorial is supported by the "community support of the 5,000 resident town and 13,000 resident county" in which it's located. For example, $1.5M in renovations was recently funded partly by the community. As of February 2023, Delta Memorial only has ~$542k of long-term liabilities. Short-term liquidity options are included within their unrestricted cash that make up their days cash on hand calculation – per management, the amount included should be less than 300k, as Delta Memorial has yet to pay for a CT machine recently purchased through COVID funding.

Revenue

Revenue trends will help provide a year-over-year understanding of the current fiscal condition from a "top-line" perspective. Using annualized Sep. 2022 through Feb. 2023 financials, Delta Memorial faces a nine percent decrease in net patient revenue (NPSR) from the prior year. Hospital leadership shared that revenue has been limited due to a growing volume of patients with Medicare Advantage coverage, clinical staff poaching by local hospitals/other healthcare facilities and increased denials by Medicare Advantage plans. Delta Memorial is facing significant competition for staff from a nearby FQHC, which generally offers higher hourly wages. For example, the director of home health and a clinic manager recently left Delta Memorial to work at the nearby Federally Qualified Health Center (FQHC).

Delta Memorial receives City Sales Tax as well as Desha County Millage Tax. The city levies a sales and use tax to support the Hospital of 1.25% and 0.75% during the fiscal years ended June 30, 2021, and 2020, respectively. Specifically, the levy is intended to finance the operation and maintenance of the Hospital and to pay and secure the repayment of bonds. Collections received after December 31, 2018, can also be used

for general operations and other purposes of the municipal government. The Hospital received approximately $924,000 and $726,000, or 4%. of its operating and nonoperating revenue from sales tax proceeds during the fiscal years ending June 30, 2021, and 2020, respectively. The Hospital received Desha County Millage Tax of approximately $45,000 and $43,000, or 0.2%, of its operating and nonoperating revenue from county millage tax proceeds during the fiscal years ended June 30, 2021, and 2020, respectively[59].

Delta Memorial has made significant improvements in the identification and development of key service lines/offerings, by thoughtfully targeting clinical improvement opportunities with high impact. This is seen through the swing bed program, BreakThru program and the launch of NS100.

BreakThru Medical Withdrawal Management program is a medical withdrawal management service delivered by a multidisciplinary team. This program consists of eight Medicaid patients, who must be screened and followed-up over the course of five years. Whereas a national program has a 27% success rate, Delta Memorial's BreakThru is successful with approximately 67% of patients.

Through a partnership with the Sunflower Management Group, Delta Memorial recruited and hired full-time, dedicated swing bed employees for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) to build out its swing bed program (also called skilled nursing services). Delta Memorial designed this unique program for patients who are not well enough to be discharged home, but not recommended for acute care. Some examples of these skilled nursing needs include the following non-exhaustive list: IV therapy & IV medication provision, sterile dressing changes, rehabilitation following a stroke or orthopedic surgery, strength training following a lengthy hospitalization, and pain management. Per hospital leadership, this swing bed program is "strictly outcome-driven with objectives around a quality assurance program," individualized care plans, evidence-based policies, and procedures. Utilization has already jumped from 150 (in the last six months) to 281 patient days in the month of January 2023. This may be partly due to management's grassroots marketing campaigns to promote education and awareness of this program on social media platforms.

Delta Memorial has also secured an innovative product, NeuroSolutions 100 (NS100), a class II, FDA-cleared, percutaneous electrical nerve stimulation (PENS) device that treats chronic pain without the use of narcotics. Input costs are approximately $3k and the procedure must be completed by a CRNA or MD. Management is confident this product will distinguish the hospital from its competitors.

Expenses

Trends in expenses can also provide insight into effectiveness of the sustainability plan and impact on the current fiscal condition. As discussed extensively throughout the sustainability portion, DMH is targeting reduction in high costs (*e.g.*, contract nursing rates and consultant rates), while also expanding service offerings that prove to be reliable revenue drivers (*e.g.*, swing beds).

Nursing hourly rate of $67.50 (employed with no benefits) has dropped to $55 hourly for full-time staff (resulting in savings of 300k annualized), as leadership looks to make standard rates more competitive. To combat "nursing hopping", hospital leadership has enacted a deferral rule against hiring nurses that have

[59] Independent Auditor's Report and Financial Statements *Praxity* June 30, 2021, and 2020

left and attempted to re-enter the Delta Memorial workforce within the same year. Currently, Delta Memorial does not have travel agency contracts which had previously been a financial burden.

Supplemental Funding

All COVID-related supplemental funding received by Delta Memorial has been fully received and recognized to-date. The Supplemental Funding table below summarizes the material supplemental funding that was received. Most of the funding was recognized in fiscal years 2021 and 2020 (Delta Memorial's fiscal year ends June 30th).

Table 36: Delta's Supplemental Funding

Supplemental Funding	Total Amount Received
PPP Loan	$ 1,494,983
CARES Act	$ 3,850,000
American Rescue Plan Rural Payments	$ 700,000
State Support	$ 300,000
Total	$ 6,344,983

Break-Even Analysis

Given the trends associated with Delta Memorial's operational outlook and fiscal condition, and the potential impact of the sustainability plan, a break-even analysis was performed to approximate the current net income (loss). A break-even analysis was performed based on a trailing six-month annualization of Delta Memorial's income statement. As flagged, their annualized net income, based on September 2022 – February 2023 is ($313,306). The currently quantified sustainability plan, if all impact dollars are achieved, has a potential impact of $3,251,000.

Table 37: Delta's Break-Even Analysis

Metric	September	October	November	December	January 2023	February 2023	Breakeven over the last 2 quarters	12 Month Total	18 Month Total
Net patient service revenue	$ 1,452,669	$ 1,207,368	$ 1,298,384	$ 1,222,397	$ 1,238,278	$ 1,636,876	$ 8,055,972	$ 16,111,944	24,167,916
Other Operating Revenues	6,774	13,785	8,987	12,022	7,021	5,073	53,662	107,324	160,986
Total Revenue	1,459,443	1,221,153	1,307,371	1,234,419	1,245,299	1,641,949	8,109,634	16,219,268	24,328,902
Salaries, Wages, Benefits and Payroll Taxes	957,713	990,032	834,801	963,997	1,053,732	878,138	5,678,413	11,356,826	17,035,239
Supplies	125,875	141,717	152,752	142,928	144,157	108,811	816,240	1,632,480	2,448,720
Total Operating Expenses Less D&A & Interest	1,494,605	1,759,603	1,493,495	1,480,671	1,676,798	1,416,199	9,321,371	18,642,742	27,964,113
EBITDA	**(35,162)**	**(538,450)**	**(186,124)**	**(246,252)**	**(431,499)**	**225,750**	**(1,211,737)**	**(2,423,474)**	**(3,635,211)**
Depreciation	80,709	87,333	82,746	82,441	83,422	133,696	550,347	1,100,694	1,651,041
Total Operating Expenses	1,575,314	1,846,936	1,576,241	1,563,112	1,760,220	1,549,895	9,871,718	19,743,436	29,615,154
Operating Income (Loss)	**(115,871)**	**(625,783)**	**(268,870)**	**(328,693)**	**(514,921)**	**92,054**	**(1,762,084)**	**(3,524,168)**	**(5,286,252)**
Interest Expense	(2,626)	(3,026)	(3,569)	(3,494)	(2,321)	(4,083)	(19,119)	(38,238)	(57,357)
Non-Operating Income (Expenses)	288,984	206,427	270,439	263,396	239,590	355,714	1,624,550	3,249,100	4,873,650
Net Income (Loss)	**$ 170,486**	**$ (422,382)**	**$ (2,000)**	**$ (68,791)**	**$ (277,653)**	**$ 443,685**	**$ (156,653)**	**$ (313,306)**	**$ (469,959)**

Capital Considerations

In addition to all the operational and financial considerations described above, Delta Memorial's physical plant requires certain capital improvements to continue, sustain and enhance operations. In June 2006, Delta Memorial Hospital relocated to a new healthcare facility at 811 South 65 Highway in Dumas. The facility was constructed in 2006. The two-story structure is comprised of red iron structural steel components. A new "Durolast" roofing system was installed three years ago replacing the roll roofing that was originally

in place. This roofing system carries a 20-year warranty. All mechanical and electrical components are original to the facility. Boilers, HVAC, potable and non-potable water systems, and electrical components are maintained per manufactures recommendations. Preventative maintenance is performed at least quarterly based on the equipment.

Hospital leadership provided a capital budget that included approximately $6M in medical equipment over the next three fiscal years. During our on-site review and plant tour, we observed several additional capital / infrastructure items that also will require investment and major funding in the immediate future, including adding a nurse call light system to areas that have failed with funding covered by SHIP. The estimated budget to repair call lights is $157k. Many of Delta Memorial's beds are 20+ years old (the newest is nine years old) – frequent issues with these beds results in a reduced census; hospital leadership was candid that two patients were transferred recently due to the precarious condition of two hospital beds, limiting the hospital to a census of 18. Estimated one-time bed purchase costs are 190k.

The Delta Health Services building on 808 Highway 65 South was constructed in the late 70's and renovated three years ago, consisting of new flooring, ceiling grid and tile, painting, windows, 14 HVAC units, a new drive canopy, millwork, bathroom fixtures, furniture, and all new medical equipment. HVAC, potable water systems, and electrical components are maintained per manufacturers recommendations. Preventative maintenance is performed at least quarterly based on the equipment. Per facility management, all are likely to be in good working condition for years to come.

Off-site buildings include two structures:

- Building 1: Home Health Services is in a leased offsite building, consisting of three offices and a Nurse work area. This building is maintained per the lessor contract agreement.
- Building 2: The Nursing Home is not in fully useful condition, as noted by a leaking roof and partially dilapidated interior. Part of it is used for file storage. The grounds are maintained.

Table 38: Delta's Proposed Capital Equipment

Delta Memorial Hospital
Capital Budget
Fiscal Year Ended 2023, 2024, 2025

PROPOSED CAPITAL EQUIPMENT	Department Requesting	FY 2022-2023	FY 2023-2024	FY 2024-2025
Colonoscope	Operating Room		30,000.00	
Gastroscope	Operating Room	25,000.00		
Lucas Automated CPR Device	Emergency Room	16,000.00		
Pulmonary Function Machine Minibox	Respiratory Therapy	31,500.00		
Omnicell Dispensing System	Pharmacy	151,000.00		
Bone Densitometer	Radiology		50,000.00	
Ortho Workstation	Laboratory	5,000.00		
Incubator	Laboratory			6,000.00
Microscope	Laboratory	8,000.00		
Glucometers	Laboratory		10,000.00	
Evident HIS Server Upgrade	Information Technology	135,000.00		
Yearly Totals		**371,500.00**	**90,000.00**	**6,000.00**

Upcoming Obligations

Delta Memorial's CPSI (Electronic Medical Record) is due for a hardware and software upgrade as current equipment is end of life and unsupported should they go down. These upgrades are needed to receive full reimbursements for patient services rendered. The anticipated one-time CPSI upgrade cost is $162k.

Sustainability Plan

Given the revenue cycle management challenges and consistently negative operating margin described earlier, a strong sustainability plan is critical at Delta Memorial. An aggressive sustainability plan was kicked off October 2022 by new leadership. This plan delineated several revenue enhancement and expense reduction items that had either already been implemented or were planned for the near future. If each portion of the plan is implemented fully as projected, there would be a $3.2M improvement in the bottom line, as summarized below in *Table 39*.[60]

Table 39: Delta Memorial's Sustainability Plan

Delta Health Hospital Sustainability Plan Summary
Sustainability Plan Summary

North Arkansas Regional Medical Center Sustainability Plan Summary ACTION	FINANCIAL IMPACT *Action Complete*	*Action Ongoing*	*Action Pending*	*Total*
Revenue Enhancement:				
Expand Therapy Offering - Hire 3 physical therapists, physical therapy assistants, 1 occupational therapist as full-time staff		130,000		130,000
Launch BreakThru - Identify and provide case care for patients suffering from Opioid, Benzodiazepine, Alcohol or Polysubstance abuse		400,000		400,000
Launch NS-100 Service Offering: Provide neuropathy solutions to patients maxed out on Gabapentin		500,000		500,000
Hire Rural Health Clinic Social Worker: Provide community and resource support		15,000		15,000
Recruit and Launch Psych APRN Program		40,000		40,000
Launch New Adult Pysch Unit		750,000		750,000
Recruit physicians in needed specialities	*Impact unknown*			-
Increase 340B Utilization: Correct abnormal contracts, direct contract managing, increase pharmacy dispensing locations and physician education		400,000		400,000
Addition of InterQual Software		70,000		70,000
Invest in Employee Benefits and Move to Self-Insured Health Insurance		70,000		70,000
Implement Swing Bed Clinical Liaisons		60,000		60,000
Improve CCM Utilization		69,000		69,000
Add AHA IT Consortium Connectivity Contract	*Impact unknown*			-
TOTAL REVENUE ENHANCEMENT IMPACT	**$ -**	**$ 2,504,000**	**$ -**	**$ 2,235,000**
Expense Reduction:				
Travel nurse contracts - Gradually decrease rates from $67.50/hr to $50/hr, while offering commitment incentives to bring contract nurses as full-time staff		320,000		320,000
Staff Reductions - Eliminate positions and avoid backfilling vacancies				-
CFO: Backfill vacant CFO position with manager	*Impact unknown*			-
COO: Eliminate COO position due to the restructuring of job duties and creation of admin assistant position		100,000		100,000
Decrease cost of General and Professional Liability Premiums		280,000		280,000
Contract reductions - Renegotiate contracts with third party payers (insurance companies)		180,000		180,000
Decrease clinic collection costs by bringing coding, billing and collections back in-house		50,000		50,000
Decrease consultant costs by eliminating Affinity Healthcare Contract	86,000			86,000
TOTAL EXPENSE REDUCTION IMPACT	**$ 86,000**	**$ 930,000**	**$ -**	**$ 1,016,000**
***TOTAL IMPACT**	**$ 86,000**	**$ 3,434,000**	**$ -**	**$ 3,251,000**

**Total does not include one-time or annual anticipated costs*
*** Does not include direct lawsuit by BRS LLP*

Revenue Enhancements

- Launch BreakThru Service Line:
  - Identify and provide care for patients suffering from Opioid, Benzodiazepine, Alcohol, and Polysubstance abuse. This program helps with placement and follow-up care as the patient is monitored to remain free of chemical dependency. Delta Memorial will medically stabilize these patients for into days before they go into extended treatment centers. (March 2023)
    - Annual anticipated costs are 240k and annual net positive revenue impact after cost is 400k.
- Strengthen swing bed program through full-time recruitment and clinical liaisons:
  - Continue full-time employee recruitment for three physical therapists, three physical therapy assistants, and one occupational therapist.
    - One-time anticipated costs are $150k and annual anticipated savings is $130k.

[60] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

    - Implement swing bed clinical liaisons to be stationed at referring sites to promote the hospital's swing bed program.
        - Annual anticipated costs are $40k and annual projected net revenue impact is $60k.
- Launch new NS-100 service line to provide patients who have maxed out on Gabapentin prescriptive doses for pain and diabetic neuropathy with a new neuropathy treatment option. (February 2023)
    - Annual anticipated cost is $350k and annual net positive revenue impact is $500k.
- Launch Rural Health Clinic (RHC) social worker service. Per leadership, this service is a necessary component for patient care that will allow continuity of care, but it will be a near breakeven service line. (January 2023)
    - Annual anticipated cost is $80k and annual anticipated net revenue increase is $40k.
- Launch new adult psych unit in old geriatric unit wing of hospital since this will compete for Delta Memorial's 25 bed number (limits CAH number). This is an underserved population, and this new service line will maximize the number of available beds.
    - Anticipated start-up costs are $500k and anticipated annual net savings is $750k.
- 340B program expansion
    - Increasing 340B utilization through correcting abnormal contracts, direct contract managing, increase pharmacy dispensing locations, and physician education.
- Group Purchasing Organization participation savings
    - Per hospital leadership, the implementation of a new group purchasing organization (GPO) contract should allow DMH to see greater rebates on toggles, switches, and other IT related items. Currently DMH gets rebates on three of nine possible category items. By adding this contract and being part of the consortium, laws have allowed for DMH to take advantage of the other six categories. Anticipated rebates and savings are unable to be quantified at this time. The cost for this program is based on a percentage of rebates received.

<u>Expense Reductions</u>

- Travel Nurse Contracts:
    - Hospital leadership has been able to successfully decrease travel nurse contract nursing costs by decreasing the contract rate gradually from $67.50 per hour to $50.00 per hour, while offering commitment incentives to get nursing to come on as full-time employees. Currently the rate has already been decreased to $55.00 per hour for contract nursing.
        - This is an estimated one-time anticipated cost of $20k; annual anticipated net savings include $320k.
- Reduction in Consultant Costs:
    - Delta Memorial recently eliminated two consultant contracts; leadership restructured meeting style from weekly business development meeting to a daily huddle meeting that covers operations, safety, and business development.
        - Annual anticipated savings of $86k.
- Revenue Cycle Management:
    - Coding, billing, and collections are intended to be brought back in-house (which will require training), with anticipated annual costs of $70k and annual anticipated net savings of $50k

    - During the remaining two years left of the Trilogy and Delta Memorial partnership, Trilogy Solution Services will renegotiate contracts with third party payers (insurance companies), engage the higher volume of claims that are inappropriately denied, configure appropriate billing systems, and reduce accounts receivable.
        - Delta Memorial will add InterQual Software (in addition to MCG standards) to manage inpatient admissions for appropriate approval of Third-Party Payers.
            - Anticipated annual costs are $19k and projected net annual revenue improvement is $70k
- C-Suite Reduction:
    - Upon departure of current CFO, hospital leadership promoted an internal administrative staff member rather than hiring a more costly outside executive.
    - Leadership decided to not replace the COO at this time, rather focusing on restructuring job duties and training an administrative assistant to learn the credentialing part of the previous COO's scope of work.
        - This is estimated at $70k in annual anticipated costs and $100k in annual anticipated net savings.
- Contract Reductions:
    - Hospital leadership was able to successfully renegotiate several contracts that resulted in annual savings:
    - Through the switch of agents and parties to Texas Hospital Insurance Exchange (THIE) (January-April 2023), Delta Memorial can expect to decrease costs of general and professional liability premiums (anticipated 16-month savings of $280k).

DeWitt Hospital and Nursing Home

Quick Facts

- Classification: CAH
- Licensed Beds: 25
- Closest Facility: 30 miles
- Average Age of Plant: 16.45 years
- Average Daily Patient Occupancy Rate: 13.2%
- Average length of stay (ALOS): 3.98 days
- Total full-time employees (FTEs): 106
- 501(c)(3)
- 10-year sale-leaseback agreement with the city (hospital is responsible for maintenance and improvements)

Location: DeWitt, Arkansas County
County Population: 16,722 (2021)

Table 40: DeWitt's Key Statistics

Operating Statistics		
C&C Equivalents	$	1.7 M
Current Assets	$	3.3 M
Net A/R	$	1.3 M
Total Assets	$	6.5 M
Days Cash on Hand		52.32
Quick Ratio		2.56
Current Ratio		2.84
Debt Service Coverage Ratio		Not provided
Days in Net AR		46.20
Average Age of Plant		16.45
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	9.9 M
Other Revenue	$	1.3 M
Total Revenue	$	11.2 M
Salaries, Wages & Benefits	$	6.6 M
EBITDA	$	(0.6 M)
Operating Income	$	(0.6 M)
Non-Operating Income/(Expense)	$	1.3 M
Net Income	$	0.6 M
Operating Margin %		-6%

Key Challenges

- Low and fluctuating patient volume, Medicare Advantage reimbursement difficulties, and potentially expensive facility improvement needs (generator, air handler, roof leaks, kitchen ventilation).

1 *Patient Volume Trends*

- Volume is low. Recent increases in observations and drops in inpatient admissions include:
  - Current YTD Average daily census (ADC) was 3.84, based on seven-month July. 2022 through Jan. 2023 operations
  - From Jul. 2022 through Jan. 2023, acute discharges totaled 44% less than the same period in the prior year (Jul. 2021 through Jan. 2022)
  - Hospital may potentially see an 8.5% increase in net patient revenue (NPSR) from the prior year, according to annualized trailing 6-months data

2 *Financial Status*

- Days cash on hand: 52 (based on Feb. 2023 financials)
- Quick Ratio: 2.56
- Operating margin: Annualized Net income (based on Sept. 2022 through Feb. 2023 financials) is a net loss of -$633k
- Has spent supplemental funding on equipment, facility upgrades, and plans to purchase a new clinic for $225,000
- Has $500k in unspent reserves

3 *Labor Challenges*

- No significant staffing challenges: hospital has good culture, long tenures, no nurses left for travel positions, limited use of travelers
- Conducts outreach to nearby schools and offers scholarships to nursing students

4 *Technology Challenges*[61]

- No significant IT challenges: has not suffered any cybersecurity attacks and does have insurance
- Does not have CRO so relies on RCM vendors for bulk of RCM needs
- EMR (Azalea) is affordable and easy to learn but has had growing pains

5 *Sustainability Plan*

- No financial estimates for any plan items
- Hiring/Retaining Staff/Recruiting young physicians: Has already brought in a new doctor, is staying in contact with med school students, offering 1-on-1 trainings for new nurses
- Develop/maintain programs: opened IOP geriatric behavioral health program which brings in safe revenue, looking to increase marketing for revenue generating swing bed program
- Partnerships: Considering joining a group purchasing organization (Premier) to purchase supplies at a larger hospital's (Jefferson Regional Medical Center) negotiated rates

[61] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- Seriously considering REH designation to capture additional funding opportunities but apprehensive about being a first adopter and the impact on other revenue sources

6

Physical Plant

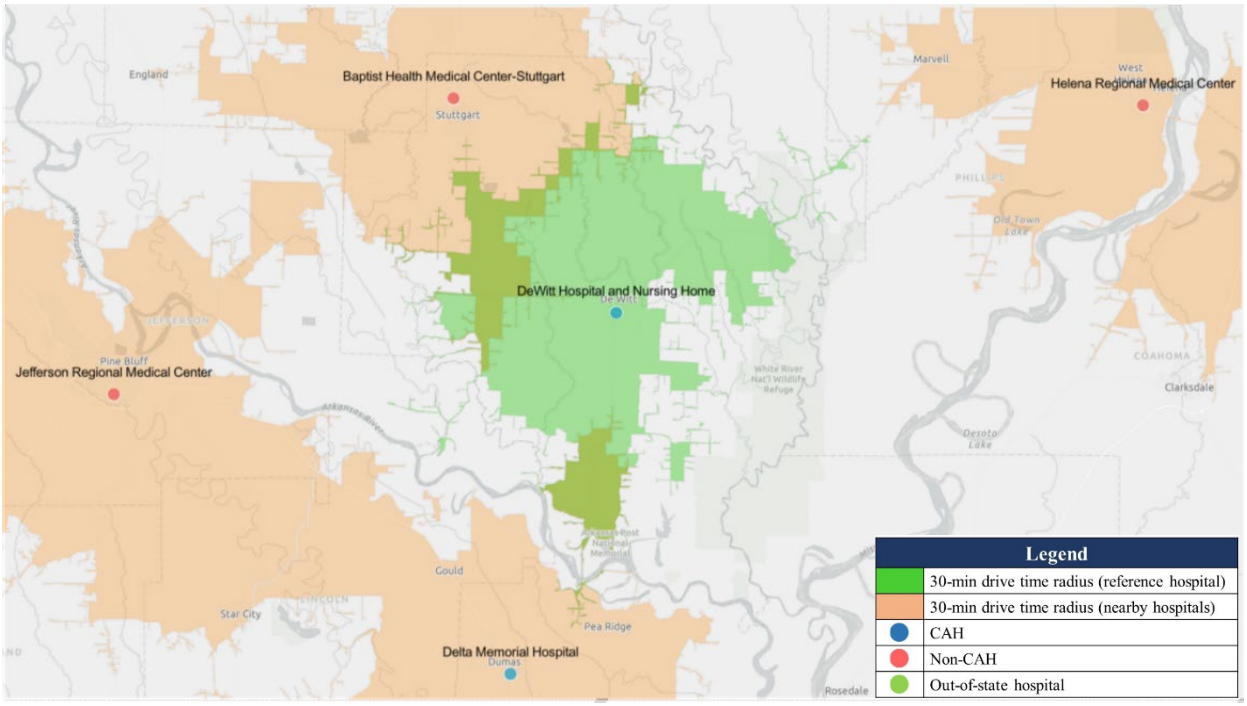
- Recently purchased significant equipment (HVAC, boilers, clinical, etc.)
- Leadership identified at least ~$200k (A&M estimated) in additional concerns: generator, air landlers, roof leaks (*$80k), laundry machine ($18k), kitchen ventilation hood ($12k), 10-15 new computers

Drive Time Assessment - Alternatives in the Surrounding Community

DeWitt Hospital and Nursing Home is the only hospital within the town of DeWitt and is one of two hospitals within Arkansas County, a county in southeast Arkansas with a population of roughly 17,000. The Hospital serves an estimated population of ~8,000 people (the large majority reside in the cities of DeWitt and Gillett, while a few hundred more are from smaller towns or rural farms). An estimated population of 39,311 lives within a 30-mile radius of DeWitt.[62]

The two closest alternative hospitals to DeWitt are on average 31 miles away: Baptist Health Medical Center – Stuttgart is 29.4 miles to the northwest in neighboring city of Stuttgart and the only other hospital in Arkansas County; and Delta Memorial Hospital, another CAH, is 33.4 miles to the south in Dumas. Additional alternatives lie beyond a 35-mile or 45-minute drive. People living to the west or east of DeWitt may find that their closest alternatives are about 55 miles away from DeWitt at Jefferson Regional Medical Center or Helena Regional Medical Center, respectively.

Figure 13: DeWitt Drive Time Assessment



[62] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

Observations Related to Operational Outlook

As of 2022, DeWitt has 25 licensed acute care beds, an 8-bed geriatric psychiatric unit, and a 60-bed nursing home facility. The hospital's low volume can be observed across its operational statistics. In 2022, DeWitt reported 106 total annualized inpatient discharges (82 acute and 24 swing bed) with an adjustment factor of 9.39 resulting in a total adjusted discharges figure of 770. Hospital leadership notes that DeWitt's patient volume trends and acuity level vary consistently by season: Volumes generally decrease over winter months and holidays and pick up in spring but overall has a low patient volume.

Between July 2022 and December 2022, the average daily census (ADC) was 3.31, which increased to 3.48 YTD in January 2023. In comparison, the Arkansas State benchmark for ADC Beds is 2.16, and the ADC Swing-SNF Beds is 1.54[63]. DeWitt's below average ADC highlights the hospital's low patient volumes. However, the hospital has noted recent increases in observation admissions and decreases in inpatient admissions. The annualized Jul. 2022 through Dec. 2022 average length of stay (ALOS) was 3.98, and the occupancy rate was ~13%. National benchmarks include a range of 4-5.2 days for ALOS and the average occupancy rate varied between is 40-60%. For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%.[64] The nursing home census was 29 out of the 60 licensed beds, as of March 13, 2023.

Table 41: DeWitt's Operational Indicators

Key Indicators - Operational Outlook	
(July 2022 - Dec. 2022 Annualized)	
Total Inpatient Discharges	82
Adjustment Factor	9.39
Total Adjusted Discharges	770
Hospital Patient Days	326
Adjusted Patient Days	3,060
Average Daily Census	3.3
Average Length of Stay	4.0
Emergency Department Visits	2,796
Occupancy Rate	13.2%
Total FTEs	106
Total CFTEs	68
Case Mix Index	N/A
Labor Cost / Net Patient Revenue	66.3%
FTEs per Adjusted Occupied Bed	3.4

Table 42: DeWitt's Balance Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	1,691,858
Inventory and Prepaid Expenses	$	320,554
Current Assets	$	3,276,985
Total Assets	$	6,499,715
Current Liabilities	$	1,153,136
Total Long-Term Debt	$	1,325,186
Total Liabilities	$	2,478,322
Net Position	$	4,021,393
Daily Expenditures	$	32,337
Days Cash on Hand		52.3
Quick Ratio		2.6
Current Ratio		2.84
Debt Service Coverage Ratio		Not provided
Average Age of Plant		16.45
Days in Net Accounts Receivable		46.20
Debt to Operating Revenue		12%

The hospital has a total of 106 full-time employees (FTEs), of which 68 are clinical FTEs. FTEs per each adjusted occupied bed (also called "FTEs per adjusted ADC") was 3.42, which is below the state benchmark for FTEs per adjusted ADC of 4.6-5.72.[65] Labor cost as a percentage of net patient revenue was ~ 66%

[63] *CAH Financial Indicators Report: Summary of Indicator Medians by State.* May 2022 State Medians Report 2022 (FLEX)
[64] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/
[40]CAH Financial Indicators Report: Summary of Indicator Medians by State. May 2022 State Medians Report 2022 (FLEX)
[65] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

compared to the benchmark of 50% - 60% for rural non-CAHs. 66 DeWitt's performance suggests that the hospital staff is relatively lean compared to the average hospital.

DeWitt managed to maintain staffing during COVID by offering bonuses, adjusting wages, not using contract nurses, and encouraging nurses that reside in the area to not leave for travel nursing contracts. The hospital did utilize two contract travel nurses for short six-week stints in the latter half of 2022 but did not use any during COVID and did not have any on staff as of A&M's on-site visit. However, there are growing concerns about staff sustainability as current physicians near retirement, so the hospital has extended recruiting and training efforts to scout for new physicians. Recruitment strategies and details are described in further detail in the Sustainability Plan section.

Observations Related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (Feb. 2023). Based on the initial data received, A&M's on-site review, and 2023 data, DeWitt's financial condition appears healthy, supported by a strong cash position, available liquidity options, and no current debt. Cash and cash equivalents had dipped slightly during fall 2022 due to increases to payroll following the addition of a new physician but have since improved. The hospital has $32k in daily expenditures and 52.3 days cash on hand as of Feb. 2023.

Cash Position

COH has decreased from 61 days in July 2022 to 52.3 days in February 2023. February 2023 cash and cash equivalents ($1.69M) were down from July 2022 amounts ($1.98M) but can be explained by a timing issue with its payroll checking account and the October 2022 purchase of a new clinic, which subsequently increased payroll costs. Besides the one-time payroll checking account issue, hospital leadership did not note any additional revenue cycle management (RCM) or billing challenges. DeWitt employs an RCM vendor, Accordias, which manages the hospital's registration, coding, copay, billing, and posting. Only Medicaid nursing home billing is performed in-house. The hospital is content with the vendor and has the capability to access daily summarized reports.

DeWitt's self-reported quick ratio of 0.99 uses a net A/R balance of $1,204,527 at Dec. 2022 whereas the balance sheet in monthly financials shows a net A/R balance of $1,273,675. Furthermore, DeWitt divides current assets by total liabilities instead of just current liabilities. A&M calculation takes total current assets, subtracts prepaid expenses and inventory, and divides the remaining amount by current liabilities. This produces a quick ratio of 2.2 in December 2022, and the 2.56 listed above for February 2023.

DeWitt does not produce monthly cash flow statements. As such, a cash flow runout analysis could not be performed.

Debt

DeWitt does not currently hold any debt or bonds. The Hospital has $500,000 available to it via two credit lines. The Hospital is currently not using a total of $500,000 in available lines of credit from two local banks.

[66] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Revenue

Revenue trends will help provide a year-over-year understanding of the current fiscal condition from a "top-line" perspective. Using annualized Sept. 2022 through Feb. 2023 data, DeWitt will potentially see an 8.5% increase in net patient revenue (NPSR) from the prior year. This seems to be consistent with the on-site review accounts of an increase in service volume driven by typical seasonal trends as well as the recent additions of two new physicians. DeWitt will also see an estimated 318% increase in its net income from the prior year. DeWitt's monthly operating revenues are still not enough to cover its operating expenses despite the increase in NPSR. However, the hospital also receives significant support from the city of DeWitt in the form of a permanent 1.5% city tax. In 2022, DeWitt received $987,355 in additional non-operating revenue from the city, which appears to be enough to cover the hospital's monthly operating losses and help the hospital break even in annualized financials. In *Table 43: DeWitt Income* Statement Metrics, annualized trailing 6-months financial data shows that the city support and other non-operating revenues allows the hospital to see a positive net income.

DeWitt's sustainability plan (discussed in detail below) documents a variety of recruiting, hiring, and retaining efforts. Large amounts of supplemental support (*e.g.*, CARES Act, PPP loan forgiveness) totaling approximately $3.4M helped bolster DeWitt's financials in FY2022 and fund long-term facility upgrades and clinical equipment purchases.[67]

Table 43: DeWitt's Income Statement Metrics

Income Statement Metrics			
	FY22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 9,129,441	$ 9,909,394	9%
Other Revenue	1,309,586	1,260,264	-4%
Total Revenue	**10,439,027**	**11,169,658**	**7%**
Salaries, Wages & Benefits (SWB) Expense	6,473,633	6,574,807	2%
Supplies Expense	2,678,769	1,533,418	-43%
Other Operating Expense	2,300,289	3,694,845	61%
EBITDA	**(1,013,664)**	**(633,412)**	**38%**
Depreciation Expense	342,384	-	-100%
Operating Income	**(1,356,048)**	**(633,412)**	**53%**
Non-Operating Income (Expense)	1,060,203	1,278,616	21%
Net Income	**(295,845)**	**645,204**	**318%**
Operating Margin	-13%	-6%	56%
NPSR / Adj Discharge		$ 12,875	
Expense / Adj Discharge		$ 15,336	

** Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

The hospital experienced increases in salaries, wages, benefits, and payroll tax (SWB) expenses and operating expenses, such as supplies, which are reflective of adjustments made to adapt to the increase in service volume. The increase in expenses captures the hospital's two newly hired physicians in 2022, who were part of the hospital's sustainability plan efforts to recruit, hire, and retain staff. In October 2022, DeWitt also began to manage a local physician's clinic, which increased the November 2022 payroll; the Hospital expects to purchase the clinic for $225,000 in early June or July 2023. The addition of the clinic

[67] See Table 42: DeWitt Supplemental Funding.

will likely increase future electronic medical record (EMR) costs by $1,200-$1,300 per month as the hospital implements its existing EMR vendor, Azalea Health, at the clinic. DeWitt's leadership shared that relations with Azalea have largely been positive as the system has been easy to learn and interfaces with the hospital's RCM.

Supplemental Funding

As mentioned above, supplemental funding helped bolstered DeWitt's financial position in the last two fiscal years. Most COVID-related funds have been recognized, but DeWitt has yet to realize an unknown amount from FEMA, a 2021 emergency retention tax credit, and $1.5M in ARPA funds to be used for payroll. *Table 44*: DeWitt Supplemental Funding summarizes the material supplemental funding that was received.

Table 44: DeWitt's Supplemental Funding

Supplemental Funding	Total Amount Received
CARES Act	$ 2,705,000
American Rescue Plan Rural Payments	$ 341,000
American Rescue Plan State of AR	$ 419,000
Total	**$ 3,465,000**

Break-Even Analysis

A break-even analysis was performed to approximate DeWitt's current net Income (Loss). A break-even analysis was performed based on a trailing six-month annualization of the DeWitt income statement. As shown in the table below, their annualized FY23 net income is $645,204. That is, DeWitt looks to break even within 2023 just by maintaining its current operations. Although the sustainability plan makes mention of additional hiring and new programs, that plan did not provide a quantifiable estimated impact on the hospital's bottom line.

Table 45: DeWitt's Break-even Analysis

DeWitt Income Statement	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Breakeven Over the Last 2 Quarters	12-Month Total	18-Month Total
Net patient service revenue	$ 786,891	$ 718,930	$ 750,200	$ 980,948	$ 874,720	$ 843,008	$ 4,954,697	$ 9,909,394	$ 14,864,091
Other Operating Revenues	221,579	97,252	71,052	177,142	45,376	17,731	630,132	1,260,264	1,890,396
Total Revenue	1,008,470	816,182	821,252	1,158,090	920,096	860,739	5,584,829	11,169,658	16,754,487
Salaries, Wages, Benefits and Payroll Taxes	543,304	554,982	540,846	561,051	560,520	526,700	3,287,403	6,574,807	9,862,210
Supplies	149,424	132,743	110,954	150,766	130,292	92,530	766,709	1,533,418	2,300,127
Total Operating Expenses Less D&A	962,735	1,010,877	956,764	1,079,245	961,862	930,052	5,901,535	11,803,070	17,704,604
EBITDA	**$ 45,735**	**$ (194,695)**	**$ (135,512)**	**$ 78,845**	**$ (41,766)**	**$ (69,313)**	**$ (316,706)**	**$ (633,412)**	**$ (950,117)**
Depreciation	-	-	-	-	-	-	-	-	-
Total Operating Expenses	962,735	1,010,877	956,764	1,079,245	961,862	930,052	5,901,535	11,803,070	17,704,604
Operating Income (Loss)	**$ 45,735**	**$ (194,695)**	**$ (135,512)**	**$ 78,845**	**$ (41,766)**	**$ (69,313)**	**$ (316,706)**	**$ (633,412)**	**$ (950,117)**
Interest Expense	-	-	-	-	-	-	-	-	-
Non-Operating Income (Expenses)	79,174	183,799	98,722	85,349	96,109	96,155	639,308	1,278,616	1,917,924
Net Income (Loss)	**$ 124,909**	**$ (10,896)**	**$ (36,790)**	**$ 164,194**	**$ 54,343**	**$ 26,842**	**$ 322,602**	**$ 645,204**	**$ 967,807**

Capital Considerations

Hospital leadership asserts that they do not anticipate any significant capital expenditures in the next eighteen months as they have recently purchased an HVAC system, boilers, and clinical equipment. However, during our on-site reviews and tours, we learned of and observed several additional capital and infrastructure items that will also require investment and major funding, potentially in the next 18 months. At least $200k will be needed to replace or repair an aged generator, an aging air handler, a leaking washing

machine ($18k), an aged kitchen vent hood ($12k), and active roof leaks over the nursing home facilities ($80k).

Upcoming Obligations

In October 2022, DeWitt began managing a local physician's clinic in a bid to retain his services for a few additional years before that physician retires. Hospital leadership plans to purchase the clinic outright in the summer of 2023 for approximately $225,000. The addition of that clinic will likely increase future RCM costs by $1,200-$1,300 per month through their vendor Azalea.

In its sustainability plan, DeWitt noted that they did not expect any immediate obligations, having made facility upgrades, purchased equipment, and hired additional staff in the last year.

Sustainability Plan

DeWitt indicated in their sustainability plan a focus on recruiting, hiring, and retaining quality staff and developing and maintain its programs. Most of these efforts have already been achieved or are in-progress, but the hospital has not quantified their impact on its financials. [68]

Table 46: DeWitt's Sustainability Plan Summary

Sustainability Plan Summary

DeWitt Hospital and Nursing Home Sustainability Plan Summary*	FINANCIAL IMPACT		
ACTION	*Action Complete*	*Action Pending*	*Total*
Revenue Enhancement:			
Expand Outpatient Services - Opened a geriatric behavioral health program, an intensive outpatient program (IOP), for patients from DeWitt's nursing facility and from other local nursing facilities	*Impact unknown*	*Impact unknown*	-
Enhancing Swingbed Program - Looking to apply new marketing strategies and to add occupational and speech therapy via hiring to grow the swing bed program; would cost $4.5K/mo.	*Impact unknown*	*Impact unknown*	-
Maximize Medicare Rehab program: Utilize the program to the full extent with now adequate staffing	*Impact unknown*	*Impact unknown*	-
Reopen cardiology clinic: Finalizing contract to bring a cardiologist clinic back to DeWitt (half day clinic, twice a month)	*Impact unknown*	*Impact unknown*	-
Sleep study program is back at full capacity since the pandemic	*Impact unknown*	*Impact unknown*	-
TOTAL REVENUE ENHANCEMENT IMPACT	$ -	$ -	$ -
Recruitment and Retention Efforts			
Travel nurse contracts - Offer long-term contracts of $28/hr for nurses returning from travel assignments.	*Impact unknown*	*Impact unknown*	-
Offering extended, individualized, one-on-one training for new nurses	*Impact unknown*	*Impact unknown*	-
Marketing effort to attract pro re nata nurses from surrounding hospitals	*Impact unknown*	*Impact unknown*	-
Maintain staff morale: Making a concerted effort to recognize, reward, and involve current staff	*Impact unknown*	*Impact unknown*	-
Hired young home-grown physician: hired a young physician to provide long-term coverage a the rural health clinic and the ER	*Impact unknown*	*Impact unknown*	
Contract discussions with a future physician who will be avialalbe in three years	*Impact unknown*	*Impact unknown*	
Now managing and will purchase a physician clinic: Purchasing the CMO's clinic for $225K to extend his career; also hired an APRN to cover needed days	*Impact unknown*	*Impact unknown*	
Offering a new contract to an existing FRHC/ER physician to allow a 3-4 day week that would extend his career	*Impact unknown*	*Impact unknown*	
Securing a new contract with the primary ER physician	*Impact unknown*	*Impact unknown*	
TOTAL RECRUITMENT AND RETENTION IMPACT	$ -	$ -	$ -
***TOTAL IMPACT**	**Impact unknown**	**Impact unknown**	**Impact unknown**

**DeWitt did not quantify its sustainability plan initiatives. Impact on revenue is not known. Known costs to implement are provided.*

Service Line Expansion:

- In the last year, DeWitt has opened Senior Life Solutions, an intensive outpatient geriatric behavioral health program, to try to meet the community's behavioral health needs. It is already revenue-generating and is a positive factor for the hospital's cost report payments. DeWitt also recently started a swing bed program using grant money from the Arkansas Rural Health Partnership (ARHP). The hospital plans to add occupational and speech therapy to the program and generate additional revenue by increasing the number of referrals that can be accepted.

Hiring and retaining staff:

[68] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

- In the last one to two years, DeWitt has offered more long-term contracts to its nurses with current rates starting at $28 per hour, after a small increase because of COVID. DeWitt has also attracted new staff, one physician (who started July 2022), two physicians who hospital leadership forecast will be available in three years after completing their studies, and a cardiologist (who joined January 2023 and allowed the Hospital to offer cardiology services). As discussed above, DeWitt also plans to purchase outright the local physician's clinic, which the Hospital already manages, in summer 2023 for approximately $225,000.

Service Line Expansion:

- In the last year, DeWitt has opened Senior Life Solutions, an IOP geriatric behavioral health program, to try to meet the community's behavioral health needs. It is already revenue-generating and is a positive factor for the hospital's cost report payments. DeWitt also recently started a swing bed program using grant money from the Arkansas Rural Health Partnership (ARHP). The hospital plans to add occupational and speech therapy to the program and generate additional revenue by increasing the number of referrals that can be accepted.

REH Consideration:

- The hospital is now considering the rural emergency hospital (REH) designation so that it might capture an additional $272k per month in supplemental funding but is hesitant of how the conversion might impact its other revenue sources (*i.e.*, UPL, 340B, and IOP cost-based programs) and how closing its inpatient services might impact a community that has limited healthcare options. Hospital leadership noted DeWitt is the sole/preferred provider end-of-life care in the area; but if it converted to REH status, DeWitt would no longer be able to provide that service to the community.

Drew Memorial Hospital

Quick Facts

- Classification: Non-CAH
- Licensed Beds: 60
- Closest Facility: 17.5 miles
- Average Age of Plant: 11 years
- Average Daily Patient Occupancy Rate: 47%
- Average length of stay (ALOS): 3.4 days
- Total full-time employees (FTEs): 451

Location: Monticello, Drew County
County Population: 46,317 (2021)

Table 47: Drew's Key Statistics

Operating Statistics		
C&C Equivalents	$	1.2 M
Current Assets	$	9.5 M
Net A/R	$	6.8 M
Total Assets	$	52.5 M
Days Cash on Hand		11.26
Quick Ratio		2.45
Current Ratio		2.84
Debt Service Coverage Ratio		-4.91
Days in Net AR		71.96
Average Age of Plant		11.05
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	34.0 M
Other Revenue	$	0.4 M
Total Revenue	$	34.4 M
Salaries, Wages & Benefits	$	20.6 M
EBITDA	$	(4.3 M)
Operating Income	$	(7.0 M)
Non-Operating Income/(Expense)	$	(0.7 M)
Net Income	$	(7.7 M)
Operating Margin %		-21%

Key Challenges

- Volume reduced from previous year, Cash tight, non-performing RCM vendor/process, high staff turnover, physical plant requires HVAC update

1 *Patient Volume Trends*

- Volume reduced from prior year (based on annualized stats from July 2022 – Feb 2023 vs FY 22)
- Annualized adjusted discharges FY23 (5,386) were 21% less than FY22 (6,775)
- Annualized adjusted patient days FY23 (18,458) were 26% less than FY22 (24,902)

2 *Financial Status*

- Days cash on hand (DCOH):
  - 27.7 (Dec. 2022)
  - ~11 (Feb. 2023)
- Reported A/R, net days at 68.11; calculated at 71.96 (Feb. 2023)
- Quick Ratio: 2.4 (Feb. 2023)
- Operating margin: Annualized Net income (based on September 2022 through February 2023 financials) is a net loss of ($7.7M)
- Supplemental funding bolstered FY21 and FY22 financial position

3 *Labor Challenges*

- Stopped using travel nurse contracts and switch to in-house contracts
- High staff turnover
- Competition from neighboring hospitals
- Not enough cash to adjust pay rates, decrease nurse to patient ratios, etc. which is creating staffing shortages that are impacting the ability to take patients and increase census

4 *Technology Challenges*[69]

- Delayed Cerner implementation to July 2023
- Cerner implementation may not align with possible downstream partnership with Baptist Health
- While the Cerner implementation may improve RCM in the long-run, improvement will not be immediate and may also require a change in RCM vendors

5 *Sustainability Plan*

- Revenue enhancement: Many new services / programs proposed (*i.e.*, chemical dependency)
  - New programs will require costs to establish, and likely to have incremental revenue grow with delayed financial impact
- Expense Reduction: Many expense reduction actions have already taken place ($1.1M impact)
  - Additional expense reductions plans exist ($2.1M impact), but no actions taken pending decision to move forward with plan (*e.g.*, bring RCM in house, decision on partnership, etc.)

