STROUDWATER

STRATEGIC, FINANCIAL AND OPERATIONAL ASSESSMENT

Nevada Regional Medical Center

Interviews Conducted: February 20-22, 2024
Preliminary Report: March 29, 2024
Final Report:

Eric Shell, MBA, CPA
Cameron Smith, MBA, CPHQ

OVERVIEW

- Nevada Regional Medical Center (NRMC) is a 71-bed, city-owned, short-term acute care hospital, providing acute care, swing bed, emergency medicine, labor & delivery, imaging, laboratory, rehabilitation, respiratory therapy, infusion, and related ancillary services to the residents of Nevada, Missouri, and surrounding communities. In addition to the services listed above, NRMC also operates four Rural Health Clinics (RHCs), two specialty clinics, and one additional clinic located throughout the service area
  - NRMC provides labor & delivery, as well as pre- and post-natal care, via three Family Practice/Obstetric (FP-OB) providers and one OB/GYN provider (OB/GYN only performs cesarean sections); this arrangement is instrumental to the overall success of NRMC since NRMC is one of the only birthing centers within a 60-mile radius; reported that efforts are underway to recruit an additional two FP-OBs
  - Additionally, 30 of NRMC's beds belong to their Inpatient Psychiatric Facility (IPF) which provides geriatric and adult psychiatric care to residents throughout east-central Missouri
- NRMC's operating margin was negative between FY 18 and FY 23 with annualized projections for FY 24 indicating a further decreasing operating margin as well as a declining EBITDA which indicates declining financial performance
  - A significant influx of cash is required to allow for growth oriented strategies to increase revenue and volumes
- Days cash on hand (DCOH) increased significantly from 9 days in FY 18 to 190 days in FY 20 due to receipt of approximately $13.0M in relief funding related to the COVID-19 pandemic
  - DCOH subsequently decreased to 1 in FY 24 due to use of COVID-19 relief funding to respond to the demands of the pandemic, significant negative cash flows from operations, payback of Medicare advance payments, and repayments of debt service and DSH payments
- Due to not meeting bond covenant requirements, NRMC bondholders engaged Stroudwater Associates to perform a Strategic, Financial, and Operational Assessment (SFOA) to serve as a complement to the two prior consultant reports that were prepared in FY 2022 and FY 2023 to further guide NRMC leadership on the efforts to improve NRMC's financial performance
  - Stroudwater Associates has been engaged by Build America Mutual (BAM) to conduct the SFOA report

AFFORDABLE CARE ACT (ACA) AND THE EVOLVING PAYMENT SYSTEM

- The Affordable Care Act (ACA) was passed in 2010 and upheld by the U.S. Supreme Court in 2012, 2015, and 2021; despite multiple attempts at repeal, the ACA remains largely intact, and the healthcare system overall remains headed in the direction of value-based reimbursement and population health
  - With most significant provisions, such as payment, insurance, and delivery-system reforms currently being implemented, the healthcare industry is moving to address future market changes including:
    - Payment systems transitioning from volume-based to value- and population-based
    - Quality/patient safety as new drivers of hospital market share
    - Payment cuts that are real, forcing increased efficiency
- Regardless of shifts in government power, rural hospitals and providers must position themselves for the new market-based competitive environment through the pursuit of strategies that consider the delivery system and payment system transition towards population-based payment which includes, but is not limited to the following:
  - Sound financial and operational management
  - Adoption of technology
  - Pursuit of high-quality care
  - Alignment with primary care providers
  - Development of future alignment strategies
- Recommendations in this report are made in the context of best positioning NRMC for the rapidly evolving healthcare market

PROJECT OVERVIEW

ENGAGEMENT PURPOSE

Overview

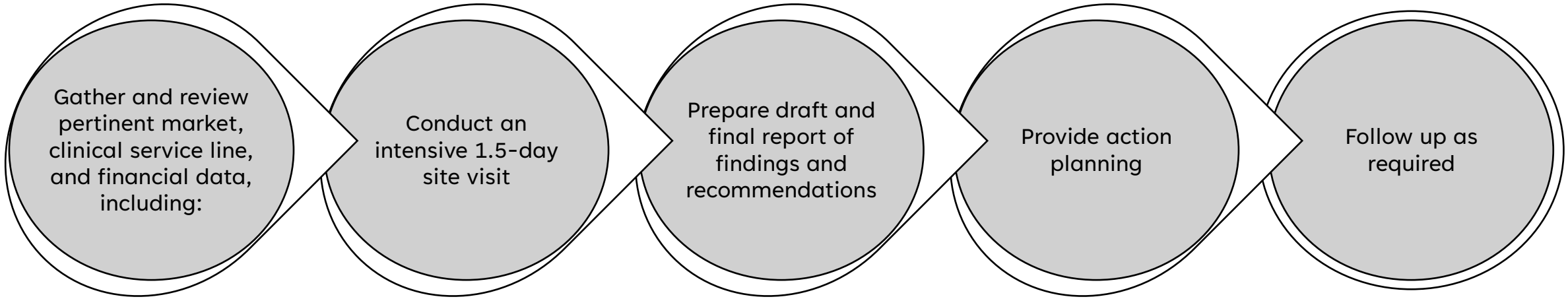
- NRMC's bondholders engaged Stroudwater to improve the financial performance of NRMC, specifically focusing on:
  - Answering financial, operational, and industry-specific questions presented by administration
  - Identifying top opportunities that will result in improved financial and operating performance
  - Best-position NRMC for success in the rapidly evolving healthcare market, including new payment and delivery care models, and promoting value within a population health management system