6 *Physical Plant*

- $4.4M in Capital improvements/Medical Equip in next three years

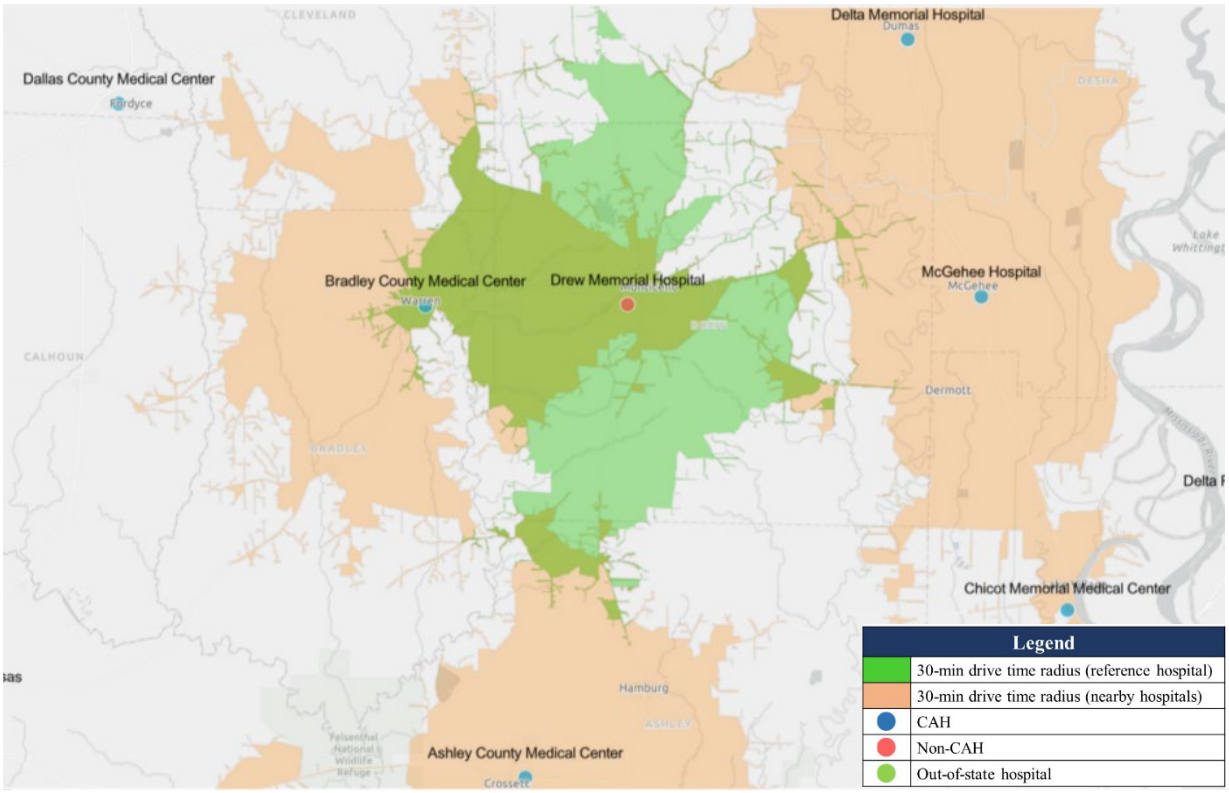
[69] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- Aging air handlers/HVAC not able to always maintain temp in facility in hotter months – require portable A/C. 2 operating rooms are closed due to failed air handler. No plans to replace or repair given current liquidity challenges

Drive Time Assessment - Alternatives in the Surrounding Community

A population estimated at 66,743 is located within a 30-mile radius of Drew Memorial.[70] Drew Memorial is the only hospital within Drew County (population roughly 17,000). The three closest alternative hospitals to Drew Memorial are on average 21 miles away: Bradley County Medical Center is 17.5 miles to the west in neighboring Warren County; McGehee Hospital is 30 miles to the east in McGehee County; and Delta Memorial is 33 miles to the northeast in Dumas County. Additional alternatives lie beyond a 35-mile or 45-minute drive. Ashley County Medical Center is located 40 miles away and may serve as an alternative hospital to populations living south of Drew Memorial. There are no reasonably close alternative hospitals to the north.

Figure 14: Drew's Drive Time Assessment



Observations Related to Operational Outlook

The YTD average length of stay was 3.4 days, and the average daily census (ADC) was 15.4 (Acute only) and 28.4 (including Psych and Observation) while the occupancy rate for the year was 47%.

[70] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

For comparison, the national benchmark average LOS for non-CAH facilities is 5.4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%. [71]

In 2022, Drew Memorial reported 1,759 annual inpatient discharges with an adjustment factor of 3.05 resulting in total adjusted discharges of 5,357. Month-on-month volumes during the year remained relatively consistent with slight variation.

Although month-on-month stats remained relatively consistent, there was decrease in acute patient days towards the end of the year (766 in Jan 2022 versus 603 in Dec. 2022) and a rise in swing bed patient days (31 days in Jan 2022 versus 98 days in Dec 2022). This trend would contribute to the 2022 average acute length of stay being less than state benchmarks and occupancy rates being at or above benchmarks. Overall, all key metrics were lower than the previous year and fell below expectations.

Table 48: Drew's Operational Indicators

Key Indicators - Operational Outlook	
(Apr 22 - Feb 23)	
Total Inpatient Discharges	1,768
Adjustment Factor	3.05
Total Adjusted Discharges	5,386
Hospital Patient Days	6,060
Adjusted Patient Days	18,458
Average Daily Census (Acute)	15.5
Average Daily Census (including Psych + Obs)	28.4
Average Length of Stay	3.3
Emergency Department Visits	9,661
Occupancy Rate	47.3%
Total FTEs	451
Total CFTEs	Not Provided
Case Mix Index	1.15
Labor Cost / Net Patient Revenue	61%
FTEs per Adjusted Occupied Bed	5.2

Total FTEs were 451. The total clinical FTEs count was not provided. FTEs per each adjusted occupied bed (also called "FTEs per adjusted ADC") was 5.2. The state benchmark for FTEs per adjusted ADC was 4.6-5.72. [72] Labor cost per net patient revenue was at ~61% compared to the benchmark of 50% - 60% for rural non-CAHs. [73]

FTEs per adjusted ADC was in line with benchmarks and labor cost per net patient service revenue was slightly above benchmarks, which is indicative of a change in workload that contributes to net patient service revenues and would correlate to a slight rise in swing bed patient days seen towards the end of 2022 (26 in February 2022 and 98 in Dec 2022). While there appears to be enough inpatient and outpatient volume to justify the number of FTEs, the revenues generated by that volume seems lower than one would typically expect. Increases in reimbursement from payers for

Table 49: Drew's Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	1,217,882
Inventory and Prepaid Expenses	$	1,322,327
Current Assets	$	9,500,461
Total Assets	$	52,459,398
Current Liabilities	$	3,342,603
Total Long-Term Debt	$	25,352,648
Total Liabilities	$	28,695,251
Net Position	$	23,764,147
Daily Expenditures	$	108,200
Days Cash on Hand		11.3
Quick Ratio		2.4
Current Ratio		2.84
Debt Service Coverage Ratio		(4.91)
Average Age of Plant		11.05
Days in Net Accounts Receivable		71.96
Debt to Operating Revenue		74%

[71] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

[72] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

[73] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

services may assist with getting labor costs as a percentage of NPSR back under the benchmark, which is an initiative Drew has focused on as part of their sustainability plan. This is further described in the sustainability plan section below.

Observations Related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (Feb. 2023). Based on the initial data received, A&M's on-site review, and 2023 data, Drew Memorial's cash position has been deteriorating since March 2022, with a gradual decrease in cash and cash equivalents from $12.6M to $1.22M in Feb 2023. Daily expenditures range between $106k–$119k with 11.3 days cash on hand as of Feb 2023. With the deteriorating cash position, especially in the context of the current daily expenditures, the sustainability plan's expense reduction efforts will be highly valuable as these actions are more likely to yield rapid impact.

Cash Position

Understanding the Days cash on hand (COH) in conjunction with trends in accounts receivables will give insight into revenue cycle management inadequacies. COH has decreased 60% from December 2022 to February 2023 while accounts receivable (A/R) has slightly increased. Additionally, days in A/R has increased approximately 11 days in six months (from 60.2 in Sept 2022 to 72 in February 2023). When asked about A/R days and cash position, Drew's leadership noted repeated difficulties working with their revenue cycle management (RCM) vendor; recounting pain points around denials, coding issues and authorizations. Cash flow runout analysis was forecasted based on data received from May 2022 through February 2023. As seen in the cash flow runout table below, unfavorable cash flow has continued. These trends clearly align with the concerns voiced by leadership and further emphasize the need to address RCM challenges as a part of the sustainability plan.

Table 50: Drew's Cash Flow Runout

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Beginning Balance	$ 6,112,182	$ 5,197,298	$ 4,503,261	$ 3,603,094	$ 3,082,375	$ 1,868,620
Patient Receipts [1]	2,541,567	2,811,286	2,385,254	2,017,580	1,983,296	2,558,291
UPL Receipts [2]	1,008,323	-	-	1,125,799	-	1,125,799
Transfer from Money Market	956,376	924,827	1,155,126	554,128	1,006,989	1,175,950
Other	70,151	25,665	85,019	285,321	16,517	16,139
Total Receipts	4,576,417	3,761,778	3,625,399	3,982,828	3,006,802	4,876,179
Disbursements	2,468,243	2,070,157	2,232,116	2,571,977	1,970,346	3,216,234
Long Term Debt P&I Payments	119,644	119,644	119,644	119,644	119,469	119,469
Medicare Recoupment	310,368	327,275	11,526	45,869	104,265	-
Payroll Net	1,467,314	1,003,477	996,720	1,062,025	1,006,110	1,004,829
Transfer to Money Market	956,376	924,827	1,155,126	554,128	1,006,989	1,175,950
Other	169,355	10,434	10,435	149,904	13,378	10,435
Total Disbursements	5,491,300	4,455,814	4,525,567	4,503,547	4,220,557	5,526,917
Ending Balance	$ 5,197,298	$ 4,503,261	$ 3,603,094	$ 3,082,375	$ 1,868,620	$ 1,217,882
Net Increase (Decrease)	(914,883)	(694,036)	(900,168)	(520,719)	(1,213,755)	(650,738)

Debt

Drew Memorial's current debt profile consists of debt service obligations and long-term revenue bonds secured by real estate mortgage and hospital revenue. In summary, there were three bonds issued in 2010

(Series 2010A, 2010B, and 2010C) secured by real estate mortgage, a 2017 "Hospital Revenue Temporary Bond", and two bonds issued by the USDA in 2018 that were used to satisfy the 2017 bond and is secured by hospital revenue and a mortgage on the facility on a parity basis with the Series 2010 Bonds. See Appendix: Exhibit A for details on current debt structure, including debt service requirements as of March 31, 2021, and details related to the hospital's existing long-term revenue bonds.

Revenue

With deteriorating cash on hand, uncertainties regarding revenue cycle management, and required debt-service liabilities, revenue trends will help provide a year-over-year understanding of the current fiscal condition from a "top-line" perspective. Using annualized Sept. 2022 through Feb. 2023 financials, Drew Memorial appears to be facing a 19% drop in net patient service revenue (NPSR) from the prior year. This seems to be consistent with the hospital's reported service volume decline as compared to the previous year. Large amounts of supplemental support (*e.g.*, CARES Act, PPP loan forgiveness) helped bolster Drew Memorial's financials in FY2022. Supplemental funding is outlined in the table below. The hospital's sustainability plan includes approximately $4M in revenue enhancements, however, $3.3M of this impact comes from initiatives that have not been executed and includes projected revenues from new or enhanced services (*i.e.*, chemical dependency) that will likely take time to establish and reach the projected annual impact described.

Table 51: Drew's Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 41,769,602	$ 33,980,294	-19%
Other Revenue	417,640	373,994	-10%
Total Revenue	**42,187,242**	**34,354,288**	**-19%**
Salaries, Wages & Benefits (SWB) Expense	20,882,351	20,581,542	-1%
Supplies Expense	8,609,834	3,016,364	-65%
Other Operating Expense	14,608,516	15,028,178	3%
EBITDA	**(1,913,459)**	**(4,271,796)**	**-123%**
Depreciation Expense	2,870,619	2,773,248	-3%
Operating Income	**(4,784,078)**	**(7,045,044)**	**-47%**
Non-Operating Income (Expense)	11,263,819	(683,754)	-106%
Net Income	**6,479,741**	**(7,728,798)**	**-219%**
Operating Margin	-11%	-21%	-81%
NPSR / Adj Discharge		$ 6,309	
Expense / Adj Discharge		$ 7,686	

**Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

Trends in expenses can also provide insight into effectiveness of the Sustainability plan and contributors to the current fiscal condition. Flat salaries, wages, benefits, and payroll tax (SWB) expenses and other

operating expenses (excluding supplies) are not reflective of adjustments typically made when facing significant drops in service volume. Drew Memorial's SWB per Paid FTE peaked at $5,625 per Paid FTE in December 2022.

The hospital's sustainability plan's expense reduction efforts projects $3.2M in year one savings, however, $2.1M of this impact comes from initiatives that have not been executed and include establishing an in-house revenue cycle management team which will require hiring of skilled personnel. Furthermore, this also include service line optimization that may require execution of a partnership before any impact can be realized.

Supplemental Funding

As previously indicated, supplemental funding helped bolstered Drew Memorial's financial position in the last two fiscal years. This funding has been recognized to-date based on when Drew Memorial recognized revenues. The Supplemental Funding table below summarizes the significant supplemental funding that was received.

Table 52: Drew's Supplemental Funding

Supplemental Funding	FY2021	FY2022
CARES Act	$ 5,332,000	$ 6,425,000
American Rescue Plan Act (ARPA)		$ 981,000
Arkansas' ARPA (SFRF)		$ 750,000
AR Community Development Block Grant		$ 490,000
Paycheck Protection Program (PPP)		$ 3,235,300
Total	**$ 5,332,000**	**$ 11,881,300**

Notes:

Table above is based on when Drew Memorial recognized revenues.
The CARES Act includes the recognized portion of HRSA Provider Relief Funds and CRF funds provided by the State.
Hospital has received $2,092,000 in total ARPA funds but has only recognized $981k in revenue for FY2022
PPP Loan was forgiven in June 2021

Break-Even Analysis

Given the trends associated with Drew Memorial's operational outlook and fiscal condition, and the potential impact of the sustainability plan, a break-even analysis was performed to approximate the current Net Income (Loss). A below break-even analysis was performed based on a trailing 6-month annualization of the Drew Memorial income statement. As flagged with the in-table red circle below, their annualized FY23 net income is negative $7,728,798. The currently quantified sustainability plan, if all impact dollars are achieved, has a potential impact of $7,294,687.

Table 53: Drew's Break-even Analysis

Drew Memorial Income Statement	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	Breakeven over the last 2 Quarters	12 Month Total	18 Month Total
Net patient service revenue	$ 3,170,848	$ 2,907,668	$ 2,543,558	$ 2,560,691	$ 3,412,775	$ 2,394,607	$ 16,990,147	$ 33,980,294	$ 50,970,441
Other Operating Revenues	33,856	33,738	31,481	30,718	26,458	30,746	$ 186,997	373,994	560,991
Total Revenue	3,204,704	2,941,406	2,575,039	2,591,409	3,439,233	2,425,353	17,177,144	34,354,288	51,531,432
Salaries, Wages, Benefits and Payroll Taxes	1,704,172	1,820,466	1,656,851	1,884,767	1,549,036	1,675,479	10,290,771	20,581,542	30,872,313
Supplies	201,111	304,869	315,730	214,791	273,281	198,400	1,508,182	3,016,364	4,524,546
Total Operating Expenses Less D&A	3,125,451	3,381,676	3,065,976	3,350,177	3,334,901	3,054,861	19,313,042	38,626,084	57,939,126
EBITDA	**$ 79,253**	**$ (440,270)**	**$ (490,937)**	**$ (758,769)**	**$ 104,332**	**$ (629,508)**	**$ (2,135,898)**	**$ (4,271,796)**	**$ (6,407,694)**
Depreciation	231,104	231,104	231,104	231,104	231,104	231,104	1,386,624	2,773,248	4,159,872
Total Operating Expenses	3,356,555	3,612,780	3,297,080	3,581,281	3,566,005	3,285,965	20,699,666	41,399,332	62,098,998
Operating Income (Loss)	**$ (151,850)**	**$ (671,375)**	**$ (722,040)**	**$ (989,872)**	**$ (126,772)**	**$ (860,612)**	**$ (3,522,522)**	**$ (7,045,044)**	**$ (10,567,566)**
Interest Expense	(73,543)	(71,023)	(76,293)	(67,469)	(72,729)	(72,348)	(433,405)	(866,810)	(1,300,215)
Non-Operating Income (Expenses)	33,116	3,217	52,082	321	792	2,000	91,528	183,056	274,584
Net Income (Loss)	**$ (192,278)**	**$ (739,180)**	**$ (746,252)**	**$ (1,057,021)**	**$ (198,709)**	**$ (930,960)**	**$ (3,864,399)**	**$ (7,728,798)**	**$ (11,593,197)**

Capital Considerations

In addition to all the operational and financial considerations described above, Drew Memorial's physical plant requires certain capital considerations to continue, sustain, and enhance operations. Hospital leadership provided a capital budget that included approximately $4.4M in medical equipment over the next three fiscal years. During our on-site reviews and tours, we observed several additional capital and infrastructure items that also will require investment and major funding over the next few years. The hospital was built in multiple different phases, with the original section of the building dating back to 1972. There was another addition in the late 1970s, along with several expansions throughout the 1990s. Particularly concerning are the issues with the air handlers that are significantly aged over the older parts of the building. There is already one air handler that is currently inoperable that sits over the old operating rooms of the hospital, which equates to approximately 7,500 square feet that is unusable without adding portable heating / AC units. Two additional air handlers that sit over the old part of the facility are end of life and need to be replaced as well as they are from the 1970s. These units are operating at approximately 20% capacity, and so the facility struggles with keeping different areas cool during the summer and warm in the winter.

Upcoming Obligations

Drew Memorial is preparing for a new electronic medical record (EMR) implementation, as it moves from Computer Programs and Systems, Inc (CPSI) to Cerner Health. Having completed several initial testing sessions, Drew is solely responsible for Cerner travel-related reimbursement at this time. The hospital estimates that the transition to Cerner will cost the hospital an additional $200k per year and implementation costs are included in the monthly/annual fees and are not separate in the agreement. A decision to make a change in revenue cycle management is likely to be considered after the Cerner implementation, however nothing definitive has been established at this time.

Sustainability Plan

Given the revenue cycle management challenges and consistently below budgeted operational statistics described earlier, a strong sustainability plan is critical at Drew Memorial. Hospital leadership provided a sustainability plan that included several revenue enhancement and expense reduction items that had either already been implemented or were planned for the near future.[74] Per leadership, many of the revenue enhancement items were difficult to quantify, however, several of the original revenue enhancement and expense reduction initiatives were quantified and new initiative were submitted post on-site review as part of an updated sustainability plan. The updated plan quantification contributes $4.7M to the $7.3M Sustainability plan summarized below in the table below.

Table 54: Drew's Sustainability Plan

Drew Memorial Health System Sustainability Plan Summary	FINANCIAL IMPACT		
ACTION	*Action Complete*	*Action Pending*	*Total*
Revenue Enhancement:			
Behavioral Health Services - Broaden admission criteria, expand outpatient services, begin chemical dependency program	-	1,422,370	1,422,370
Renegotiate payor contracts - Negotiate with BCBS, UHC, and other payors	487,000	-	487,000
Pulmonary Rehab Program - Establish outpatient program. Delays due to Cerner delays.	-	315,000	315,000
Primary care / Urgent care Services - Establish providered based RHC / urgent care services	-	525,000	525,000
Expand 340b - Expanded 340b program and patient assistance program for co-pays	-	1,000,000	1,000,000
Expand Outpatient Specialty Clinic - Add additional providers (ENT, Pulmonologist, Urologist)	*Impact unknown*	-	*Impact unknown*
Hospital Based Specialties - Add or expand service offerings; including addition of Velys Robot for orthopedics	308,353	-	308,353
Marketing - Established focused and enhanced plan	*Impact unknown*	-	*Impact unknown*
TOTAL REVENUE ENHANCEMENT IMPACT	**$ 795,353**	**$ 3,262,370**	**$ 4,057,723**
Expense Reduction:			
***Travel nurse contracts -** Eliminate and replace with inhouse contracts	$165/hr changed to $85/hr		
Staff Reductions - Eliminate positions and avoid backfilling vaccancies	248,000	766,000	1,014,000
Contract Reductions - Renegotitate contractual obligations (phsyc, pharm mgmt, RCM vendor, Aramark, other)	305,000	309,000	614,000
****Service Line Optimization -** Eliminate Women's Service Clinic and possible addn reduction of nonperforming services	491,764	515,000	1,006,764
New Initiatives from updated plan - Bring RCM in house and other expense reduction measures	60,000	542,200	602,200
TOTAL EXPENSE REDUCTION IMPACT	**$ 1,104,764**	**$ 2,132,200**	**$ 3,236,964**
***TOTAL IMPACT**	**$ 1,900,117**	**$ 5,394,570**	**$ 7,294,687**

**Travel nurse elimination impact not included in Total*
***Total includes potential service line optimizating impact of $450k to "Action pending", however decision to take action is not final*
****Total Impact is expected to be realized primarily in or after 2023 and does not include Recruitment and retention efforts and Funding opportunities*

Revenue Enhancements

- Behavior Health Services
  - They have decreased the admitting age from 65 to 55 on their geriatric psychiatric unit to increase the census on the unit. Unit is already staffed, and no additional costs are anticipated to support the additional census. DMHS also intends on expanding outpatient mental health services beyond IOP to accommodate a diverse age range (children to geriatric patients) and offer IOP to patients after detox (impact of $96k). There are also plans to enroll in Rural Life 360 program if deemed eligible.
  - DMHS intends on converting 11 geripsych beds for use of a new Chemical dependency program with a projected impact of $1.3M. This will however require additional licensures, certifications, and specialized staff and exact timelines for impact may be at risk.
- Renegotiate Payer Contracts
  - They have renegotiated their Blue Cross and UnitedHealth payer contracts. Blue cross renegotiation led to $1,000 increase in reimbursement per inpatient discharge. These changes went into effect in June 2022 and should already be seen in the trailing six months financials. The BCBS negotiation resulted in a $487k impact.
- Pulmonary Rehab Program

[74] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

    - They are hoping to open an outpatient Pulmonary Rehab program in May 2023 that shows potential increased reimbursement of $211,000 - $379,000. There have been a number of issues getting the program started that are tied to Drew's Cerner implementation and the new EMR is needed to begin the program. DMHS has suggested the possibility of starting the program on paper in case of further Cerner delays and projects $315k impact in the quantification in the Sustainability Plan Summary table above.
- Primary care / Urgent care Services
    - DMHS intends on establishing a provider based RHC / urgent care with annual impact of $525k.
- Expand 340B
    - They have expanded the hospital's 340B program and anticipates an additional $1,000,000 from the expansion and by instituting a patient assistance program for co-pays. The expanded program is anticipated to go live April 1st, 2023, and Drew Memorial is expecting to see revenues from the program increase shortly after the go live date.
- Expand Outpatient Specialty Clinic and Hospital based specialists
    - They have added several physicians, including another general surgeon who started in September 2022, a physician assistant for urology, a Pulmonologist in December 2022, and an Ear, Nose, and Throat (ENT) physician who started in February 2023.
    - They have expanded their Orthopedic offering by signing an agreement for a VELYS Robot in January 2023. First robotic cases were to be done on March 22nd, 2023, with anticipated annual impact of $308k.
- Marketing
    - DMHS has started a focused marketing effort enhanced visibility and presence.

<u>Expense Reductions</u>

- Travel Nurse Contracts
    - Hospital leadership has been able to successfully eliminate travel nurse contracts that were $165 per hour in March 2022 for in house contracts that are between $68 - $8 per hour.
        - In-house contracts are still significantly above regular hourly rate at around $35 per hour more. Part of the issue is currently hourly wages for staff are not competitive; Drew Memorial needs to perform wage increases to be competitive with the area, but they do not have the funds to do so.
- Staff Reduction
    - They have eliminated several non-clinical positions across the organization that have resulted in annual savings:
        - Eliminated Greeter positions in August 2022 for annual savings of ~$144,000.
        - Not backfilling three positions that became vacant for an annual savings of ~$104,000.
        - Additional 15 positions being reviewed with impact potential of $766,000.
- Contract Reductions
    - Hospital leadership was able to successfully renegotiate several contracts that resulted in annual savings:

        - Psychiatrist contract renegotiated back in September 2022 for an estimated savings of approximately $100,000 annually.
        - Renegotiated contract with pharmacy management company for annual savings of $50,000.
        - Negotiated a rate decrease with their RCM Vendor in October 2022 for a savings of $75,000 split over six months (remaining savings will be recognized by Q1 of 2023).
        - Renegotiated their contract with Aramark in November 2022 for dietary and environmental services resulting in an annual savings of $80,000.
        - DMHS believes other contracts exist with reduction potential and potential impact of $309,000.
- Service Line Optimization
    - They have eliminated Women's Services Clinic in August 2022 resulting in elimination of yearly loss of $491,764.
    - They are evaluating opportunities around a range of related service lines which could eliminate an annual loss of $450,000 - $515,000 if eliminated. Nothing is implemented as of the date of A&M's on-site visit.
- New Initiatives from updated plan
    - Cost reduction efforts such as change of employee benefits from BCBS to UHC (action complete) and reduction in printing expense (action planned) have an impact of $60,000 and $7200, respectively.
    - DMHS has a plan to bring RCM in house. This would require hiring skilled staff and is believed to have an impact of $535,000. In this plan, the "early out" and "bad debt" vendors would remain outsourced.

Recruitment and Retention

As part of their sustainability plan, DMHS is involved in several recruitment and retention efforts. They are partnering with University of Arkansas at Monticello to try and recruit new nurses and decrease traveler usage / costs. Approximately $150,000 to start the scholarship program was given by the Foundation. They are also partnering with South Arkansas Community College in a RN clinical instructor program. Efforts are also underway to enhance certifications and skills of existing radiology staff and DMHS hopes to start recruitment H1B efforts for MT staff in the lab.

In early 2023, Drew Memorial leadership and representatives from the Baptist Health System met multiple times to discuss Drew Memorial potentially joining the consolidated Baptist Health System, which has integrated other challenged regional hospitals in the past. Pressures around staffing, sustainability, payer contracts, and supply chain underlie Drew Memorial's engagement in these discussions. Baptist completed a review prior to this meeting, noting Drew Memorial's weaknesses around RCM, labor challenges, information technology and data/management tools. Drew's hospital board member Carl Lucky stated the following in regard to those discussions:

"*We've made a lot of progress physically at this hospital and we provide a lot of great services. But we are struggling to keep the right people in the right jobs for a long enough time to get things accomplished*."[75]

The partnership would be a sublease model, with Baptist subleasing the 501(c)(3) from the County for 20-25 years, with the County retaining full ownership. The discussions mentioned a start date of June/July 2023. Baptist board leadership believes that the partnership model would stabilize Drew's revenue cycle issues and offer additional support to address other opportunities that they identified (*e.g.*, labor challenges, data management tool immaturity, supply chain optimization, etc.). Baptist would want Drew to support efforts to increase the local sales tax by at 0.75-1% from the current 4.4% to compete with CAH funding levels.

Drew has considered CAH status but is limited by the 25-bed rule and is too close to Warren to meet the 30–35-mile restriction.

[75] Deltaplex News, January 27th, 2023; *Memorial System Hospital Board discusses financial condition with new partnership.* Drew Memorial System Hospital Board discusses financial condition with new partnership – Deltaplex News

Eureka Springs Medical Center

Quick Facts

- Classification: CAH
- Licensed Beds: 15
- Closest Facility: 11.1 miles
- Average Age of Plant: 75
- Average Daily Patient Occupancy Rate: 8%
- Average length of stay (ALOS): 5.3 days
- Total full-time employees (FTEs): 60

Location:
Eureka Springs, Carroll County
County Population: 28,435
(2021)

Table 55: Eureka Springs' Summary Statistics

Operating Statistics		
C&C Equivalents	$	6.0 M
Current Assets	$	7.2 M
Net A/R	$	0.9 M
Total Assets	$	8.6 M
Days Cash on Hand		244.38
Quick Ratio		9.22
Current Ratio		9.47
Debt Service Coverage Ratio		No long term debt - only capital leases
Days in Net AR		49.18
Average Age of Plant		N/A
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	6.5 M
Other Revenue	$	0.8 M
Total Revenue	$	7.3 M
Salaries, Wages & Benefits	$	4.6 M
EBITDA	$	(1.7 M)
Operating Income	$	(1.8 M)
Non-Operating Income/(Expense)	$	3.9 M
Net Income	$	2.1 M
Operating Margin %		-25%

Key Challenges

- Eureka Springs leadership shared challenges surrounding low inpatient and swing bed average daily census (ADC) (but improving after hospitalist change) and month-over-month decrease in emergency department (ED) volume (Sept. 2022 to Feb. 2023). Cash and Cash equivalents includes "Restricted funds" that are inflating days cash on hand (COH) to 244 days, IT updates planned, and the average age of physical plant is 75 years.

1. *Patient Volume Trends*[76]:
   - Annualized acute discharges (46) were 63% lower than prior year (126)
   - Annualized swing bed discharges (16) were roughly the same as prior year (14)
   - ED discharges (3,078) were roughly the same as prior year (3,076)
2. *Financial Status*[77]
   - DCOH: 244 days
   - Quick Ratio: 9.2 (Feb. 2023)
     - Both figures above are inclusive of a $3.6M hospice license sale, of which management indicated the funds are restricted
   - Operating margin: Annualized operating margin is a ($1.8M) net loss
   - Net Income is a net gain of $2.1M (that net gain is inclusive of $3.9M in "non-operating other revenue" which itself is inclusive of $3.6M in proceeds from the sale of a home health/hospice license)
   - RCM is outsourced to their electronic medical record (EMR) vendor
   - Department level claims processing backlog in Dec. 2022 lead to reduced financial performance in Jan. 2023. The problem has purportedly since been resolved
   - Per hospital leadership, accounts receivable (A/R) balance includes many claims that are aged out of collectability (as old as 2019 and 2020). Leadership aims to recategorize these claims as bad debt
   - A/R days is currently at 49.2 days
3. *Labor Challenges*
   - Stopped travel agency staffing in Feb. 2023
   - Average RN tenure is seven years
4. *Technology Challenges*[78]
   - EMR requires frequent updates
   - In process of obtaining new cyber insurance coverage. Previous insurer no longer offering cyber security policies
5. *Sustainability Plan*
   - Hospital leadership hopes to engage in revenue enhancement efforts by collaborating with the community and other providers to share resources and determine new service lines for the area such as respiratory therapy (expected to generate $80k - $100k annually)
   - A new pharmacist is scheduled to start in July 2023 and intends on enhancing hospital 340B revenues

[76] Annualized Sept. 2022 to Feb. 2023 stats versus annualized Sept. 2021 to Feb. 2022 stats.
[77] Annualized Sept. 2022 to Feb. 2023 stats versus annualized Sept. 2021 to Feb. 2022 stats.
[78] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- Expense reduction efforts include implementation of a supply chain software and internal assessments for optimizing efficiencies (*i.e.*, staffing)
- Capital expenditures and technology updates for the purpose of increased efficiency, improving the patient experience, and increasing testing and therapy services. This is expected to cost ~$685k
- Eureka Springs is not currently interested in REH designation because of concern over loss of swing beds

6 *Physical Plant*

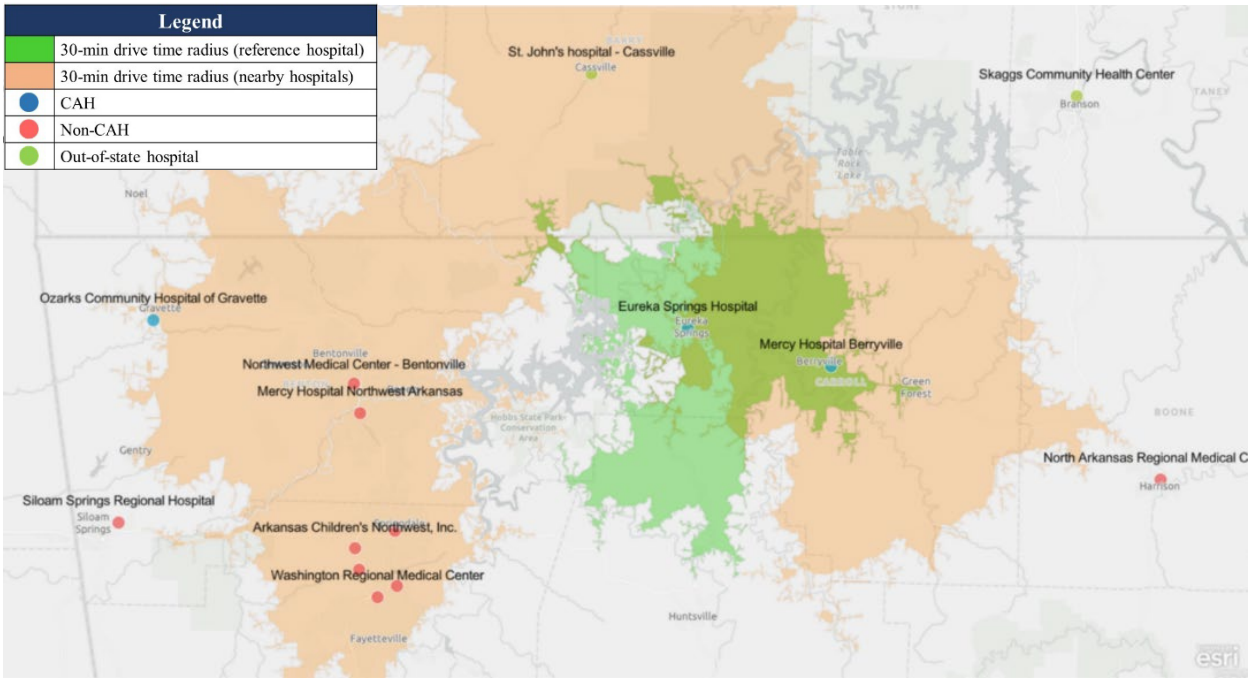
- The average age of the facility itself is 75 years (one building that is 94 years old and the other is 56 years old). Many of Eureka Springs's assets are past useful life and are fully depreciated
- With the exception of a few recent updates, most equipment and infrastructure are dated but functioning due to regular preventative maintenance and regular servicing
- An air handler recently stopped functioning, but this did not impact direct patient care areas and is not currently being repaired.
- The hospital's governing board and management is actively looking at options for facility improvements and have engaged an architect for this project

Drive Time Assessment - Alternatives in the Surrounding Community

A population estimated at 416,153 is located within a 30-mile radius of Eureka Springs.[79] Eureka Springs Hospital is one of two hospitals within Carrol County, a county in northwest Arkansas with a population of roughly 28,435. The two closest alternative hospitals to Eureka Springs are Mercy Hospital – Berryville (11.1 miles to the east) and St. John's Hospital – Cassville (20.23 miles to the northwest) located in neighboring cities of Berryville, AR and Cassville, MO, respectively. Additional alternatives lie beyond a 25-mile, or 45-minute drive include Northwest Medical Center in Bentonville, AR. People living to the south or southwest of Eureka may find that their closest alternative is about 26 miles from Eureka Springs at Northwest Medical Center-Springdale or Regency Hospital - Springdale.

[79] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

Figure 15: Eureka Springs' Drive Time Assessment



Observations Related to Operational Outlook

The YTD average length of stay (ALOS) was 5.3 days, and the acute average daily census (ADC) was 0.7. Total ADC was 1.16 while the occupancy rate for the year was ~8%. For comparison, the national benchmark ALOS for CAH facilities is 4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%.[80] The Arkansas state benchmark for ADC is 2.98. A higher ALOS, lower ADC, and lower occupancy rate, compared to benchmarks is consistent with deteriorating or low inpatient volume stats.

As of Feb. 2023, Eureka Springs has reported 46 annualized inpatient discharges with an adjustment factor of 13.04 resulting in total adjusted discharges of 600.[81] Annualized adjusted patient days for the current year were 3,155. Annualized ER visits for the current year were 3,078. Although inpatient census has been low, hospital leadership is anticipating an increase in inpatient volume after assigning a new hospitalist

[80] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/
[40] CAH Financial Indicators Report: Summary of Indicator Medians by State. May 2022 State Medians Report 2022 (FLEX)
[81] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue.

provider to Eureka Springs. Leadership also noted that inclement weather and tourism plays a role in volumes' trends seen at Eureka Springs.

Total FTEs were 60. The total clinical FTEs count was 36. FTEs per each adjusted occupied bed (also called "FTEs per adjusted ADC") was 3.97. The state benchmark for FTEs per adjusted ADC was 4.6-5.72.[82] Labor cost per net patient revenue was at 72% compared to the benchmark of 50%-60% for CAHs.[83] Staffing at Eureka Springs has had some reliance on agency and contract labor, however, as of Feb. 2023, there was no/limited reliance on agency staffing a leadership expects to see a reduction of such expense.

Table 56: Eureka Springs' Operational Outlook

Key Indicators - Operational Outlook	
(Sept 2022 - Feb 2023)	
Total Inpatient Discharges	46
Adjustment Factor	13.04
Total Adjusted Discharges	600
Hospital Patient Days	242
Adjusted Patient Days	3,155
Average Daily Census	0.7
Average Length of Stay	5.3
Emergency Department Visits	3,078
Occupancy Rate	8%
Total FTEs	60
Total CFTEs	Not provided
Case Mix Index	Not provided
Labor Cost / Net Patient Revenue	72%
FTEs per Adjusted Occupied Bed	4.0

Observations related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (Feb. 2023). Based on the initial data received, A&M's on-site review, and 2023 data, Eureka Springs' cash position is relatively stable with Feb. 2023 cash and cash equivalents at $6.0M. Management has stated that $5.4M of these funds are "restricted funds" by the Eureka Springs Hospital Commission (aka the Board) and that these funds are "currently being utilized for the anticipated expansion and renovation of the physical hospital facility". According to hospital leadership, at least $3.6M of these "Restricted funds" are from the sale of a home health / hospice license that was sold in Feb. 2023. These funds have been included in the days DCOH, quick ratio, and other financial assessments because hospital-provided data included them in hospital financials as a cash asset which is consistent with the assessment of other hospitals. Daily expenditures were $24.7k with 244 days cash on hand as of Feb. 2023. The stability of these figures combined with the quick ratio of 9.2 (including the $3.6M sale proceeds) displays a stable outlook for Eureka Springs's current financial condition.

Table 57: Eureka Springs' Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	6,024,328
Inventory and Prepaid Expenses	$	191,246
Current Assets	$	7,237,558
Total Assets	$	8,618,228
Current Liabilities	$	764,428
Total Long-Term Debt	$	-
Total Liabilities	$	2,515,376
Net Position	$	6,102,852
Daily Expenditures	$	24,652
Days Cash on Hand		244.4
Quick Ratio		9.2
Current Ratio		9.47
Debt Service Coverage Ratio		No long term debt - only capital leases
Average Age of Plant		N/A
Days in Net Accounts Receivable		49.18
Debt to Operating Revenue		No long term debt - only capital leases

[82] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.
[83] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Cash Position

As mentioned above, days cash on hand (COH) is 244 days as of Feb. 2023. If the $3.6M licensure sale is removed, the DCOH calculation drops to ~97 days, and the quick ratio is approximately 4.45. This is consistent with a healthy financial picture. In an effort to support the strong cash position, Eureka Springs leadership has made deliberate efforts on its revenue cycle management (RCM) to ensure cash flow through regular revenue cycles. Specifically, leadership has focused on cleaning up accounts receivables (A/R) and uncollectable/bad debt balances. RCM is overseen by Eureka Springs leadership but is outsourced to Eureka Springs's electronic medical record provider, MedHost. In this arrangement, coding and registration is done by Eureka Springs and all other components of RCM are conducted by MedHost. Eureka Springs's current A.R days is 49.2.

Debt

Eureka Springs holds imaging equipment "debt" in the form of a capital lease; however, it does not currently hold any long-term debt or bonds.

Revenue

Using annualized FY23 financials from Sept. 2022 to February 2023, Eureka Springs may see a 19% decrease in net patient revenue (NPSR) from the prior year. This appears to be consistent with the hospital's reported recent service volume decreases. Revenue in Jan. 2023 was reduced as a result of an internal RCM hold that slowed claims from being processed but this appears to have since been resolved.

The clear driver for revenue at Eureka Springs is outpatient revenue. Specifically, outpatient ancillary and emergency room revenue. This explains why Eureka Springs's adjustment factor was relatively high at 13.04, because the adjustment factor is a normalization of gross revenues by the inpatient component of those revenues and gives insight into the relative weight of the outpatient component of gross revenues.

Table 58: Eureka Springs' Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 8,063,878	$ 6,495,592	-19%
Other Revenue	404,431	768,728	90%
Total Revenue	**8,468,309**	**7,264,320**	**-14%**
Salaries, Wages & Benefits (SWB) Expense	4,404,434	4,649,312	6%
Supplies Expense	716,696	572,492	-20%
Other Operating Expense	3,600,007	3,760,320	4%
EBITDA	**(252,828)**	**(1,717,804)**	**-579%**
Depreciation Expense	136,639	97,732	-28%
Operating Income	**(389,467)**	**(1,815,536)**	**-366%**
Non-Operating Income (Expense)	260,557	3,881,586	1390%
Net Income	**(128,910)**	**2,066,050**	**1703%**
Operating Margin	-5%	-25%	-443%
NPSR / Adj Discharge		$ 10,832	
Expense / Adj Discharge		$ 15,141	

**Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

Eureka Springs's reduction in volumes is consistent with a 20% decrease in supply cost compared to the prior year. This is largely due to closer hospital oversight of supplies and enforcement of standard stock inventory levels. However, salaries, wages, benefits, and payroll taxes (SWB), increased by six percent compared to prior year. This does not include the cost of contract labor – hospital leadership substantially reduced agency/contract staff usage in Feb. 2023. This may explain the rise in SWB because contract labor costs are not commonly factored into SWB calculation. According to leadership, costs related to the potential of age-related physical plant maintenance challenges and associated capital expenses for aged equipment are looming. Outside of these physical plant related challenges, total operating expense has increased three percent compared to the prior year. This is largely due to the increase in payroll costs mentioned above.

Supplemental Funding

Eureka Springs has recognized a total of $182k in supplemental funding from various sources. The table to below summarizes the funding amounts and sources of funding received.

Table 59: Eureka Springs' Supplemental Funding

Supplemental Funding	FY2020	FY2021
Local, State & Tribal Govt Asst	$ 134,317	
Other Assistance Received	$ 7,148	$ 40,468
Total	**$ 141,465**	**$ 40,468**

Notes:

Total provider relief fund amounts received are unknown/were not provided.

Break-Even Analysis

The below break-even analysis is based on a trailing six-month annualization of the Eureka Springs's income statements. This break-even analysis was performed to better visualize month-on-month revenue and expense trends. As seen in the Break-even analysis table below, Net Income (Loss) remains relatively consistent, with the exception of Jan. 2023 and Feb. 2023. In January, Net Income (Loss) appears worse than prior months ($400k) due to a reduction in revenue secondary to an internal RCM hold that delayed claim remittance and resulted in lower Jan. 2023 revenue. Expenses also may appear higher than usual due to the booking of architect invoices that were later re-booked as construction expense in the balance sheet. Feb. 2023 Net Income (Loss) appears to outperform previous months reporting a net gain of $3.7M. This is due to other non-operating revenue from the sale of a home health/hospice license that was mentioned in the preceding sections.

Table 60: Eureka Springs' Break-even Analysis

Metric	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Breakeven over the last 2 Quarters	12 Month (Annualized)	18 Month Total
Net patient service revenue	$ 516,015	$ 599,379	$ 584,285	$ 590,261	$ 469,567	$ 488,289	$ 3,247,796	$ 6,495,592	$ 9,743,388
Other Operating Revenues	100,047	5,254	23,110	29,856	1,280	224,817	384,364	768,728	$ 1,153,092
Total Operating Revenue	616,062	604,633	607,395	620,117	470,847	713,106	3,632,160	7,264,320	10,896,480
Salaries, Wages, Benefits and Payroll Taxes	371,289	398,582	381,740	404,144	409,316	359,585	2,324,656	4,649,312	6,973,968
Supplies	60,887	28,512	57,803	51,158	36,354	51,532	286,246	572,492	858,738
Other Expenses	314,612	324,069	292,811	320,538	426,701	201,429	1,880,160	3,760,320	5,640,480
Total Operating Expenses Less D&A	746,788	751,163	732,354	775,840	872,371	612,546	4,491,062	8,982,124	13,473,186
EBITDA	**$ (130,726)**	**$ (146,530)**	**$ (124,959)**	**$ (155,723)**	**$ (401,524)**	**$ 100,560**	**$ (858,902)**	**$ (1,717,804)**	**$ (2,576,706)**
Depreciation	2,795	2,795	2,795	2,795	18,843	18,843	48,866	97,732	146,598
Total Operating Expenses	749,583	753,958	735,149	778,635	891,214	631,389	4,539,928	9,079,856	13,619,784
Operating Income (Loss)	**$ (133,521)**	**$ (149,325)**	**$ (127,754)**	**$ (158,518)**	**$ (420,367)**	**$ 81,717**	**$ (907,768)**	**$ (1,815,536)**	**$ (2,723,304)**
Interest Income/(Expense)	(938)	(882)	(3,091)	(973)	(1,058)	(978)	(7,920)	(15,840)	(23,760)
Oth Non-Opr Rev/(Exp)	22,957	23,015	23,490	24,824	25,310	3,650,392	3,769,988	3,897,426	4,024,864
Non-Operating Revenues/(Expenses)	22,019	22,133	20,399	23,851	24,252	3,649,414	3,762,068	3,881,586	4,001,104
Net Income (Loss)	**$ (111,502)**	**$ (127,192)**	**$ (107,355)**	**$ (134,667)**	**$ (396,115)**	**$ 3,731,131**	**$ 2,854,300**	**$ 2,066,050**	**$ 1,277,800**

Capital Considerations

The hospital consists of two sections: One of which is 94 years old and another that is 56 years old. Although the facility is currently functioning due to consistent preventative maintenance, there is a serious need for material updates at minimum and potentially a new physical plant. There exists a risk of equipment needing replacement such as generators, boilers, chillers that are functioning and have been maintained, but are from 1986. The hospital has engaged an architect and engineer regarding updates and a possible $30M facility plan based on hospital provided architect invoice.

The hospital is also in process of obtaining new cyber insurance coverage. The previous insurer is no longer offering cyber security policies.

In addition to these capital considerations, the hospital is exploring technology investments and updates to increase efficiencies and improve patient satisfaction. These capital expenses are projected to cost nearly $685k and include hospital beds, gurneys, RT equipment, pharmacy, and other hospital-wide technologies.

Upcoming Obligations

In addition to the facility itself being aged, Eureka Springs also has some significantly aged equipment. The chiller, boiler and generators are all from 1986. All equipment appears to be functioning, but it has required regular preventative maintenance and is beyond end of life. There have been some upgrades to facility. For example, a new nurse call system was installed around 2018 and the domestic hot water heater is aged, but still newer than the 1986 equipment. The roof is about eight to ten years old and does not currently have any significant leaks.

Sustainability Plan

Eureka Springs has a number of revenue enhancing and expense reducing initiatives as part of their sustainability plan.[84] Revenue enhancement efforts include collaborating with the community and other providers to share resources and determine new service lines for the area such as respiratory therapy (expected to generate $80k - $100k annually). Hospital leadership has also already engaged a new pharmacist who intends on developing the 340b program. Expense reduction efforts include implementation of a supply chain software and internal assessments for optimizing efficiencies, i.e. staffing. Capital expenditures and technology updates for the purpose of increased efficiency, improving the patient experience, and increasing testing and therapy services are also part of Eureka Springs' plan.

Table 61: Eureka Springs' Sustainability Plan

Eureka Springs Hospital Sustainability Plan Summary	FINANCIAL IMPACT		
ACTION	*Action Complete*	*Action Pending*	*Total*
Revenue Enhancement:			
Collaborate with community and other providers	*Impact Unkown*	-	*Impact Unkown*
Enhanced Respiratory Service Offerings (PFT, Smoking cessation program)	-	90,000	90,000
340b encahncement	-	*Impact unkown*	*Impact unkown*
TOTAL REVENUE ENHANCEMENT IMPACT	**$ -**	**$ 90,000**	**$ 90,000**
Expense Reduction:			
Internal assessments for optimizing efficiencies (i.e. staffing)	*Impact Unkown*	*Impact Unkown*	*Impact Unkown*
Staffing Ratio Optimization	*Impact Unkown*	-	*Impact Unkown*
Supply chain software implementation	*Impact Unkown*	-	*Impact Unkown*
Technology Updates/Investments		*Impact Unkown*	*Impact Unkown*
TOTAL EXPENSE REDUCTION IMPACT	**$ -**	**$ -**	**$ -**
TOTAL IMPACT	**$ -**	**$ 90,000**	**$ 90,000**

- Streamlining administrative processes
    - Leadership aims to have conducted a review of administrative processes to identify areas for improvement in an effort to implement new systems and processes to streamline workflows and reduce the time and resources required for administrative tasks.

[84] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

- Investing in technology
    - Leadership has invested in innovative technologies to improve patient care, reduce waste, and increase efficiency. For example, leadership invested in a UV-C system that offers Mobile, and stationary hospital-grade UV-C disinfection. It has improved efficacy, sustainability, and decreased cost-per-disinfection, plus it is safer than chemical spraying and allows for an extra layer of protection to improve patient outcomes, protect hospital visitors, and safe-guard staff.
    - Leadership is also looking at the future when it comes to technology, to improve both clinical and financial operations, and is considering investing in hospital-wide technologies. This will help streamline the patient care experience as well as address staff needs decreasing frustrations and burnout. To further the patient care experience, leadership will be upgrading current patient care technology, for example there will be an upgrade of the patient care monitors throughout the facility that will be better suited to collect data and make it easily available. The cost for this upgrade totals to approximately $220,500.
    - Another area that requires a technological upgrade is the pharmacy, leadership will be adding an automated medication dispensing system that will improve pharmacy efficiency since currently medication fills are manual and this upgrade will streamline patient medication usage as well as monitor inventory, this addition's initial investment will be $18,000. Even though these are all large expenses they are much-needed upgrades to ensure patient care remains top priority while improving hospital wide efficiency.
- Improving patient experience
    - Leadership believes that a positive patient experience is essential to their success as a healthcare provider. To this end, leadership has implemented several initiatives aimed at improving the patient experience, including improving communication with patients and families, providing more personalized care, and improving the comfort and aesthetics of the facilities. Leadership is investing in improving patient comfort and their ability to heal through the purchase of upgraded hospital beds at the cost of $300,000. Leadership will not see an increase in revenue through this purchase, however an increase in patient comfort and care is the goal here. New gurneys will also be purchased for the Emergency Department, with a focus of adding gurneys with the ability to weigh patients. **This is a most important addition** due to the need for accurate weights for stroke patients because the life-saving medication is weight-based dosing. The investment cost for this upgrade totals $16,700.
- Improving financial performance
    - Leadership has conducted a review of financial performance to identify areas for improvement. Leadership has implemented cost-saving measures, such as implementing supply chain software and optimizing staffing levels, to improve financial performance and ensure long-term sustainability.
- Fostering collaboration
    - Leadership believes that collaboration is key to achieving success in healthcare. Leadership has established partnerships with other healthcare providers, community organizations, and government agencies to share resources, reduce duplication, and promote best practices.
- Community Involvement

- Leadership believes that the community is key to success, and it has rebuilt relationship with the community over the past several years and will continue to foster that positive relationship that we have all strived so hard to grow.

- Future Endeavors
  - To remain a need in the community leadership is focusing on the needs of the community and what new service lines would be of great benefit to them as well as boost the hospital's sustainability. Eureka Springs is void of respiratory care, and due to the rising need being seen for respiratory services for post COVID-19 patients who continue to struggle as well as chronic respiratory patients, leadership is dedicated to bringing these much-needed services in house. In the next 12-18 months leadership aims to be investing in multiple respiratory technologies that will allow complete pulmonary functioning tests, this technology will also allow focus on asthma education for both adult and pediatric patients, and it will further allow leadership to offer smoking cessation programs for the community which will improve community health overall. By adding these services, it benefits us as a facility because the potential for increased inpatient and outpatient revenue. The equipment purchases and operation costs totaled $29,995 with the potential to increase net revenue by $80,000-$100,000 annually.

Fulton County Hospital

Quick Facts

- Classification: CAH
- Licensed Beds: 25
- Closest Facility: 24.8 miles
- Average Age of Plant: 27.1 years
- Average Daily Patient Occupancy Rate: ~19%
- Average length of stay (ALOS): 5.0
- Total full-time employees (FTEs): 108

Location: Salem, Fulton County
County Population: 12,145 (2021)

Table 62: Fulton's Summary Statistics

Operating Statistics		
C&C Equivalents	$	(0.0 M)
Current Assets	$	5.1 M
Net A/R	$	4.3 M
Total Assets	$	8.3 M
Days Cash on Hand		-0.44
Quick Ratio		4.01
Current Ratio		4.25
Debt Service Coverage Ratio		-0.76
Days in Net AR		154.94
Average Age of Plant		27.06
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	9.9 M
Other Revenue	$	0.3 M
Total Revenue	$	10.2 M
Salaries, Wages & Benefits	$	5.7 M
EBITDA	$	0.1 M
Operating Income	$	(0.4 M)
Non-Operating Income/(Expense)	$	0.6 M
Net Income	$	0.2 M
Operating Margin %		-4%

Executive Summary

Key Challenges

Fulton County is in a dire financial position and at risk of closure. That risk is compounded by the lack of other hospitals within a 30-minute drive time of Fulton County (see the Drive Time Assessment section immediately below for this visualization) and by its extremely high average days in accounts receivable (A/R) due in part to a problematic electronic medical record (EMR) implementation and timely billing difficulties. Hospital leadership is not confident in the ability to continue current operations in the medium- or long-term. They have had discussions with Baxter Regional about a potential partnership or acquisition and are also considering converting to the rural emergency hospital (REH) designation.

1. *Patient Volume Trends*
   - The average daily census of the hospital has been deteriorating over the last few years. On the day of our visit there were only two inpatients in the hospital
   - Leadership reported that sometimes there will be as many as 14 patients in the inpatient ward, but census is often quite low
2. *Financial Status*
   - Fulton County had only $494k (17.5 days) of cash on hand at the end of December 2022. This days of cash on hand metric has further deteriorated to a negative position in February 2023
   - In early 2023, the hospital obtained a $250k line of credit from their local bank that they have started using
3. *Labor Challenges*
   - In large part due to its location, the hospital is struggling with maintaining staffing levels across all levels and areas. Many staff members are filling multiple roles (*e.g.*, the Chief Nursing Officer (CNO) is also the scope procedure nurse and has been taking extra night shifts to fill staffing gaps)
4. *Technology Challenges*[85]
   - In October 2021, the hospital had a problematic conversion of their EMR system that they are still working to mitigate. For the first five months following the transition, the hospital was entirely unable to bill for services. This has contributed to a massive spike in average accounts receivable (A/R) days, which were 172.9 as of December 2022. Back-end functionality of the system is still not in place, requiring significant manual work to translate internal records to the billing system
5. *Sustainability Plan*
   - Fulton County does not have a robust sustainability plan. Given the limited capital available for investment and deteriorating average daily census (ADC), many components of the hospital's plan involve reducing costs rather than increasing revenues and lack quantification
6. *Physical Plant*
   - Fulton County's physical plant is in poor condition with an average age of plant of 27.1 years and little to no funds available for capital expenditure. The facility has been creative and obtained numerous grants over the years to fund capital upgrades, but much is still needed from a physical plant perspective

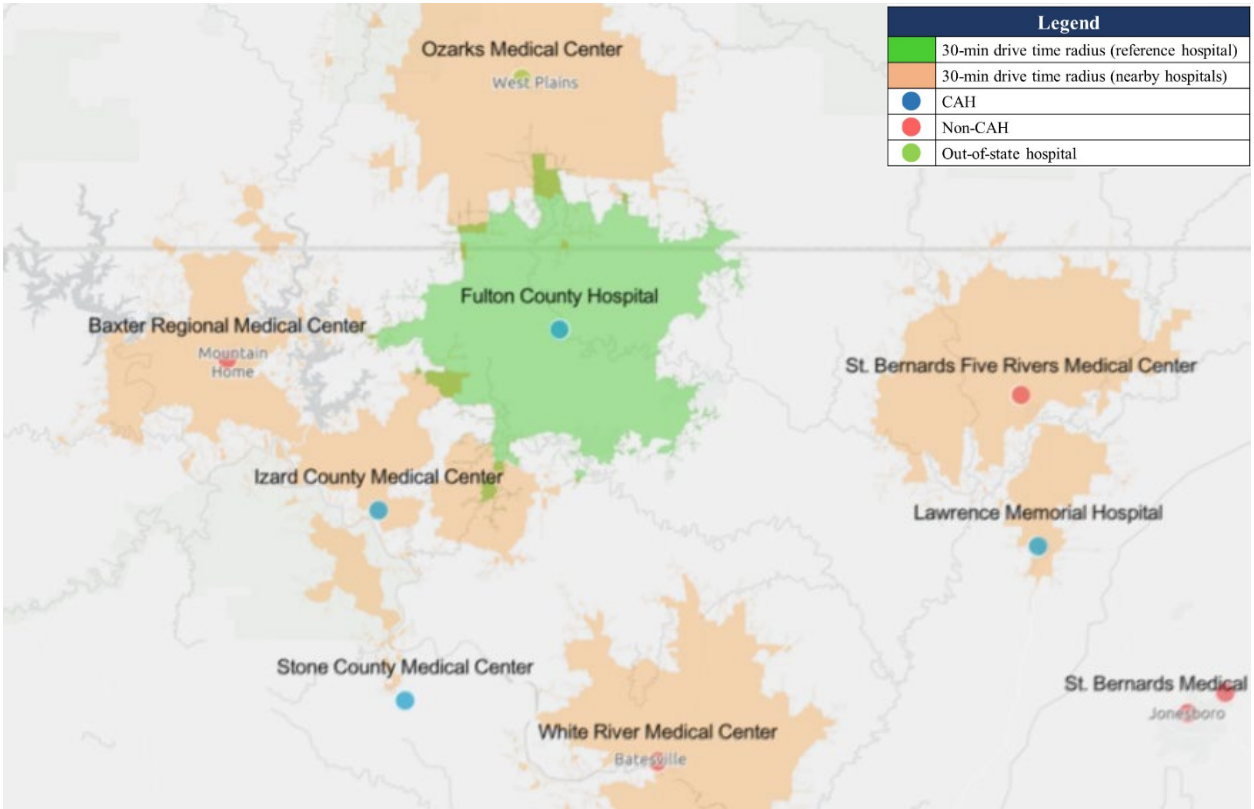
[85] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- In the older portion of the facility, which houses the inpatient units, there is insufficient documentation of the electrical system wiring, which means that the facilities staff must guess-and-check what breakers control what systems/rooms
- One of the hospital's two boilers is nonfunctional. The hospital doesn't use chillers, instead using several condensers and many dedicated AC units throughout the building. Seven air handlers need to be replaced
- There is no ability to turn off water to only a specific part of the building, only to turn off water to the entire facility if a repair is needed somewhere

Drive Time Assessment - Alternatives in the Surrounding Community

A population estimated at 83,724 is located within a 30-mile radius of Fulton County.[86] The two closest alternative hospitals are Ozarks Medical Center, which is 24.8 miles to the north across the Missouri border, and Izard County Medical Center, which is 25 miles southwest in Calico Rock.

Table 63: Fulton County Drive Time Assessment



[86] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

Observations Related to Operational Outlook

The fiscal year-to-date as of February 2023 acute average length of stay at Fulton County was 5.0 days and the acute average daily census (ADC) was 2.8. The total ADC (including swing beds) is 4.8 while the occupancy rate was 19%.

For comparison, the national benchmark ALOS for CAH facilities is 4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%.[87] Fulton County had an ALOS that was 1 day over the national benchmark and an occupancy rate that was well under benchmark, indicating that the hospital has fewer patients on average than other CAHs and that those patients tend to stay for longer than patients at other CAHs.

To date in fiscal 2023 Fulton County reported an annualized 204 annual acute inpatient discharges with an adjustment factor of 7.44, resulting in total adjusted discharges of 1,518.

Total annualized acute inpatient days in fiscal year 2023 were 1,022, indicating an adjusted patient days of 7,602. Fulton County leadership reported that ADC has been declining recently, potentially due to patient concerns about the risk of contracting COVID-19 in the hospital.

As of February 2023, the hospital had 108 full-time employees (FTEs). This leads to 3 FTEs for each adjusted occupied bed. The state benchmark for FTEs per adjusted occupied bed was 4.6-5.72.[88] Labor cost as a percent of Net Patient Service Revenue (NPSR) was 57.8% for fiscal year 2023 to date, compared to the benchmark of 50% - 60% for CAHs.[89] That the FTEs per adjusted occupied bed are significantly under benchmark while the labor cost as a percent of NPSR may indicate that Fulton County

Table 64: Fulton's Operational Outlook

Key Indicators - Operational Outlook	
(Calendar Year 2022)	
Total Inpatient Discharges	204
Adjustment Factor	7.44
Total Adjusted Discharges	1,518
Hospital Patient Days	1,022
Adjusted Patient Days	7,602
Average Daily Census	2.8
Average Length of Stay	5.0
Emergency Department Visits	3,366
Occupancy Rate	19.1%
Total FTEs	108
Total CFTEs	Not provided
Case Mix Index	Not provided
Labor Cost / Net Patient Revenue	57.8%
FTEs per Adjusted Occupied Bed	3.0

Table 65: Fulton's Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	(12,390)
Inventory and Prepaid Expenses	$	298,218
Current Assets	$	5,094,602
Total Assets	$	8,270,517
Current Liabilities	$	1,197,582
Total Long-Term Debt	$	2,624,754
Total Liabilities	$	3,822,337
Net Position	$	4,448,179
Daily Expenditures	$	27,907
Days Cash on Hand		(0.4)
Quick Ratio		4.0
Current Ratio		4.25
Debt Service Coverage Ratio		(0.76)
Average Age of Plant		27.06
Days in Net Accounts Receivable		154.94
Debt to Operating Revenue		26%

[87] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

[40]CAH Financial Indicators Report: Summary of Indicator Medians by State. May 2022 State Medians Report 2022 (FLEX)

[88] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

[89] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

is having trouble hiring and retaining staff and has raised compensation and benefits to account for that difficulty.

Observations Related to Current Fiscal Condition

The assessment and observations related to the current fiscal condition below are based on the latest data received from Fulton County leadership, which is as of February 2023.

Cash Position

As of February 2023, the hospital's cash and cash equivalents dipped into a negative balance. This cash position is in part due to issues that occurred in October 2021 during a transition to a new electronic medical record (EMR) and revenue cycle management (RCM) system. Back-end system errors during the migration of data to the new system have impeded the hospital's ability to send any patient bills out until the spring of 2022, and lingering issues have continued to hamper Fulton County's ability to collected net patient service revenues in a timely manner. As of February, the average days that net patient service revenues took to be collected had grown to 155, far above standard benchmarks.

Debt

The lion's share of Fulton County's $2.6M of debt as of February 2023 is a series of hospital revenue bonds that were issued by the county in 2007 to finance improvements and additions to the hospital facility. The original principal of the bonds was $3.4M and they carry a fixed interest rate of 4.5%. The bonds are due to mature in March 2037. There was additionally a $1.8M series of sales and use tax bonds issued by the county in September 2013 that carry a lower interest rate of 2.9% and are being repaid by the proceeds of a 0.5% county sales tax. The 2013 series will mature in March 2025.

Revenue

Comparing the prior fiscal year results against numbers annualizing the six months of financials ending February 2023, Fulton County has grown its NPSR by 13%. However, as discussed in the section above, the hospital has been struggling to bill and collect NPSR for the patient services being provided, so this growth in revenues has had a limited impact on the hospital's short-term financial position.

Table 66: Fulton's Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 8,753,853	$ 9,933,760	13%
Other Revenue	453,627	292,800	-35%
Total Revenue	**9,207,480**	**10,226,560**	**11%**
Salaries, Wages & Benefits (SWB) Expense	5,396,545	5,741,146	6%
Supplies Expense	2,803,584	1,664,114	-41%
Other Operating Expense	2,207,136	2,673,978	21%
EBITDA	**(1,199,785)**	**147,322**	**112%**
Depreciation Expense	449,633	523,452	16%
Operating Income	**(1,649,418)**	**(376,130)**	**77%**
Non-Operating Income (Expense)	1,317,636	587,726	-55%
Net Income	**(331,782)**	**211,596**	**164%**
Operating Margin	-18%	-4%	79%
NPSR / Adj Discharge		$ 8,730	
Expense / Adj Discharge		$ 9,318	

**Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

Fulton County has seen a moderate six percent increase in SWB expenses and a significant 54% reduction in supplies expense from fiscal year 2022 to the current period. Supply expense is generally variable and correlated to patient volumes, and the reduction in supply expense is roughly proportional to the decrease in ADC that Fulton County has seen since fiscal year 2022.

Supplemental Funding

Over the course of fiscal years 2020 through 2022, Fulton County has recognized $5.4M of supplemental funding from the CARES Act Provider Relief Fund and a Paycheck Protection Program loan that was forgiven in 2021.

Table 67: Fulton County Supplemental Funding

Supplemental Funding	Total Amount Received
CARES Act Provider Relief Fund	$ 4,427,719
Paycheck Protection Program (PPP)	$ 923,665
Total	**$ 5,351,384**

Break-Even Analysis

The below break-even analysis is based on a trailing six-month annualization of Fulton County's income statements. As seen in the Break-even analysis table below, their annualized net income for that period was $211.6k. However, as discussed in the section above, there is a significant lag between when NPSR is recognized on the income statement and when those amounts are collected.

Table 68: Fulton's Break-even Analysis

Fulton County Income Statement	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Breakeven Over the Last 2 Quarters	12-Month Total	18-Month Total
Net patient service revenue	$ 1,201,329	$ 941,088	$ 430,395	$ 1,002,147	$ 739,379	$ 652,542	$ 4,966,880	$ 9,933,760	$ 14,900,640
Other Operating Revenues	18,068	21,699	43,784	24,847	4,918	33,084	146,400	292,800	439,200
Total Operating Revenue	1,219,397	962,787	474,179	1,026,994	744,297	685,626	5,113,280	10,226,560	15,339,840
Salaries, Wages, Benefits and Payroll Taxes	466,330	507,952	472,726	481,863	511,669	430,033	2,870,573	5,741,146	8,611,719
Supplies	79,519	106,064	62,629	134,225	154,827	112,206	649,470	1,298,940	1,948,410
Total Operating Expenses Less D&A	820,214	908,531	798,756	871,247	890,150	750,721	5,039,619	10,079,238	15,118,857
EBIDA	**$ 399,183**	**$ 54,256**	**$ (324,577)**	**$ 155,747**	**$ (145,853)**	**$ (65,095)**	**$ 73,661**	**$ 147,322**	**$ 220,983**
Depreciation	43,621	43,621	43,621	43,621	43,621	43,621	261,726	523,452	785,178
Total Operating Expenses	863,835	952,152	842,377	914,868	933,771	794,342	5,301,345	10,602,690	15,904,035
Operating Income (Loss)	**$ 355,562**	**$ 10,635**	**$ (368,198)**	**$ 112,126**	**$ (189,474)**	**$ (108,716)**	**$ (188,065)**	**$ (376,130)**	**$ (564,195)**
Interest	9,210	9,109	8,658	21,634	(4,131)	9,018	53,498	106,996	160,494
Non-Operating Revenues (Expenses)	51,545	51,510	51,358	62,186	29,011	48,253	293,863	587,726	881,589
Net Income (Loss)	**$ 407,107**	**$ 62,145**	**$ (316,840)**	**$ 174,312**	**$ (160,463)**	**$ (60,463)**	**$ 105,798**	**$ 211,596**	**$ 317,394**

Capital Considerations

The original Fulton County building was constructed in 1963 and an expansion housing the emergency department, outpatient department, and small surgical suite for performing scopes was added in 2007. There are a number of parts of the hospital's infrastructure that are in critical need of capital investment. Of greatest concern is the electrical system in the older, original portion of the facility. Over the 50 years since construction was completed, the electrical system's documentation insufficient documentation of the electrical system wiring, which means that the facilities staff must guess-and-check what breakers control what systems/rooms. It is unclear how much investment would be required to comprehensively address this issue.

The facility has two boilers, one of which is out of commission and needs to be replaced. Air conditioning is handled by using condensers and individual AC units throughout the hospital. The air handlers responsible for patient areas have been replaced relatively recently, but there are five or six additional handlers that need replacement. Generally, the HVAC infrastructure in the 2007 expansion is in better repair than the original building.

Sustainability Plan

Fulton County is exploring several potential initiatives to increase hospital volume and revenues as well as to reduce expenses. Hospital leadership's ability to focus on the creation of a long-term strategic sustainability plan has been hampered by the more urgent liquidity and operational issues that require immediate action. As such, many of these initiatives are currently in a tentative or exploratory phase and have not been quantified.[90]

[90] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

Table 69: Fulton's Sustainability Plan

Fulton County Sustainability Plan Summary	Financial Impact		
	Action Complete	Action Pending	Total
Revenue Enhancement/Expense Reductions:			
Increase number of scope procedures performed		*Impact Unknown*	*Impact Unknown*
Change hospitalist provider to cut cost and increase patient volume	56,000	*Impact Unknown*	*56,000 / Impact Unknown*
Sell or merge EMS service to reduce losses		*Impact Unknown*	*Impact Unknown*
Potential partnership for swing bed program		*Impact Unknown*	*Impact Unknown*
Consolidate two discrete nurse stations into one to create labor efficiencies		*Impact Unknown*	*Impact Unknown*
Increase clinic volumes		*Impact Unknown*	*Impact Unknown*
Replace original windows with more efficient glass		*Impact Unknown*	*Impact Unknown*
Assess a potential adult behavioral health unit		*Impact Unknown*	*Impact Unknown*
Assess a potential conversion to Rural Emergency Hospital (REH)		*Impact Unknown*	*Impact Unknown*
TOTAL IMPACT	**56,000**	**-**	***56,000***

Revenue Enhancements and Expense Reductions

- Increase number of scope procedures performed:
  - Fulton County offers scope procedures out of the small surgical suite that was added with the facility's 2007 expansion. Leadership is exploring potential avenues to increase the volume of scopes performed and, as a result, increase revenue in the service area.
- Change hospitalist provider to cut cost and increase patient volume:
  - The hospital is in the final stages of contracting a new hospitalist provider to replace the current provider. On the cost side, the new contract will save roughly $56k annually. Hospital leadership also believes that the new hospitalist will contribute to growing inpatient volumes and mitigating the long-term trend of decreasing ADC.
- Sell or merge EMS service to reduce losses:
  - Fulton County currently operates the county's ambulance service at a loss. The county provides a small amount of financial support for the operation of the service, not nearly enough to offset the significant expense that it costs to run per hospital leadership. Fulton County has been looking into potential mergers or partnerships for the EMS service that it hopes can help minimize losses.
- Potential partnership for swing bed program:
  - The hospital is in the preliminary stages of considering a merger or partnership with a significantly larger hospital that could drive additional patient volumes and revenue for the facility.
- Consolidate two discrete nurse stations into one:
  - Currently there are separate nurse stations at the opposite ends of an L-shaped corridor that contains the swing bed and med/surg patient areas. Construction of a consolidated nurse station at the junction of the two areas would allow the hospital to make more efficient use of its nursing staff and, as a result, reduce labor costs over time.
- Increase clinic volumes:
  - Fulton County currently operates a wound care clinic with a physician that travels to the facility one day a week. Hospital leadership is considering adding an additional physician to run the wound care clinic another day each week as well as potentially adding new services or specialties.
- Replace original windows with more efficient glass:

    - Heating and cooling the hospital is currently more expensive than it would be if there were funds available to invest in more efficient infrastructure such as updated windows that limit the amount of energy required to keep the hospital at appropriate temperatures and humidity.
- Assess a potential adult behavioral health unit:
    - Expanding services to include an adult behavioral health unit could be an additional source of revenue that may be relatively less resource-intensive to get started than adding other new services or specialties.
- Assess a potential conversion to Rural Emergency Hospital (REH)
    - Converting the facility to an REH could offer Fulton County the opportunity to focus its limited resources on the provision of emergency services to the community while obtaining advantageous reimbursement rates from Medicare patient services.

Great River Medical Center (GRMC)

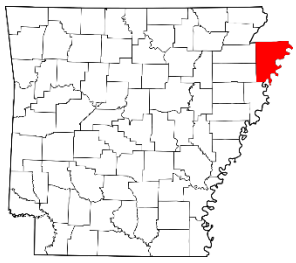
Quick Facts

- Classification: Non-CAH
- Licensed Beds: 99
- Closest Facility: 18 miles
- Average Age of Plant: 23.35 years
- Average Daily Patient Occupancy Rate: 17%
- Average length of stay (ALOS): 3.36
- Total full-time employees (FTEs): 213 FTEs
- Mississippi County Hospital System (the Hospital) is an affiliate unit of Mississippi County, Arkansas within the meaning of Section of 4.02 of the Revenue Procedure 95-48, 1995-2 C. B 419 with an effective date of March 13, 2009. The Hospital is comprised of Great River Medical Center (GRMC) and South Mississippi County Regional Medical Center (SMC).
- A&M has bifurcated the two hospitals to delineate the financial and operational differences between the two, as well as provide a standardized approach to compare SMC to CAH and GRMC to general hospitals under review. Per leadership, Great River Physician Services (GRPS) expenses will be consolidated with GRMC.

Table 70: GRMC's Summary

Operating Statistics		
C&C Equivalents	$	12.4 M
Current Assets	$	34.8 M
Net A/R	$	8.9 M
Total Assets	$	39.7 M
Days Cash on Hand		123.2
Quick Ratio		3.3
Current Ratio		3.4
Debt Service Coverage Ratio		No Long Term Debt
Days in Net AR		121.4
Average Age of Plant		23.3
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	26.6 M
Other Revenue	$	1.9 M
Total Revenue	$	28.5 M
Salaries, Wages & Benefits	$	19.1 M
EBITDA	$	(8.2 M)
Operating Income	$	(9.0 M)
Non-Operating Income/(Expense)	$	5.6 M
Net Income	$	(3.3 M)
Operating Margin %		-31%

Location: Blytheville, Mississippi County
County Population: 39,661 (2021)



Key Challenges

- CEO and CFO will exit from leadership roles in May and July, respectively. Candidates for the CEO role are being interviewed. Current COO will be taking over CFO role.
- High dollar amount denials from certain Medicare Advantage plans.
- Paying high wages to contracted nurses (scheduled to terminate five contract nursing positions by Mid-April).

1 *Patient Volume Trends*

- General decreasing trend in patient volume correlated with the recent cancer center closure (March 6th)

2 *Financial Status*

- Quick ratio is 3.28. Net accounts receivable (AR) days are 121.4. Days Cash on Hand is 123 days, which includes $9M in certificates of deposits (CDs)
- Great River Medical Center (GRMC) and South Mississippi County (SMC) finances are intertwined, as executive and management costs split across GRMC and SMC (50/50), whereas shared, non-managerial administrative staff is split 70/30 (GRMC/SMC)
- Clinical staff work at both hospitals, receive paychecks from "home cost center" with hours consolidated and accrued from respective facilities
- Currently, one in-house RCM department completes billing for both SMC and GRMC; leadership is scoping out secondary vendor support with denial billing/denial management

3 *Labor Challenges*

- GRMC partners with St. Bernards in Jonesboro, for shared providers/services, pharmacy coverage, supply chain and admissions/transfers.
- Leadership described staffing to be a main hospital challenge, since GRMC competes with eight other hospitals within 60 miles for staff

4 *Technology Challenges*[91]

- Transitioned to EpowerDoc from paper and then switched to Emergency Department Information System (EDIS). Athena Health is used in the clinics
- Experienced a 2018 ransomware attack, which was covered by insurance

5 *Sustainability Plan*

- A combined sustainability plan was provided, along with call outs to improve up front collections, reduce census to reduce labor costs and improve service line offerings

6 *Physical Plant*

- Average age of plant is 23.35 but has longevity due to preventative maintenance; Of note, GRMC acquired a new chiller, fixed issues with med gas post Joint Commission visit and requires a new cooling tower (~$180k)
- Anesthesia machines are nearing end of life, along with the need to replace telemetry equipment, call light system, cardiac monitors and four elevators at GRMC

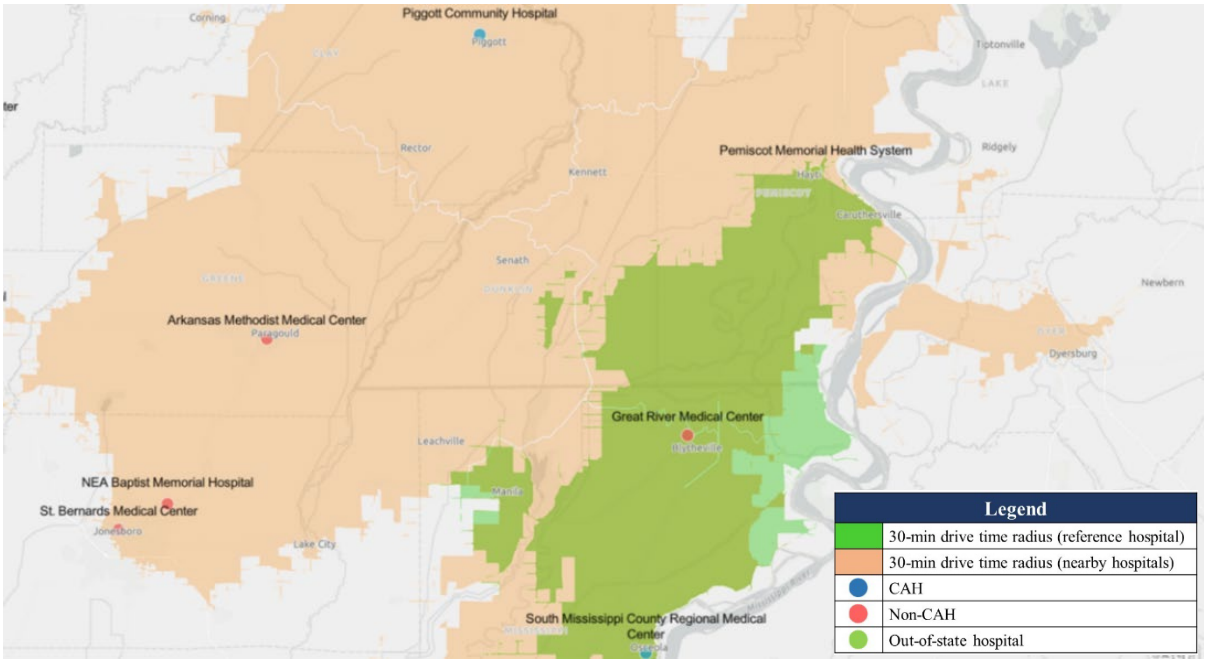
[91] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

Drive Time Assessment - Alternatives in the Surrounding Community

Within a 30-mile radius, an estimated population of 142,346 resides within a 30-mile radius of GRMC, which would no longer have access to GRMC if this facility closed.[92] This region includes Mississippi County, Lauderdale County, Dyer County, Dunklin County and Pemiscot County.

The two closest alternative hospitals to GRMC are on average 22 miles away: South Mississippi County Regional Medical Center (SMC) is the nearest alternative, at approximately 18 miles Southwest of GRMC; Pemiscot Memorial Health System is a close second, only 26 miles away; Arkansas Methodist Medical Center and Piggott Community Hospital are approximately 45 miles away. At approximately 54 miles away, NEA Baptist Memorial Hospital and St. Bernard's Medical Center.

Figure 16: GRMC's Drive Time Assessment



Observations Related to Operational Outlook

The year-to-date (YTD) average length of stay in 2022 was 3.29 days. ALOS is an indicator of efficiency – if all other things are equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. GRMC's ALOS is lower than the national average of approximately 4-5.4 days. The average daily census (ADC) was 16.62 in December 2022. Licensed for up to 99 beds, GRMC's occupancy rate is 17%, lower than the average rural hospital in Arkansas. In 2016, average occupancy rates hovered around 30%.[93] Occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). This combined with a low inpatient census explains why occupancy rates at GRMC are also below benchmark.

[92] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.
[93] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

In 2022, GRMC reported 1,844 annual inpatient discharges with an adjustment factor of 2.68, resulting in total adjusted discharges of 4,945.[94] Annual ER departmental visits totaled 13,695. Month-on-month volumes during the year remained relatively consistent with slight variation: Compared to December 2021, year-end key operating metrics for December 2022 show that admissions, emergency visits, outpatient visits and deliveries have relatively remained the same (with the exception of observation, which decreased by 31%). Apart from pain management, surgery cases have also decreased, with most of the reduction attributed to decreasing endoscopies and inpatient procedures.

Table 71: GRMC's Operational Indicators

Key Indicators - Operational Outlook	
(Jul 2022 - Dec 2022 Annualized)	
Total Inpatient Discharges	1,844
Adjustment Factor	2.68
Total Adjusted Discharges	4,945
Hospital Patient Days	6,066
Adjusted Patient Days	16,266
Average Daily Census	16.6
Average Length of Stay	3.3
Emergency Department Visits	13,695
Occupancy Rate	16.8%
Total FTEs	213
Total CFTEs	Not Provided
Case Mix Index	Medicare = 1.18 ; All other Payers = 1.087
Labor Cost / Net Patient Revenue	71.6%
FTEs per Adjusted Occupied Bed	4.8

The hospital employs a total of 213 full-time employees (FTEs). Clinical FTE count was not shared with A&M. FTEs per adjusted occupied bed (also called "FTEs per adjusted ADC") was 4.77. The state benchmark for FTEs per adjusted ADC was 4.6-5.72.[95] Labor cost per net patient revenue was at 72% compared to the benchmark of 50% - 60% for rural non-CAHs.[96] A high labor cost per net patient revenue ratio could be a sign that the organization is not managing its labor costs effectively, which can impact its financial performance. When labor costs are high, it can limit the organization's ability to invest in other areas such as new equipment, technology, or facility upgrades. It can also affect the organization's ability to remain competitive in the market, as high labor costs may result in higher prices for patients.

Table 72: GRMC's Balance Sheet Metrics

Balance Sheet Metrics	
(as of Feb. 2023)	
C&C Equivalents	$ 12,405,308
Inventory and Prepaid Expenses	$ 1,668,195
Current Assets	$ 34,791,774
Total Assets	$ 39,684,554
Current Liabilities	$ 10,089,347
Total Long-Term Debt	No LT Debt
Total Liabilities	$ 10,448,238
Net Position	$ 29,236,316
Daily Expenditures	$ 100,675
Days Cash on Hand	123.2
Quick Ratio	3.3
Current Ratio	3.45
Debt Service Coverage Ratio	N/A
Average Age of Plant	23.35
Days in Net Accounts Receivable	121.38
Debt to Operating Revenue	1%

Observations related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (Dec. 2022, Jan. 2023, or Feb. 2023). Based on the initial data received, A&M's on-site review, and 2023 data, GRMC appears to currently be in a relatively stable financial position but resources and costs are shared with SMC which is in a much weaker financial position.

[94] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue.

[95] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

[96] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Cash Position

Understanding the days cash on hand (DCOH) in conjunction with trends in accounts receivable (A/R) will give insight into revenue cycle management (RCM). Hospital leadership stated repeated difficulties with collecting payments from select Medicare Advantage plans and these delays in payments result in write-offs. DCOH is currently ~123 days, but this includes ~$9M in certificate of deposits. Days in net accounts receivable is up to 121 days.

Debt

Per management, there is no long-term debt shared between SMC and GRMC besides a shared Master Lease. This line of credit allows management to compare rates and secure competitive pricing on equipment or other assets. Since 2019, management has decreased capital lease obligations from $2,510,881 to $840,913 by December 2021 for a 66.5% decrease, approximately $1.67M for both GRMC and SMC - $1.24M is attributed to GRMC, $417,500 at SMC.

Revenue

There is an 8% decrease in Net Patient Service Revenue (NPSR) when comparing last fiscal year to trailing six months. An increase in other revenue (by 125%) is due to loans and COVID relief funds which have bolstered total revenue.

The hospital also receives tax millage monies monthly from the County, as well as a county sales tax. The millage rate is assessed on person property and real estate in Blytheville. The millage rate is 0.67%. In October 2014, the voters of Mississippi County, Arkansas approved a ½ cent sales tax for the support of the Hospital System. Collection of the tax began on January 1, 2015 and will sunset after five years. The Hospital received $2,942,282 and $2,482,741 during the years ended December 31, 2021, and 2020, respectively.

Table 73:GRMC's Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 28,843,086	$ 26,613,923	-8%
Other Revenue	850,316	1,913,246	125%
Total Revenue	**29,693,403**	**28,527,169**	**-4%**
Salaries, Wages & Benefits (SWB) Expense	17,565,499	19,051,796	8%
Supplies Expense	8,494,689	6,287,268	-26%
Other Operating Expense	8,011,178	11,372,270	42%
EBITDA	**(4,377,963)**	**(8,184,164)**	**-87%**
Depreciation Expense	792,308	765,838	-3%
Operating Income	**(5,170,271)**	**(8,950,002)**	**-73%**
Non-Operating Income (Expense)	9,375,414	5,600,606	-40%
Net Income	**4,205,143**	**(3,349,396)**	**-180%**
Operating Margin	-17%	-31%	-80%
NPSR / Adj Discharge		$ 5,382	
Expense / Adj Discharge		$ 7,579	

** Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

Management's struggles to appropriately flex staff and manage costs has led to the closure of select services (*i.e.*, the intensive care unit). During the pandemic, costs of labor skyrocketed; In 2021, GRMC reported $957,283 for travelers, whereas in 2022, costs increased to $4.5M. Since then, labor costs have decreased to approximately $723,388 in 2023. The hospital has plans to further remove costs by eliminating three (out of 11) contract nurse positions, as well as an internal contract, by mid-April.

Contract labor is broken down as follows: Eight contracted employees in Med/Surg, two in the ER, three in OB/GYN, three in Lab, two in Respiratory, and one in Radiology. At one-point, contracted nursing costs were as high as $135 per hour; these rates have been decreased to the current rate of $90-$100 per hour. Anticipated savings through the elimination of outside staffing total $655,200 per year, along with a subsequent $152,880 per year through the elimination of one in-house traveler. Management is actively recruiting full-time employees, as well as retaining staff through the internal contract pricing (approximately half the price of traveler cost). Needs of each department are discussed at least monthly.

Management has also identified initiatives to reduce costs associated with high end drugs for cancer treatment (discussed further in the Sustainability Plan section).

Supplemental Funding

All COVID-related supplemental funding received by GRMC to date is summarized in the table below. The table below breaks out the significant supplemental funding that was received.[97]

Table 74: GRMC's Supplemental Funding

Supplemental Funding for GRMC & SMC	Total Amount Received
CARES Act / Provider Relief Fund	$15,337,241
PPP Loan (forgiven in 2021)	$2,218,995
Total	**$17,556,236**

Break-Even Analysis

Given the trends associated with GRMC's operational outlook and fiscal condition, and the potential impact of the sustainability plan, a break-even analysis was performed to approximate the current Net Income (Loss). The below break-even analysis is based on a trailing six-month annualization of GRMC's income statement. As seen in the table below, their annualized FY23 net income is a negative $3,349,396. The currently quantified sustainability plan, if all impact dollars are achieved, has a potential impact of $2,458,080.

[97] Supplemental funding represents amounts received by Mississippi County Hospital System, which includes both Great River Medical Center and SMC Regional Medical Center.