Purpose

- To identify performance-improvement opportunities that will result in increased financial stability, with areas to address including:
  - Evaluation of historic/potential demand for clinical services
  - Identification of opportunities to appropriately address clinical service line gaps
  - Reimbursement and cash flow with emphasis on selected service lines
  - Physician practice management
  - Hospital expense analysis
  - Organizational architecture and management principles
  - Strategic direction

*Please note that this report was based on our determination of the highest value opportunities for NRMC as identified during the site visit. Additional opportunities may exist for performance improvement that were not reported or detected during the visit.

ENGAGEMENT METHODOLOGY



- Detailed inpatient utilization data
- Detailed outpatient utilization data for all outpatient revenue centers (e.g., rehab, lab, radiology, etc.)
- Recently-filed Medicare cost report
- Latest provider statistical and reimbursement reports
- Historical and most recent audited financial statements
- Financial and utilization (inpatient and outpatient) projections

- Interviews with CEO, CFO, CNO, COO, medical staff, selected department managers/directors, and members of the hospital board
- Preview findings and preliminary recommendations before virtual site visit departure

FINANCIAL SUMMARY

Profit & Loss
Financial Analysis
Conclusions

FINANCIAL STATEMENTS

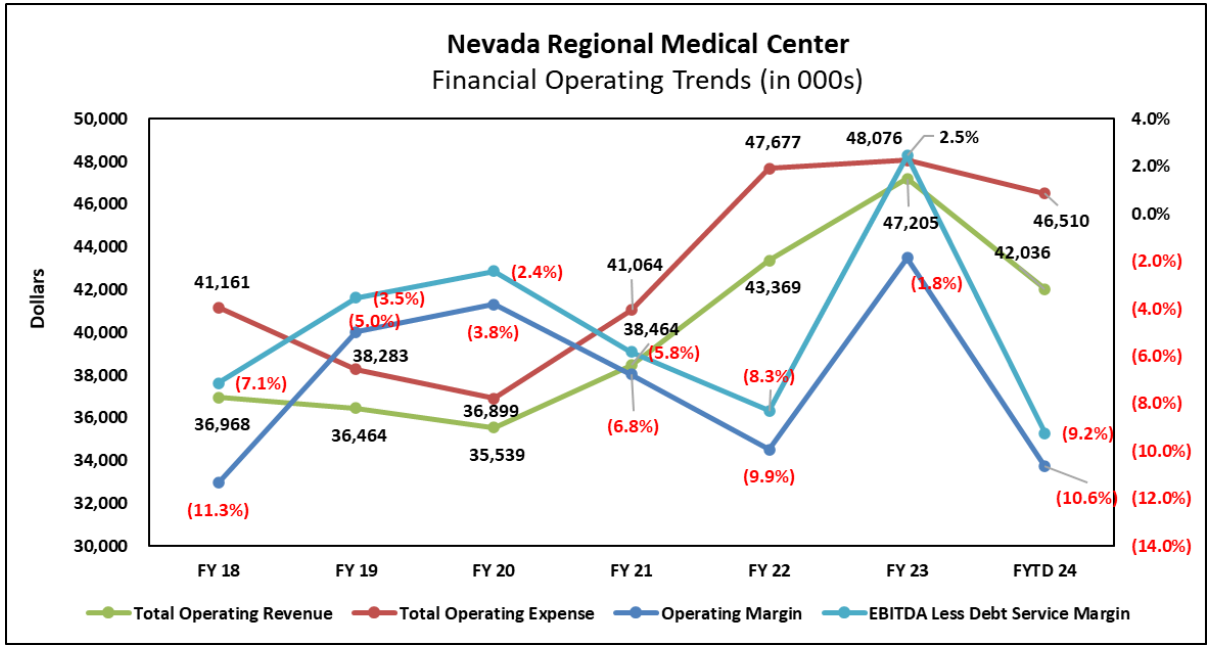
- The following provides a high-level overview of financial performance from FY 19 to annualized FY 24
  - FY 23 and annualized FY 24 figures are based on unaudited financial statements
  - Annualized FY 24 figures are summarized based on operational data provided by NRMC
  - Dollars are presented in thousands (000's)
- Financial trends over the measured period include:
  - 27% increase in total operating revenue with a 17% increase in Net Patient Services Revenue
  - Growth in other operating revenue driven primarily by 340B revenue and sales tax revenue
  - 16.8% growth in total operating expenses (33% growth in other professional services between FY 18 and FY 23)
  - Negative operating margin in all years including annualized FY 24 (see Profitability Analysis for additional detail)
  - Growth in total non-operating income, particularly FY 21 and FY 22 due to the recognition of COVID-19 relief funding
  - Growth in cash from FY 18 to FY 20 driven by COVID-19 relief funding, followed by significant declines from FY 21 to FYTD 24 due to repayment of Medicare advance payments, negative cash flow from operations, use of funds to respond to the COVID-19 pandemic, and paybacks related to debt service and DSH payments (see Liquidity Analysis for additional detail)
- These trends have been analyzed in the financial section of this report