Table 75: GRMC's Break-even Analysis

Great River	September	October	November	December	January 2023	February 2023	Breakeven over the last 2 quarters	12 Month Total	18 Month Total
Net patient service revenue	$ 2,453,104	$ 2,277,338	$ 2,687,813	$ 2,262,791	$ 2,406,236	$ 1,219,680	$ 13,306,962	$ 26,613,923	$ 39,920,885.19
Other Operating Revenues	277,241	40,587	52,894	448,813	54,941	82,147	956,623	1,913,246	$ 2,869,868.91
Total Operating Revenue	2,730,345	2,317,925	2,740,707	2,711,604	2,461,177	1,301,827	14,263,585	28,527,169	42,790,754
Salaries, Wages, Benefits and Payroll Taxes	1,529,769	1,602,406	1,502,833	1,799,695	1,571,000	1,520,197	9,525,898	19,051,796	$ 28,577,693.31
Supplies	818,377	568,178	591,483	505,785	341,723	318,088	3,143,634	6,287,268	$ 9,430,902.00
Total Operating Expenses Less D&A	3,470,372	3,421,644	2,885,851	3,209,455	2,215,461	3,152,886	18,355,667	36,711,334	$ 55,067,000.31
EBIDA	**(740,027)**	**(1,103,718)**	**(145,144)**	**(497,850)**	**245,716**	**(1,851,059)**	**(4,092,082)**	**(8,184,164)**	**(12,276,246)**
Depreciation	65,644	64,682	63,935	63,403	63,570	61,685	382,919	765,838	$ 1,148,757.00
Total Operating Expenses	3,536,016	3,486,326	2,949,786	3,272,858	2,279,031	3,214,571	18,738,586	37,477,172	$ 56,215,757.31
Operating Income (Loss)	**(805,671)**	**(1,168,400)**	**(209,079)**	**(561,253)**	**182,146**	**(1,912,744)**	**(4,475,001)**	**(8,950,002)**	**(13,425,003)**
Interest	(1,296)	(5,276)	(831)	(1,160)	(1,735)	(7,142)	(17,440)	(34,880)	$ (52,320.00)
Non-Operating Revenues (Expenses)	402,656	2,241,323	228,199	636,378	288,407	105,780	3,902,743	5,635,486	$ 7,368,229.09
Net Income (Loss)	**$ (404,310)**	**$ 1,067,646**	**$ 18,289**	**$ 73,964**	**$ 468,818**	**$ (1,814,106)**	**$ (589,698)**	**$ (3,349,396)**	**$ (6,109,094)**

Capital Considerations

Management identified select equipment needs for GRMC. A cooling tower (at $174,924), GE Anesthesia Machines (at $180k) and C-Arm Replacement (at $149k) were listed as upcoming purchases – totaling $503,924. During the on-site visit, management identified the need to replace telemetry equipment, call light system, cardiac monitors and four elevators at GRMC. Anticipated budget for telemetry equipment, call light system, cardiac monitors and elevators was not provided by management.

Upcoming Obligations

GRMC and SMC share a Master Lease, which allows management to compare rates and secure competitive pricing on equipment and other assets. GRMC carves out $358,891 a month for these payments. [98]

Sustainability Plan

Given the revenue cycle management challenges and consistently negative operating margin, a strong sustainability plan is critical for GRMC future viability. Management provided a sustainability plan which includes quantified numbers (see: Sustainability Plan Summary table below), operational initiatives across revenue cycle management, and planned expansions. [99]

[98] Source: MCHS (SMC and Great River) BS IS Sep-Feb.

[99] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

Table 76: GRMC's Sustainability Plan

Great River Medical Center Sustainability Plan Summary
Sustainability Plan Summary

GRMC Sustainability Plan Summary* ACTION	Action Ongoing	Action Pending	Total
Revenue Enhancement:			
Improve Revenue Cycle Management: Improve collections, manage denials, identify charity care, complete registration and track pre-authorizations in efforts to reduce denied reimbursement/improve revenue.	*Impact Unknown*		
Increase 340B Retail Program: Expand into additional retail pharmacy locations	*Impact Unknown*		-
Rural Health Clinic (RHC) Designation: Improve reimbursement with Great River Physician Services (GRPS) as the RHC designation enables GRMC to increase patient referrals to 340B retail pharmacies**		450,000	450,000
TOTAL REVENUE ENHANCEMENT IMPACT	**$ -**	**$ 450,000**	**$ 450,000**
Expense Reduction:			
Travel nurse contracts - Eliminate 3 of 11 contract nurses and 1 in-house traveler	808,080		808,080
Anticipated savings of $655,200/year and $152,880/year for internal contract			-
Replace current contracts with full-time staff: Continue with current sign on bonuses for new recruits.			-
19 Travelers at GRMC with an hourly range of $90/hr - $100/hr; 3 internal contracts at $50-$55/hr			-
Reduce Consulting Costs and Management Positions: Eliminated two consulting contracts and 2 nurse manager positions	125,000		125,000
Reduce Leadership Payroll: Combined COO role with CNO	75,000		75,000
Increase utilization of International Recruitment for key clinical staff (lab, radiology, respiratory, nursing)	393,120		-
Consolidate Rural Health Clinics: Closed 2 under performing clinics at GRMC (and related hospital departments)	1,000,000		1,000,000
TOTAL EXPENSE REDUCTION IMPACT	**$ 2,401,200**	**$ -**	**$ 2,008,080**
***TOTAL IMPACT	**$ 2,401,200**	**$ 450,000**	**$ 2,458,080**

** Management provided a consolidated sustainability plan; Although efforts were made to delineate initiatives between GRMC and SMC by the A&M team, select iniatives may overlap in between facilities.*
*** Estimated improved reimbursement is 400-500k; unclear if it's one-time or annual*

Revenue cycle management is centralized into one business unit, which means that these initiatives are consistent across GRMC and SMC. Although the sustainability plan does not call out any quantified anticipated savings along its RCM strategy, management provided the following details around focused areas to improve:

- **Launch of Experian to utilize pre-authorization (PA) module, eligibility, and discovery***:* Scheduled to kick early June, this new tool will improve the PA process by consolidating authorizations in one central system. It also provides real-time eligibility for secondary and tertiary insurance.
- **Improve up-front collections***:* Increase utilization of patient portal and educate patient population on the ability to pay via our portal and other options, cash, check, card etc. With the purchase of the Experian product, staff will be able to verify real-time patient insurance information, such as deductible and copays at point of entry and during pre-registration. GRMC and SMC will be able to expand financial counseling and payment options.
- **Improve Registration Process***:* To ensure that the demographics are correct, and documentation are obtained at point of registration, audits will be completion will be done monthly and added to the patient access manager's performance improvement plan for compliance.
- **Identify Need for Charity Care**: Through the new upfront collection process, management aims to identify patients that could qualify for financial assistance earlier in the process.
- **Denials Management***:* As more payers are converted to electronic EOBs, staff will be able to better assess the details of denials.
- **Improve Accounts Payable (AP) Process:** CFO and accounting team and other financial team members will review processes and have regular meetings to identify issues and develop action plans to improve processes. This is in efforts to improve accuracy of data and keep accrual process timely and more accurate.
- **Establish Standardized Data Reporting and Analytics:** Management hopes to foster a team approach in the Financial Department that involves all managers. It hopes to educate them on the

importance of their personal and departmental role and how it impacts finances (*i.e.*, PO's, Charges, documentation etc.)

Revenue Expansion:

- **Forecast Local Job Growth**: Management plans to try to meet with current industries to educate them on the need for viable hospitals in the county and the industrial base. 3,200 jobs are forecast to be added in Mississippi county due to the expansion of steel industries within the area. Although these jobs are not forecast to be hired for until 2024, they are likely to result in a positive revenue impact for both facilities should this forecast become reality.
- **Expand Retail Pharmacy Locations**: In 2022, management enrolled with two Walmart's, one Kroger and two specialty pharmacies. Management is working with Verity to identify other viable contracts for 2023.

Expense Reduction:

- **Maintain Appropriate Census Staffing:** New Med/Surg GRMC staffing plan will eliminate 3 of 11, outside vendor contracted nursing staff members. Costs were as high as $135/hr. Current rate is around $90/hr. Management also plans on eliminating one in-house traveler at $70 per hour at the end of April. Anticipated savings from outside staffing are $655,200 per year and internal contract is $152,880 a year. Management is currently in the process of interviewing four nurses.
- **Recruitment of Full-Time Staff:** Management plans to replace current contracts with full-time staff, as well as continue with current sign-on bonuses for new recruits.
- **Increase Utilization of International Recruitment**: Management plans to replace five current ($218,400 per year) contracts with full-time hospital staff (at $87,360 a year); this results in an anticipated savings of $393,120 annually
- **Retention of Staff** Continue to maintain current staff while recruiting full-time staff. Management is working on internal contract pricing (which is approximately half the price of traveler cost) as well as routinely evaluating needs with departmental directors
- **Continue to Keep ICU Closed:** In efforts to reduce nurse labor (ICU travel expenses were $1.02M over nine months), management is focusing efforts to hire eight full-time nurses.
- **Rural Health Clinic (RHC) Designation**: Management consolidated two RHC's into one to improve financial results in 6/2022. Estimated improved reimbursement is $400k-$500k at Great River Physician Services (GRPS). This RHC designation enabled management to increase patient referrals to 340B retail pharmacies
- **Discontinue Operations of Under-Performing Clinics:** Management closed two clinics at GRMC and related hospital departments due to significant losses being incurred in both with continuing declining referrals and volumes.
- **Reduce Consult Costs and Management Positions:** Management canceled two outside service consulting contracts and eliminated two Nurse Manager positions duties assigned to other staff members already at hospital. Anticipated annual savings are $250,000 with shared cost of $125,000 per year for each facility.
- **Reduce Administrative Team:** Combined COO role with CNO while transitioning current COO to existing CFO role. Departments will be aligned by remaining Administrative Team. This is estimated for a savings of $150,000 with a shared cost of $75,000 a year at each facility.

Recruitment and Retention

- As part of their sustainability plan, GRMC is in the progress of setting up a residency program with New York Institute of Technology (NYIT)'s Doctor of Osteopathic Medicine (D.O.) Program and Arkansas State University. The D.O. Program is interested in increasing residency spots – recently, they expressed that there may be funding assistance that would make the program available with no cost to the facility. Management believes this could generate additional revenue to SMC and GRMC without additional cost, with the potential to also support future physician recruitment.
- Management continues recruitment of full-time nursing staff with Arkansas Northeastern College.
- Management continues engagement with a global staffing organization for international candidates.

Howard Memorial Hospital

Background/Overview

- Classification: CAH
- Licensed Beds: 20
- Closest Facility: 24.4 miles
- Average Age of Plant: 10.8 years
- Average Daily Patient Occupancy Rate: 14%
- Average length of stay (ALOS): 1.8
- Total full-time employees (FTEs): 189 FTEs

Location: Nashville, Howard County
County Population: 12,676 (2021)

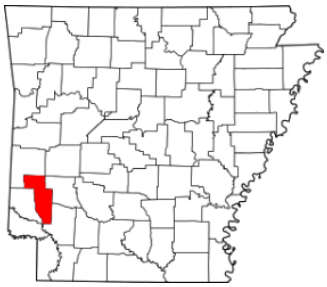


Table 77: Howard's Summary Statistics

Operating Statistics		
C&C Equivalents	$	9.1 M
Current Assets	$	14.6 M
Net A/R	$	2.0 M
Total Assets	$	32.8 M
Days Cash on Hand		124.56
Quick Ratio		3.99
Current Ratio		4.31
Debt Service Coverage Ratio		-5.34
Days in Net AR		29.88
Average Age of Plant		10.80
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	24.7 M
Other Revenue	$	1.6 M
Total Revenue	$	26.3 M
Salaries, Wages & Benefits	$	12.6 M
EBITDA	$	(0.2 M)
Operating Income	$	(2.4 M)
Non-Operating Income/(Expense)	$	1.1 M
Net Income	$	(1.3 M)
Operating Margin %		-9%

Key Challenges

- Howard Memorial has felt the impacts of the pandemic on patient volumes and labor costs.

1 *Patient Volume Trends*

- The re-opening of the nearby Sevier/De Queen CAH has negatively impacted patient volumes, particularly in the emergency department and radiology unit

2 *Financial Status*

- Howard Memorial has strong revenue cycle management (RCM) led by the CFO. Average days in accounts receivable (A/R) is 29.9
- The hospital is not in a dire financial position, with ~124 days cash on hand and a quick ratio of 3.99
- Howard Memorial receives County support via a sales tax that services the bonds used to finance the construction of the facility

3 *Labor Challenges*

- The hospital has struggled with retaining staff in its rural area, and they've had to use agency nurses and travel respiratory therapists during the pandemic
- They increased minimum wage to $15 per hour and adjusted 401k matching to try to improve retention

4 *Technology Challenges*[100]

- The facility dealt with a cybersecurity incident in December
- Howard Memorial uses CPSI for its inpatient EMR and E-Clinical Works for clinics

5 *Sustainability Plan*

- The hospital aims to improve its services and facilities, including considering the reintroduction of dialysis services, expanding ICU beds, and building new capacity for the physical therapy practice
- The hospital is working on expense reductions and uses a productivity tool to monitor departmental performance against the budget
- The hospital leased a $2M surgical robot to improve market share, with the expectation of break-even if 100 new cases are performed per year. The robot lease has no payments for the first six months. The hospital expects an increase of $400k in revenue and $200k in net operating income in the 2023 budget
- The hospital successfully received all stimulus funds it applied (~$3M total supplemental support)
- The hospital learned about FEMA funding for costs above the PRF cap and submitted its first FEMA application recently for two projects: contract labor (travel nurses) and supply costs. The hospital received over $60k for contract labor, and supply costs. Reimbursement is still pending
- The hospital has equipment upgrades planned in radiology, including upgrading the fluoro system, bone density machine, ultrasound, X-ray, and acquiring a new ABI machine

[100] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- The hospital opened a new pediatric rehab therapy during the pandemic, which is growing well and exceeding expectations per hospital leadership
- They're considering ways to improve the underperforming cardiac and pulmonary rehab department as well as opening satellite birthing services starting in September, as the nearest places for birth services are Hot Springs or Texarkana.

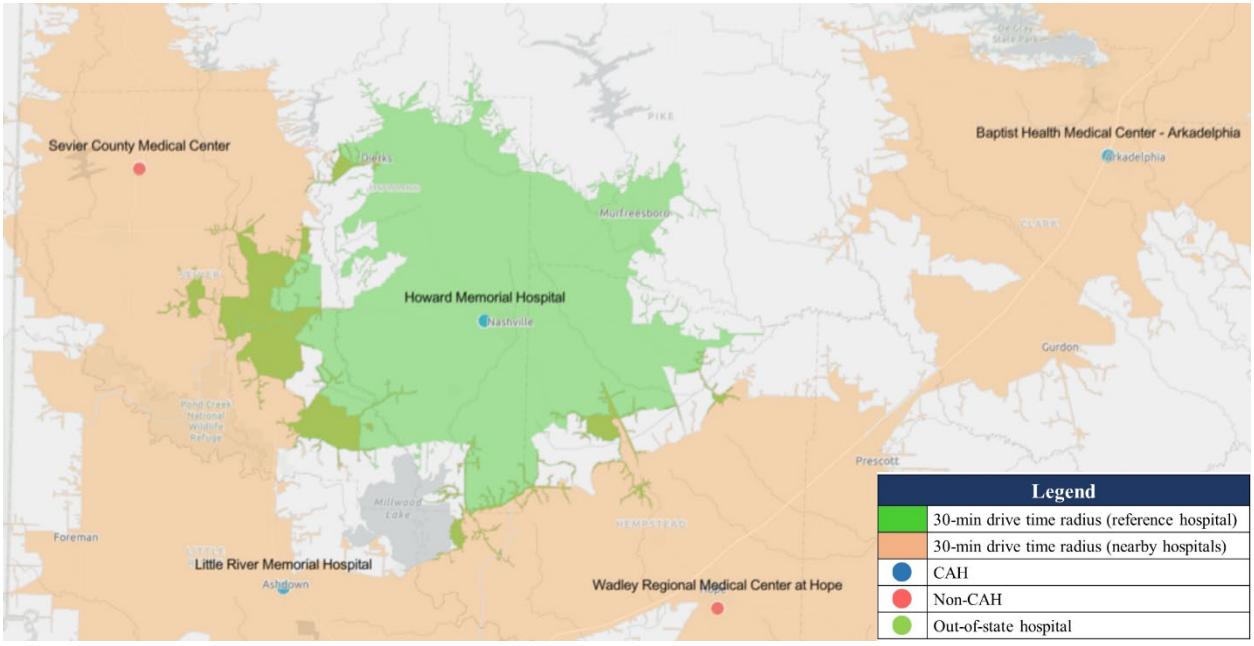
6 *Physical Plant*

- Much of the hospital's physical plant maintenance is contracted out.
- Two of Howard's three boilers are roughly 14-years old, with the third having been recently replaced after it became inoperative.
- The facility roof is also 14-years old and is nearing end-of-life. The hospital has not gotten a quote for the cost of replacement, as it does not have capital at this time to have the work done.
- Radiology equipment is largely on five-year leases with accompanying maintenance contracts.

Drive Time Assessment - Alternatives in the Surrounding Community

A population estimated at 70,139 is located within a 30-mile radius of Howard Memorial.[101] The three closest alternative hospitals are: Little River Memorial Hospital, 24.4 miles to the southwest in Ashdown; Wadley Regional Medical Center at Hope, 26.9 miles southeast in Hempstead County; and Sevier County Medical Center, 27.4 miles to the northwest in De Queen.

Table 78: Howard Memorial Drive-Time Assessment



[101] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

Observations Related to Operational Outlook

For the period between September 2022 and February 2023, the average length of stay (ALOS) at Howard Memorial was 1.8 days and the average daily census (ADC) was 5.7, while the occupancy rate was 14.2%.

For comparison, the national benchmark ALOS for CAH facilities is 4 days and the average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%.[102] Howard Memorial was significantly under the benchmarks for both ALOS and for occupancy, meaning they had fewer patients and the patients that they did have stayed in inpatient care for less time than is average for CAHs.

Over the six-month period, Howard Memorial reported an annualized 568 inpatient discharges with an adjustment factor[103] of 7.69, indicating a total adjusted discharges of 4,369. Annualized inpatient days were 1,038, giving an adjusted patient days of 7,984.

As of February 2023, Howard Memorial had 189 full-time employees (FTEs). This leads to 4.3 FTEs for each adjusted occupied bed. The state benchmark for FTEs per adjusted occupied bed was 4.6-5.72.[104] Labor cost as a percent of per net patient service revenue (NPSR) was 51.1% for fiscal year 2023 to date, compared to the national benchmark of 50% - 60% for CAHs.[105] That both of these metrics are under or at the low end of the benchmarks indicates that Howard is making efficient use of its staff.

Table 79: Howard's Operational Outlook

Key Indicators - Operational Outlook	
(Sep. 2022 - Feb. 2023 Annualized)	
Total Inpatient Discharges	568
Adjustment Factor	7.69
Total Adjusted Discharges	4,369
Hospital Patient Days	1,038
Adjusted Patient Days	7,984
Average Daily Census	5.7
Average Length of Stay	1.8
Emergency Department Visits	10,688
Occupancy Rate	14.2%
Total FTEs	189
Total CFTEs	Not Provided
Case Mix Index	Not Provided
Labor Cost / Net Patient Revenue	51.1%
FTEs per Adjusted Occupied Bed	4.3

Table 80: Howard's Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	9,060,592
Inventory and Prepaid Expenses	$	1,075,696
Current Assets	$	14,633,541
Total Assets	$	32,759,606
Current Liabilities	$	3,394,199
Total Long-Term Debt	$	2,679,330
Total Liabilities	$	6,073,530
Net Position	$	26,686,076
Daily Expenditures	$	72,738
Days Cash on Hand		124.6
Quick Ratio		4.0
Current Ratio		4.31
Debt Service Coverage Ratio		(5.34)
Average Age of Plant		10.80
Days in Net Accounts Receivable		29.88
Debt to Operating Revenue		10%

[102] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

[103] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue.

[104] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

[105] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Observations Related to Current Fiscal Condition

The below assessment and observations related to the current fiscal condition are based on the latest data received from Howard Memorial leadership, which is as of February 2023.

Cash Position

As of February 2023, the hospital's cash and cash equivalents were $9.1M. With an average daily cash expenditure of $73k over the six months ending February 2023, this is enough liquidity to cover just under 125 days of operations. Over the same time period, the average days in net accounts receivable was a healthy 29.88 days.

Debt

Howard Memorial had roughly $2.7M of long-term debt and capital leases as of February 2023, the majority of which is made up of a roughly $2M capital lease the hospital recently entered for a surgical robot. The remaining balance is largely capital leases for other pieces of equipment—primarily in radiology—and software leases.

Revenue

Comparing the prior fiscal year results against figures annualizing the six months of financials ending February 2023, the hospital seen a modest 7% decrease in net patient service revenue (NPSR) while other operating revenues have held relatively steady with a growth of 3%. Howard Memorial leadership noted during an onsite review of the hospital that the January 2023 re-opening of Sevier County Medical Center in nearby De Queen had negatively affected patient volumes.

Table 81: Howard's Income Statement Metrics

Income Statement Metrics			
	FY22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 26,570,853	$ 24,736,100	-7%
Other Revenue	1,519,665	1,562,432	3%
Total Revenue	**28,090,518**	**26,298,532**	**-6%**
Salaries, Wages & Benefits (SWB) Expense	15,153,876	12,638,238	-17%
Supplies Expense	3,751,214	3,846,610	3%
Other Operating Expense	9,739,603	10,022,441	3%
EBITDA	**(554,175)**	**(208,757)**	**62%**
Depreciation Expense	2,057,421	2,159,975	5%
Operating Income	**(2,611,596)**	**(2,368,732)**	**9%**
Non-Operating Income (Expense)	2,338,927	1,106,393	-53%
Net Income	**(272,669)**	**(1,262,338)**	**-363%**
Operating Margin	-9%	-9%	3%
NPSR / Adj Discharge		$ 5,662	
Expense / Adj Discharge		$ 6,562	

** Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

Howard Memorial saw a significant 17% drop in costs related to salaries, wages, and benefits (SWB), and held steady with 3% growth in expenses on supplies as well as on other non-SWB, non-supply operating costs. The overall 7% reduction in operating expense from fiscal year 2022 to the current period approximately offset the drop in NPSR, resulting in a modest improvement in earnings before income, taxation, depreciation, and amortization (EBITDA) and operating income and a minor bump in operating margin.

Supplemental Funding

Over the course of fiscal years 2020 and 2021, Howard Memorial recognized just over $3M of supplemental funding from state and federal sources. The Supplemental Funding table below provides a breakdown of fund sources and the amounts recognized.

Table 82: Howard's Supplemental Funding

Supplemental Funding	Total Amount Received
AR Community Development Block Grant	$ 204,000
AEDC - AR Ready for Business	$ 100,000
Medicaid - ARP Surge Staff Grant	$ 200,000
HHS - Stimulus (HRSA)	$ 2,529,326
Total	**$ 3,033,326**

Break-Even Analysis

The below break-even analysis is based on a trailing six-month annualization of Howard Memorial's income statement. As highlighted in the table below, the hospital's annualized net income for that period was ($1.26M).

Table 83: Howard's Break-even Analysis

Howard Memorial Income Statement	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Breakeven Over the Last 2 Quarters	12-Month Total	18-Month Total
Net patient service revenue	$ 1,183,610	$ 2,332,654	$ 2,159,815	$ 2,188,791	$ 2,270,258	$ 2,232,922	$ 12,368,050	$ 24,736,100	$ 37,104,150
Other Operating Revenues	175,082	144,224	100,251	118,251	125,651	117,757	781,216	1,562,432	2,343,648
Total Operating Revenue	1,358,692	2,476,878	2,260,066	2,307,042	2,395,909	2,350,679	13,149,266	26,298,532	39,447,798
Salaries, Wages, Benefits and Payroll Taxes	1,077,625	1,361,430	1,209,820	227,051	1,310,719	1,132,474	6,319,119	12,638,238	18,957,357
Supplies	371,617	269,408	309,816	278,268	327,780	366,416	1,923,305	3,846,610	5,769,915
Total Operating Expenses Less D&A	1,982,132	2,410,146	2,026,524	2,229,418	2,252,631	2,352,793	13,253,644	26,507,289	39,760,933
EBIDA	**$ (623,440)**	**$ 66,732**	**$ 233,542**	**$ 77,624**	**$ 143,278**	**$ (2,114)**	**$ (104,378)**	**$ (208,757)**	**$ (313,135)**
Depreciation	226,653	167,139	165,858	179,504	171,346	169,488	1,079,988	2,159,975	3,239,963
Total Operating Expenses	2,208,785	2,577,285	2,192,382	2,408,922	2,423,977	2,522,281	14,333,632	28,667,264	43,000,896
Operating Income (Loss)	**$ (850,093)**	**$ (100,407)**	**$ 67,684**	**$ (101,880)**	**$ (28,068)**	**$ (171,602)**	**$ (1,184,366)**	**$ (2,368,732)**	**$ (3,553,098)**
Interest	5,959	2,656	2,647	2,091	3,032	4,664	21,049	42,097	63,146
Non-Operating Revenues (Expenses)	449,593	79,127	(111,275)	55,803	9,091	70,858	553,197	1,106,393	1,659,590
Net Income (Loss)	**$ (400,500)**	**$ (21,280)**	**$ (43,591)**	**$ (46,077)**	**$ (18,977)**	**$ (100,744)**	**$ (631,169)**	**$ (1,262,338)**	**$ (1,893,507)**

Capital Considerations

Howard Memorial leverages capital leases and service agreements for the provision of many aspects of the hospital's physical plant and major equipment, and the facility is in a good state of repair. The use of capital leases and accompanying service agreements allows the hospital to spread the cost of, *e.g.*, radiology equipment out over several years and to regularly update the equipment as new technology and models are released. The hospital has two boilers that are roughly 14 years old and a third boiler that was recently replaced when the third 14-year-old boiler became inoperative. With the replacement of the third boiler the

hospital updated their service contract for all three boilers to increase the frequency of maintenance. The hospital does not have any chillers or chiller towers and instead relies on condensers for its cooling needs during warm months. The current condensers use increasingly hard to find and the hospital would like to replace them with a new chiller if and when the necessary capital becomes available, but Howard Memorial has not yet included a chiller in its capital expenditures budget.

The facility roof is 14 years into an original life expectancy of 20 years and is beginning to require more frequent patching and upkeep. Howard Memorial has not yet budgeted for a new roof but expects to do so in the medium-term. The total fiscal year 2023 capital budget provided by hospital leadership includes $3.2M of investments, the largest of which is the roughly $2M surgical robot discussed in *Debt* above and in the *Sustainability Plan* section below.

Sustainability Plan

Howard Memorial develops a Strategic Plan and Goals annually to present to the hospital's board of directors for approval. During the on-site review and in the documentation that Howard Memorial provided, hospital leadership identified several additional revenue-enhancing or cost-reducing initiatives above and beyond those contained in the 2023 Strategic Plan and Goals. These items are not quantified but represent opportunities for Howard Memorial to improve its long-term sustainability and financial condition. [106]

Table 84: Howard's Sustainability Plan

Howard Memorial Sustainability Plan Summary	Financial Impact		
	Action Complete	Action Pending	Total
Revenue Enhancement/Expense Reductions:			
Develop market assessment to inform strategic plan	*Impact Unknown*		*Impact Unknown*
Invest in and begin offering robotics surgery	*Impact Unknown*		*Impact Unknown*
Expand denial prevention program to improve reimbursements	*Impact Unknown*		*Impact Unknown*
Retain support for reviewing zero balance accounts receivable	*Impact Unknown*		*Impact Unknown*
Identify and expand into new outpatient services	*Impact Unknown*	*Impact Unknown*	*Impact Unknown*
Increase swing bed utilization to 30% of patient days		*Impact Unknown*	*Impact Unknown*
Increase cardiac/pulmonary rehab patient volume		*Impact Unknown*	*Impact Unknown*
Hire full-time marketer to increase awareness of hospital services		*Impact Unknown*	*Impact Unknown*
Increase physical therapy unit footprint		*Impact Unknown*	*Impact Unknown*
TOTAL IMPACT	***Impact Unknown***	***Impact Unknown***	***Impact Unknown***

<u>Revenue Enhancements and Expense Reductions</u>

- Develop market assessment to inform strategic plan
  - Howard Memorial developed a market assessment in early 2022 to identify areas of unmet need and opportunities to expand volume or service offerings. A component of that assessment was a surgical-specific market analysis which informed the recent investment in robotics-assisted surgery.
- Invest in and begin offering robotics surgery
  - In early 2023 Howard Memorial began offering robots surgery using the recently leased equipment. The hospital has also contracted with two robotics-trained surgeons to perform these services and is actively considering additional services that could be offered using the new capital investment.
- Expand denial-prevention program to improve reimbursement

[106] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

    - The hospital has augmented its existing denial-prevention program with a second contract with a third party in order to better prevent denials and improve the hospital's NPSR.
- Retain support for reviewing zero balance accounts receivable
    - Howard Memorial has also contracted with a third-party vendor to perform reviews of zero balance accounts receivable to identify any underpayments from commercial payers. In a twelve-month period so far this initiative has identified almost 70 accounts with underpayments and resulted in an additional $325k in collections.
- Identify and expand into new outpatient services
    - The hospital opened a pediatric therapy center in early 2021 after identifying a need in the community for physical and occupational therapy as well as speech pathology services for children. Patient volume growth has been robust in the two years since.
    - Howard Memorial is continuing to work to identify additional outpatient services that would benefit the community and the hospital's financial condition.
- Increase swing bed utilization to 30% of patient days
    - Improving the utilization of swing beds would allow the hospital to improve revenues using the resources it currently has available.
- Increase cardiac/pulmonary rehab patient volume
    - Howard Memorial is targeting cardiac/pulmonary rehab as a service line with growth potential.
    - The hospital upgraded their nuclear imaging capabilities to include a dual camera system in 2020 and intends to increase the system's utilization to 15 studies per month in fiscal 2023.
- Hire full-time marketer to increase awareness of hospital services
    - In addition to expanding service offerings to meet community needs and improve revenues, Howard Memorial is retaining a full-time marketing resource to heighten awareness of hospital services.
- Increase physical therapy unit footprint
    - Howard Memorial has a strong physical therapy service offering that has grown to the point where physical space is becoming a primary limiting factor. Increasing the floor space for the unit would allow for its continued growth and enable the hospital to offer additional services such as silver sneakers programs.

Magnolia Regional Medical Center

Background/Overview

- Classification: Non-CAH
- Licensed Beds: 49
- Closest Facility: 21.7 miles
- Average Age of Plant: N/A
- Average Daily Patient Occupancy Rate: 19%
- Average length of stay (ALOS): 3.9 days
- Total full-time employees (FTEs): 187

Location: Magnolia, Columbia County
County Population: 22,672 (2021)

Table 85: Magnolia's Summary Statistics

Operating Statistics		
C&C Equivalents	$	9.6 M
Current Assets	$	16.4 M
Net A/R	$	4.2 M
Total Assets	$	42.5 M
Days Cash on Hand		120.69
Quick Ratio		5.47
Current Ratio		5.77
Debt Service Coverage Ratio		-19.99
Days in Net AR		57.74
Average Age of Plant		N/A
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	26.0 M
Other Revenue	$	1.0 M
Total Revenue	$	27.0 M
Salaries, Wages & Benefits	$	15.5 M
EBITDA	$	(2.1 M)
Operating Income	$	(4.4 M)
Non-Operating Income/(Expense	$	2.7 M
Net Income	$	(1.8 M)
Operating Margin %		-16%

Key Challenges

- Although the facility is only ~12 years old, there are many issues with the physical plant that will require significant capital investment to mitigate
- Maintaining staffing is a significant challenge. The hospital's general surgeon is leaving in the summer of 2023 and his departure will leave a major services gap until a replacement can be found, which hospital leadership expects will take at least six or seven months

1 *Patient Volume Trends*

- The hospital has experienced a decrease in overall inpatient volume, with payers opting for more patients to receive observation care (billed as outpatient) rather than being admitted for inpatient care
- The hospital's orthopedic service line has seen significant growth, including the hiring of a new orthopedic surgeon who performs robotic knee replacements. This has contributed to an increase in outpatient revenue

2 *Financial Status*

- Days cash on hand has been steadily decreasing and is currently around 120 days.
- Additional expenses are being incurred in the cost of supplies and labor
- The hospital's long-term debt includes a $1.165M note payable for an orthopedic surgery robot, which is repaid based on equipment usage
- The hospital has experienced delays in reimbursements due to the transition from a municipal entity to a 501(c)(3) organization in October 2020
- Hospital leadership has concerns about the increasing contracts for anesthesiologists, hospitalists, radiologists, and general increases in expenses that are not currently being offset by revenue increases

3 *Labor Challenges*

- As mentioned above, the hospital's sole general surgeon is leaving this summer, and it will be at least a six or seven-month process to find and onboard a replacement
- The hospital's obstetrics (OB) unit was closed due to staffing issues and the departure of an OB nurse. The service stopped in 2021 but was officially closed last year
- The hospital used travel nurses during the pandemic and still has ~four in its med/surg unit, down from a peak of ~seven
- The residency program at a nearby medical school was paused in May of 2022 and will not resume until 2029

4 *Technology Challenges*[107]

- Magnolia Regional did not report any major IT challenges. The hospital has roughly a million dollars in IT-related capital expenditures planned through 2025, including hardware, cybersecurity upgrades, and updates to the clinics' electronic medical record (EMR)

5 *Sustainability Plan*

- The hospital has plans to re-add swing beds for patients in need of rehab services following orthopedic surgeries
- The hospital is considering the potential for wound care and pain management clinics, although the financial impact of these clinics is expected to be relatively small

[107] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- Maintaining the capacity of the surgical services department during the upcoming lack of a general surgeon is a key challenge and goal in the near-term. Orthopedic surgery is a clear driver of revenue growth, and the hospital has added additional CRNAs, other nursing staff, and new equipment to increase the throughput and capacity of the OR
- Magnolia Regional is planning to move certain (currently off-site) clinic operations to on-campus, saving ~$90k over 12 months due to the off-site lease being terminated early, and increasing reimbursement rates for clinic visits slightly

6

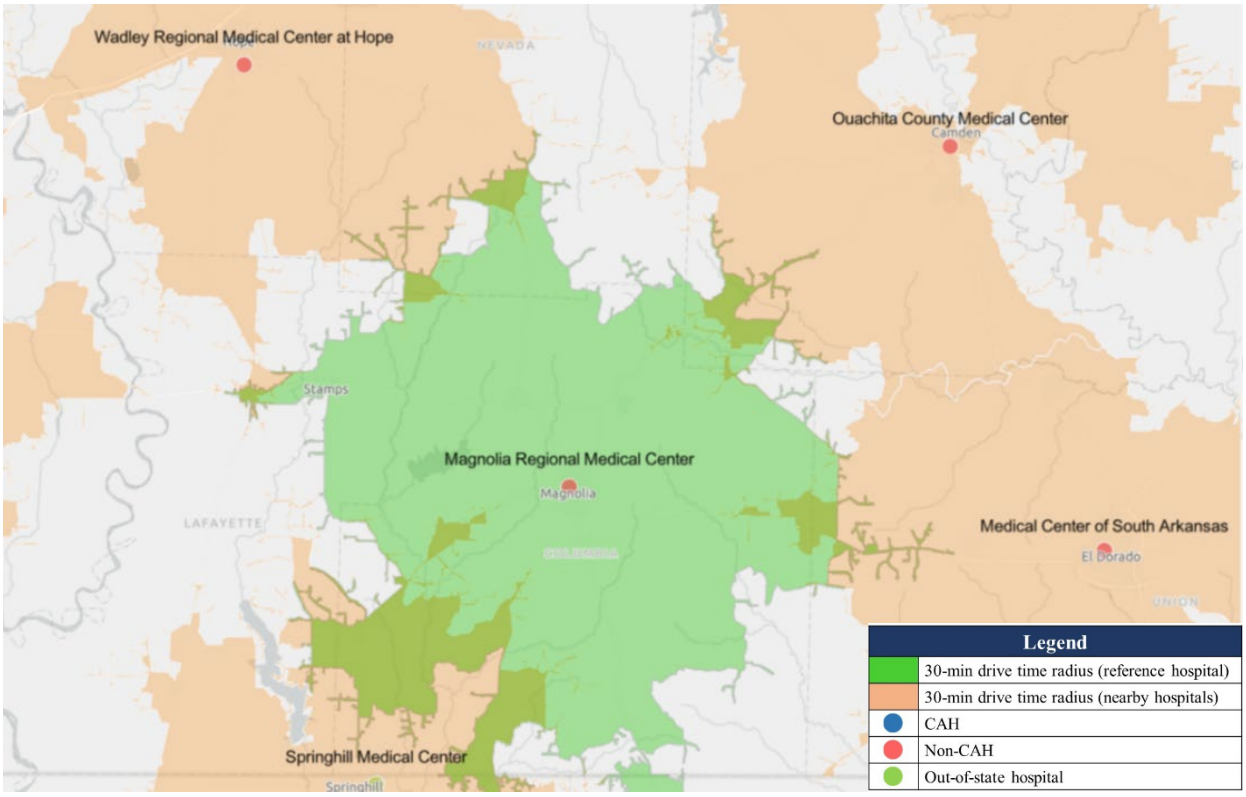
Physical Plant

- The hospital requires significant maintenance and upgrades for its facilities and equipment. Much equipment has not received preventative maintenance or been upgraded or replaced for 12 years
    - Issues include outdated kitchen and laundry equipment, plumbing and electrical systems, generator upgrades, air handlers, chillers, vacuum pumps, fire safety, and roof replacements
    - The building management control system for the hospital is out of date, and many components are nonresponsive. They won't know if those things need to be fully replaced until the control system has been updated/patched (unresponsiveness could be because of damaged equipment or could just be that the software is out of date). Hospital leadership was in the process of soliciting bids for this work when A&M visited and as such did provide cost estimates
- There are no cleanouts in the hospital plumbing, making it very difficult to maintain the plumbing and to prevent blockages/flooding. Flooding is somewhat frequent and has at times been significant

Drive Time Assessment - Alternatives in the Surrounding Community

A population estimated at 36,860 is located within a 30-mile radius of Magnolia Regional.[108] The three closest alternative hospitals to Magnolia Regional are on average 28.7 miles away: Springhill Medical Center is 21.7 miles south-southwest and just across the Louisiana border; Ouachita County Medical Center is 31.4 miles to the northeast in Camden, AR; and Medical Center of South Arkansas is 33 miles east in El Dorado, AR.

Figure 17: Magnolia's Drive Time Assessment



Observations Related to Operational Outlook

Magnolia Regional's average daily census (ADC) over the six-month period ending December 2022 was 9.1 and the average length of stay (ALOS) was 3.9. Compared against the 49 acute care beds that the hospital is licensed for, this represents an occupancy rate of 18.7%.

For comparison, the national benchmark average LOS for non-CAH facilities is 5.4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%.[109]

[108] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.
[109] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

Over the same period, Magnolia Regional reported 866 annualized total inpatient discharges. Based on the most recent financial data available the hospital's adjustment factor[110] was 5.20, signifying an annual adjusted discharges figure of 4,504. The annualized number of emergency department visits over the six months was 10,904.

There were 187 total full-time employees (FTEs), of which 83 were directly related to patient care ("clinical" FTEs or CFTEs). FTEs per adjusted occupied bed (FTEs per adjusted ADC) was 3.9, significantly below the state benchmark for FTEs per adjusted ADC of 4.6-5.72.[111] Labor costs as a percent of net patient service revenue (NPSR) was 59.7% compared to the benchmark of 50% - 60% for rural non-CAHs.[112] FTEs per adjusted ADC was below benchmarks and labor costs as a percent of NPSR was towards the high end of the benchmark range.

Table 86: Magnolia's Operational Indicators

Key Indicators - Operational Outlook	
(Jul. 2022 - Feb. 2023 Annualized)	
Total Inpatient Discharges	866
Adjustment Factor	5.20
Total Adjusted Discharges	4,504
Hospital Patient Days	3,340
Adjusted Patient Days	17,371
Average Daily Census	9.1
Average Length of Stay	3.9
Emergency Department Visits	10,904
Occupancy Rate	18.7%
Total FTEs	187
Total CFTEs	83
Case Mix Index	1.36
Labor Cost / Net Patient Revenue	59.7%
FTEs per Adjusted Occupied Bed	3.9

Table 87: Magnolia's Balance Sheet Metrics

Balance Sheet Metrics	
(as of Feb. 2023)	
C&C Equivalents	$ 9,631,555
Inventory and Prepaid Expenses	$ 877,809
Current Assets	$ 16,421,732
Total Assets	$ 42,469,938
Current Liabilities	$ 2,843,923
Total Long-Term Debt	$ 1,375,655
Total Liabilities	$ 5,123,944
Net Position	$ 37,345,994
Daily Expenditures	$ 79,802
Days Cash on Hand	120.7
Quick Ratio	5.5
Current Ratio	5.77
Debt Service Coverage Ratio	(19.99)
Average Age of Plant	N/A
Days in Net Accounts Receivable	57.74
Debt to Operating Revenue	5%

Observations Related to Current Fiscal Condition

Unless specified otherwise, the figures and discussion below are based on financials from the six-month period ending February 2023, the most recent financials received from hospital leadership.

Cash Position

As of the end of February 2023, Magnolia Regional had $9.7M of cash and cash equivalents on hand. With an average daily expenditure of $79,802 this equates to just over 120 days of cash on hand. The average days that elapsed between when services were billed and when they were collected ("days in net accounts receivable") was 57.7, up moderately from an average

[110] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue

[111] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

[112] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

days in net accounts receivable of 51.9 in fiscal year 2022. The cash flow table below shows the hospital's cash flows over the last six months of available data (Sep. 2022 – Feb. 2023).

Table 88: Magnolia's Regional Cash Flow

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Beginning Balance	$ 10,669,552	$ 10,858,848	$ 10,293,675	$ 10,002,040	$ 9,789,628	$ 9,547,525
Operating Activities	(33,249)	(566,286)	(343,265)	(250,143)	(115,869)	(26,200)
Financing Activities	209,463	(18,299)	31,592	19,143	(145,310)	88,930
Investing Activities	13,083	19,412	20,038	18,588	19,076	21,299
Net Increase (Decrease)	189,297	(565,173)	(291,635)	(212,412)	(242,103)	84,029
Ending Balance	$ 10,858,848	$ 10,293,675	$ 10,002,040	$ 9,789,628	$ 9,547,525	$ 9,631,554

Debt

Magnolia Regional has little long-term debt. The hospital's long-term debt burden as of the end of February 2023 was just under $1.4M, or 5% of annual revenues, and the annual principal and interest payments on debt is $222k for the current fiscal year. Hospital leadership stated that the majority of the existing debt stems from a note payable that was used to finance an orthopedic surgery robot with repayments based off the use of the equipment.

Revenue

The hospital's NPSR has held relatively stable from fiscal year 2022 to the current data with an increase of 1% while other non-NPSR operating revenues saw an increase of $225k or 31%. These figures are roughly in keeping with Magnolia Regional's flat patient volume over the same period.

Table 89: Magnolia's Income Statement Metrics

Income Statement Metrics			
	FY22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 25,884,393	$ 26,046,358	1%
Other Revenue	725,844	950,728	31%
Total Revenue	**26,610,237**	**26,997,086**	**1%**
Salaries, Wages & Benefits (SWB) Expense	15,148,946	15,538,612	3%
Supplies and Other Operating Expense	13,529,549	13,572,788	0%
EBITDA	**(2,068,258)**	**(2,114,314)**	**-2%**
Depreciation Expense	2,661,085	2,327,904	-13%
Operating Income	**(4,729,343)**	**(4,442,218)**	**6%**
Non-Operating Income (Expense)	3,175,064	2,676,895	-16%
Net Income	**(1,554,279)**	**(1,765,323)**	**-14%**
Operating Margin	-18%	-16%	7%
NPSR / Adj Discharge		$ 5,783	
Expense / Adj Discharge		$ 6,980	

** Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

Magnolia Regional's salaries, wages, and benefits (SWB) expenses have held relatively stable from fiscal year 2022 to the current period, seeing a moderate 3% increase over that time. Non-SWB operating expenses including supplies remained flat.

Supplemental Funding

Magnolia Regional has previously received and recognized supplemental funding from a variety of state and federal sources. The Supplemental Funding table to the right breaks out the sources of supplemental funds by the fiscal year in which those funds were recognized on the hospital's income statement.

Table 90: Magnolia's Supplemental Funding

Supplemental Funding	FY2021	FY2022
CARES Act Provider Relief Fund	$ 8,830,000	$ 130,000
American Rescue Plan Act (Rural Payments)		$ 1,113,000
Arkansas' ARPA (SFRF)	$ 243,000	$ 470,000
DHS SHIP Grant Funds		$ 281,000
Paycheck Protection Program (PPP)	$ 2,331,553	
Total	**$ 11,404,553**	**$ 1,994,000**

Break-Even Analysis

As seen in the Income Statement table above. Magnolia Regional's net income has remained slightly negative over the last six months except for September, when the hospital recognized several sources of supplemental funding as non-operating revenues. At the hospital's current rate it will likely require just under $1.8M of funding to break even over the next 12 months and just under $3.5M for the next 18 months.

Table 91: Magnolia's Income Statement

Magnolia Regional Income Statement	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Breakeven Over the Last 2 Quarters	12-Month Total	18-Month Total
Net patient service revenue	$ 2,103,428	$ 2,005,426	$ 2,272,659	$ 2,115,562	$ 2,328,606	$ 2,197,498	$ 13,023,179	$ 26,046,358	$ 39,069,537
Other Operating Revenues	74,572	41,919	85,170	92,594	87,376	93,733	475,364	950,728	1,426,092
Total Operating Revenue	2,178,000	2,047,345	2,357,829	2,208,156	2,415,982	2,291,231	13,498,543	26,997,086	40,495,629
Salaries, Wages, Benefits and Payroll Taxes	1,312,588	1,312,946	1,214,459	1,318,134	1,352,544	1,258,635	7,769,306	15,538,612	23,307,918
Supplies	346,057	467,673	406,936	479,763	462,269	415,065	2,577,763	5,155,526	7,733,289
Total Operating Expenses Less D&A	2,489,984	2,396,560	2,331,035	2,460,547	2,497,233	2,380,341	14,555,700	29,111,400	43,667,100
EBIDA	**$ (311,984)**	**$ (349,215)**	**$ 26,794**	**$ (252,391)**	**$ (81,251)**	**$ (89,110)**	**$ (1,057,157)**	**$ (2,114,314)**	**$ (3,171,471)**
Depreciation	201,840	201,902	201,590	202,091	203,188	153,341	1,163,952	2,327,904	3,491,856
Total Operating Expenses	2,691,824	2,598,462	2,532,625	2,662,638	2,700,421	2,533,682	15,719,652	31,439,304	47,158,956
Operating Income (Loss)	**$ (513,824)**	**$ (551,117)**	**$ (174,796)**	**$ (454,482)**	**$ (284,439)**	**$ (242,451)**	**$ (2,221,109)**	**$ (4,442,218)**	**$ (6,663,327)**
Interest	1,478	1,431	1,385	1,338	1,762	773	8,167	16,334	24,501
Non-Operating Revenues (Expenses)	1,741,803	87,000	80,425	90,479	78,089	93,872	2,171,668	2,676,895	3,182,121
Net Income (Loss)	**$ 1,227,979**	**$ (464,117)**	**$ (94,371)**	**$ (364,003)**	**$ (206,350)**	**$ (148,579)**	**$ (49,441)**	**$ (1,765,323)**	**$ (3,481,206)**

Capital Considerations

The current Magnolia Regional facility was constructed relatively recently—in 2010—meaning that the average age of the physical plant and equipment is at most 13 years which is lower than many of the other hospitals under review. That said, Magnolia Regional has significant infrastructure issues that will take substantial investment to remediate.

One such issue is with the plumbing infrastructure; the hospital was built without plumbing cleanouts, which makes preventative maintenance and fixing blockages both difficult and expensive. Hospital

facilities staff reported that there is a flooding incident about once a quarter and that, depending on the location of the blockage and flooding, they can cause substantive disruptions to the provision of patient care.

With regard to the hospital's electrical infrastructure there is one noteworthy item. The hospital was built with a single as opposed to two discrete electrical feeds for the facility. The hospital is connected to a single substation and, should that substation go down, must rely on its backup power generator.

There are several other areas in need of capital investment. First, the facility's building management control system is out of date and many of the pieces of physical plant are unable to communicate with it. Second, much of the kitchen equipment was inherited from the previous county hospital and is in urgent need of replacement; maintenance bills for the routine repair of items are a drain on hospital resources and it would be a good long-term investment to replace them entirely. Second, there are several clinic roofs separate from the main hospital that are in need of replacement. Third, the hospital currently does its own laundry on-campus, and the laundering equipment from 2010 is nearing end-of-life and needs to be replaced or the hospital needs to transition to outsourced laundry services. Finally, there are a variety of HVAC-related items that need repair or replacement, including air handlers, chillers, vacuum pumps, and boilers due to limited regular maintenance since they were installed.

Sustainability Plan

Magnolia Regional leadership has identified multiple opportunities for investment in the hospital's future sustainability. An overview of these opportunities is provided in the Sustainability Plan table below, and a more in-depth discussion of each item follows.[113]

Table 92: Magnolia's Sustainability Plan

Magnolia regional Sustainability Plan Summary	Financial Impact		
	Action Complete	Action Pending	Total
Revenue Enhancement/Expense Reductions:			
Orthopedic Surgery Clinic			
New Nurse Practitioner	*Impact Unknown*		*Impact Unknown*
New Physician Assistant	*Impact Unknown*		*Impact Unknown*
Hire Revenue Consultant	*Impact Unknown*		*Impact Unknown*
Internal Medicine Clinic			
Moving off-campus clinic on-campus to maximize reimbursements		*60,000*	*60,000*
Terminate off-campus lease early to save remaining payments	*30,000 (non-recurring)*		*30,000 (non-recurring)*
Physician Recruitment			
New primary care physician starting mid-April 2023	*Impact Unknown*		*Impact Unknown*
Additional physician recruitment in surgical and non-surgical specialties		*Impact Unknown*	*Impact Unknown*
Surgical Services Department			
Consultant for department efficiency	*Impact Unknown*		*Impact Unknown*
Hire additional surgical team to accommodate new volume	*Impact Unknown*		*Impact Unknown*
Contract new anesthesia provider		*Impact Unknown*	*Impact Unknown*
New Programs and Services			
Develop new wound care facility		*6,000*	*6,000*
Develop new pain management program		*Impact Unknown*	*Impact Unknown*
Revenue Management Director			
Hire new full-time Revenue Cycle Director	*Impact Unknown*		*Impact Unknown*
Infrastructure Improvements			
Upgraded generator system	*Impact Unknown*		*Impact Unknown*
Create detailed facility condition report		*Impact Unknown*	*Impact Unknown*
Reduce travel nurse dependency		*Impact Unknown*	*Impact Unknown*
TOTAL IMPACT	***30,000***	***66,000***	***96,000***

Revenue Enhancements and Expense Reductions

- Orthopedic surgery clinic:

[113] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

    - Magnolia Regional has hired a nurse practitioner and physician assistant to support the fast-growing orthopedic surgery service line and to improve efficiency and through-put of orthopedic surgeries.
    - The hospital has also retained a revenue consultant to assist with maximizing the efficiency and profitability of the orthopedic surgery clinic.
- Internal medicine clinic:
    - Magnolia Regional has begun to transition an internal medicine clinic that is currently based off-campus to an on-campus clinic. This will allow the clinic to qualify as a provider-based clinic and receive enhanced reimbursements.
    - The hospital is projected to realize a bottom line improvement of approximately $90k (lease payments and increased revenues) over a 12 month period.
- Physician recruitment:
    - Magnolia Regional has hired a new primary care physician who began work in April 2023. This hire will allow the hospital to increase both clinic and hospital capacity in order to increase NPSR.
    - The hospital also plans to hire additional physicians in other surgical and non-surgical specialties to further increase the hospital's capacity and service revenues.
- Surgical services department:
    - The hospital has retained a consultant to help improve the operational efficiency of the surgical services department.
    - Magnolia Regional has also hired an additional surgical team to prevent burnout among the existing surgical staff and to allow for additional surgical procedures to be provided through extended hours of coverage.
    - Third, the hospital has contracted with an additional anesthesia provider to provide an additional 15 days of call coverage each month and to extend the routine hours of operation.
- New programs and services:
    - Magnolia Regional is working two establish two additional programs. First is a wound care program that is targeted to launch in the second quarter of 2023. Second is a pain management program for the hospital facility that will be tied to the anesthesia service line.
- Revenue management director:
    - Magnolia Regional has brought on a full-time revenue cycle director to oversee and improve the hospital's admission, billing, and collections processes.
- Infrastructure improvements:
    - The hospital is making investments in updating its physical plant, such as repairing and replacing water heaters and updating the software of the backup generator, in order to improve operational efficiency and generate cost-savings over time.
    - The hospital is also working to create a detailed report of facility condition in order to effectively prioritize additional investments in the hospital infrastructure.
- Reduce travel nurse dependency:
    - Finally, Magnolia Regional is working to adjust internal salaries and improve its nursing recruitment pipeline to better attract and retain nursing staff and reduce the hospital's dependence on expensive traveling staff.

Mena Regional Health System

Quick Facts

- Classification: Non-CAH
- Licensed Beds: 65
- Closest Facility: 17.5 miles
- Average Age of Plant: 19.7 years
- Average Daily Patient Occupancy Rate: ~28%
- Average length of stay (ALOS): 2.7 days
- Total full-time employees (FTEs): 270
- 509(a)
- Owned by the City of Mena but does not receive tax support

Location: Mena, Polk County
County Population: 19,353 (2021)

Table 93: Mena's Summary Statistics Table

Operating Statistics		
C&C Equivalents	$	4.1 M
Current Assets	$	11.8 M
Net A/R	$	4.1 M
Total Assets	$	20.4 M
Days Cash on Hand		43.15
Quick Ratio		3.26
Current Ratio		3.71
Debt Service Coverage Ratio		-4.74
Days in Net AR		49.04
Average Age of Plant		19.74
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	30.3 M
Other Revenue	$	2.4 M
Total Revenue	$	32.7 M
Salaries, Wages & Benefits	$	21.1 M
EBITDA	$	(2.0 M)
Operating Income	$	(3.2 M)
Non-Operating Income/(Expense)	$	0.2 M
Net Income	$	(3.0 M)
Operating Margin %		-10%

Key Challenges

- Isolated location drives costly traveler nurses, higher clinician turnover rates, and frequent staffing shortages; CMS quality measurement and reporting; relatively new executive leadership.

1 *Patient Volume Trends*

- Staffing shortages are limiting capacity to treat as many patients as Mena Regional could otherwise
  - General surgery, lab, ophthalmology, and respiratory all see strong volumes
  - The average daily census (ADC) in FY22 was 18.1
  - CY2022 YTD admissions were 1,306, up from the previous year's 1,225

2 *Financial Status*

- Would break even monthly if travel clinicians were full-time employees (FTEs) – Mena Regional spends $200-250k per month on travel staff
- Cash on hand:
  - $4.1M cash on hand (based on Feb. 2023 financials)
  - Days cash on hand in Feb. 2023 was 43.2, down from 56 in Dec. 2022
- Quick Ratio: 3.3
- Accounts receivable (A/R) days have increased recently to 46-50 days as Medicare Advantage complicates timely collections
- Operating margin: Annualized net income (based on Sept. 2022 through Feb. 2023 financials) is a ($3.2M) operating loss

3 *Labor Challenges*

- Mena Regional's location in a national forest makes finding talent difficult, and staffing shortages have resulted in a reliance on travel clinicians (the hospital currently has 23 travelers across internal/external, $200-$250k per month)
- High staff turnover (~32% in 2022) caused by wage competition and relocation preferences
- Good culture, but wages are outcompeted by nearest competitors in larger cities

4 *Technology Challenges*[114]

- Hospital leadership has considered partnering with a larger medical system to access EPIC, which would integrate RCM program (TruBridge) with the ER's IT System
- Experienced a malware attack in 2021; has security measures and pricey cyber insurance in place
- Unable to afford an upgrade to their current patient monitoring system

5 *Sustainability Plan*

- No specific financial figures attached to sustainability plan items
- Focus on quality: Mena Regional currently has 7% per year of their Medicare billings at risk based on CMS quality measures and it is unclear to new leadership if they will be successfully recouping these amounts. Hospital leadership has responded by directing staff to focus on KPIs and quality and establishing monthly nurse reviews to ensure they are getting the full at-risk amount back
- Staff Initiatives: Hospital leadership has made wage scale changes to attract additional workforce

[114] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- Maintaining Services: Focusing on basics and current services rather than expanding
- Cost Reductions: Hospital leadership would like to reduce travel clinician dependency to save $200-250k per month (as discussed above) and switch to lower cost suppliers

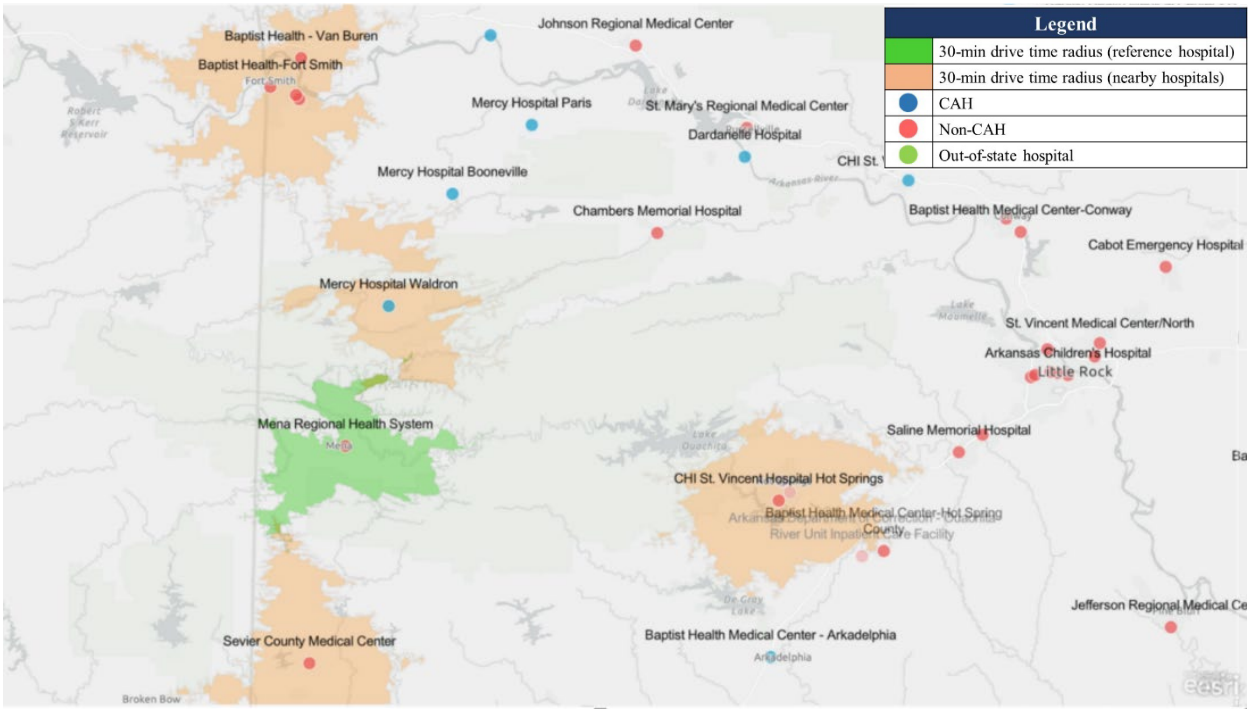
6

Physical Plant

- Repeated expansions have resulted in a facility that is complicated to repair
- Inefficient steam coils have negative impacts when trying to heat and run hot water throughout the facility
- Portions of the HVAC system have become obsolete

Drive Time Assessment - Alternatives in the Surrounding Community

Mena Regional is the only hospital in Polk County, a county on the western edge of Arkansas. Nearly half of the county lies in the Ouachita National Forest, and the hospital itself if fully "landlocked" by the forest, as described by hospital leadership. The estimated total population within a 30-mile radius of Mena



Regional is 29,142.[115] Hospital leadership estimates that Mena Regional's service area serves a population 35-40k across Polk County, neighboring counties, and even Oklahoma. There are no hospitals with a 30-mile or 45-minute drive. The nearest three alternative hospitals are 34.8 miles to the north at Mercy Hospital Waldron in Waldron, 42.1 miles to the south at Sevier County Medical Center, or 76.4 miles to the east at CHI St. Vincent Hospital – Hot Springs.

[115] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

Observations Related to Operational Outlook

Mena Regional provides the following services: Behavioral health (geriatric psychiatry), emergency, inpatient rehab, lab, OBGYN, pediatrics, radiology, surgery (general, colorectal, gynecologic, ophthalmology, urology), and therapy (occupational, speech, physical). The hospital is notably one of only 38 hospitals across the state that provides critical labor and delivery services. During the COVID pandemic, staffing challenges forced Mena Regional to combine its Med/Surg, Intensive Care, and Inpatient Rehabilitation Units to manage the workload with limited staff appropriately. In October 2022, the hospital separated the inpatient rehab unit out into a new 12-bed unit with the intention of growing inpatient volume and other services that rely on inpatient referrals. The hospital has three clinics on campus. One clinic is designated as a rural health clinic (RHC), and the hospital is working on getting RHC status for a second clinic as well before it looks to designate the third clinic.

In 2022, Mena Regional reported 1,422 annual inpatient discharges with an adjustment factor[116], of 4.66, resulting in total adjusted discharges of 6,627. [117] Many of the hospital's specialty services (*e.g.*, respiratory) are dependent on inpatient volume for referrals. Mena Regional would like to expand its services and increase patient volume since there is enough patient demand; however, the hospital lacks the clinical staffing to do so. For example, general surgery does not have enough staff to operate more than one room at a time despite having the patient demand to operate two rooms.

Table 94: Mena's Operational Indicators

Key Indicators - Operational Outlook	
(As of Feb 2023)	
Total Inpatient Discharges	1,422
Adjustment Factor	4.66
Total Adjusted Discharges	6,626
Hospital Patient Days	3,050
Adjusted Patient Days	14,212
Average Daily Census	18.1
Average Length of Stay	2.7
Emergency Department Visits	9,310
Occupancy Rate	27.8%
Total FTEs	270
Total CFTEs	185
Case Mix Index	1.15
Labor Cost / Net Patient Revenue	69.5%
FTEs per Adjusted Occupied Bed	3.2

Table 95: Mena's Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	4,105,325
Inventory and Prepaid Expenses	$	1,405,359
Current Assets	$	11,777,772
Total Assets	$	20,419,714
Current Liabilities	$	3,178,610
Total Long-Term Debt	$	201,353
Total Liabilities	$	3,379,963
Net Position	$	17,039,751
Daily Expenditures	$	95,134
Days Cash on Hand		43.2
Quick Ratio		3.3
Current Ratio		3.71
Debt Service Coverage Ratio		(4.74)
Average Age of Plant		19.74
Days in Net Accounts Receivable		49.04
Debt to Operating Revenue		1%

The YTD acute average length of stay (ALOS) was 2.66 days. Total ALOS, which includes rehab and behavioral health, has steadily increased from 4.55 days in Jan. 2022 to 5.18 days in Dec. 2022. Current

[116] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue.
[117] The annual inpatient discharges figure is from July-December 2022 operational statistics provided by the hospital.

hospital leadership attributes this increase to the previous departed hospital leadership's limited focus on quality-of-care metrics and performance indicators. The average daily census (ADC) was 18.1, while the occupancy rate for the year was 28%. For comparison, the national benchmark average LOS for non-CAH facilities is 5.4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%.[118] Mena Regional has only a slightly below average ALOS and occupancy rate, which indicates that despite the hospital's isolation, patient volume is comparable to those of other rural hospitals.

Mena Regional has a total of 270 full-time employees (FTEs), of which 185 are clinical FTEs. FTEs per each adjusted occupied bed (also called "FTEs per adjusted ADC") was 3.2. The state benchmark for FTES per adjusted ADC was 4.6-5.72.[119] Using annualized Sept. 2022 through Feb. 2023 data, labor cost per net patient service revenue (NPSR) was at 70% compared to the benchmark of 50%-60% for rural non-CAHs.[120]

FTEs per adjusted ADC and labor cost relative to NPSR both being below their respective benchmarks indicates an efficiently managed clinical workforce, but other metrics such as staff turnover and patient safety / quality should also be examined to determine if labor is being efficiently utilized. This risk appears to be heightened at Mena Regional as the hospital struggles to maintain staff and attract new talent because of its isolated location. The hospital's 2022 turnover rate was 32%, mostly driven by nurses leaving to return to a bigger city or for higher wages offered by larger hospitals or more competitive wages at critical access hospitals. According to hospital leadership, the hospital "lost a lot of staff to travelers" during the pandemic and has not seen traveler rates decrease as hoped. The potential elimination of high-wage contract traveler nurses and replacement with employed local nurses in the future could reduce relative labor costs and bring labor cost per NPSR closer to the state benchmark described above. This is further described in the *Sustainability Plan* section below.

Observations related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (Feb. 2023). Mena Regional's cash position has been deteriorating since February 2022, with a steady decrease in cash and cash equivalents from $11.73M to $4.1M in Feb. 2023. The hospital has daily expenditures of $95k with 43.2 days cash on hand as of Feb. 2023. With a deteriorating cash position driven by high daily expenditures, Mena Regional has focused on expense reduction initiatives, particularly reducing traveler nurse use, within its sustainability plans in hopes that these actions are more likely to yield rapid impacts on its bottom-line.

Cash Position

Understanding the days cash on hand (COH) in conjunction with trends in accounts receivables (A/R) will give insight into revenue cycle management (RCM) inadequacies. COH has decreased 22% from Dec. 2022 to Feb. 2023 while A/R has slightly increased. Mena Regionals' six-month (Sep. 2022 through Feb. 2023) cash flow, as seen in *Table 96*, shows a steady decrease in cash balances.

[118] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

[119] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

[120] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Additionally, days in net A/R are now 51.64, above the hospital's internal target of 45 days. When asked about A/R days and cash position, Mena Regional's leadership pointed to the growing percentage of patients with Medicare Advantage (MA) coverage, which has hurt the hospital's collection time. Mena Regional manages most of its revenue cycle in-house with dedicated administrative staff to handle billing and outpatient coding. It outsources only the inpatient coding portion of that revenue cycle work to TruBridge, and an RCM vendor that also operates an EMR under the name of CPSI that the hospital uses. Hospital leadership claims it has considered switching to a more established and robust RCM vendor by "piggybacking" off a larger hospital's system (*e.g.*, Baptist Health-Fort Smith) but that Mena Regional's operations are likely too comparatively small to be suited for such a switch. At the end of 2022, the Hospital had about ~$1M in a money market account with a 3% interest rate that effectively acts as the hospital's reserve account but is included in the cash balances above.

Table 96: Mena's Cash Flow Runout Forecast

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Beginning Cash Balance	$ 8,091,867	$ 8,113,766	$6,449,664	$5,451,904	$5,290,712	$4,799,742
Cash Flows from Operating Activities	165,392	(1,783,108)	(839,992)	49,561	(355,721)	(89,076)
Cash Flows from Financing Activities	(12,914)	245,096	(30,483)	(159,861)	(10,457)	(486,555)
Cash Flows from Investing Activities	(130,579)	(126,090)	(127,285)	(50,892)	(124,792)	(118,787)
Net Change in Cash Equivalents	21,899	(1,664,102)	(997,760)	(161,192)	(490,970)	(694,418)
Ending Cash Balance	8,113,766	6,449,664	5,451,904	5,290,712	4,799,742	4,105,324

Notes:
(1) Blue values indicate forecasted values starting in March 2023 using excel's exponential smoothing function

Debt

As of February 28, 2023, Mena Regional has $3,178,610 in current liabilities and only $201,353 in long-term liabilities. The hospital received a $2.64M PPP loan in 2020 but had that loan forgiven on June 8, 2021. At the end of 2022, the Hospital had about ~$1M in a money market account with a 3% interest rate that effectively acts as the hospital's reserve account.

Table 97: Mena's Income Statement

Income Statement Metrics			
	FY21	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 27,962,202	$ 30,274,978	8%
Other Revenue	2,284,751	2,443,416	7%
Total Revenue	**30,246,953**	**32,718,394**	**8%**
Salaries, Wages & Benefits (SWB) Expense	18,590,038	21,054,780	13%
Supplies Expense	4,936,601	3,139,734	-36%
Other Operating Expense	7,253,974	10,508,568	45%
EBITDA	**(533,660)**	**(1,984,688)**	**-272%**
Depreciation Expense	1,182,441	1,216,150	3%
Operating Income	**(1,716,101)**	**(3,200,838)**	**-87%**
Non-Operating Income (Expense)	7,547,414	234,330	-97%
Net Income	**5,831,313**	**(2,966,510)**	**-151%**
Operating Margin	-6%	-10%	-72%
NPSR / Adj Discharge		$ 4,569	
Expense / Adj Discharge		$ 5,421	

** Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior perio*

Revenue

Using annualized Sep. 2022 through Feb. 2023 financials, Mena Regional appears to have experienced an eight percent increase in net patient revenue (NPSR) from the prior year. Hospital leadership did not share any other recent volume or revenue trends during on-site interviews. Services that typically break even or are profitable include the geripsych, emergency, inpatient rehab, and ophthalmology units. Although Mena Regional is owned by the City of Mena, it receives no city tax revenue. The city is considering building new bike trails in Ouachita National Forest, which hospital leadership hopes will increase patient volume and open doors to negotiating a tourism tax with the city, but it is still too soon to tell (see the *Sustainability Plan* section for more details). The hospital does not have short-term plans to grow revenues by expanding new services as it would prefer to focus on improving quality of care within existing services.

Expenses

As described in the *Observations Related to Operational Outlook* section, Mena Regional's most pernicious expense is travel nurse labor cost. Because the hospital is landlocked by the Ouachita National Forest, the hospital offers external traveler nurse rates as high as $150 per hour and "internal traveler" rates around $50-60 per hour, which are double that of employed rates, to attract talent to Mena. The hospital currently has 23 traveler nurses in total: 13 "internal travelers" and ten external travelers, who cost the hospital $250k per month. Since implementing the internal traveler program, the hospital has reduced traveler expenses for ~50%, and hospital leadership purports that monthly operations would break even – and possibly even be profitable – if all 23 traveler nurses were instead full-time employees. During on-site interviews, hospital leadership shared that supply costs have been steadily increasing and will be targeted in the sustainability plan. [121]

[121] Supply expenses have been excluded from this table. The hospital's FY2021 audited financials bundles Supply Expenses with Other Expenses, whereas recent monthly financial data separates Supply Expenses as an individual line item.

Supplemental Funding

Mena Regional gave back approximately $6.2M in CARES Act funding, due to not having adequate expenses or lost revenues to cover the funding in the time periods designated by HRSA. This has played into some of the liquidity challenges faced by Mena, as hospital leadership explained that much of Mena's traveler usage costs have been incurred after the money was returned to HRSA. According to hospital leadership, Mena Regional has recognized $728k of a $740k American Rescue Plan Act (ARPA) payment and has until 2026 to recognize the remaining ~$12k. The hospital has recognized to-date the funding amounts listed below.

Table 98: Mena's Supplemental Funding

Supplemental Funding	FY2020	FY2021
CARES Act Provider Relief Fund	$ 1,230,000	$ 3,200,000
American Rescue Plan Act (Rural Payments)		$ 964,000
Arkansas' ARPA (SFRF)		$ 735,000
State Support (Various)	$ 1,600,000	
Paycheck Protection Program (PPP)		$ 2,644,059
Total	**$ 2,830,000**	**$ 7,543,059**

Break-Even Analysis

Given the trends associated with Mena Regional's operational outlook and fiscal condition, and the potential impact of the sustainability plan, the below break-even analysis was performed to approximate the current net income (Loss). That break-even analysis is based on a trailing six-month annualization of the Mena Regional income statement. As shown in table, their annualized net income based on the trailing six months of September 2022 – February 2023 is ($2,966,510).

Table 99: Mena's Break-Even Analysis

Mena Regional Income Statement	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Breakeven Over the Last 2 Quarters	12-Month Total	18-Month Total
Net patient service revenue	$ 2,485,196	$ 2,655,042	$ 2,567,102	$ 2,495,221	$ 2,372,062	$ 2,562,866	$ 15,137,489	$ 30,274,978	$ 45,412,467
Other Operating Revenues	185,261	174,715	186,936	259,915	201,943	212,938	1,221,708	2,443,416	3,665,124
Total Revenue	2,670,457	2,829,757	2,754,038	2,755,136	2,574,005	2,775,804	16,359,197	32,718,394	49,077,591
Salaries, Wages, Benefits and Payroll Taxes	1,686,875	1,782,920	1,837,844	1,665,775	1,834,907	1,719,069	10,527,390	21,054,780	31,582,170
Supplies	233,904	195,839	228,816	437,014	227,210	247,084	1,569,867	3,139,734	4,709,601
Total Operating Expenses Less D&A	2,842,540	2,735,176	2,716,471	3,039,295	2,965,186	3,052,873	17,351,541	34,703,082	52,054,623
EBITDA	**$ (172,083)**	**$ 94,581**	**$ 37,567**	**$ (284,159)**	**$ (391,181)**	**$ (277,069)**	**$ (992,344)**	**$ (1,984,688)**	**$ (2,977,032)**
Depreciation	101,077	100,136	100,136	100,136	97,687	108,903	608,075	1,216,150	1,824,225
Total Operating Expenses	2,943,617	2,835,312	2,816,607	3,139,431	3,062,873	3,161,776	17,959,616	35,919,232	53,878,848
Operating Income (Loss)	**$ (273,160)**	**$ (5,555)**	**$ (62,569)**	**$ (384,295)**	**$ (488,868)**	**$ (385,972)**	**$ (1,600,419)**	**$ (3,200,838)**	**$ (4,801,257)**
Interest Expense	(1,801)	(1,700)	(1,700)	(1,700)	(2,423)	(1,038)	(10,362)	(20,724)	(31,086)
Non-Operating Income (Expenses)	5,792	1,582	1,582	106,025	4,041	8,505	127,527	255,054	382,581
Net Income (Loss)	**$ (269,169)**	**$ (5,674)**	**$ (62,687)**	**$ (279,970)**	**$ (487,250)**	**$ (378,505)**	**$ (1,483,255)**	**$ (2,966,510)**	**$ (4,449,765)**

Capital Considerations

In addition to all the operational and financial considerations described above, Mena Regional's physical plant requires certain capital considerations to continue, sustain, and enhance operations. The hospital's strained finances have delayed facility maintenance repairs and upgrades. Mena Regional has provided a capital budget that included approximately $2.34M in property repairs and medical equipment needs for the three years: $854k is marked as critical this year, $835k for year two, and $653k for year three.

The main body of the hospital was built in 1980 and has seen many separate additions since then. In 1998, the Inpatient Rehab Center was added. Then in 2006, the hospital again expanded to build a new Emergency

Room and Women's Center. The hospital is now 130,400 square feet in total. The multiple separate expansions of the hospital have made repairs difficult and costly. Mena Regional now has issues with its original 1980 air handlers, water tank, steam reheating, electrical system, plumbing, and pipes. Most notably, eight of 11 air handlers are due for replacement. A 500-gallon water tank, a steam boiler, and 17 frequently faulty steam coils all need replacing as they can no longer maintain heated rooms or deliver hot water throughout the facility.

Mena Regional's current facility patient monitoring system was described by leadership as "piecemeal" and inefficient. The hospital considered upgrading to a different system but was discouraged by the cost.

Upcoming Obligations

Mena Regional does not have any upcoming obligations. The hospital has only a few capital leases and very little long-term debt.

Sustainability Plan

Mena Regional's overall challenge is to achieve sustainability despite the limitations imposed by its rural location and staffing challenges. The hospital's sustainability plan lists efforts aimed at reducing the hospital's reliance on traveler nurses, recruiting talent, and growing revenue by capturing referrals and carefully expanding services but has not been quantified. [122]

Table 100: Mena's Sustainability Plan

Mena Regional Health System Sustainability Plan Summary
Sustainability Plan Summary

Mena Regional Health System Sustainability Plan Summary*	FINANCIAL IMPACT		
ACTION	*Action Complete*	*Action Pending*	*Total*
Revenue Enhancement:			
Clinic Practices: Acquired a clinic practice in July 2022 and is in process of converting to an RHC		Impact unknown	Impact unknown
Operating Quality and Efficiency: Implemented monthly operating reviews to focus on quality-of-care metrics and improve hospital effectiveness		Impact unknown	Impact unknown
Inpatient Rehab Unit: Separated out unit from combined medsurge/ICU/inpatient unit to grow ADC through referrals and geropsych patient volume growth		Impact unknown	Impact unknown
TOTAL REVENUE ENHANCEMENT IMPACT	**$ -**	**Impact unknown**	**Impact unknown**
Expense Reduction:			
Travel nurse contracts - Created an "internal" traveler program, which has reduced traveler expenses by 50%		Reduced traveler expenses by ~50%	Impact unknown
TOTAL EXPENSE REDUCTION IMPACT	**$ -**	**Impact unknown**	**Impact unknown**
****TOTAL IMPACT**	**Impact unknown**	**Impact unknown**	**Impact unknown**

**Mena did not provide quantified estimates of their sustainabiltiy plan items' financial impact; all figures were gathered during on-site reviews*
***Total Impact does not include Recruitment & Retention efforts and Funding opportunities*

Expense Reductions

- To mitigate the cost of travel clinicians, Mena Regional has created an "Internal" traveler program that aims to decrease their need for traveler agency nurses and their high rates. As discussed above in the *Expenses* section, traveler rates can be as high as $150 per hour whereas internal traveler rates are lower at $50-60 per hour. Although internal traveler rates are still 60% higher than employed full-time rates, this program has helped reduce travel nurse labor expenses by almost 50%.

Recruitment and Retention

[122] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

- Mena Regional has established a partnership with a local two-year college's nursing program to recruit nurses early in their training, offer rotational clinic experience, and grow a pipeline of talent that hospital leadership hopes will stay in Mena and work at the hospital. Unfortunately, the hospital has found it difficult to retain new graduates as many students at the nursing program are not local to Mena and eventually return to their hometowns upon graduation. The hospital also offers a short summer program for high schoolers with enough STEM credits to explore the different aspects of health care. Mena Regional did not provide quantification to measure how helpful these programs have been to the recruitment process.
- Since the pandemic, the hospital has also adjusted its nursing pay scale by nearly 30% to become more competitive in the recruiting market. That adjustment added $300k to monthly operating expenses. After opening in January 2023, Sevier County Medical Center in De Queen, AR has purportedly begun offering much higher rates, which has attracted staff away from Mena despite the 30% pay scale adjustment.

Revenue Enhancements

- New hospital leadership spoke frankly about how the hospital has not put sufficient focus on care quality and operational metrics and performance indicators in recent years. In early 2023, the hospital begun implementing monthly operating reviews to bring hospitalists, nurses, and all other key stakeholders together to discuss clinic practices. There is a particular focus on quality-of-care metrics and aligning operations to diagnosis related groups (DRGs) to ensure that community needs are met and that clinics are effective.
- To grow patient service revenues, Mena Regional has added a marketing specialist to develop referrals patterns in the surrounding markets and promote the profitable geripsych program to pre-pandemic volume levels. The effect of the marketing specialist on revenue or expenses has not been quantified.
- In July 2022, the hospital acquired a clinic practice in July and is in the process of converting it to a rural health clinic (RHC). Hospital leadership believes that RHC status would provide better reimbursements rates and help improve operating margin. The hospital has not yet estimated how large the RHC impact will be.
- The City of Mena is considering building new hiking and biking trails and accommodations in hopes of attracting tourism revenue to the city. The plan is supported by the city, Polk County, the state, and the Walton Foundation. Mena Regional believes that if the plan succeeds, the tourism will increase the hospital's patient volume significantly since the hospital is otherwise geographically isolated. Hospital leadership also hopes that the plan will open doors to a discussion with the city about implementing a new tourism tax to support the hospital with an additional revenue source. The project was initially expected to begin building in the spring of 2023 but seems to still be in the discussion phase.
- Mena Regional had briefly considered REH status but dismissed the option given the large, rural service area that it provides services to.

North Arkansas Regional Medical Center

Quick Facts

- Classification: Non-CAH
- Licensed Beds: 174
- Closest Facility: 29 miles
- Average Age of Plant: 26.1 years
- Average Daily Patient Occupancy Rate: 11%
- Average length of stay (ALOS): 3.0
- Total full-time employees (FTEs): 684
- 501(c)(3)
- Owned by the County, leased to the hospital through 2061 with the options to renew

Location: Harrison, Boone County
County Population: 37,830 (2021)

Table 19: NARMC's Summary Statistics

Operating Statistics		
C&C Equivalents	$	31.2 M
Current Assets	$	50.9 M
Net A/R	$	15.5 M
Total Assets	$	86.3 M
Days Cash on Hand		115.81
Quick Ratio		3.96
Current Ratio		4.27
Debt Service Coverage Ratio		-14.84
Days in Net AR		60.20
Average Age of Plant		26.14
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	93.3 M
Other Revenue	$	2.8 M
Total Revenue	$	96.1 M
Salaries, Wages & Benefits	$	52.6 M
EBITDA	$	(1.8 M)
Operating Income	$	(4.9 M)
Non-Operating Income/(Expense)	$	0.1 M
Net Income	$	(4.8 M)
Operating Margin %		-5%

Key Challenges

- Difficulty meeting monthly expenses has required hospital to draw on reserves to fund operations. Other challenges: $8.5M in immediate facility and equipment needs, facility is too large for patient volume, persistent staffing challenges because of wage competition.

1 *Patient Volume Trends*

- Ancillary and surgery volumes are down and are still recovering from COVID
- As mentioned above, NARMC is experiencing consistent patient volumes and demand, but staffing shortages limits capacity to meet that demand
    - NW Arkansas population is growing but other nearby hospitals have limited services, which has driven patients to NARMC
    - Although the hospital is licensed for 174 beds, it only has staffing available for a max capacity at 90-100 beds and has an average daily census (ADC) of 30-40 beds
        - Average Daily Census is 23.4 (as of Feb. 2023)
        - Average Daily Census in July 2022 was 24.1
- Growing shift to outpatient and observation status because of Medicare Advantage inpatient authorization difficulties

2 *Financial Status*

- Cash on hand: $31.9M cash on hand (based on Dec. 2022 financials)
- Days cash on hand: 119
- Includes $32.6M in Net Internally Designated Funds that are typically reserved for future capital improvements
- Quick Ratio: 3.8
- A/R days: 54-58
- Operating margin: Annualized Net income (based on Sept. 2022 through Feb.2023 financials) is a net loss of ($4.8M)
- Reluctantly drew down $10M from reserves to cover operating loss in 2022; typically reserves are only to be used for capital improvements not operations
- RCM is all in-house

3 *Labor Challenges*

- Has reduced contract labor need, hopes to eliminate 15 more contracts this year
- Partnering with local college's respiratory therapy program to address difficulty in staffing nursing & respiratory
- Good culture, low turnover rates, long tenures, wages are now competitive with competitors

4 *Technology Challenges*[123]

- Difficulty finding skilled IT staff: has 37 total staff but that includes security
- Looking at $5.2M EMR conversion (MEDITECH and eClinicalWorks EMR to MEDITECH Expanse) to eliminate communication and workflow issues
- Cybersecurity status: NARMC has had no incidents in the past and does have expensive insurance and phishing prevention methodologies in place

5 *Sustainability Plan*

- 340B program enhancement will generate $457k per month in estimated savings

[123] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- Revenue growth: mostly generated from chargemaster increases; considerations for adding new services lines (*e.g.*, detox, med management, etc.) are restricted by cost and integration challenges; total estimated revenue growth of $75k per month.
- Expense reduction: estimated $1.2M in savings via reductions in supply use/cheaper supplier, contract staff, and salaries
- Revenue capture: billing and charge capture improvements will generate an estimated $125k per month

6

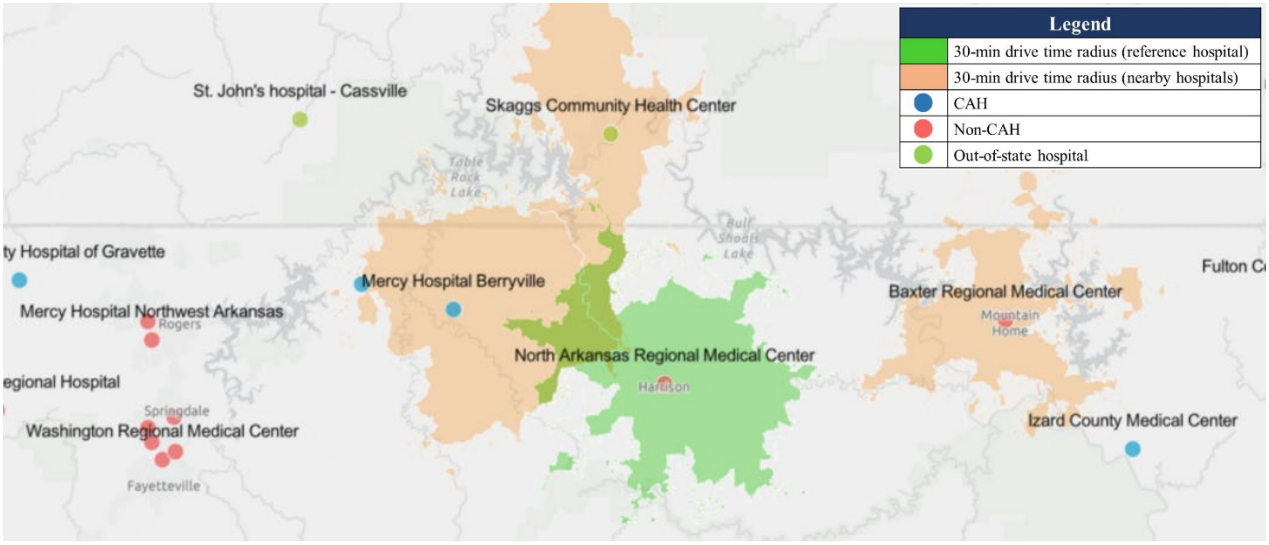
Physical Plant

- Has not been proactive about facility maintenance, requires ~$8.5M in immediate property and equipment improvements

Drive Time Assessment - Alternatives in the Surrounding Community

NARMC leadership estimates that ~95,000 people reside within the five counties that the hospital services, while a population estimated at 148,179 is located within a 30-mile radius of NARMC [124]. NARMC is the only hospital within Boone County (population ~37,000). The two closest alternative hospitals to NARMC are on average 21 miles away: Mercy Hospital – Berryville is 29.2 miles to the west in neighboring Warren County, and Skaggs Community Health Center is 30 miles to the east in McGehee County; and Delta Memorial is 34 miles to the north across state lines in Branson, Missouri. Additional alternatives lie beyond a 35-mile or 45-minute drive. Baxter Regional Medical Center is located 49.5 miles away and may serve as an alternative hospital to populations living east of NARMC. There are no reasonably close alternative hospitals to the south.

Figure 20: NARMC's Drive Time Assessment



Observations Related to Operational Outlook

NARMC provides acute inpatient and outpatient care, psychiatric, and emergency care services to patients in Boone County and surrounding areas of Northwest Arkansas. The Dec. 2022 average length of stay (ALOS) was 3.0 days, which is down from the July 2022 ALOS of 3.66. Leadership states that the hospital

[124] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

has been making "significant progress" towards reducing ALOS over the last few years by streamlining the discharge process and working with local nursing homes to expedite the prior approval process. The hospital's lack of specialty services, complications in admission timing, and trends towards increased long-term bed use have all negatively impacted ALOS. The average daily census (ADC) was 18.7 in Dec. 2022 (Acute only), and leadership claims total hospital ADC was ~30-40. The hospital is licensed for 174 beds, but leadership claims limited staffing only allows for a max capacity at 90-100 beds. As such, hospital facilities appear excessive relative to patient volume as the occupancy rate in Dec. 2022 was ~11% (ADC of 18.7). ADC improved in Feb 2023 to ~24.3

For comparison, the national benchmark average LOS for non-CAH facilities is 5.4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%. [125]

In 2022, NARMC reported 2,212 annual inpatient discharges with an adjustment factor of 5.19, resulting in total adjusted discharges of 11,471. [126] Month-on-month volumes during the year remained consistent with slight variation.

NARMC is the second largest employer in the county, and hospital leadership estimates that NARMC employs 65-70% of the physicians in the local market. The hospital has 684 total full-time employees (FTEs). FTEs per each adjusted occupied bed (also commonly referred to as "FTEs per adjusted ADC") was 7.2. The state

Table 101: NARMC's Operational Outlook

Key Indicators - Operational Outlook	
(July 22 - Dec 2022 Annualized)	
Total Inpatient Discharges	2,212
Adjustment Factor	5.19
Total Adjusted Discharges	11,471
Hospital Patient Days	6,714
Adjusted Patient Days	34,817
Average Daily Census	18.7
Average Length of Stay	3.0
Emergency Department Visits	23,682
Occupancy Rate	10.6%
Total FTEs	684
Total CFTEs	N/A
Case Mix Index	1.27
Labor Cost / Net Patient Revenue	56%
FTEs per Adjusted Occupied Bed	7.1

Table 102: NARMC's Balance Sheet Metrics

Balance Sheet Metrics	
(as of Feb. 2023)	
C&C Equivalents	$ 31,226,948
Inventory and Prepaid Expenses	$ 3,778,685
Current Assets	$ 50,888,565
Total Assets	$ 86,273,773
Current Liabilities	$ 11,903,815
Total Long-Term Debt	$ 17,155,000
Total Liabilities	$ 29,058,815
Net Position	$ 57,214,958
Daily Expenditures	$ 269,638
Days Cash on Hand	115.8
Quick Ratio	4.0
Current Ratio	4.27
Debt Service Coverage Ratio	(14.84)
Average Age of Plant	26.14
Days in Net Accounts Receivable	60.20
Debt to Operating Revenue	18%

[125] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

[126] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue.

benchmark for FTEs per adjusted ADC was 4.6-5.[127] Labor cost per net patient revenue was at 56%, in line with the benchmark of 50% - 60% for rural non-CAHs.[128]

While NARMC has faced difficulty competing for staff due to labor cost increases precipitated by the COVID-19 pandemic, the hospital maintained 5% turnover rates during the pandemic by implementing contract-based retention bonuses. Contract wages have returned to a more manageable level, and there are plans to remove 15 of the remaining 25 contract nurses by the end of 2023.

Observations related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (February 2023). Based on the initial data received, A&M's on-site review, and Jan. and Feb. 2023 data, NARMC appears to be in a decent but declining financial condition as cash position has deteriorated since July 2022. Cash and cash equivalents (including net internally designated funds) have decreased from $38.3M to $31.9M in December 2022. The hospital has daily expenditures of $270k with 115.8 days cash on hand, as of Feb 2023. The deteriorating cash position, which has been compounded by recent draws on reserves to fund hospital operations, has highlighted the necessity of the sustainability plan's breadth of expense reduction efforts for short-term impact.

Cash Position

Understanding the days cash on hand (COH) in conjunction with trends in accounts receivables (A/R) provides insight into revenue cycle management (RCM) inadequacies. COH as of December 2022 is 115.8 days. NARMC's RCM is conducted entirely in-house and has not encountered significant issues beyond finding it difficult to find staff within the local community to do billing and coding. The hospital has designated business office space to focus on hospital accounts and partners with BSI Medical Billing to collect on clinic bills. Collections in 2022 made up 99.8% of the hospital's net revenues. Days in net A/R during December 2022 was 60.20 days and just above the hospital's average of 54-58 days, as noted by hospital leadership. NARMC's consistently negative cash flow from July 2022 through March 2023 can be seen in the Cash Flow table below.[129]

Table 103: NARMC's Cash Flow Runout Forecast

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Beginning Cash Balance	$ 366,036	$ (419,116)	$ (10,535)	$(456,001)	$ (841,225)	$(755,293)	$ (84,120)
Cash Flows from Operating Activities	(785,152)	(1,091,419)	(472,966)	234,617	(1,414,068)	(828,827)	(336,562)
Cash Flows from Financing Activities	-	1,500,000	27,500	-	1,500,000	1,500,000	-
Cash Flows from Investing Activities	-	-	-	-	-	-	-
Net Change in Cash Equivalents	(785,152)	408,581	(445,466)	234,617	85,932	671,173	(336,562)
Ending Cash Balance	$(419,116)	$ (10,535)	$(456,001)	$(221,384)	$ (755,293)	$ (84,120)	$(420,682)

Debt

NARMC's current debt profile consists of debt service obligations and two long-term revenue "Refunding" bonds, (one from 2021 and one from 2022) secured by hospital assets and revenue. To finance facility

[127] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.
[128] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*
[129] This table does not include the hospital's internally designated funds worth ~$30M.

purchases and renovation projects, NARCM borrowed $4.5M in 2019 and another $10.2M in 2021 from a financial institution that extended the loan via a variable-to-fixed interest rate swap.

Short-term liquidity options: The hospital has a $2M revolving bank line of credit with no amounts outstanding as of March 2023.

Revenue

Revenue trends will help provide a year-over-year understanding of the current fiscal condition from a "top-line" perspective. Using annualized Sep. 2022 through Feb. 2023 financials, NARMC faces a 9% decrease in total operating revenues from the prior year. This is largely due to a decrease in Other Revenues, as NPSR is largely flat. Hospital leadership shared that revenue has been limited due to a growing volume of patients covered by Medicare Advantage plans, staffing limitations, and the operation of costly services. A post-COVID increase in wage competition has restricted staffing, which in turn has depressed current patient service volumes compared to pre-COVID levels. The hospital also operates several critical but costly loss-leader services – such as emergency, labor and delivery, and hospice health – that remain open because of their community value. At the same time, revenue-generating services, such as surgery, are experiencing lower patient volumes.

Monthly operational losses have required NARMC to draw on ~$10M in reserves intended for capital improvements to fund operations and cover long-term debt since April 2022. Supplemental support (*e.g.*, CARES Act, ARPA program) helped bolster NARMC financials in FY2021 and FY2022. Supplemental funding is outlined in the Supplemental Funding table below. The hospital's sustainability plan includes revenue enhancements of $582k per month, achieved mostly through improved billing practices, an enhanced 340B program, and new massage therapy service. Most initiatives began in 2022 and will be realized in 2023.

Table 104: NARMC's Income Statement Metrics

Income Statement Metrics			
	FY22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 93,628,154	$ 93,273,110	0%
Other Revenue	11,966,735	2,801,618	-77%
Total Revenue	**105,594,889**	**96,074,728**	**-9%**
Salaries, Wages & Benefits (SWB) Ex	49,619,332	52,553,536	6%
Supplies Expense	34,800,084	19,659,246	-44%
Other Operating Expense	16,418,612	25,682,904	56%
EBITDA	**4,756,861**	**(1,820,958)**	**-138%**
Depreciation Expense	3,127,230	3,046,306	-3%
Operating Income	**1,629,631**	**(4,867,264)**	**-399%**
Non-Operating Income (Expense)	902,830	103,478	-89%
Net Income	**2,532,461**	**(4,763,786)**	**-288%**
Operating Margin	2%	-5%	-428%
NPSR / Adj Discharge		$ 6,860	
Expense / Adj Discharge		$ 7,424	

** Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior peri*

Expenses

Trends in expenses can also provide insight into likely effectiveness of the sustainability plan and contributors to the current fiscal condition. Although, NARMC leadership notes that wages are higher compared to pre-COVID levels, salaries, wages, benefits, and payroll tax (SWB) expenses have remained consistent from July 2022 through February 2023 at ~$4M - $4.5M per month. A key focus of the hospitals' sustainability plan is to reduce reliance on contract nurses and reduce contract labor expenses. A part of the Premier group purchasing organization, the hospital has been able to maintain its supply cost per admission, according to hospital leadership.[130] The sustainability plan's expense reduction efforts projects $760k in savings per month, much of which will come from forecast reductions in supply costs, contract staff, and salaries. Most cost reduction efforts were initiated in 2022 and are already reflected in lower supply SWB and supply costs in annualized Sept. 2022 through Feb. 2023 financials.

Annualized Sept. 2022 through Feb. 2023 financials show a 56% increase in other expenses and a 44% decrease in supplies, but on-site interviews with leadership revealed that the significant increase/decreases in these line items are due to differences in how expenses are allocated between the annual audited financials and monthly financial statements.

Supplemental Funding

All COVID-related supplemental funding received by NARMC has been fully received and recognized to-date based on when NARMC recognized revenue. The table below summarizes the significant supplemental funding that was received.

Table 105: NARMC's Supplemental Funding

Supplemental Funding	FY2020	FY2021
CARES Act Provider Relief Fund	$ 10,481,100	$ 4,521,000
American Rescue Plan Act (Rural Payments)		$ 3,975,000
State Support (Various)	$ 2,224,000	$ 2,175,000
Total	**$ 12,705,100**	**$ 10,671,000**

Break-Even Analysis

Given the trends associated with NARMC's operational outlook and fiscal condition, and the potential impact of the sustainability plan, a break-even analysis was performed to approximate the current Net Income (Loss). The below break-even analysis is based on a trailing 6-month annualization of the NARCM income statement. As seen in the table below, their annualized FY23 net income is ($4,763,782). The currently quantified sustainability plan, if all impact dollars are achieved, has an annualized potential impact of $16,844,197.

[130] NARMC's January and February financials included one combined line item, "Supplies and Other Expenses." As such, standalone supply expenses could not be extracted.

Table 106: NARMC's Break-even Analysis

NARCM Income Statement	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	Breakeven Over the Last 2 Quarters	12-Month Total	18-Month Total
Net patient service revenue	$ 7,583,492	$ 7,450,054	$ 7,983,495	$ 7,829,006	$ 8,387,428	$ 7,403,080	$ 46,636,555	$ 93,273,110	$ 139,909,665
Other Operating Revenues	101,207	330,581	251,829	201,835	135,010	380,347	1,400,809	2,801,618	4,202,427
Total Revenue	7,684,699	7,780,635	8,235,324	8,030,841	8,522,438	7,783,428	48,037,364	96,074,728	144,112,092
Salaries, Wages, Benefits and Payroll Taxes	4,259,269	4,386,079	4,449,584	4,547,537	4,643,468	3,990,831	26,276,768	52,553,536	78,830,304
Supplies	1,632,741	1,465,295	1,813,585	1,641,461	-	-	6,553,082	19,659,246	29,488,869
Total Operating Expenses Less D&A	8,062,479	8,006,398	8,450,318	8,215,353	8,466,844	7,746,451	48,947,843	97,895,686	146,843,529
EBITDA	$ (377,780)	$ (225,763)	$ (214,994)	$ (184,512)	$ 55,594	$ 36,977	$ (910,479)	$ (1,820,958)	$ (2,731,437)
Depreciation	252,053	252,055	249,264	249,904	260,418	259,459	1,523,153	3,046,306	4,569,459
Total Operating Expenses	8,314,532	8,258,453	8,699,582	8,465,257	8,727,262	8,005,910	50,470,996	100,941,992	151,412,988
Operating Income (Loss)	$ (629,833)	$ (477,818)	$ (464,258)	$ (434,416)	$ (204,824)	$ (222,482)	$ (2,433,632)	$ (4,867,264)	$ (7,300,896)
Interest Expense	(45,210)	(45,210)	(45,210)	(42,300)	(41,777)	(41,396)	(261,103)	(522,206)	(783,309)
Non-Operating Income (Expenses)	(1,861,205)	1,209,036	1,117,040	(702,553)	1,023,137	(472,613)	312,842	625,684	938,526
Net Income (Loss)	$ (2,536,247)	$ 686,007	$ 607,572	$ (1,179,268)	$ 776,536	$ (736,491)	$ (2,381,891)	$ (4,763,782)	$ (7,145,673)

Capital Considerations

In addition to all the operational and financial considerations described above, NARMC's physical plant requires certain capital considerations to continue, sustain, and enhance operations. Hospital leadership admitted that facility maintenance has been reactive while necessary upgrades have been delayed because of insufficient funding for necessary parallel improvements to other equipment. NARMC has provided a capital budget that included approximately $8.5M in property and medical equipment needs for the next year, of which $3.1M is for critical facility improvements. The hospital was built in 1948 as a county hospital and has seen many separate additions since then. The hospital now consists of 27 separate buildings and facility areas (including the hospital's 15 medical clinics) that total ~500k square feet.

The piecemeal construction of the hospital has made repairs difficult and costly. Particularly concerning are the issues with the generators, emergency power system, boilers, and roofing. Two of the hospital's three generators have now failed, which leaves the hospital reliant on a single, risky generator. The emergency power paralleling switch gear and digital master control are 25-years old, obsolete, and need a complete replacement as repairs are impossible. Similarly, two boilers are beyond repair as they are from 1972 and as such the facility struggles with water heating in certain parts of the facility, including the labor and delivery rooms. The fourth-floor roofing built in 2010 has reached its end-of-life and needs replacement as leaking is imminent. During our on-site tour, the baseboards on the fourth floor were torn up as they were affected by water damage.

Upcoming Obligations

NARMC uses two electronic medical record (EMR) systems: MEDITECH Client Server in its inpatient services and eClinicalWorks in its ambulatory services. To reduce communication and workflow issues, NARMC is now considering combining the two EMR systems by implementing MEDITECH Expanse. The hospital has been quoted $5.2M total for the software, hardware, and consultants needed for the migration. The switch would require a 14-month implementation, and NARMC would like to sign a contract as soon as possible.

Sustainability Plan

NARMC plans to try to address its operational losses through a sustainability plan with more than 50 quantified initiatives that focus on revenue capture, revenue generation, and expense reduction to target a monthly financial impact of $1.4M, or $23.78M annualized.[131] Of the $1.4M total in total impact, revenue

[131] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

enhancement initiatives will drive $657k, and cost reduction initiatives will drive $747k. Most of these initiatives have been implemented or already completed in 2022, while the few remaining will start in 2023.

Table 107: NARMC's Sustainability Plan Summary

North Arkansas Regional Medical Center Sustainability Plan Summary	FINANCIAL IMPACT		
ACTION	*Action Complete*	*Action Pending*	*Total*
Revenue Enhancement:			
Revenue Generation - Enhance 340B program and increase other revenue sources	$ 373	$ 6,382,200	6,382,573
Net Revenue Capture - Improve billing practices and rebill missed claims	$ 936,546	$ 560,000	1,496,546
TOTAL REVENUE ENHANCEMENT IMPACT	$ 936,919	$ 13,884,400	$ 14,821,319
		$ -	
Expense Reduction:			
Supply and Vendor Cost Reduction - Renegotiate contracts and reduce medical equipment, drug, and office supply costs	$ 473,436	$ 898,399	1,371,835
Labor and Staffing Cost Reduction - Eliminate contract position, reduce overtime costs, and avoid backfilling vacancies	$ 969,440	$ 5,032,000	6,001,440
Service Reduction - Closed clinic	$ 201,912	$ -	201,912
Operational Efficiency Generation - Capture rebates, eliminate fees, and reduce length of stay	$ 174,000	$ 1,212,000	1,386,000
TOTAL EXPENSE REDUCTION IMPACT	$ 1,818,788	$ 7,140,290	$ 8,959,078
****TOTAL IMPACT**		$ -	$ 23,780,397

**One-time gain or cost reduction, annualized for 2023*
***Total Impact is expected to be realized primarily in or after 2023 and does not include Recruitment and retention efforts and Funding opportunities*

Expense Reductions

- Reducing supply and vendor contract costs:
  - NARMC has identified 30 opportunities to reduce total monthly costs by $114k through reducing supply use, switching to lower-cost supplies/drugs, and renegotiating supplier and vendor contracts. Of the $114k total, NARMC has already completed initiatives to begin seeing $39k in cost reductions.
  - Supplies include propane, linen, high-cost drugs, skin staplers, etc.; renegotiations will include inventory management, compliance software, water vendors. Most notably, the hospital believes it can achieve a monthly $50k cut in COVID supply spend by the end of 2023, as COVID-19 cases remain low with sufficient available medication. In interviews, hospital leadership said that the hospital will likely surpass estimations and achieve an actual monthly impact closer to ~$60k.
- Reducing labor and staffing costs:
  - NARMC has already captured $81k in expense reductions by not backfilling certain roles ($80k) and discontinuing its nuclear medicine call ($1.1k). NARMC has identified two more opportunities to reduce labor and staffing costs by $419k by reducing contract staff ($300k) and redefining productivity targets and methodologies ($119k). At the peak of the COVID pandemic, the hospital employed 40 contract nurses. Leadership shared that by cutting 15 contracts in 2022 and decreasing the contract hourly rate, the hospital saved ~$600k monthly, about double their estimates. The hospital plans to save an additional $300k by cutting another 15 from the remaining 25 contracts. NARMC is also in the process of adjusting certain labor methodologies and productivity targets and estimates that it can achieve $119k in monthly saved labor hours.
- Reducing services:
  - On November 1, 2022, NARMC closed its Eureka Springs clinic and has been saving $16.8k every month from prior clinic expenses.

- Generating operational efficiencies and other efforts:
    - The hospital has already saved $14.5k per month by capturing purchase refund fees in 2022 ($12.5k) and eliminating late fees ($2k). The hospital has identified two more opportunities to increase operational effectiveness and save $101k in monthly operational costs. In 2023, the hospital plans reduce its average length of stay (ALOS) and save $81k monthly by improving case management, streamlining the discharge process, and collaborating with local nursing homes to expedite the prior-approval process. Considerable progress has already been made as leadership notes that ALOS was 2.98 days in February 2023 compared to 3.66 days in July 2022. The hospital hopes to save an additional $20k by capturing inpatient drug rebates in June 2023.

Net Revenue Capture

- NARMC has recaptured an additional $78k per month by either rebilling or improving their billing practice. Most notably, the hospital rebilled $55k in pharmacy chemo-infusion claims starting in August 2022 for a one-time $55k gain. The hospital plans to capture $47k per month more in 2023 by moving non-provider-based clinics to provider-based status so that it can utilize provider-based billing ($33k) and has identified an RCM improvement opportunity in eliminating late charges to reduce its denial rate ($11.5k).

Revenue Generation

- The hospital had yet to complete any revenue generation initiatives in 2022 but expects to see a revenue increase of $531k per month by 2023 as its efforts are realized.
- 340B Program: When NARMC originally qualified for the 340B Drug Pricing Program as a disproportionate share hospital (DSH) in 2010, it went after only basic outpatient drugs as it did not yet have a chemo-infusion center. Over time, the hospital added contract pharmacy locations to boost 340B revenue. In 2022, the hospital has begun converting its remaining 14 RHCs to also become provider-based to acquire higher reimbursement rates. Hospital leadership expects these efforts to drive a significant portion of its expected $457k per month increase in 340B revenue.

Although the hospital is restricted from growing revenues via entirely new service lines because of labor and staffing shortages, the hospital has identified $75k in monthly revenue enhancements by increasing prices and through non-service revenue lines. In September 2022, the hospital expanded its therapy services and estimated an $3.1k increase to monthly EBITDA, which it has yet to fully realize but does expect volume to increase in coming months. Beginning in 2023, the hospital should also see a revenue boost of $30k per month as it receives new per member per month (PMPM) fees from Main Street Health as part of a new contract around population health data ($30k).[132] NARMC increased Chargemaster rates by 5% on April 1, 2023 and expects to see a boost to monthly net revenue by $41k.

[132] See more at www.mainstreethealth.com

Ouachita County Medical Center

Quick Facts

- Classification: Non-CAH
- Licensed Beds: 98
- Closest Facility: 30.0 miles
- Average Age of Plant: 32.3
- Average Daily Patient Occupancy Rate: 8%
- Average length of stay (ALOS): 3.0 days
- Total full-time employees (FTEs): 313
- 501(c)(3), comprised of: Ouachita County Medical Center, Ouachita County Medical Services, and Ouachita Physician Services, LLC.
- County owns and leases to the hospital

Location: Camden, Ouachita County
County Population: 22,306 (2021)

Table 21: Ouachita's Summary Statistics

Operating Statistics		
C&C Equivalents	$	1.8 M
Current Assets	$	9.2 M
Net A/R	$	4.4 M
Total Assets	$	25.0 M
Days Cash on Hand		16.97
Quick Ratio		2.29
Current Ratio		2.52
Debt Service Coverage Ratio		0.14
Days in Net AR		43.54
Average Age of Plant		32.30
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	36.7 M
Other Revenue	$	1.7 M
Total Revenue	$	38.4 M
Salaries, Wages & Benefits	$	17.7 M
EBITDA	$	1.1 M
Operating Income	$	0.1 M
Non-Operating Income/(Expense)	$	5.9 M
Net Income	$	6.0 M
Operating Margin %		0.2%

Key Challenges

- In-house clinical staff shortage and high reliance on travel agency staffing, collection delays from Medicare Advantage plans, and aged components of physical plant.
- Hospital leadership shared challenges around staff sourcing, noting increased turnover and competition from neighboring hospitals. Revenue enhancement initiatives have been identified and primarily revolve around establishing and/or expanding OB/GYN, general surgery, cardiac cath. lab, and ear nose and throat (ENT) services. Ouachita County also hopes to engage in clinical documentation efforts to scrub claims for potential additional revenue as it has successfully found financial impact in such previous efforts.
- Recruiting sufficient skilled staff resources have been amongst the greatest challenges faced at Ouachita County. The utilization of swing bed and respite care services have been negatively impacted due to inadequate staffing. This challenge has been exacerbated by Ouachita County's financial climate and competition from neighboring hospitals.

1 *Patient Volume Trends* [133]

- Jan. 2023 inpatient discharges (92) improved vs trailing six-month average (80)
- Adult/acute adjusted discharges (1,141) were down 34% versus prior year (1,729) while total adjusted discharges (5,159), were down 18% versus prior year (6,267)
- Adult/acute and total adjusted discharge days were further reduced 55% and 20%, respectively (adult/acute: 3,432 in FY23 vs 7,654 in FY22 – total: 15,936 in FY23 vs 19,881 in FY22)
- ER discharges (13,246) were roughly the same (+2%) as prior year (12,982)
- Observation and Chemical Dependency Unit (CDU) (968 and 158, respectively) had a 16% increase in annualized volume compared to prior year (832 and 136, respectively)

2 *Financial Status* [134]

- Days Cash on Hand (COH): 17.0 days
- Quick Ratio: 2.29
- Net Income: Based on the latest financial data provided, annualized net income is a net loss of ($102k) after removal of $6.1M of ARPA funding, and net positive $5.98M if ARPA funds are included
- RCM is mostly done in-house but bad debt and write-offs are outsourced to collections

3 *Labor Challenges*

- Staffing challenges, due to cash position and competition with surrounding areas, have resulted in increasing use of high-cost agency staffing in multiple departments (nursing, lab, and respiratory therapy, for example)
- Temporarily increased ER nurse pay rates by $10 per hour and then reversed that change after six months of worsened morale

4 *Technology Challenges* [135]

- Uses MedHost for inpatient and outpatient - uses MedHost's Emergency Department Information System (EDIS) as the ER module in the emergency room

5 *Sustainability Plan*

[133] Annualized Aug. 2022 to Jan. 2023 stats versus annualized Aug. 2021 to Jan. 2022 stats.
[134] Annualized Sept. 2022 to Feb. 2023 data.
[135] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- Expense Reduction
    - Reduce $2M in expenses by closing certain service lines (*i.e.*, urgent care, family care clinic, RHC, and sleep studies)
    - All capital purchase on hold unless required for patient care purposes
- Revenue Enhancement
    - According to hospital leadership during A&M's onsite review, hospital leadership received authorization through negotiation with certain health plan to implement clinical documentation improvements and back bill one year of claims resulting in a $1M increase in outpatient gross revenue Dec. 2022 ($8.9M) vs previous month ($7.8M)
    - Plan to expand 340B program and grow volume of existing services (OB/GYN), surgery, cardiac cath. program, and ENT)
    - Increasing liquidity through sale of real estate and two additional clinical practices
- Hospital leadership is not interested in converting to REH designation because it would be required to give up services that are critical to the local community including OB, acute inpatient services, etc.)
- The hospital is close to defense industry employers (including a multiple launch rocket system production program) which rely on the hospital for employee-covered health services.
    - For example, in Oct. 2022, Boeing and Aerojet opened a new facility in in the area, which is forecast to add 326 new jobs by 2024.

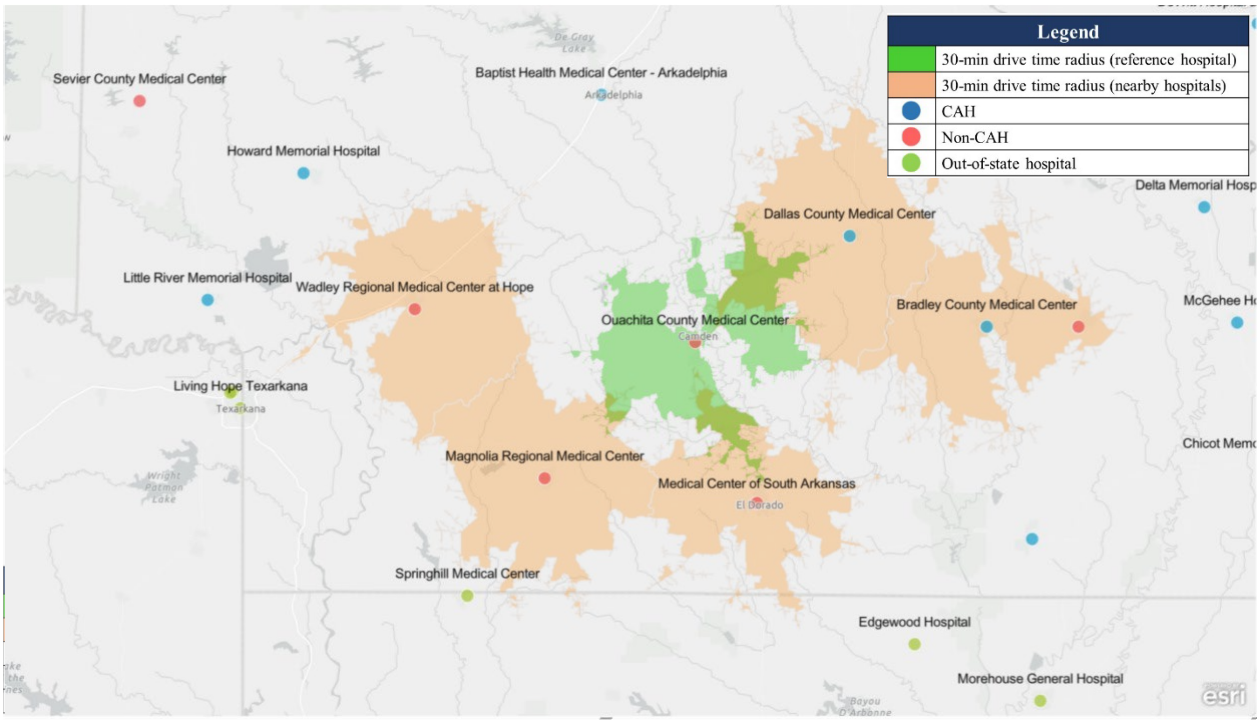
6 *Physical Plant*

- Average age of plant: 32.3 years
- There is an extensive deferred maintenance list from 10+ years ago with over $4.2M of identified deferred maintenance.

Drive Time Assessment - Alternatives in the Surrounding Community

A population estimated at 41,542 is located within a 30-mile radius of Ouachita[136]. Ouachita County Medical Center is the only hospital within Ouachita County (population roughly 22,306). Ouachita leadership indicated that the Hospital's service population is ~55k and growing because neighboring hospitals are cutting services and driving volume towards Ouachita. The three closest alternative hospitals to Ouachita are on average 32 miles away: Medical Center of South Arkansas is 30 miles to the south in El Dorado; Dallas County Medical Center is 32.3 miles to the northeast in Fordyce; and Magnolia Regional Medical Center is 35 miles to the southwest in Magnolia. Additional alternatives lie beyond a 35-mile or 45-minute drive. People living to the west of Ouachita may find that their closest alternative is about 50 miles from Ouachita at Wadley Regional Medical Center or 55.6 miles away at Baptist Health Medical Center-Arkadelphia.

Figure 22: Ouachita's Drive Time Assessment



Observations Related to Operational Outlook

The hospital provides access to multiple services including acute inpatient and outpatient care, emergency care, swing bed, cardiology, OB/GYN, ENT, general surgery, and chemical dependency (CDU) services.

The YTD average length of stay (ALOS) was 3.0 days for adults/acute and 3.1 for Total discharges (all ages). The average daily census (ADC) was 1.8 and 8.2, respectively, while the average occupancy rate for the year was 8%.

For comparison, the national benchmark average LOS for non-CAH facilities is 5.4 days and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals

[136] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

in Arkansas, in 2016, average occupancy rates hovered around 30%.[137] Ouachita's LOS, occupancy rate, and ADC fell below benchmarks. This is suggestive of low inpatient volume and census trends. Total ADC being far greater than Adult/acute ADC suggests that the census is comprised primarily of non-adult patients.

Based on Aug. 2022 – Jan. 2023 annualized data, Ouachita reported 214 Adult/acute (968 Total) annual inpatient discharges with an adjustment factor[138] of 5.33 resulting in total adjusted discharges of 1,141 for adults/acute (5,159 Total). Adult/acute adjusted discharges (1,141) were down 34% compared to prior year (1,729) while Total adjusted discharges (5,159), were down 18% as compared to prior year (6,267). Adult/acute and Total adjusted discharge days were further reduced 55% and 20%, respectively (Adult/acute: 3,432 in FY23 and 7,654 in FY22; Total: 15,936 in FY23 and 19,881 in FY22). ER discharges remained relatively consistent with prior year and observation and chemical dependency unit (CDU) displayed a 16% increase in volume as compared to prior year. Taken together, these data trends indicate that, while ER activity remained consistent, inpatient volumes trended down and may have converted to an increase in observation status. Overall, all key metrics were lower than the previous year and fell below state benchmarks for both ALOS and Occupancy rate.

Table 108 - Ouachita's Operational Outlook

Key Indicators - Operational Outlook	
(Aug. 2022 - Jan. 2023 Annualized)	
Total Inpatient Discharges	968
Adjustment Factor	5.33
Total Adjusted Discharges	5,159
Hospital Patient Days	2,990
Adjusted Patient Days	15,936
Average Daily Census (Adult/acute)	2
Average Daily Census (total)	8.2
Average Length of Stay	3.1
Emergency Department Visits	13,246
Occupancy Rate	8.4%
Total FTEs	313
Total CFTEs	189
Case Mix Index	1.54
Labor Cost / Net Patient Revenue	48.3%
FTEs per Adjusted Occupied Bed	7.2

Table 109 - Ouachita's Balance Sheet

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	1,759,641
Inventory and Prepaid Expenses	$	813,939
Current Assets	$	9,181,345
Total Assets	$	24,999,349
Current Liabilities	$	3,648,249
Total Long-Term Debt	$	1,971,408
Total Liabilities	$	6,588,386
Net Position	$	18,410,963
Daily Expenditures	$	103,696
Days Cash on Hand		17.0
Quick Ratio		2.3
Current Ratio		2.52
Debt Service Coverage Ratio		0.14
Average Age of Plant		32.30
Days in Net Accounts Receivable		43.54
Debt to Operating Revenue		5%

Ouachita County's total number of full-time employees (FTEs) is 313. The total clinical FTEs count is 189. FTEs per each adjusted occupied bed was 7.2. The state benchmark for FTES per adjusted ADC was 4.6-5.72.[139] Labor cost per net patient service revenue was 48% compared to the benchmark of 50% - 60% for rural non-CAHs.[140] FTEs per adjusted

[137] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

[138] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue.

[139] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.

[140] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

ADC being above the benchmark and labor cost per net patient service revenue falling below benchmarks is consistent with the substantive drop in volume experienced at Ouachita. That drop in volume can particularly be seen in the 55% drop in Adult/acute adjusted discharge days (3,432) as compared to the prior year (7,654 Adult/acute adjusted discharge days).

Observations Related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (Dec. 2022, Jan. 2023, or Feb. 2023). Based on the initial data received, A&M's on-site review, and 2023 data, Ouachita's cash position has been deteriorating since Sept. 2022, with a decrease in cash and cash equivalents from $6.2M to $1.8M in Feb. 2023. Daily expenditures are currently ~$103.7k per day, with 17.0 days cash on hand (COH) as of Feb. 2023. With that deteriorating cash position, especially in the context of the current daily expenditures, the sustainability plan's expense reduction is critical as they are more likely to yield rapid impact vs. revenue opportunities.

Cash Position

Days COH has decreased 66% since $6.1M in ARPA funds were received in Sept. 2022. Daily expenditures have also reduced, which is likely the result of multiple service line closures that are further described in the 'Sustainability Plan' section below, as well as drastic reductions in salaries in Sept. 2022. Ouachita County maintains all revenue cycle management (RCM) functions in-house with the exception of outsourcing bad debt collection efforts. In July 2022, Ouachita County's claims process with a large payer experienced delays in claim submission, however, hospital leadership was able to correct the process and work with the payer to eventually scrub data for reimbursable charges associated with procedural claims and allowed Ouachita to make these adjustments resulting in increased reimbursements seen as a $1M increase in gross revenue in Dec. 2022.

Debt

Ouachita booked $1.97M in notes payable in Feb. 2023. Through on-site review, A&M learned that this amount consists of Medicare advance payments, capital leases, and certain long-term debt obligations. It is not clear as to the current nature of these liabilities, so the entire $1.97M was booked as non-current liabilities.

Revenue

With a deteriorating days cash on hand, ongoing staffing concerns, and active operational investments in existing service lines and strategic service line closures; Ouachita County's year-over-year statement of operations trends will help in contextualizing the current fiscal condition. Using annualized Sept. 2022 through Feb. 2023 financials, Ouachita County appears to actually have increased net income with a 144% improvement from FY21 audited financial data (as of Sept. 2021). This is largely due to a 19% improvement in top line revenue compared to just a six percent increase in total operating expense. However, operating income in FY21 was a loss of ($3.7M) and annualized 2023 operating income was under $100k prior to addition of interest and $6M of ARPA funds ("non-operating revenue"). This suggests that, despite the improvement in revenue, the current fiscal year has substantial risk of falling into an operating loss if disregarding the ARPA funds. It is also important to note that non-operating income for both FY21 and FY22 have been bolstered with supplemental funding ($6.3M in 2021, and $6M in 2022 in ARPA funds). These large amounts of supplemental support[141] helped bolster Ouachita County's financials for both FY21

[141] CARES Act, ARPA, etc.

and FY22.[142] Supplemental funding is outlined in Table 11 below. The hospital's sustainability plan includes approximately $2.5 million in projected revenue enhancements. However, this impact comes from initiatives that include projected revenues from new or enhanced services (*i.e.,* surgical practice expansions, increase in cardiac catheterization procedures) that will likely take time to implement.[143]

Expenses

Trends in expenses can also provide insight into the major contributors to the current fiscal condition and the potential effectiveness of Ouachita County's sustainability plan. For example, there was a 40% reduction in depreciation from FY21 ($1.7M) to FY23 ($1M). Based on on-site review, A&M learned that this was largely due to the sale of certain real estate held by the hospital. There was also a 46% increase ($3.8M) in "other expenses". This is likely a recategorization of expenses between monthly expense categories versus audited financial expense breakouts. The key element related to expenses is total operating expenses that only had a 6% variance and expenses per adjusted discharge rose 8% from FY21 ($6,882) to FY23 ($7,434).

The hospital's sustainability plan's expense reduction efforts projects $2.1 million in savings, however, roughly half of this impact comes from agency/contract labor use reduction initiatives that are generally difficult to implement and will likely take time to realize. Approximately $1M of impact is realized based on actions that already been executed (primarily staff reductions). However, $0.6M of this impact comes from a 340B drug cost reduction program that is likely already realized in the existing financial outlook. The sustainability plan is discussed further in the sustainability plan section below.

Supplemental Funding

As mentioned above, supplemental funding helped bolster Ouachita's financial position in the last two fiscal years. This funding has been recognized to-date based on when Ouachita recognized revenues. The Supplemental Funding table to the right summarizes the supplemental funding that was received.

Table 110: Ouachita's Supplemental Funding

Supplmental Funding	2020	2021	2022
PPP Loan	3,384,000		
Provider Relief Fund (CARES)	5,800,000	1,200,000	
Community Development Grant	100,961	399,039	
Arkansas Ready to Work Grant	100,000		
ARPA Funding			6,077,853
Total	**$ 9,384,961**	**$ 1,599,039**	**$ 6,077,853**

Notes:
1.Source is 2021 Audited financials
2.PPP loan was not completely forgiven; total PPP amount was $3.6M

Break-Even Analysis

Given the trends associated with Ouachita's operational outlook and fiscal condition, and the potential impact of the sustainability plan, a break-even analysis was performed to approximate the current net income (loss). The below break-even analysis is based on a trailing six-month annualization of Ouachita County's income statement. As seen in the table below, their annualized FY23 net income is $5,976,297. This includes the impact of ~$6M of ARPA funds that were received in Sept. 2022. The ARPA funds were

[142] See Ouachita's Supplemental Funding Table 110.

[143] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

removed from the Sept. 2022 monthly financials and added back to the 12 Month Annualized financials as "Non-operating (Revenue) / Expense". If ARPA funds are removed completely, the net income (loss) for the 12-month annualized financials is a loss of ($.1M). The 18-month total net income is $5,925,519 and is less than the 12-month figure due to the fact that ARPA funds are not recurring and are being used to mitigate the month-on-month operating loss. The currently sustainability plan, **if all projected expense reductions and revenue enhancements are fully achieved**, has a maximum potential impact of $5,239,339 (including possible real estate sales of ~$720k).

Table 111 - Ouachita's Break-even Analysis

Ouachita Income Statement	Sep-23	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Breakeven over the last 2 Quarters (Includes ARPA Funds)	Breakeven over the last 2 Quarters (excluding ARPA)	12 Month Annualized (includes ARPA Funds)	18 Month Total (Includes ARPA Funds)
Net patient service revenue	$ 4,888,729	$2,284,838	$1,910,590	$3,309,365	$2,986,499	$2,976,460	$ 18,356,481	$ 18,356,481	$ 36,712,962	$ 55,069,443
Other Operating Revenues	544,115	61,679	84,529	70,219	54,701	48,363	863,606	863,606	1,727,213	2,590,819
Total Operating Revenue	5,432,844	2,346,517	1,995,119	3,379,584	3,041,200	3,024,823	19,220,087	19,220,087	38,440,175	$ 57,660,262
Salaries, Wages, Benefits and Payroll Taxes	1,491,302	1,498,452	1,414,890	1,561,828	1,582,713	1,324,923	8,874,108	8,874,108	17,748,216	26,622,324
Supplies	568,702	370,031	530,005	492,069	528,257	443,600	2,932,664	2,932,664	5,865,328	8,797,992
Other Expenses	1,657,564	1,213,579	914,323	1,272,654	1,065,911	743,499	6,867,530	6,867,530	13,735,060	20,602,590
Total Operating Expenses Less D&A	3,717,568	3,082,062	2,859,218	3,326,551	3,176,881	2,512,022	18,674,302	18,674,302	37,348,604	56,022,906
EBITDA	**$ 1,715,276**	**$ (735,545)**	**$ (864,099)**	**$ 53,033**	**$ (135,681)**	**$ 512,801**	**$ 545,785**	**$ 545,785**	**$ 1,091,571**	**$ 1,637,356**
Depreciation	159,801	84,298	83,632	83,560	83,562	83,205	578,058	578,058	1,003,817	1,505,725
Total Operating Expenses	3,877,371	3,166,359	2,942,849	3,410,111	3,260,443	2,595,227	19,252,360	19,252,360	38,352,421	57,528,631
Operating Income (Loss)	**$ 1,555,473**	**$ (819,842)**	**$ (947,730)**	**$ (30,527)**	**$ (219,243)**	**$ 429,596**	**$ (32,273)**	**$ (32,273)**	**$ 87,754**	**$ 131,631**
Interest	(74,380)	(3,636)	(4,763)	(2,406)	(5,806)	(3,664)	(94,655)	(94,655)	(189,310)	(283,965)
Non-Operating Revenues/(Expenses)	-	-	-	-	-	-	6,077,853		6,077,853	6,077,853
Non-Operating Revenues (Expenses)	(74,380)	(3,636)	(4,763)	(2,406)	(5,806)	(3,664)	5,983,198	(94,655)	5,888,543	5,793,888
Net Income (Loss)	**$ 1,481,093**	**$ (823,478)**	**$ (952,493)**	**$ (32,933)**	**$ (225,049)**	**$ 425,932**	**$ 5,950,925**	**$ (126,928)**	**$ 5,976,297**	**$ 5,925,519**

Note: The 12-Month Annualized Depreciation was based on five months and did not include Sept. 2022 because sale of real estate resulted in a lower depreciation schedule moving forward.

Capital Considerations

The hospital requires certain cosmetic updates and roof repairs. Equipment in the facility is aged but functioning due to a competent plant operations team and regular preventative maintenance. Some equipment replacements (such as an updated nurse call systems) may be required soon since they have reached end of life and are no longer serviceable. Other pain points include mechanical, electrical, and plumbing (MEP) challenges, HVAC system update/repairs, aged generators, and transfer switch. There is currently sufficient back up for these areas, however, they pose a capital risk if preventative maintenance cannot repair the equipment soon. There is a new chiller and new boiler. There is an extensive deferred maintenance list from 2013 with over $4.2M of identified deferred maintenance.

Upcoming Obligations

Ouachita does not have any upcoming obligations as hospital leadership has emphasized maintaining a lean budget. All major capital expenditures have been placed on hold, so long as patient care is not negatively impacted.

Ouachita is not likely to switch to REH designation. To remain financially viable, Ouachita has already closed its urgent care, family care clinic, rural health clinic, and sleep studies services to shave $2M from its expenses. An REH designation would require the hospital to forgo all acute inpatient services, but as Ouachita's remaining services (*e.g.*, catheterization lab, obstetrics, EMS, hospice, ER, chemical dependency unit, imaging) are critical to the local community, closing those remaining inpatient services is a non-starter for hospital leadership.

Sustainability Plan

Ouachita County sustainability plans focus on maintaining and bolstering the remaining services it has left.[144] Hospital leadership is trying to recruit a second general surgeon, which would allow the hospital to accept more surgery cases. Ouachita County is also examining the possibility of adding substance abuse treatment to its chemical dependency service through the reliance on grant funding opportunities. The hospital has seen an increase in cardiac cases in the last year. The cardiac catheterization laboratory has been a good source of revenue for Ouachita County historically, and hospital leadership hopes to increase cardiac catheterization revenue. The Sustainability Plan Summary table above outlines revenue enhancement and expense reduction initiatives.

Table 112: Ouachita's Sustainability Summary

Ouachita County Medical Center Sustainability Plan Summary	FINANCIAL IMPACT		
ACTION	*Action Complete*	*Action Pending*	*Total*
***Revenue Enhancement:**			
Increase OB/GYN Service Line	-	220,991	220,991
Increase Gen Surgery Service Line	-	177,310	177,310
Increase Heart Cath Procedures	1,920,000	-	1,920,000
Additional Service Line (ENT)	147,910	-	147,910
Payor Communication	-	*Impact unkown*	*Impact unkown*
TOTAL REVENUE ENHANCEMENT IMPACT	**$ 2,067,910**	**$ 398,301**	**$ 2,466,211**
Expense Reduction:			
RHC Closure	100,000	-	100,000
ER LOCUMS Reduction	11,400	31,800	43,200
RN Contract Labor Reduction	-	415,870	415,870
RT Contract Labor Reduction	-	409,474	409,474
MT Contract Labor Reduction	-	172,104	172,104
Phlebotomy Staff Reduction	152,776	-	152,776
Advertised Position Elimination	33,280	-	33,280
Security Guard Reduction	40,560	-	40,560
Screening Booth Termination	52,416	-	52,416
Quality Dept Staff Reduction	11,440	-	11,440
Limited Hiring	*Impact Unkown*	-	*Impact Unkown*
Capital Purchases	*Impact unkown*	-	*Impact unkown*
OT Monitoring & Reduction	*Impact Unkown*	-	*Impact Unkown*
Fleet Reduction	3,900	-	3,900
Grant Funded Fleet Addition	49,253	-	49,253
Marketing Cost Reduction	5,200	-	5,200
AP Analysis	-	*Impact unknown*	*Impact unknown*
**340B Discount Drug Program	563,961	-	563,961
TOTAL EXPENSE REDUCTION IMPACT	**$ 1,024,186**	**$ 1,029,248**	**$ 2,053,434**
TOTAL IMPACT	**$ 3,092,096**	**$ 1,427,549**	**$ 4,519,645**

**Financial impact of Ob/Gyn and Gen Surgery servcie lines is "Action Pending" because it is based on practice growth of new providers whereas Heart Cath and ENT is "Action Complete" because it is based on annualization of existing volume*

***340b is not a revenue driver for Ouachita and the cost saving impact is already realized in FY23 financials*

Revenue Enhancements

- OB/GYN Service Line:

[144] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

    - Ouachita County lost their OB/GYN physician in 2022 but were fortunate enough to onboard a well-seasoned OB/GYN physician from West Texas during the summer.
    - That new OB/GYM physician brings new services to the community, such as fertility/infertility treatment(s), uterine & bladder prolapse surgery, etc.
    - Hospital leadership is confident that this provider addition to the medical staff will bolster the OB/GYN service line and increase revenue stream.
- General Surgery Line:
    - Two general surgeons stopped practicing in 2022; they were the only two serving the hospital and they were near retirement age.
    - Hospital leadership has onboarded one new general surgeon (on 10/13/2022) who offers a broad array of general surgeries. Additionally, this surgeon is skilled in some thoracic and vascular procedures and is performing those that are within his scope of practice.
- Addition Service Line - Otolaryngology (ear nose and throat (ENT)):
    - Hospital leadership rented Camden based clinic space to an ENT who intends on performing basic ENT-type operations in Ouachita County's Operating Room.
    - Per hospital leadership, this ENT currently performs 7-10 cases every second Friday of the month. Should that estimate hold true, that would result in 221 cases per annum with an estimated revenue stream of $147,910 from this added service line.
- Payer Communication:
    - Ouachita County has worked with payers to see where the hospital may be failing to code for all reimbursable charges. Certain payers recently helped hospital leadership with one such data-scrub related to certain surgical procedures and allowed Ouachita County to make these adjustments, which hospital leadership stated has resulted in increased reimbursement levels for those procedures.

<u>Expense Reductions</u>

- Rural Health Clinic (RHC) Closing:
    - The hospital closed the Stephens Community Clinic in Stephens, Arkansas in late July 2022 (prior to the receipt of ARPA funds in Sept. 2022).
    - Forecast Savings Per Year: ~$100,000
- ER Locum Tenens (Contract Labor) Reduction:
    - August 2022 through December 2022:
        - Ouachita County had a team of three ER doctors provide coverage for the ER. Several local area doctors also aided in this work to ensure 24/7 ER coverage. In September, one local ER doc left as he moved to another hospital.
        - The amount of stated savings varied by month based on hospital leadership's ability to use FTE labor vs contracted labor, varying between $1,000 and $6,000 per month over this period.
    - Future Goal:
        - It is the hope of the hospital that ER contract labor will be further reduced with a financial impact of $43,200. To alleviate the pressure of the loss of an ER doctor to El Dorado, hospital leadership is actively searching for another ER doctor.
- Other Clinical Contract Labor Reductions:

    - Hospital leadership has also worked to reduce their reliance on other clinical contract labor, including RN, respiratory therapist (RT), and medical technologist (MT) contract labor. In September and November of 2022, they were able to reduce RN and RT clinical contract labor by an average of ~$8K for those months, and MT contract labor by an average of ~$2K those months.
- Staff Reduction & Redirecting Job Role of Phlebotomy Services:
    - On 12/25/2022 two employed phlebotomists left Ouachita County for new roles. On 01/14/2023 four more employed phlebotomists departed employment at Ouachita County as the hospital decided to reduce and eliminate a few phlebotomist positions and pass this duty on to nursing staff.
    - Forecast Cost Savings: $152,776 per annum exclusive of benefits and payroll taxes.
- Advertised Position Elimination:
    - Hospital leadership decided not to fill a junior accountant position and those job functions have been reassigned to the senior accountant, payroll clerk, and accounts payable staff.
    - Forecast Cost Avoidance: $33,280 per annum exclusive of benefits and payroll taxes.
- Grant Funded Fleet Addition:
    - Ouachita County received ARHP+ grant funding related to opioid addiction and these funds were utilized to purchase one 15-passenger van for its Chemical Dependency Unit. It was at no direct cost to the hospital and was funded via this grant.
    - Forecast Cost Avoidance: $49,253
- 340B Drug Program:
    - The 340B drug program benefits the hospital by reducing medication expenses. From 7/1/22 to 2/28/23 the 340B discount drug program reduced medication costs for Ouachita County by $375,974. The forecast annual benefit from that is $563,961

<u>Other Initiatives</u>

- Building Sales:
    - Ouachita County divested from property in Stephens, Arkansas, when the Stephens Community Clinic closed.
        - Forecast Earnings: $20,000.00.
        - Forecast Cost Savings: No longer needs to maintain, insure, etc. this property.
    - Hospital leadership also sold a building on California Avenue in Camden, Arkansas to an audiologist.
        - Forecast Earnings: $51,341.88.
        - Forecast Cost Savings: No longer needs to maintain, insure, etc. this property.

Ozarks Community Hospital

Quick Facts

- Classification: CAH
- Licensed Beds: 25
- Closest Facility: 18.5 miles
- Average Age of Plant: N/A
- Average Daily Patient Occupancy Rate: 72%
- Average length of stay (ALOS): 5.69 days
- Total full-time employees (FTEs): 162

Location: Gravette, Benton County
County Population: 293,692 (2021)

Operating Statistics		
C&C Equivalents	$	0.1 M
Current Assets	$	12.3 M
Net A/R	$	11.2 M
Total Assets	$	41.0 M
Days Cash on Hand		0.64
Quick Ratio		0.60
Current Ratio		0.65
Debt Service Coverage Ratio		-2.59
Days in Net AR		77.32
Average Age of Plant		Accumulated Depreciation not Broken out in AFS
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	52.3 M
Other Revenue	$	4.6 M
Total Revenue	$	56.8 M
Salaries, Wages & Benefits	$	31.7 M
EBITDA	$	(6.2 M)
Operating Income	$	(7.0 M)
Non-Operating Income/(Expense)	$	18.1 M
Net Income	$	11.0 M
Operating Margin %		-12%

Key Challenges

- A liquidity crunch brought about by Medicare advance recoupment issue, 700 unpaid Medicare inpatient days, exhausted credit lines, vulnerable IT system.

1 *Patient Volume Trends*

- No significant concerns. Patient volume is growing as the nearby urban area encroaches upon Ozarks Community service area (serves 20-30k but has ~75k population within 15-mile radius)
- Relies on swing bed program (ADC 15-16) to bring in new patients
- A significant switch from traditional Medicare to Medicare Advantage (MA is now 40% of total payer mix) has complicated claims and rates

2 *Financial Status*

- Cash on hand:
  - Decreased 76%, from $471k in September 2022 to ~$113k in February 2023
  - 0.64 days cash on hand at the end of February 2023
  - The hospital is stretching accounts payable to try and preserve operating liquidity, but it is unclear how much longer that can continue.
- Quick Ratio: 0.60
- Net Accounts Receivable (A/R): ~77 days
  - In 2022, Ozarks Community saw 700 unpaid inpatient swing bed days beyond Medicare's cap of 100 reimbursable swing bed days. Hospital leadership is working to recategorize the days as nursing home days
- Operating margin: Annualized net income (based on Sept 2022 through Feb 2023 financials) is $1.53M
  - This net income figure somewhat clouds the cash challenges facing Ozarks Community, as $8.99M of non-operating income is due to "Apple debt being forgiven"
    - Apple is a company owned by the CEO, who previously owned the land that the hospital sits on.
  - Hospital leadership asserts that monthly loss of ~($500k) (~$4.5M in revenue, ~$5M in expenses) could be offset by potential 340B payments
- Debt: Heavy long-term debts (approximately $28.4M) are causing a liquidity crunch

3 *Labor Challenges*

- More difficulty staffing because of higher wage competition since becoming non-profit
- High but improving turnover area given proximity to urban area and competition with nearby larger hospitals (turnover rate was 22% in 2022, down from 36% in 2021)
- The need for travel clinicians is back to pre-COVID levels

4 *Technology Challenges*[145]

- Cybersecurity needs improvement: Focus on facility investments has detracted from IT investments

[145] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

- The hospital has had multiple cybersecurity incidents. The most recent hacking (on April 4, 2023) will take approximately a month to identify the extent of damage
- No cybersecurity insurance because hospital leadership is skeptical of benefits
- Limited phishing training and lack of budget for two-factor authentication

- Hospital leadership is content with current electronic medical records, CPSI. They have fully in-house revenue cycle management (RCM)

5 *Sustainability Plan*

- Revenue enhancements:
  - 340B program: Leadership believes 340B program enhancement will eventually generate $500k+ per month and assist hospital in breaking even.
    - Received ~$374k in March 2023
  - New services: Ozarks Community has hired new physicians to expand existing practices, reopen geriatric psychiatry program (net revenue of $100k per month), and expand surgery (upfront cost of approximately $500k but hospital leadership believe this expansion will ultimately net millions in new revenue)
  - Chargemaster rates: Increased by 35% in late 2022
- Debt restructuring: Hospital leadership hopes to consolidate real estate debt with COVID loan debt

6 *Physical Plant*

- Facility is in good condition: hospital has been proactive with preventative maintenance, everything is easy to replace, and boilers and generators are well-maintained

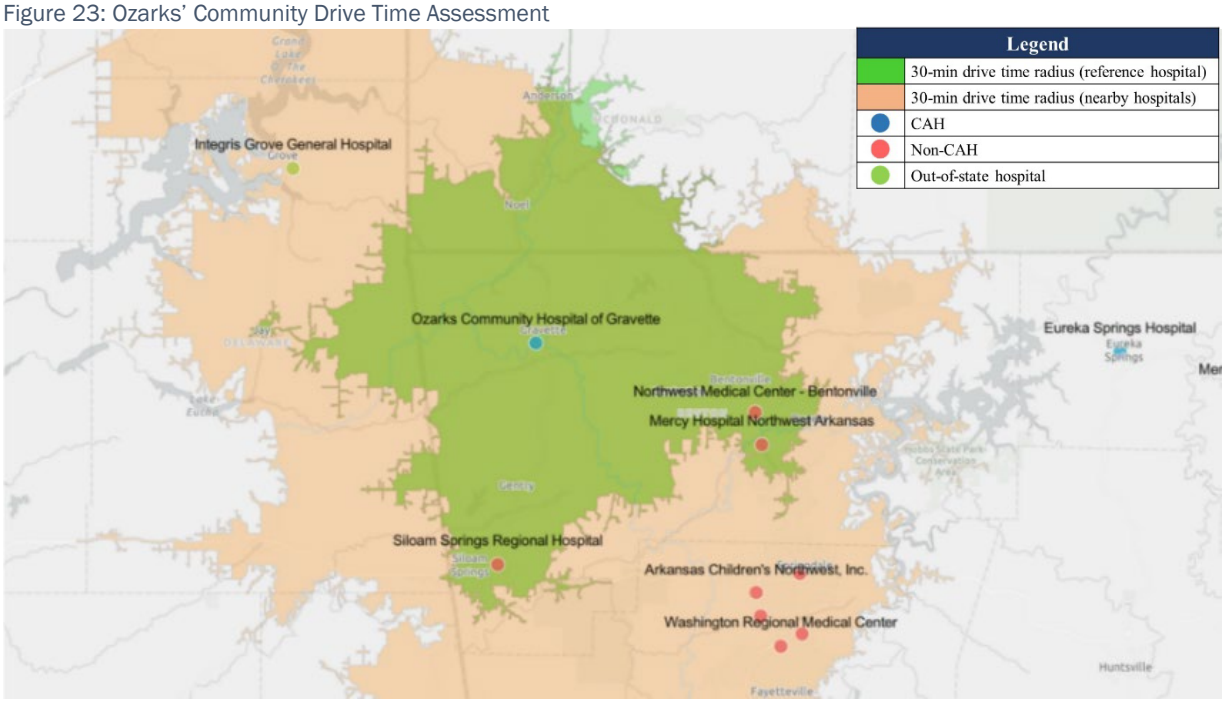
Drive Time Assessment - Alternatives in the Surrounding Community

Ozarks Community is the only hospital within the town of Gravette and is one of four hospitals located within Benton County, a county in the northwestern corner of Arkansas with a population of roughly 284,000 and growing. Gravette, a previously shrinking community, is now growing with more than 4,000 residents and new businesses. The expansive growth of the nearby Bentonville-Fayetteville urban area, aided by the recent extension of Interstate 49, has increased the population near Ozarks and Gravette. The estimated total population within a 30-mile radius of Ozarks Community is 367,864.[146]

[146] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

The three closest alternative hospitals to Ozarks Community are on average 22 miles away: Siloam Springs Regional Hospital is 18.5 miles to the south in Siloam Springs; Northwest Medical Center – Bentonville and Mercy Hospital Northwest Arkansas are 23.2 and 24.9 miles away, respectively, to the southeast in Bentonville. There are additional alternatives, such as Washington Regional Medical Center, within a 30-mile or 45-minute drive. Patients willing to cross state borders and be treated in Oklahoma can also go to Integris Grove General Hospital 29.1 miles away to the northwest in Grove, Oklahoma.

Figure 23: Ozarks' Community Drive Time Assessment



Observations Related to Operational Outlook

Ozarks Community operates the main hospital facility in Gravette, AR and 16 rural health clinics (RHCs). Two RHCs are in Gravette, AR; one is in Rogers, AR; and the other 13 are in Southwest Missouri. All 16 RHCs are cost-reimbursed and profitable.

In 2022, Ozarks Community reported 254 annual inpatient discharges and 121 swing bed discharges with an adjustment factor[147] of 4.01, resulting in total adjusted discharges of 1,018. The physical expansion and population growth of the Bentonville-Fayetteville urban area in northwest Arkansas is encroaching upon Gravette and bringing in additional patient volume. Most of the hospital's services (*e.g.*, behavioral, ENT, lab, respiratory, surgery, swing bed, therapy, wound care) are seeing growing patient volumes. The hospital is looking to expand several of these services by recruiting new physicians and purchasing new equipment (hospital growth plans are discussed in further detail in the *Sustainability Plan* section below). The hospital has a strong swing bed referral program with an average daily census (ADC) of 15-16 patients. The program brings in patients from Mercy Hospital Northwest Arkansas and other nursing homes in the area who

[147] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue.

oftentimes then require specialty care while at Ozarks Community. The swing bed program accounted for 5,169 patient days in 2022, while acute care patient days totaled 1,446.

The 2022 average length of stay (ALOS) for acute care patients was 5.7 days. The acute-only ADC was 3.96, while the occupancy rate for the year was 16%. When including swing bed days, the ADC jumps to 18.1 in 2022, improving the occupancy rate to ~72%. For comparison, the national benchmark average LOS for CAH facilities is 4.0 days, and average occupancy rates range widely from 40 to 60% depending on location (*i.e.*, rural vs urban). For rural hospitals in Arkansas, in 2016, average occupancy rates hovered around 30%.

Table 114: Ozarks' Operational Indicators

Key Indicators - Operational Outlook	
(Jun. 2022 - Nov 2022 Annualized)	
Total Inpatient Discharges	254
Adjustment Factor	4.01
Total Adjusted Discharges	1,018
Hospital Patient Days	1,446
Adjusted Patient Days	5,797
Average Daily Census	4.0
Average Length of Stay	5.7
Emergency Department Visits	3,710
Occupancy Rate	72%
Total FTEs	162
Total CFTEs	Not Provided
Case Mix Index	Not Provided
Labor Cost / Net Patient Revenue	60.6%
FTEs per Adjusted Occupied Bed	2.2

Ozarks Community has 162 full-time employees (FTEs), of which 94 are clinical. FTEs per each adjusted occupied bed (also called "FTEs per adjusted ADC") is 2.23. The state benchmark for FTEs per adjusted ADC was 4.6-5.72.[148] Using annualized Sept. 22 through Feb. 23 data, Labor cost per net patient service revenue (NPSR) was at 60.6% compared to the national benchmark of 50% - 60%.[149,150] FTEs per adjusted ADC and labor cost relative to NPSR both being below their respective benchmarks indicates an efficiently managed clinical workforce, but other metrics such as staff turnover and patient safety / quality should also be examined to determine if labor is being efficiently utilized.

Table 115: Ozarks' Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	112,567
Inventory and Prepaid Expenses	$	1,065,137
Current Assets	$	12,340,316
Total Assets	$	40,962,440
Current Liabilities	$	18,940,167
Total Long-Term Debt	$	28,444,407
Total Liabilities	$	47,384,574
Net Position	$	(6,422,134)
Daily Expenditures	$	175,393
Days Cash on Hand		0.6
Quick Ratio		0.6
Current Ratio		0.65
Debt Service Coverage Ratio		(2.59)
Average Age of Plant		Accumulated Depreciation not Broken out in AFS
Days in Net Accounts Receivable		77.32
Debt to Operating Revenue		50%

Ozarks Community has experienced greater hospital competition for staff over the last year because it is difficult to offer competitive wages given Ozarks Community's payer mix. Nonetheless, the hospital's turnover rate is showing improvement, having decreased from 36% in 2021 to 22% in 2022. The 2023 YTD retention rate is currently 96%. Hospital leadership attributes the improvement to work and culture initiatives that include implementing minimum wage increases, pay adjustments, metric-based

[148] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.
[149] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*
[150] Ozarks Community provided its January and February income statement combined. This did not affect the calculation of annualized financial figures.

compensation, and career development opportunities. The hospital employs seven contract nurses from a nationwide bidding platform that has managed to keep contract prices relatively low. The need for travel nurses has also fallen back to pre-pandemic levels with the hospital currently having only four travelers. Three of those travelers work in the hospital's increasingly busy lab as the hospital has found it particularly difficult to recruit lab technicians.

The hospital has been proactive in the maintenance of its facilities and has made major repairs and replacements to major equipment and facility systems in the last four years. However, the hospital's IT system has not received as much investment. The hospital has been the victim of multiple cybersecurity incidents in recent years. On April 4, 2023, the hospital was breached by an international hacking group, and hospital leadership does not believe they will know the full extent of the damage for a month's time. Previous cybersecurity incidents included catching a worm virus that had not yet affected any data and suffering a phishing ransomware attack that lost the hospital one day of financial data. Despite its history, Ozarks Community does not have cybersecurity insurance and hospital leadership does not believe they can afford two-factor authentication. The hospital does conduct IT trainings, send quarterly phishing notifications, and uses VPNs.

Ozarks Community is not interested in converting to the rural emergency health (REH) hospital designation. Hospital leadership did not share further details.

Observations Related to Current Fiscal Condition

Ozarks Community's liquidity is being stressed by its liabilities. To meet Medicare advance payment recoupment, hospital leadership took out a loan to repay a portion of the advance amount. Now, the hospital is still liable for the entire loan amount, but at terms that are more favorable to the facility's cash flow. In 2022, the hospital had exceeded Medicare's allowable 100 inpatient swing bed days by approximately 700 days and as such Ozarks Community was not paid for the entirety of those services. With exhausted lines of credit, the hospital has negative monthly cash flow and few liquidity options remaining. Based on the initial data received, A&M's on-site review, and 2023 data, Ozarks Community's cash position has been deteriorating from September 2022 to February 2023. The hospital has daily expenditures of $175k and 0.6 days cash on hand as of February 2023. Hospital leadership believes that sustainability plan initiatives, such as expanding services and enhancing its 340B program, will help the hospital break even.

Cash Position

Cash on hand (COH) has decreased 76% in six months, from $471k in September 2022 to $113k in February 2023. Days cash on hand is only 0.64 days based on the February 2023 balance sheet. This decrease is mostly attributed to the hospital's high debt obligations. Meanwhile, accounts receivable (A/R) has increased 11.55% during the same period – days in A/R is 77.3.[151]

In 2022, the hospital had approximately 700 inpatient days that went unpaid. Hospital leadership claims they did not realize that they had exceeded Medicare's allowed 100 days of swing bed care (reimbursed at ~$2,000 per day). The hospital is now working to isolate those excess days and recategorize them as nursing home days so that they will not adversely impact the hospital's cost report.

[151] During the on-site review, hospital leadership claimed that days in net A/R is ~40days when self-pay is excluded, but A&M could not verify these claims.

Ozarks Community performs most of its revenue cycle management (RCM) in-house, and hospital leadership did not disclose any difficulties in the RCM or collections process. Although the hospital does have an upfront self-pay service, it works with a popular RCM vendor to provide self-pay options.

Ozarks Community did not submit cash flow statements for the months of December 2022, January 2023, and February 2023. As such, a cash flow runout analysis could not be performed.

Debt

During COVID, Ozarks Community received $9.6M from CMS through COVID-19 Accelerated and Advance Payments (CAAP) and another $6.5M under the USDA COVID guaranteed loan program. Ozarks Community spent the total $16.2M prior to July 1, 2022. The CAAP loan came as two separate CMS Advance payments that totaled $9.6M. When CMS began recoupment, the standard 11-month, 25% recoupment ($600k per month) was applied only to the initial payment. However, when the 50% recoupment window was activated 11-months later, the recoupment was purportedly applied to both payments. Hospital leadership claims they had not been made aware of the combined schedule before initially receiving the payments. This put Ozarks Community in a position to have to repay CAAP at 50% over an accelerated nine-year amortization, which hospital leadership stated they do not believe they can afford to maintain.

To pay off the second CMS advance payment, hospital leadership took out a $3.5M loan against its furniture, fixtures, and equipment (FFE), which is currently an interest-only loan that must be amortized. This FFE loan has essentially shifted the liability around on Ozarks Community's balance sheet, and the hospital is now repaying the remaining CAAP balance of $2,487,714.76 over five years at 4% interest.

Revenue

Ozarks Community has a monthly total operating revenue of approximately $4M-$5M, with a degree of month-to-month fluctuation. Using annualized September 2022 through February 2023 financials, Ozarks Community appears to be facing a 12% increase in net patient revenue (NPSR) from the prior year. As discussed above in the *Observations Related to Operational Outlook* section, this increase is consistent with hospital leadership's accounts of growing patient volume and service revenue across multiple services, particularly in its swing bed program and geropsychiatry (geripsych) program. The hospital's specialty care services (*e.g.*, cardiopulmonary, ENT, orthopedic, podiatry, and wound care) are also all profitable.

The hospital also has notable behavioral health service lines. The Gravette depression clinic, the only one of its kind in the region, offers a ketamine therapy program that helps the hospital generate about $1M in annual revenue. The hospital also expects significant revenue growth of $100k per month with the re-opening of its geripsych program, which was profitable before it was shut down during the pandemic (see the *Sustainability Plan* section below).

Ozarks Community currently does not receive support from Benton County. Hospital leadership believes it may be easier and more appropriate to ask for support if it gains 501(c)(3) status.

Table 116: Ozarks' Community Income Statement Metrics

Income Statement Metrics			
	FY22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 46,681,563	$ 52,259,042	12%
Other Revenue	11,814,333	4,573,814	-61%
Total Revenue	**58,495,896**	**56,832,856**	**-3%**
Salaries, Wages & Benefits (SWB) Expense	30,168,135	31,671,580	5%
Supplies Expense	12,200,768	13,596,336	11%
Other Operating Expense	16,565,260	17,725,202	7%
EBITDA	**(438,267)**	**(6,160,262)**	**-1306%**
Depreciation Expense	657,343	853,092	30%
Operating Income	**(1,095,610)**	**(7,013,354)**	**-540%**
Non-Operating Income (Expense)	9,992,130	8,542,283	-15%
Net Income	**8,896,520**	**1,528,929**	**-83%**
Operating Margin	-2%	-12%	-559%
NPSR / Adj Discharge		$ 51,319	
Expense / Adj Discharge		$ 62,697	

** Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Expenses

Ozarks Community continues to see elevated operating costs compared to pre-COVID 2019. Monthly operating expenses total approximately $5M, exceeding monthly operating revenues by $500K, which the hospital believes it can address with its sustainability plan initiatives around revenue growth. Annual operating expenses have increased 7% from $59.6M in 2021 to $63.8M in 2022. In 2022, the hospital saw labor costs increase by 5% after raising the minimum wage and adding four traveler nurses (three lab technicians and one nurse). Employee costs, including contract labor and benefits, were $12.4M in Q3 of 2022. Fortunately, the need for travel nurses has returned to pre-COVID levels, according to hospital leadership. Because of the conversion to nonprofit status in 2022, Ozarks Community may have the ability to renegotiate with vendors and suppliers and reduce its supply expenses in the future.

Supplemental Funding

Ozarks Community received significant supplemental funding to support its operations and bolster its financial position during the COVID-19 pandemic. However, the hospital did not provide a full list of its received funds. It is known that the hospital received $9.7M in COVID-19 Accelerated and Advance Payments, $6.5M in Rural Development COVID-19 Response payments, at least $7M in PPP loans, and at least $1.2M in AR Cares loans.

Break-Even Analysis

A break-even analysis was performed to approximate Ozarks Community's current net income (loss). The below break-even analysis is based on a trailing 6-month annualization of OCH's income statements. As shown in the table below, their annualized FY23 net income is $1,528,929. This positive net income is generated off of the $8.99M in debt forgiveness though, and if the debt forgiveness is excluded Ozark is facing approximately a $7.4M loss. Notably, hospital leadership believes that the expansion of its 340B program will generate an additional ~$500k per month in revenue and allow the hospital to achieve a monthly breakeven. The currently quantified sustainability plan, if all impact dollars are achieved, has a minimum potential impact of $10M.

Table 117: Ozarks' Community Break-Even Analysis

Ozarks Community Hospital	September 2022	October 2022	November 2022	December 2022	January & February 2023	Breakeven over the last 2 Quarters	12 Month Total	18 Month Total
Net patient service revenue	$ 4,002,821	$ 4,866,630	$ 4,141,022	$ 5,320,921	$ 7,798,127	$ 26,129,521	$ 52,259,042	$ 78,388,563
Other Operating Revenues	458,946	289,913	282,903	474,994	780,151	$ 2,286,907	4,573,814	6,860,721
Total Revenue	4,461,767	5,156,543	4,423,924	5,795,914	8,578,277	28,416,428	56,832,856	85,249,284
Salaries, Wages, Benefits and Payroll Taxes	2,632,571	2,566,110	2,523,164	2,627,593	5,486,352	15,835,790	31,671,580	47,507,370
Supplies	1,122,060	1,272,093	1,212,902	1,439,984	1,751,129	6,798,168	13,596,336	20,394,504
Total Operating Expenses Less D&A	5,332,836	5,107,137	5,309,051	5,579,896	10,167,639	31,496,559	62,993,118	94,489,677
EBITDA	**$ (871,069)**	**$ 49,406**	**$ (885,127)**	**$ 216,018**	**$ (1,589,362)**	**$ (3,080,131)**	**$ (6,160,262)**	**$ (9,240,393)**
Depreciation	53,142	53,143	53,143	71,084	196,034	426,546	853,092	1,279,638
Total Operating Expenses	5,385,978	5,160,280	5,362,194	5,650,980	10,363,673	31,923,105	63,846,210	95,769,315
Operating Income (Loss)	**$ (924,211)**	**$ (3,737)**	**$ (938,270)**	**$ 144,934**	**$ (1,785,396)**	**$ (3,506,677)**	**$ (7,013,354)**	**$ (10,520,031)**
Interest Expense	(30,095)	(41,963)	(51,102)	(93,393)	(296,020)	(512,573)	(1,025,146)	(1,537,719)
Non-Operating Income (Expenses)	-	-	-	552,204	8,989,525	9,541,729	9,567,429	9,593,129
Net Income (Loss)	**$ (954,306)**	**$ (45,700)**	**$ (989,372)**	**$ 603,745**	**$ 6,908,109**	**$ 5,522,479**	**$ 1,528,929**	**$ (2,464,621)**

Capital Considerations

Ozarks Community was built in the mid-1970's, starting with just the Gravette hospital. Throughout the 1990s and 2000s, the hospital expanded and added clinics to its network of facilities. During the pandemic, the hospital also added an annex. The hospital has been diligent in its facility maintenance and has not allowed equipment and the facilities to fall into critical disrepair. The hospital used COVID funding to make major improvements to the Gravette hospital and clinic facilities during the pandemic. Between 2019 and 2022, the hospital spent $5.39M to repair or replace major parts and systems of the hospital, such as the roof, boilers, chillers, generator, cooling tower, elevators, central sterilizer, and electric switch gear. An on-site facility tour revealed a well-maintained facility with either new or reparable equipment and systems.

Ozarks Community currently has identified $2,641,122 in anticipated capital expenditures, the large majority of which will be spent on surgery equipment, a central sterile upgrade, an automatic sprinkler system, main switch gear replacement, an HVAC rebuild, and the new geripsych day program. Since becoming a non-profit, the hospital now employs a grant writer to identify grant funds that will be used for more expensive items and some of these anticipated items. The hospital leases most of its major medical equipment. It purchased new radiology equipment (x-ray, CT, MRI) in 2016. Hospital leadership advised that they do not typically budget for capital expenditures.

Upcoming Obligations

Ozarks Community does not have upcoming obligations that are not part of its sustainability plan. The hospital has discussed with Mercy Hospital Northwest Arkansas in the past about potentially joining the Mercy hospital system to secure Ozarks Community's future. Ozarks Community suggested that the Mercy Foundation hold it as a subsidiary of the Mercy hospital system but retain Ozarks Community's own operations. According to hospital leadership, Mercy has hesitated at Ozarks Community's payer mix in the past. Discussions between the two hospitals are in very early stages.

Sustainability Plan

An aggressive and achievable sustainability plan is critical to Ozarks Community's ability to navigate through its current liquidity crunch and try to break even with its monthly operations. Hospital leadership provided a sustainability plan that includes a few key critical initiatives to directly target its monthly operating margin and liquidity problem.[152] Leadership believes that successfully enhancing its 340B program alone will generate the $500k per month needed to meet its $5M monthly operational expenses.

Table 118: Ozarks' Sustainability Breakdown

Ozarks Community Hospital Sustainability Plan Summary
Sustainability Plan Summary

Ozarks Community Hospital Sustainability Plan Summary*	FINANCIAL IMPACT		
ACTION	*Action Complete*	*Action Pending*	*Total*
Revenue Enhancement:			
Chargemaster Increase: Brought Chargemaster rates closer to competition levels with 35% increase in late 2022		$ 600,000	
General Hospital Patient Volume: Signed an employment agreement with an internist to work in hospital and clinic*		Impact unknown	
Hospital Ancillaries: Hired family practice physician with a large existing practice to increase patient volume in ancillaries*		Impact unknown	
Behavioral Health Services: Hired local psychiatrist and team of psych-certified nurse NPs to restart geriatric psych "day program"		$ 1,200,000	
Surgery Services: Negotiating with local general surgeon and anesthesiologist to expand surgery service**		estimated Millions	
Home and nursing home: Intends to sign a local physician who will see exclusively see home and nursing home patients****			
Accountable Care Organization: Enrolled in an ACO and expects first payment in 2024		$ 1,000,000	
Medicare CCM: partnering with Main Street Health chronic care management program that pays the hospital per-member-per-month		$ 1,200,000	
340B Program: Recently became eligible for the drug discount program and expects it to grow once referral scripts are added		$ 6,000,000	
TOTAL REVENUE ENHANCEMENT IMPACT	$ -	$ 10,000,000	$ -
Expense Reduction:			
Converted to non-profit status: Converting to a non-profit in 2022 has reaped tax liability benefits and lowered supply costs		75% discount on IT supplies	$ -
Re-amortize debt: Hopes to consolidate $6.5M COVID loan and $3.5 FFE loan through USDA guaranteed loan program to extend loan terms and reduce cash flow requirements		Impact unknown	
TOTAL EXPENSE REDUCTION IMPACT	$ -	$ -	$ -
***TOTAL IMPACT	Impact unknown	Impact unknown	Impact unknown

**Ozarks did not provide a quantified estimate of the revenue enhacement impact*
*** The new general surgeon will cost $500,000/year to retain on an administrative salary, but the hospital believes he will generate an unspecified millions of dollars in revenue*
****Total Impact is expected to be realized primarily in or after 2023 and does not include Funding Opportunities*
*****Ozarks did not provide a quantified estimate of the revenue enhacement impact but did estimate that cost of home and nursing home physician will be expensive*

Revenue Enhancements

- Doubling "Other income" revenue streams:
  - Ozarks Community expects to generate "other income" at an annualized rate of $8M by the end of 2023.
  - Since becoming a nonprofit in 2022, Ozarks Community has become eligible to participate in the 340B drug discount program. The hospital's 340B program currently contracts with three pharmacies. Ozarks Community is already seeing over $100k per month in new income doing only direct prescriptions and hospital leadership expects the program to generate more than $500k per month once referral scripts are added. Hospital leadership claims that this $500k per month increase will supplement current monthly operating revenues of $4.5M to break even with the hospital's monthly operating expenses of $5M.
  - Ozarks Community has enrolled in an Accountable Care Organization (ACO) which projects an annual ret revenue of $1M. The hospital is already halfway to achieving that projection but will not receive the first installment of the annual payment until the beginning of 2024.
  - Ozarks Community signed a deal with a Main Street Health[153] chronic condition management (CCM) program that will pay the hospital $15 per member per month

[152] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.
[153] Main Street Health | Reinventing Rural Healthcare (mainstreetruralhealth.com)

(PMPM) for providing care management for patients covered by Medicare Advantage plans and then pay an additional $100 per annual wellness visit provided. Ozarks Community has ~8,000 patients covered by Medicare Advantage plans and believes it can enroll 5,000 in this program, generating $100k per month.

- Recruiting and New Services
    - The hospital will be expanding its behavioral health service offerings. It has entered into an agreement with a local psychiatrist and team of nurse practitioners to provide services in Gravette and serve satellite clinics via telehealth. The psychiatrist will also restart the hospital's geripsych "day program" that closed during the pandemic and expects to generate revenues of $100k per month. The program, which will treat patients from area nursing homes during the day, was previously a significant source of revenue with a positive operating margin. Geripsych patients are more likely to have traditional Medicare rather than Medicare Advantage plans, which benefits the hospital's cost report. After the geripsych program is established, the hospital plans to apply for the Rural LIFE360 program.
    - Ozarks Community has hired or will be hiring the following: An internist to increase patient volume at both the Gravette hospital and clinic starting August 2023; a family practice physician with an existing practice to increase patient volume in hospital ancillaries starting May 2023; and a local physician, who has already started, to grow the home/nursing home patient volume, which would also feed the hospital's geripsych day program, wound care, podiatry, and outpatient lab services. The hospital has also negotiated with a local general surgeon and anesthesiologist to expand the surgery service. The hospital is offering the surgeon an administrative salary and control, but hospital leadership believes an expanded surgery service line will "generate millions of dollars in revenue."
- Chargemaster Rate Increases
    - In late 2022, the hospital increased its Chargemaster rates by 35% to bring in an estimated additional $50k per month and help the 2023 cost report break even. However, the hospital's payer contracts are on a fixed-fee schedule, so the bottom-line impact of the price increase will be positive but limited. Ozarks Community's prices were previously lower than other competitors in the market such that the hospital's rates remain slightly below market even after a 35% increase.

<u>Expense Reductions:</u>

- Capitalizing on Non-profit Status:
    - Ozarks Community expects that savings from its conversion to non-profit status will offset any increases caused by general healthcare inflation. Ozarks Community's new non-profit status has allowed the hospital reap tax liability benefits and lower supply and service costs. Although the hospital was too new to nonprofit operations in 2022 to capitalize on vendor and supplier repricing, it has already saved 75% on certain IT equipment and services, a savings of several hundred thousand dollars. The hospital is now also eligible for grants and programs limited to non-profit, as discussed above in the *Capital Considerations* section.

Debt Consolidation:

Ozarks Community is hoping to consolidate several current outstanding debt instruments through the USDA guaranteed loan program, which will effectively refinance the $6.5M COVID loan and the $3.5M FFE loan discussed earlier. The longer-term loan would significantly reduce cash flow required to service the debt but cannot be achieved until Ozarks Community has survived several years as a non-profit.

Piggott Community Hospital

Quick Facts

- Classification: CAH
- Licensed Beds: 25
- Closest Facility: 34 miles
- Average Age of Plant: 23.23 years
- Average Daily Patient Occupancy Rate: 49.2%
- Average length of stay (ALOS): 3.8
- Total full-time employees (FTEs): 231.73 FTEs; 153.23 CTEs

Location: Piggott, Clay County
County Population: 14,350 (2021)

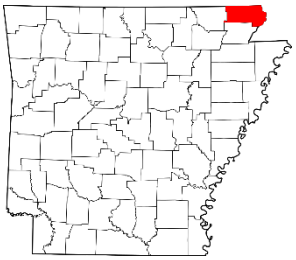


Table 119: Piggott's Summary Statistics

Operating Statistics		
C&C Equivalents	$	1.4 M
Current Assets	$	6.8 M
Net A/R	$	5.1 M
Total Assets	$	8.6 M
Days Cash on Hand		18.73
Quick Ratio		3.33
Current Ratio		3.54
Debt Service Coverage Ratio		-4.89
Days in Net AR		73.97
Average Age of Plant		23.23
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	25.0 M
Other Revenue	$	2.1 M
Total Revenue	$	27.2 M
Salaries, Wages & Benefits	$	15.1 M
EBITDA	$	(0.7 M)
Operating Income	$	(1.2 M)
Non-Operating Income/(Expense)	$	(0.1 M)
Net Income	$	(1.2 M)
Operating Margin %		-4%

Key Challenges

- Lack of space and land adjacent to hospital limits revenue as new services cannot be easily added.

1 *Patient Volume Trends*

- As nearby hospitals close and cut services, Piggott Community has seen its strong patient volume continue to grow, especially in its 2 RHCs, home health, pain, and wound care clinics. Piggott Community has absorbed ~70-80% of patients that previously went to Twin Rivers, Piggott Community's closest neighboring hospital which closed in 2018

2 *Financial Status*

- Piggott Community has an average daily census of 8.2 for acute (12.3 including swing beds)
- Quick ratio is 3.3 with days cash on hand at 18.7 days
- Accounts Receivable (AR) days are high: Gross average of about 65 days per Pigott vs A&M calculated of 74 for Net A/R Days
- Hospital leadership recently used a line of credit to purchase a cooler and buy a 5-acre property. They are actively paying off capital leases (which includes EQ lighting, x-rays, and c-arm in the pain management clinic). Sales tax from the city (~$40k per month) helps fund future capital needs for the emergency department

3 *Labor Challenges*

- Relatively stable provider and nursing staff
- Of note, Piggott Community did not hire any travel nurses during the pandemic; nurses are paid ~$30 per hour on average, with the average nurse tenure being 50 years, median of ten years

4 *Technology Challenges*[154]

- No CIO
- Scheduled for firewall conversion from Cisco to Palo Alto, email exchange server conversion to cloud, procurement of mobile medication bar code scanners and standardized computers in each patient room (estimated $60k in costs, although it is expected to be higher), and new med-carts (est. $60k cost)
- Piggott Community has experienced two ransomware attacks in the past 6-7 years

5 *Sustainability Plan*

- They are efficient with clinical labor costs (3.54 FTEs per adjusted occupied bed), strategic with market growth (continuing doing Home Health across different regions) and looking to expand equipment/resources to fill existing gaps (*e.g.*, purchase of an MRI machine)
- To address growing community needs, Piggott Community recently added a new cardiology clinic and expanded pulmonary telemedicine capabilities

6 *Physical Plant*

- Facilities are in good working order; however, the Hospital would like to expand its specialty medical building

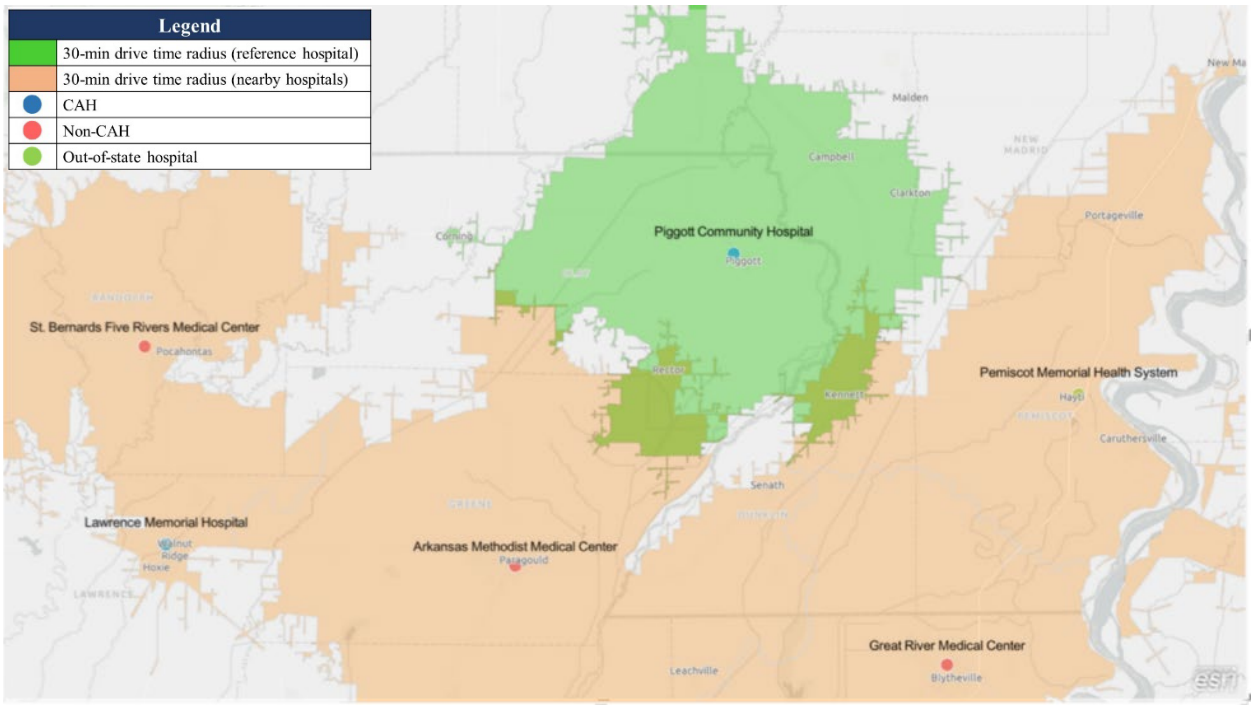
[154] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

Drive Time Assessment - Alternatives in the Surrounding Community

An estimated population of 145,139 resides within a 30-mile radius of Piggott Community[155] This site encompasses Clay County, Green County, Butler County, Dunklin County, and Pemiscot County.

The closest hospital to Piggott Community is Arkansas Methodist Medical Center 34 miles away, followed by Pemiscot Memorial Health System 37 miles away. Great River Medical Center, St. Bernards Five Rivers Medical Center, and Lawrence Memorial Hospital support the surrounding regions at 48 miles, 53 miles, and 58 miles, respectively.

Figure 24: Piggott's Drive Time Assessment



Observations Related to Operational Outlook

The hospital is licensed for up to 25 beds. The acute average length of stay (ALOS) for inpatient stay is 3.8. Piggott Community's ALOS is lower than the national average of approximately 4-5.4 days. ALOS is an indicator of efficiency – if all other things are equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings.

[155] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

The acute average daily census (ADC) was 8.2, with an occupancy rate is 49.2%, consistent with rural hospitals in Arkansas. ADC jumps to 12.3 when swing beds are included. Occupancy rates range widely from 40 to 60% depending on location [156] (*i.e.*, rural vs urban), which means Piggott is consistent with others by remaining within this benchmark.

In 2022, Piggott Community reported 817 annual inpatient discharges with an adjustment factor of 5.33[157], resulting in total adjusted discharges of 4,353. Annual ER departmental visits totaled 6,565. The percentage of admissions from the ER is generally between 60-70%.

Approximately ~46% of all patients are covered by traditional Medicare.

Piggott Community has notably increased its home health service offering; over the course of two years, its home health census has increased from 70-75 patients per day up to 220 per day. Due to it's success, Piggott Community is colloquially referred to as the "home health agency attached to a hospital". The growth of PCH's home health service offering has been a key contributor to its strong balance sheet and overall financial position.

Month-on-month volumes during the year remained relatively consistent with slight variation; There is noted low census day in August and November, with a high in December; Volume has generally been lower than the previous fiscal year. Due to recent surrounding hospital closures, leadership noted an influx of Missouri patients, commenting that, "sometimes we'll have more Missouri addresses [currently admitted] than folks from Arkansas".

Table 120: Piggott's Operational Indicators

Key Indicators - Operational Outlook	
(Calendar Year 2022)	
Total Inpatient Discharges	817
Adjustment Factor	5.33
Total Adjusted Discharges	4,353
Hospital Patient Days	3,143
Adjusted Patient Days	16,744
Average Daily Census	8.2
Average Length of Stay	3.8
Emergency Department Visits	6,565
Occupancy Rate	49.2%
Total FTEs	232
Total CFTEs	153
Case Mix Index	Not provided
Labor Cost / Net Patient Revenue	60.3%
FTEs per Adjusted Occupied Bed	3.5

Table 121: Piggott's Balance Sheet Metrics

Balance Sheet Metrics		
(as of Feb. 2023)		
C&C Equivalents	$	1,434,029
Inventory and Prepaid Expenses	$	409,800
Current Assets	$	6,836,710
Total Assets	$	8,639,491
Current Liabilities	$	1,930,898
Total Long-Term Debt	$	1,881,977
Total Liabilities	$	3,812,875
Net Position	$	4,826,616
Daily Expenditures	$	76,561
Days Cash on Hand		18.7
Quick Ratio		3.3
Current Ratio		3.54
Debt Service Coverage Ratio		(4.89)
Average Age of Plant		23.23
Days in Net Accounts Receivable		73.97
Debt to Operating Revenue		7%

[156] Acute Care and Critical Access Hospital Occupancy Rate Variability by Location (2016, HFMA). https://www.hfma.org/finance-and-business-strategy/analytics/61098/

[157] The adjustment factor is a hospital performance measure that compares a hospital's inpatient revenue to its total revenue to account for the effect of outpatient care volume on total hospital discharges. It is calculated by dividing a hospital's Total Gross Revenue by its Total Gross Inpatient Revenue

The hospital employs a total of 232 full-time employees (FTEs). Of those, 153 are clinical FTEs. FTEs per adjusted occupied bed (also called "FTEs per adjusted ADC") was 3.54. The state benchmark for FTEs per adjusted ADC was 4.6-5.72.[158] Labor cost per net patient revenue was at 60% compared to the benchmark of 50% - 60% for rural non-CAHs.[159]

Observations Related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (Dec. 2022, Jan. 2023, or Feb. 2023). Based on the initial data received, A&M's on-site review, and 2023 data, Piggott Community appears to be in a mixed financial condition, with a low days cash on hand, strong assets, relatively strong quick ratio, and low debt. Cash/Restricted Cash has dropped by ~$3M from 4.4M in July 2022 to 1.4M at the end of February 2023. Accounts Receivable increased by approximately ~1.33M. Total liabilities have decreased from ~$5.8M in July 2022 to $3.8M.

Days of cash on hand is ~19 days as of February 2023. Daily expenditures are $76,561. The deteriorating cash position has highlighted the necessity of the sustainability plan's breadth of expense reduction efforts for short-term impact.

Cash Position

Understanding the days cash on hand (COH) in conjunction with trends in accounts receivable (A/R) will provide insight into revenue cycle management (RCM) complexities. Piggott Community utilizes TruBridge and Evident (also known as CPSI) for all RCM, including the medical records management, excluding home health and DME. TruBridge scrubs claims and sends patient statements. According to management, net A/R days are trending down, although they are currently at ~74 days in A/R, a relatively high average compared to the 65-day average for CAHs under this review. Although no complaints or concerns were expressed explicitly, the decrease in Cash/Restricted Cash month-over-month from Jul. 2022 to Dec. 2022 (on an average of $600k), compounded by the increase in A/R points towards lack of efficiencies and problematic revenue cycle management. In a recent February Aging Analysis Report, Piggott Community reported approximately $1.9M in A/R balance over 120 Days.

[158] See *Figure 4: Comparison of FTE / Adjusted Average Daily Census by Hospitals*.
[159] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Table 122: Piggott's Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 22,282,526	$ 25,026,424	12%
Other Revenue	1,042,294	2,124,750	104%
Total Revenue	**23,324,820**	**27,151,174**	**16%**
Salaries, Wages & Benefits (SWB) Expense	13,883,389	15,078,836	9%
Supplies Expense	6,501,636	4,817,236	-26%
Other Operating Expense	5,405,082	7,967,864	47%
EBITDA	**(2,465,287)**	**(712,762)**	**71%**
Depreciation Expense	471,844	445,942	-5%
Operating Income	**(2,937,131)**	**(1,158,705)**	**61%**
Non-Operating Income (Expense)	5,722,896	(80,742)	-101%
Net Income	**2,785,765**	**(1,239,447)**	**-144%**
Operating Margin	-13%	-4%	66%
NPSR / Adj Discharge		N/A	
Expense / Adj Discharge		N/A	

** Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

Debt

Hospital leadership recently used a line of credit to purchase a cooler and buy a 5-acre property. They are also actively paying off capital leases (which includes EQ lighting, x-rays, and c-arm in the pain management clinic). Sales tax from the city of 1% (approximately $40k per month, $450k per year) helps fund future capital needs for the emergency department. Management recently utilized a line of credit with local bank of $450k. There are no other short-term debts.

Revenue

Revenue trends will help provide a year-over-year understanding of the current fiscal condition from a "top line" perspective. Using annualized Sept. 2022 through Feb. 2023 financials, Piggott Community faces a potential 12% increase in net patient revenue (NPSR) from the prior fiscal year. This is further bolstered by an increase in ~1M in Other Revenue compared to the previous year. Salaries, Wages and Benefits (SWB) have increased by 9%, supplies have decreased by ~26% and other expenses have increased by 47% (this appears to be due to a difference in the way expenses are categorized between the audited financials and the monthly financial statements), resulting in an overall increase of 8% of Total Operating Expenses.

Expenses

Trends in expenses can also provide insight into potential efficacy of the sustainability plan and contributors to the current fiscal condition. Payroll and associated benefits represent the single largest expense for Piggott Community. Staff retention and recruitment along with salary for nursing and ancillary staff created unforeseen levels of competition for Piggott Community. Management responded with dramatic increases in salary and benefit cost for nursing and ancillary staff. Per hospital leadership, in 2022 the salary cost increase was ~10%. In 2023, staffing issues have somewhat stabilized enabling the hospital to experience a more reasonable upward salary increase of 3-7%.

Supplemental Funding

All COVID-related supplemental funding received by Piggott Community has been fully received and recognized to-date based on when Piggott Community recognized revenues. The Supplemental Funding table below summarizes the material supplemental funding that was received.

Table 123: Piggott's Supplemental Funding

Supplemental Funding	Total Amount Received
HHS Provider Relief Funds - Phase IV Funding	$ 1,591,271
AEDC Grant	$ 250,000
HHS Provider Relief Funds Rural Health Clinics	$ 200,000
State of Arkansas Cares Act Funding	$ 45,000
Arkansas Medicaid Grant	$ 250,000
COVID SHIP Grant	$ 39,317
Total	**$ 2,375,588**

Break-Even Analysis

Given the trends associated with Piggott Community's operational outlook and fiscal condition, and the potential impact of the sustainability plan, a break-even analysis was performed to approximate the current Net Income (Loss). The below break-even analysis is based on a trailing six-month annualization of the Piggott Community's income statement. As seen in the table below, Piggott's annualized FY23 net income is negative $1,239,447. The currently quantified sustainability plan, if all contemplated balance sheet improvements are achieved, has a potential impact of $2.8M.

Table 124: Piggott's Break-even Analysis

Piggott	September	October	November	December	January	February	Breakeven over the last 2 quarters	12 Month Total	18 Month Total
Net patient service revenue	$ 2,392,719	$ 1,635,610	$ 2,000,813	$ 2,117,505	$ 2,438,166	$ 1,928,399	$ 12,513,212	$ 25,026,424	$ 37,539,636.00
Other Revenue	206,198	244,755	146,247	154,816	145,701	164,658	1,062,375	2,124,750	$ 3,187,125.00
Total Revenue	2,598,918	1,880,364	2,147,060	2,272,320	2,583,867	2,093,057	13,575,586	27,151,173	$ 40,726,758.00
Salaries, Wages, Benefits and Payroll Taxes	1,205,860	1,267,943	1,205,968	1,426,260	1,350,992	1,082,395	7,539,418	15,078,836	$ 22,618,254.00
Supplies	455,093	329,378	495,613	374,878	385,689	367,967	2,408,618	4,817,236	$ 7,225,854.00
Total Expenses Less D&A & Interest	2,370,648	2,162,747	2,391,441	2,423,285	2,519,732	2,064,115	13,931,968	27,863,936	41,795,904
EBITDA	**228,270**	**(282,383)**	**(244,381)**	**(150,965)**	**64,135**	**28,942**	**(356,382)**	**(712,763)**	**(1,069,146)**
Depreciation & Amortization	43,336	42,085	42,085	44,731	42,306	8,428	222,971	445,942	$ 668,913.00
Total Operating Expenses	2,413,984	2,204,832	2,433,526	2,468,016	2,562,038	2,072,543	14,154,939	28,309,878	$ 42,464,817.00
Operating Income (Loss)	**184,934**	**(324,468)**	**(286,466)**	**(195,696)**	**21,829**	**20,514**	**(579,353)**	**(1,158,705)**	**(1,738,059)**
Interest	(6,337)	(6,231)	(6,179)	(10,039)	(6,028)	(5,557)	(40,371)	(80,742)	$ (121,113)
Non-Operating Income (Expenses)	-	-	-	-	-	-	-	-	$ -
Net Income (Loss)	**$ 178,596**	**$ (330,698)**	**$ (292,645)**	**$ (205,736)**	**$ 15,801**	**$ 14,956**	**$ (619,724)**	**$ (1,239,447)**	**$ (1,859,172)**

Capital Considerations

Piggott Community is scheduled for a firewall conversion from Cisco to Palo Alto, email exchange server conversion to cloud, procurement of mobile medication bar code scanners and standardized computers in each patient room (estimated $60k in costs, although it is expected to be higher), and new med-carts (est. $60k cost).

Piggott management further provided a capital needs breakdown during the on-site review and delineated the following capital needs by fiscal year (FY). A subsequent budget breakdown was not provided.

- In fiscal year 2023, management is expecting a new ambulance, MRI acquisition, a new practice building for the family practice, renovation of the Piggott Specialty Clinic and a hospital chiller
- In fiscal year 2024, capital considerations will be made for a new hospital therapy gym, expansion of the behavioral health clinic, updates to four negative airflow rooms and two new transportation vans
- In fiscal year 2025, capital considerations will include the Campbell Medical Clinic expansion, Kennett Home Health Agency/Clinic, hospital outpatient department expansion and renovation of the residential building to accommodate hospital administrative departments
- The hospital roof completion is expected to span across all three fiscal years (FY 23-FY25)

Upcoming Obligations

Piggott management is paying off capital leases (which includes EQ lighting, x-rays, and c-arm in the pain management clinic).

Sustainability Plan

Given the revenue cycle management challenges and consistently negative operating margin described earlier, a strong and achievable sustainability plan is important for Piggott Community's long-term viability. Management's approach has been to identify and expand services that address community needs; hence, the revenue enhancement portion focuses on the expansion of skilled nursing, cardiology, telehealth, neurology, and behavioral health. Piggott Community has also engaged Forvis, a national audit and financial company, to complete a market analysis/feasibility study to determine if there is sufficient to further expand the Piggott Community's Home Health service line.

Piggott Community provided a sustainability plan that included several revenue enhancement and expense reduction items that had either already been implemented or were planned for the near future.[160] If each portion of the plan ends up being accomplished as projected, that would result in a $2.8M change in the bottom line in a positive direction, as summarized below in *Table 121*. A new Family Clinic construction is not included within this sustainability plan, as it is beyond the 18-month scope of this review.

[160] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

Table 125: Piggott's Sustainability Plan

Piggott Community Hospital Sustainability Plan Summary
Sustainability Plan Summary

Piggott Community Hospital Sustainability Plan Summary ACTION	FINANCIAL IMPACT *Action Complete*	*Action Pending*	*Total*
Revenue Enhancement:			
Skilled Nursing Expansion - Recruit additional rehab therapy staff and APRN to provide patient care oversight*		$ 1,333,300	$ 1,333,300
Cardiology Clinic Addition: Through a partnership with St. Bernards Medical Center, PCH will provide facility and supporting staff, whereas St. Bernards will provide cardiology specialist.**	$ 45,000	$ 250,000	$ 295,000
Telehealth Expansion: Partnered with Dallas-based Access Telecare to provide pulmonology and cardiology services via telehealth.		*Impact Unknown*	$ -
Neurology Outpatient Clinic: Through a partnership with Dallas-based Access Telecare, PCH will provide on-site teleneurology clinic biweekly via telehealth.		*Impact Unknown*	$ -
Behavioral Health: Expand program through an additional clinic therapist.		$ 500,000	$ 500,000
Population Health Management: Reboot program to enroll 300 patients in Chronic Care Management (CCM)		$ 275,000	$ 275,000
TOTAL REVENUE ENHANCEMENT IMPACT	**$ 45,000**	**$ 2,358,300**	**$ 2,403,300**
Expense Reduction:			
Salary & Benefit Cost: Manage payroll and associated benefits		*Impact Unknown*	$ -
Supply Expense: Utilize current surplus in inventory		250,000	$ 250,000
Drug Expense/340B Discount Drug Program: Expand program ot specialty referrals and in-house usage		150,000	$ 150,000
TOTAL EXPENSE REDUCTION IMPACT	**$ -**	**$ 400,000**	**$ 400,000**
***TOTAL IMPACT**	**$ 45,000**	**$ 2,758,300**	**$ 2,803,300**

**This is not net; per management, "costs would back out at 30%"*
***Anticipated $250 in gross revenue; Realized $45k in gross revenue in January and February*
****Total Impact is expected to be realized primarily in or after 2023 and does not include Recruitment, Retention Efforts and Funding Opportunities*

Revenue Enhancements

- *Skilled Nursing:* Piggott Community provides much needed skilled nursing care to its surrounding community with its in-house Swing Bed program. This is a program that provides rehabilitation care following a patient's acute care hospitalization. This allows many patients to receive rehabilitation care within the hospital as opposed to needing to be relocated to a nursing home or another care location. Piggott Community has successfully recruited additional rehabilitation therapy staff and an Advance Practice Nurse who will provide general oversight of patient care-related matters. With the increase in staff capacity, coupled with a renewed interest in growing this program, the number of patients cared for daily in the Swing Bed program is anticipated to increase from an average of 3.5 to 5.0 patients per day. In addition, the average length of stay for Swing Bed patients is forecast to increase from 9 to 10 days in 2023. If achieved, the possible increase in revenue will be $1,333,000.
    - Per management, Piggott Community has met its January and February goals with $260k in gross revenue increase.
- *Cardiology Clinic Addition:* Piggott Community and St. Bernards Medical Center reached an agreement to provide outpatient cardiology services at the hospital's specialty clinic. Piggott Community provides the facility and supporting staff while St. Bernards provides the cardiology specialist. This program was recently launched with volumes exceeding projections. This will generate revenue primarily through being able to care for additional cardiology patients locally as opposed to patients being required to go to hospitals elsewhere for cardiology specialty care.
    - Per hospital leadership, Piggott Community has realized $45k in gross revenue in January and February with an anticipated $250k annual revenue.
- *Telehealth Expansion:* Largely due to the pandemic, Piggott Community needed additional physician specialty resources to adequately care for medically compromised patients who had been admitted to the hospital. Due to the lack of such services locally, Piggott Community entered into an agreement with Dallas-based Access TeleCare to provide pulmonology and cardiology services via telehealth. Because of the enhanced physician oversight and patient interaction, it is anticipated

that patients will be able to be cared for at Piggott Community that otherwise would need to be transferred to other hospitals. Increased revenue will be experienced through being able to keep patients at Piggott Community vs. transferring to a hospital elsewhere.

- *Neurology Outpatient Clinic:* There is a gap in Northeast Arkansas care options relative to the need for neurology evaluations/follow-up care. Piggott Community is in negotiations with Access TelePartners to provide an on-site tele-neurology clinic biweekly via telehealth. This will enable patients to remain in Piggott and use Piggott Community services as opposed to traveling substantial distances for care at a larger facility.
- *Home Health Care Agency Expansion:* As discussed above, Piggott Community has engaged Forvis, a national audit and financial company, to complete a market analysis/feasibility study to determine if there is a need to further expand the Piggott Community Home Health service line.
- *Behavioral Health:* For several years, Piggott Community has operated a behavioral health program devoted to the unique mental and emotional challenges faced by Seniors. This program, and an Intensive Outpatient Program, serves an unmet need in Northeast Arkansas. An additional Clinical Therapist has already been hired, which hospital leadership believes will enable the program to expand and project $500k in revenue.
- *Population Health Management:* Piggott Community provides Chronic Care Management (CCM) services to Medicare patients, with limited success. Per management, obtaining "acceptable levels of patient engagement" has been difficult. Piggott Community seeks to reboot this program to enroll another 300 patients, resulting in increased program revenue of $275k.

Expense Reductions

- *Salary & Benefit Cost:* Payroll and associated benefits represent the single largest expense for Piggott Community and as such are a planned future focus for hospital leadership but there are currently no concrete numbers for anticipated savings.
- *Supply Expense:* Piggott Community will use large inventory already on hand, which hospital leadership believes will decrease future supply costs by an estimated $250,000.
- *Drug Expense:* Piggott Community is an active participant in the 340B discount drug program and looks to expand specialty referrals and in-house usage. The incremental revenue resulting from the planned expansion is anticipated to generate an estimated $150,000 in drug expense reduction.

Recruitment and Retention

As part of their sustainability plan, Piggott Community actively recruits providers early in their career; to ensure provider sustainability/long-term coverage, the hospital offers select medical school students and/or residents have a certain percentage of tuition covered in exchange for years of service. Further quantification on tuition reimbursement (and subsequent additional details) was not provided.

South Mississippi County Regional Medical Center

Quick Facts

- Classification: CAH
- Licensed Beds: 25
- Closest Facility: 27 miles
- Average Age of Plant: 19.1 years
- Average Daily Patient Occupancy Rate: N/A at Dec.2022
- Average length of stay (ALOS): N/A at Dec. 2022
- Total full-time employees (FTEs): 58.6 FTEs
- Mississippi County Hospital System (the Hospital) is an affiliate unit of Mississippi County, Arkansas within the meaning of Section of 4.02 of the Revenue Procedure 95-48, 1995-2 C. B 419 with an effective date of March 13, 2009. The Hospital is comprised of Great River Medical Center (GRMC) and South Mississippi County Regional Medical Center (SMC).
- A&M has bifurcated the two hospitals to delineate the financial and operational differences between the two, as well as provide a standardized approach to compare SMC to CAH and GRMC to general hospitals under review. Per leadership, Great River Physician Services (GRPS) expenses will be consolidated with GRMC.

Location: Osceola, Mississippi County
County Population: 39,661 (2021)

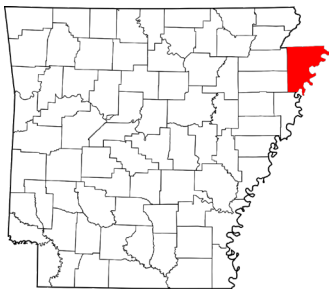


Table 126: SMC's Summary

Operating Statistics		
C&C Equivalents	$	1.4 M
Current Assets	$	(9.6 M)
Net A/R	$	1.0 M
Total Assets	$	(8.4 M)
Days Cash on Hand		49.82
Quick Ratio		-3.08
Current Ratio		-3.03
Debt Service Coverage Ratio		No Long Term Debt
Days in Net AR		72.87
Average Age of Plant		19.11
Income Statement		
(Trailing 6 Months Annualized)		
Net Patient Service Revenue (NPSR)	$	4.8 M
Other Revenue	$	1.7 M
Total Revenue	$	6.5 M
Salaries, Wages & Benefits	$	4.0 M
EBITDA	$	(3.3 M)
Operating Income	$	(3.5 M)
Non-Operating Income/(Expense)	$	1.4 M
Net Income	$	(2.1 M)
Operating Margin %		-54%

Key Challenges

- CEO and CFO will exit from leadership roles in May and July, respectively. Candidates for the CEO role are being interviewed. Current COO will be taking over CFO role.
- Leadership noted high dollar amount denials from certain Medicare Advantage plans.
- To improve financial condition, management decided to reduce census, consequently reducing costly labor, notably around contracted nurses (scheduled to terminate two contracts mid-April).

1 *Patient Volume Trends*

- Decreased patient volume over six months by a temporary closure of the hospital's medical/surgical unit. Discharges from the facility ceased at the end of July 2022 based on the data provided, and the inpatient areas were reopened in January of 2023

2 *Financial Status*

- Quick ratio is -3.08.
  - SMC has a line item on their balance sheet that is labeled, "Due to/from Affiliates that has a balance of negative ($13.16M), which is cause their current assets and net position to be negative
- Net accounts receivable (A/R) days are 72.9
- Days cash on hand is ~50 days, which includes $1M in certificate of deposits (scheduled to mature in <3 months)
- GRMC and SMC finances are intertwined, as executive and management costs split across GRMC and SMC (50/50), whereas shared, non-managerial administrative staff is split 70/30. (GRMC/SMC). Clinical staff work at both hospitals, receive paychecks from "home cost center" with hours consolidated and accrued from respective facilities. Payroll can trace charges back to appropriate site
- Currently, one in-house RCM department completes billing for both SMC and GRMC; leadership is scoping out secondary vendor support with denial billing/denial management

3 *Labor Challenges*

- SMC partners with St. Bernards Jonesboro, as seen through shared providers/services, pharmacy coverage, supply chain and admissions/transfers

4 *Technology Challenges*[161]

- Transitioned to EpowerDoc from paper and then switched to Emergency Department Information System (EDIS). Athena Health is used in the clinics
- Experienced a 2018 ransomware attack, which was covered by insurance

5 *Sustainability Plan*

- A combined sustainability plan was provided, along with call outs to improve up front collections, reduce census to reduce labor costs and improve service line offerings

6 *Physical Plant*

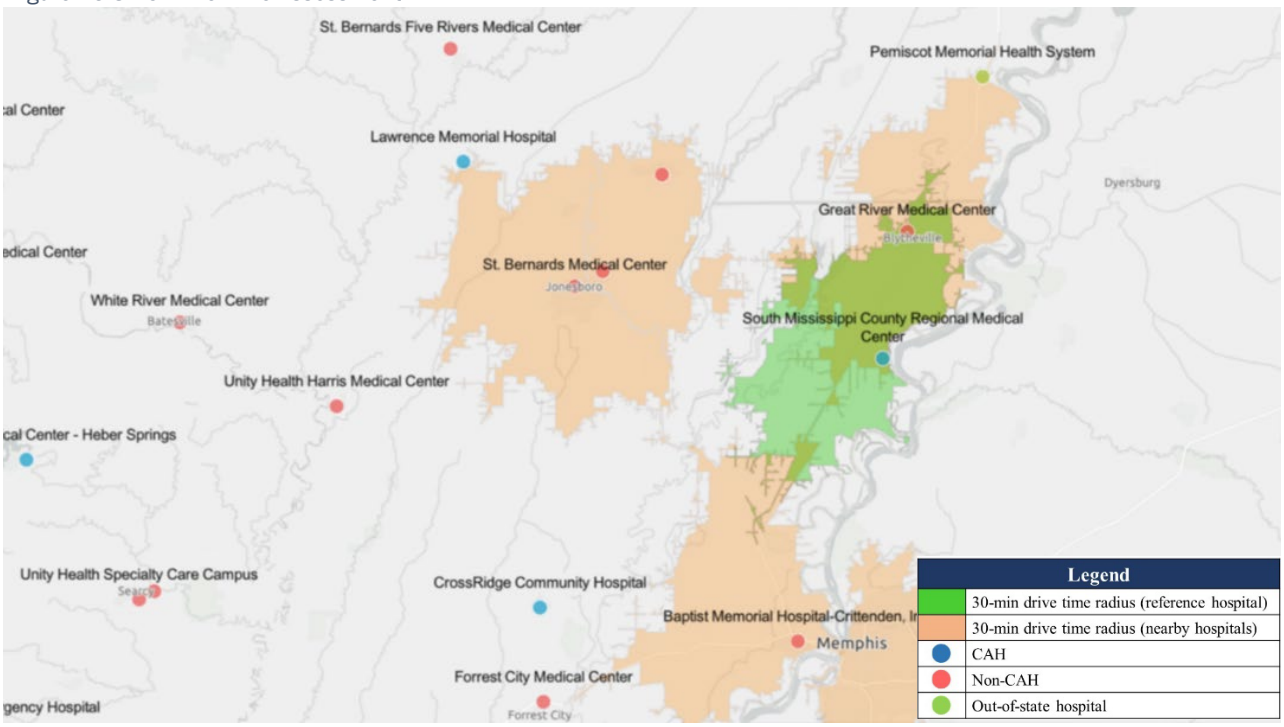
- Average age of plant is 19.1 but has longevity due to preventative maintenance
- Anesthesia machines are nearing end of life, along with the need to replace telemetry equipment, call light system, cardiac monitors and two elevators at SMC

[161] The A&M Team was not engaged in a formal Information Technology (IT) assessment across the hospital's technology stack, platforms, cybersecurity, data infrastructure and reporting. This would be considered separate work and as such, does not reflect consolidative findings captured within this report as it impacts financial budget and operations.

Drive Time Assessment - Alternatives in the Surrounding Community

Within a 30-mile radius, an estimated population of 170,616[162] resides within a 30-mile radius of SMC. The three closest alternative hospitals to SMC are on average 29 miles away: Great River Medical Center is closest at 18 miles away. St. Bernards Medical Center is second closet, at 55 miles in Jonesboro, followed by Baptist Memorial Hospital – Crittenden, Inc in Memphis, approximately 47 miles away.

Figure 25 SMC Drive Time Assessment



Observations Related to Operational Outlook

July of 2022, SMC temporarily closed their medical-surgical unit due to the lack of nursing staff needed for patient care. The unit reopened January 9th, 2023. Per management, the net inpatient revenue loss at SMC was approximately $600,000 during this period. From the limited data provided, in July 2022, SMC reported a 67% drop in admissions, 40% drop in observation, 23% drop in swing bed, 55% drop in patient days and a 55% drop in average daily census. It is unclear if this was an organic drop in patient volume or a gradual reduction in admissions (*i.e.*, diversion to other hospitals for admission) due to the upcoming med-surg closure. Prior to the closure of the inpatient units, the year-to-date (YTD) acute average length of stay in 2022 was 3.53 days. ALOS is an indicator of efficiency – if all other things are equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. SMC's ALOS is slightly under the national average of approximately 4 to 5.4 days.

The hospital is licensed with up to 25 beds. The acute average daily census (ADC) prior to the closure of the inpatient units was 3.53 for January 2022 through July 2022, and a swing bed ADC of 1.6 for the same period. For Jan 2022 through July 2022, SMC reported 195 acute inpatient discharges, and an additional 34

[162] "Hoosiers by the Numbers." Large Area Radius Tool: Hoosiers by the Numbers. Accessed April 28, 2023. https://www.hoosierdata.in.gov/big_radius/radius.asp.

swing bed discharges. Annual ER departmental visits totaled 7,647, with approximately ~95% of admissions attributed to the ER.

In lieu of the med surg closure for almost half of the year, several key metrics were not calculated, such as: Total Inpatient Discharges, Adjustment Factor, Total Adjusted Discharges, Hospital Patient Days, Average Daily Census and Occupancy Rate.

The hospital currently employs a total of 58.6 full-time employees (FTEs). Clinical FTE count was not shared with A&M. FTEs per adjusted occupied bed (also called "FTEs per adjusted ADC") cannot be calculated at Dec. 2022, given that the facility has not had any inpatient patients since July 31, 2022. Labor cost per net patient revenue was at 61.7% end of 2022, compared to 83% of trailing six months annualized. This is in line with a benchmark of 50% - 60% for rural non-CAHs.[163]

Table 127: SMC's Operational Indicators

Key Indicators - Operational Outlook	
(Calendar Year 2022)	
Total Inpatient Discharges	N/A
Adjustment Factor	N/A
Total Adjusted Discharges	N/A
Hospital Patient Days	N/A
Adjusted Patient Days	N/A
Average Daily Census	N/A
Average Length of Stay	N/A
Emergency Department Visits	7,647
Occupancy Rate	N/A
Total FTEs	59
Total CFTEs	Not Provided
Case Mix Index	1.0816 Medicare, 1.1152 for all other payors
Labor Cost / Net Patient Revenue	82.9%
FTEs per Adjusted Occupied Bed	N/A

Table 128: SMC's Balance Sheet Metrics

Balance Sheet Metrics	
(as of Feb. 2023)	
C&C Equivalents	$ 1,351,622
Inventory and Prepaid Expenses	$ 181,230
Current Assets	$ (9,552,763)
Total Assets	$ (8,360,914)
Current Liabilities	$ 3,157,793
Total Long-Term Debt	No LT Debt
Total Liabilities	$ 3,446,637
Net Position	$ (11,807,551)
Daily Expenditures	$ 27,131
Days Cash on Hand	49.8
Quick Ratio	(3.1)
Current Ratio	(3.03)
Debt Service Coverage Ratio	N/A
Average Age of Plant	19.11
Days in Net Accounts Receivable	72.87
Debt to Operating Revenue	4%

Observations Related to Current Fiscal Condition

Assessment and observations related to the current fiscal condition are based on the latest data received from hospital leadership (Feb. 2023). Based on the initial data received, A&M's on-site review, and 2023 data, SMC appears to be in a weak and declining financial condition with potential to financially improve if set on a more sustainable financial trajectory. As mentioned above, SMC's balance sheet shows a negative net position because of the line item, "Due to/from Affiliates" having a ($13.16M) balance.

Cash Position

Understanding the days cash on hand (COH) in conjunction with trends in accounts receivable (A/R) will give insight into revenue cycle management (RCM). Leadership stated repeated difficulties with collecting payments from select Medicare Advantage plans; these delays in payments result in write-offs. Days in net accounts receivable is currently at ~73 days, validating the collection challenges that were discussed by management. Days of COH is currently at ~50 days, which includes $1M in certificate of deposits.

[163] See *Figure 3: Comparison of Labor Cost to Net Patient Revenue Across Hospitals.*

Debt

Per management, there is no long-term debt shared between SMC and GRMC besides a shared Master Lease. This line of credit allows management to compare rates and secure competitive pricing on equipment or other assets. Since 2019, management has decreased capital lease obligations from $2,510,881 to $840,913 by December 2021 for a 66.5% decrease, approximately $1.67M for both GRMC and SMC - $1.24M is attributed to GRMC, $417,500 at SMC.

Revenue

There was a 43% drop in Net Patient Service Revenue (NPSR) when comparing last fiscal year to the annualized trailing six months. An increase in other revenue by ~1.68M has helped bolstered total revenue. SMC's med/surg unit was closed for six months beginning July 2022 due to the lack of nursing staff needed for patient care. Per management, net inpatient revenue loss at SMC was approximately $600,000 during this period. All but one nurse returned to SMC upon its reopening in January 2023. To fill the remaining staffing gap, SMC utilizes one traveler nurse at $90 per hour, which has a total annual cost of approximately $218,400.

In January, upon this unit's reopening, ~$95k revenue was realized for January and February. During this time, outpatient revenue remained consistent at an average of $1.7M per month.

Table 129: SMC's Income Statement Metrics

Income Statement Metrics			
	FY 22	Trailing 6 Months Annualized	Difference*
Net Patient Service Revenue (NPSR)	$ 8,483,772	$ 4,806,108	-43%
Other Revenue	56,317	1,740,910	2991%
Total Revenue	**8,540,089**	**6,547,018**	**-23%**
Salaries, Wages & Benefits (SWB) Expense	5,236,719	3,982,104	-24%
Supplies Expense	2,651,948	807,336	-70%
Other Operating Expense	2,773,827	5,099,122	84%
EBITDA	**(2,122,405)**	**(3,341,544)**	**-57%**
Depreciation Expense	209,321	192,778	-8%
Operating Income	**(2,331,726)**	**(3,534,322)**	**-52%**
Non-Operating Income (Expense)	2,917,247	1,438,518	-51%
Net Income	**585,521**	**(2,095,804)**	**-458%**
Operating Margin	-27%	-54%	-98%
NPSR / Adj Discharge		N/A	
Expense / Adj Discharge		N/A	

** Difference is calculated as the percent change from the prior to current period relative to the absolute value of the metric in the prior period*

The hospital also receives tax millage monies monthly from the County, as well as a county sales tax. The millage rate is assessed on person property and real estate in Blytheville. The millage rate is .0067. In October 2014, the voters of Mississippi County, Arkansas approved a ½ cent sales tax for the support of the Hospital System. Collection of the tax began on January 1, 2015 and will sunset after five years. The

Hospital received $2,942,282 and $2,482,741 during the years ended December 31, 2021, and 2020, respectively[164].

Expenses

A struggle to flex staff and manage costs led to the closure of certain services at the hospital (*i.e.*, Med/Surg). The hospital has recently been able to reduce its reliance on contract labor and remains focused on decreasing contract labor as part of its sustainability plan with plans to remove three more contract nurse positions by mid-April of this year. Recently, two consulting contracts and two nurse manager position duties were assigned to other staff members, with an estimated savings of $250k (shared annual of $125,000 per year for each facility). Management has also identified initiatives to reduce costs associated with high end cancer drugs.

Supplemental Funding

All COVID-related supplemental funding received by SMC has been fully received and recognized to-date based on when SMC recognized revenues. The table below summarizes the significant supplemental funding that was received.

Table 130: SMC's Supplemental Funding

Supplemental Funding for GRMC & SMC	Total Amount Received
CARES Act / Provider Relief Fund	$15,337,241
PPP Loan (forgiven in 2021)	$2,218,995
Total	**$17,556,236**

Note: Funding above represent amounts received by Mississippi County Hospital System, which includes both Great River Medical Center and SMC Regional Medical Center

Break-Even Analysis

Given the trends associated with SMC's operational outlook and fiscal condition, and the potential impact of the sustainability plan, a break-even analysis was performed to approximate the current Net Income (Loss). The below break-even analysis is based on a trailing six-month annualization of SMC's income statement. As seen in the table below, SMC's annualized FY23 net income is ($2,095,804). The currently

Table 131: SMC's Break-even Analysis

Metric	September	October	November	December	January	February	Breakeven over the last 2 quarte	12 Month Tota	18 Month Total
Net patient service revenue	$ 557,176	$ 247,033	$ 123,013	$ 332,495	$ 450,327	$ 693,010	$ 2,403,054	$ 4,806,108	7,209,162
Other Operating Revenues	869	15,326	929	351,154	494,018	8,159	870,455	1,740,910	2,611,365
Total Revenue	558,045	262,359	123,942	683,649	944,345	701,169	3,273,509	6,547,018	9,820,527
Salaries, Wages, Benefits and Payroll Taxes	322,561	345,367	326,965	376,765	325,707	293,687	1,991,052	3,982,104	5,973,156
Supplies	71,075	94,609	61,510	69,907	60,213	46,354	403,668	807,336	1,211,004
Total Operating Expenses Less D&A	831,810	934,168	682,490	767,664	801,003	927,146	4,944,281	9,888,562	14,832,843
EBITDA	**(273,765)**	**(671,809)**	**(558,548)**	**(84,015)**	**143,342**	**(225,977)**	**(1,670,772)**	**(3,341,544)**	**(5,012,316)**
Depreciation	(318)	19,329	19,329	19,329	19,329	19,391	96,389	192,778	289,167
Total Operating Expenses	831,492	953,497	701,819	786,993	820,332	946,537	5,040,670	10,081,340	15,122,010
Operating Income (Loss)	**(273,447)**	**(691,138)**	**(577,877)**	**(103,344)**	**124,013**	**(245,368)**	**(1,767,161)**	**(3,534,322)**	**(5,301,483)**
Interest Expense	(386)	(3,744)	(409)	(434)	(961)	(1,157)	(7,091)	(14,182)	(21,273)
Non-Operating Income (Expenses)	236,080	36,550	591,698	(8,392)	127,556	(7,142)	976,350	1,452,700	1,929,050
Net Income (Loss)	**$ (37,753)**	**$ (658,332)**	**$ 13,412**	**$ (112,170)**	**$ 250,608**	**$ (253,667)**	**$ (797,902)**	**$ (2,095,804)**	**$ (3,393,706)**

[164] Welch, Couch & Company, PA Certified Public Accounts *Independent Auditor's Report and Combined Financial Statements (December 31, 2021, and 2020)* Page 26

quantified sustainability plan, if all forecast expense reductions and revenue enhancements are achieved, has a potential impact of $462,080.

Capital Considerations

Management identified select equipment needs at each facility. Anesthesia machines are nearing end of life – consequently, a GE Anesthesia Machine, at $60K, is an upcoming expense. During A&M's on-site review, management highlighted the need to replace telemetry equipment, call light system, cardiac monitors, and two elevators at SMC. Anticipated budget for telemetry equipment, call light system, cardiac monitors and elevators was not provided by management.

Upcoming Obligations

GRMC and SMC share a Master Lease, which allows management to compare rates and secure competitive pricing on equipment and other assets.

Sustainability Plan

Given the revenue cycle management challenges and consistently negative operating margin described above, a strong sustainability plan is critical for SMC future viability. Management provided a sustainability plan that includes certain quantified planned expense reductions and revenue enhancements, operational initiatives across revenue cycle management and planned expansions.[165]

Table 132: SMC Sustainability Plan

South Mississippi County Sustainability Plan Summary

Sustainability Plan Summary

SMC Sustainability Plan Summary*	FINANCIAL IMPACT		
ACTION	*Action Complete*	*Action Pending*	*Total*
Revenue Enhancement:			
Improve Revenue Cycle Management: Improve collections, manage denials, identify charity care, complete registration and track pre-authorizations in efforts to reduce denied reimbursement/improve revenue.	*Impact Unknown*		
Increase 340B Retail Program: Expand into additional retail pharmacy locations	*Impact Unknown*		-
TOTAL REVENUE ENHANCEMENT IMPACT	**$ -**	**$ -**	**$ -**
Expense Reduction:			
Replace current contracts with full-time staff: Continue with current sign on bonuses for new recruits.			-
6 Travelers at SMC with an hourly range of $90/hr - $100/hr; 1 internal contract at $50-55/hr			-
Reduce Consulting Costs and Management Positions: Eliminated two consulting contracts and 2 nurse manager positions	125,000		125,000
Reduce Leadership Payroll: Combined COO role with CNO	75,000		75,000
Increase utilization of International Recruitment for key clinical staff (lab, radiology, respiratory, nursing)		262,080	262,080
TOTAL EXPENSE REDUCTION IMPACT	**$ 200,000**	**$ 262,080**	**$ 462,080**
***TOTAL IMPACT**	**$ 200,000**	**$ 262,080**	**$ 462,080**

** Management provided a consolidated sustainability plan; Although efforts were made to delineate initiatives between GRMC and SMC by the A&M team, select iniatives may overlap in between facilities.*

*** Estimated improved reimbursement is 400-500k; unclear if it's one-time or annual*

Revenue cycle management is centralized into one business unit, which means that these initiatives are consistent across GRMC and SMC. Although the sustainability plan does not call out any quantified anticipated savings along its RCM strategy, management provided the following details around focused areas to improve:

- **Launch of Experian to utilize pre-authorization (PA) module, eligibility, and discovery**: Scheduled to kick early June, this new tool will improve the PA process by consolidating authorizations in one central system. It also provides real-time eligibility for secondary and tertiary insurance.

[165] A&M makes no representation or warranty as to the accuracy or reliability of the future financial or operational performance discussed in any of the Hospitals' sustainability plans.

- **Improve up-front collections***:* Increase utilization of patient portal and educate patient population on the ability to pay via our portal and other options, cash, check, card etc. With the purchase of the Experian product, staff will be able to verify real-time patient insurance information, such as deductible and copays at point of entry and during pre-registration. GRMC and SMC will be able to expand financial counseling and payment options.
- **Improve Registration Process***:* To ensure that the demographics are correct, and documentation are obtained at point of registration, audits will be completion will be done monthly and added to the patient access manager's performance improvement plan for compliance.
- **Identify Need for Charity Care**: Through the new upfront collection process, management aims to identify patients that could qualify for financial assistance earlier in the process.
- **Denials Management***:* As more payers are converted to electronic EOBs, staff will be able to better assess the details of denials.
- **Improve Accounts Payable (AP) Process:** CFO and accounting team and other financial team members will review processes and have regular meetings to identify issues and develop action plans to improve processes. This is in efforts to improve accuracy of data and keep accrual process timely and more accurate.
- **Establish Standardized Data Reporting and Analytics:** Management hopes to foster a team approach in the Financial Department that involves all managers. It hopes to educate them on the importance of their personal and departmental role and how it impacts finances (*e.g.*, PO's, Charges, documentation etc.)

Revenue Expansion:

- **Forecast Local Job Growth**: Management plans to try to meet with current industries to educate them on the need for viable hospitals in the county and the industrial base. 3,200 jobs are forecast to be added in Mississippi county due to the expansion of steel industries within the area. Although these jobs are not forecast to be hired for until 2024, they are likely to result in a positive revenue impact for both facilities should this forecast become reality.
- **Expand Retail Pharmacy Locations**: In 2022, management enrolled with two Walmart's, one Kroger and two specialty pharmacies. Management is working with Verity to identify other viable contracts for 2023.

Expense Reduction:

- **Recruitment of Full-Time Staff:** Management plans to replace current contracts with full-time staff, as well as continue with current sign-on bonuses for new recruits.
- **Increase Utilization of International Recruitment**: Management plans to replace five current ($218,400 per year) contracts with full-time hospital staff (at $87,360 a year); this results in an anticipated savings of $262,080 annually
- **Retention of Staff** Continue to maintain current staff while recruiting full-time staff. Management is working on internal contract pricing (which is approximately half the price of traveler cost) as well as routinely evaluating needs with departmental directors
- **Reduce Consult Costs and Management Positions:** Management canceled two outside service consulting contracts and eliminated two Nurse Manager positions duties assigned to other staff

members already at hospital. Anticipated annual savings are $250,000 with shared cost of $125,000 per year for each facility.

- **Reduce Administrative Team:** Combined COO role with CNO while transitioning current COO to existing CFO role. Departments will be aligned by remaining Administrative Team. This is estimated for a savings of $150,000 with a shared cost of $75,000 a year at each facility.

Recruitment and Retention

- As part of their sustainability plan, GRMC is in the progress of setting up a residency program with New York Institute of Technology (NYIT)'s Doctor of Osteopathic Medicine (D.O.) Program and Arkansas State University. The D.O. Program is interested in increasing residency spots – recently, they expressed that there may be funding assistance that would make the program available with no cost to the facility. Management believes this could generate additional revenue to SMC and GRMC without additional cost, with the potential to also support future physician recruitment.
- Management continues recruitment of full-time nursing staff with Arkansas Northeastern College.
- Management continues engagement with a global staffing organization for international candidates.

Appendix A

Data Request Items Requested from Hospitals

Data in the following core areas was requested from each hospital to conduct the initial data analysis and develop a hospital profile prior to the on-site review:

1. *General Statistics* consisted of demographic information and operational statistics, providing a strategic lens to assess a site's operational environment and physical location. Demographics included the site's Address, County, Total Licensed Beds, Hospital Ownership (Private vs County), and Site Mapping which included a calculation of the nearest comparable facility. Operational statistics including Total Inpatient Discharges, an Adjustment Factor, Total Adjusted Discharges, Hospital Patient Days, Adjusted Patient Days, Average Daily Census, Average Length of Stay, Emergency Department Visits, Occupancy Rates, Total Full-Time Employees (FTEs) vs Total Clinical FTEs, along with Case Mix Index (if relevant) and FTEs per each Adjusted Occupied Bed.
2. *Balance Sheet Metrics* summarized a site's business assets, liabilities, and owner's equity, providing a snapshot of the facility's financial position at a given point in time. Metrics included Cash & Cash Equivalents, Net Accounts Receivable, Inventory/Supplies, Prepaid Expenses and Other, Prepaid Expenses & Other, Current Assets, Total Assets, Current Liabilities, Total Long-Term Debt, Total Liabilities, Net Position, Daily Expenditures, Days Cash on Hand, Quick Ratio, Current Ratio, Debt Service.
3. *Payer Breakdown* provided a percentage breakdown of payers by coverage type. A higher proportion of patients at rural hospitals are insured by Medicare and Medicaid than at urban hospitals. While having a high proportion of Medicare patients would be viewed as financially problematic at large hospitals, for many small rural hospitals, Medicare is the "best" payer because it explicitly pays more to cover the higher costs of care in rural hospitals classified as Critical Access Hospitals.[166]
4. *Sustainability Plan* captured a snapshot of future expense reductions and revenue to ensure sustainability remains a prioritized item. A&M evaluated the feasibility and likely impact of each facility's sustainability plan, with a focus on the following critical components of hospital sustainability:
    - Revenue enhancement, which could include a site's expansion of services, staff recruitment, or reimbursement level increases.
    - Expense reduction, which could include efforts included future cost elimination efforts, contract renegotiations, and reduction in service lines/sites and staffing.[167]
    - Improvements in revenue cycle management, from the very first patient interaction to the final payment.
    - The ability to operate profitably without one-time payments.
    - On-going efforts to increase patient volumes and decrease labor costs.
5. *Income Statement Metrics* provides a revenue and expense breakdown, including EBITDA Margin percentage and Operating Margin percentage, NPSR and expenses by adjusted discharge, NPSR

[166] *Payment and Delivery in Rural Hospitals* American Medical Association. 2021 https://www.ama-assn.org/system/files/issue-brief-rural-hospital.pdf

[167] Gleißner, W., Günther, T. & Walkshäusl, C. Financial sustainability: measurement and empirical evidence. J Bus Econ 92, 467–516 (2022). https://doi.org/10.1007/s11573-022-01081-0

and Total Expense by FTE, a break-even analysis, known payment obligations and reported supplemental funding (such as grants).

6. *Quality Indicators/Other* captures overall CMS Star Rating, Patient Satisfaction Score and Readmit-Hospital Wide 30 Day Readmit Rate as reported by Franklin BI.

Appendix B

On-Site Review Meeting Structure and Topics

On-site reviews at each hospital contained the following structure and topics:

- Over a 2–3-hour conversation with CEO and CFO, the A&M team reviewed data synthesized to date, any deviations from the current data over recent months, revenue cycle management and forecast changes in revenue, market share trends/forecasts, changes in services (addition/closure of clinics, service lines etc.) and sustainability plans options for improving revenue.
    - A&M validated Days Cash on Hand, Quick Ratio, Days in Net A/R, and other key data metrics with leadership, noted deviations from calculations and/or other anomalies.
    - Strategic business partnerships (such as mergers/acquisitions) were also discussed, if needed, as select hospitals deliberated partnerships with local health systems as part of their sustainability.
    - Hospitals were also asked if a Rural Emergency Hospital (REH) designation was appropriate and/or considered by leadership.
- With clinical leadership and HR, the A&M team discussed clinical staffing (full-time vs contract vs affiliated, % of registry staff), retention, recruitment efforts along with patient care, nurse to patient ratios, common diagnosis, staff culture, referral networks, sources of admissions and staff tenure.
- A&M addressed technical, data and security matters with the CIO (or equivalent director), with timely topics such as cybersecurity, data breaches, system conversions, risk assessments, staff preparedness, project pipeline and staff training.
- Through the on-site facility walk-through, A&M team and plant management walked through the facility in its entirety, scoping areas of deferred maintenance and possible future funding needs.