Neveda Regional Medical Center Dollars are presented in 000's	FY 18 Audited 6/29/2019	FY 19 Audited 6/30/2019	FY 20 Audited 6/30/2020	FY 21 Audited 6/30/2021	FY 22 Audited 6/30/2022	FY 23 Unaudited 6/30/2023	FYTD 24 Annualized 6/30/2024
Operating Revenue:							
Gross Patient Revenue	$ 99,622	$ 99,757	$ 101,236	$ 114,408	$ 121,108	$ 125,033	$ 116,385
Contractual Allowances	(55,377)	(56,197)	(58,381)	(68,971)	(72,352)	(72,594)	(70,322)
Charity Care	(3,317)	(2,354)	(3,106)	(2,811)	(2,043)	(3,179)	(374)
Bad Debt	(4,772)	(5,950)	(5,872)	(6,790)	(5,984)	(4,359)	(7,763)
Net Patient Revenue	36,156	35,257	33,877	35,836	40,729	42,411	37,926
Other Operating Revenue							
340B	428	933	1,200	1,288	1,225	2,755	-
Sales Tax	-	-	164	918	978	1,054	-
Other revenue	385	274	297	422	436	985	4,110
Total Operating Revenue	36,968	36,464	35,539	38,464	43,369	47,205	42,036
Operating Expenses:							
Nursing Services	8,326	7,539	7,617	8,821	9,897	8,820	-
Administrative Services	11,783	11,432	10,872	10,140	12,299	12,288	-
General Services	2,681	2,575	2,768	3,325	3,144	2,976	-
Other Prof Services	15,161	14,550	13,482	16,712	19,801	20,180	-
Interest expense	806	769	737	724	570	834	551
Depreciation and amortization	2,404	1,419	1,423	1,344	1,966	2,977	1,809
Total Operating Expense	41,161	38,283	36,899	41,064	47,677	48,076	46,510
Income (Loss) from Operations	(4,193)	(1,819)	(1,360)	(2,600)	(4,309)	(871)	(4,474)
Add-Back: Depreciation and Amortization	2,404	1,419	1,423	1,344	1,966	2,977	1,809
Add-Back: Interest	806	769	737	724	570	834	551
Less: Debt Service	(1,656)	(1,656)	(1,656)	(1,706)	(1,827)	(1,778)	(1,770)
EBIDTA Less Debt Service	(2,639)	(1,287)	(855)	(2,238)	(3,600)	1,162	(3,884)
Investment return	(6)	73	46	28	29	73	-
Other			353	(262)	(36)	66	-
Donations	76	75	66	195	10	83	-
Provider Relief Funds/PPP				9,842	5,668	-	-
Total Non-Operating Income (Expense)	70	148	464	9,803	5,671	222	1,336
Increase (Decrease) in Net Position	(4,123)	(1,671)	(895)	7,203	1,362	(649)	(3,138)
Cash and Investments, End of Period**	$ 948	$ 1,367	$ 17,790	$ 15,189	$ 7,533	$ 2,579	$ 177
AP and Accrued Liabilities	$ 4,790	$ 5,284	$ 18,465	$ 8,412	$ 6,588	$ 6,029	$ 9,156
Days of Operating Cash Available	9	14	183	140	60	21	1
Average Payment Period	45	52	190	77	53	49	75
Days in Net Accounts Receivable	50	48	48	41	40	37	63
Net AR	$ 4,926	$ 4,676	$ 4,413	$ 4,027	$ 4,503	$ 4,279	$ 6,578
Operating Margin	(11.3%)	(5.0%)	(3.8%)	(6.8%)	(9.9%)	(1.8%)	(10.6%)
EBITDA Less Debt Service Margin	(7.1%)	(3.5%)	(2.4%)	(5.8%)	(8.3%)	2.5%	(9.2%)

**Includes board designated funds

PROFITABILITY ANALYSIS

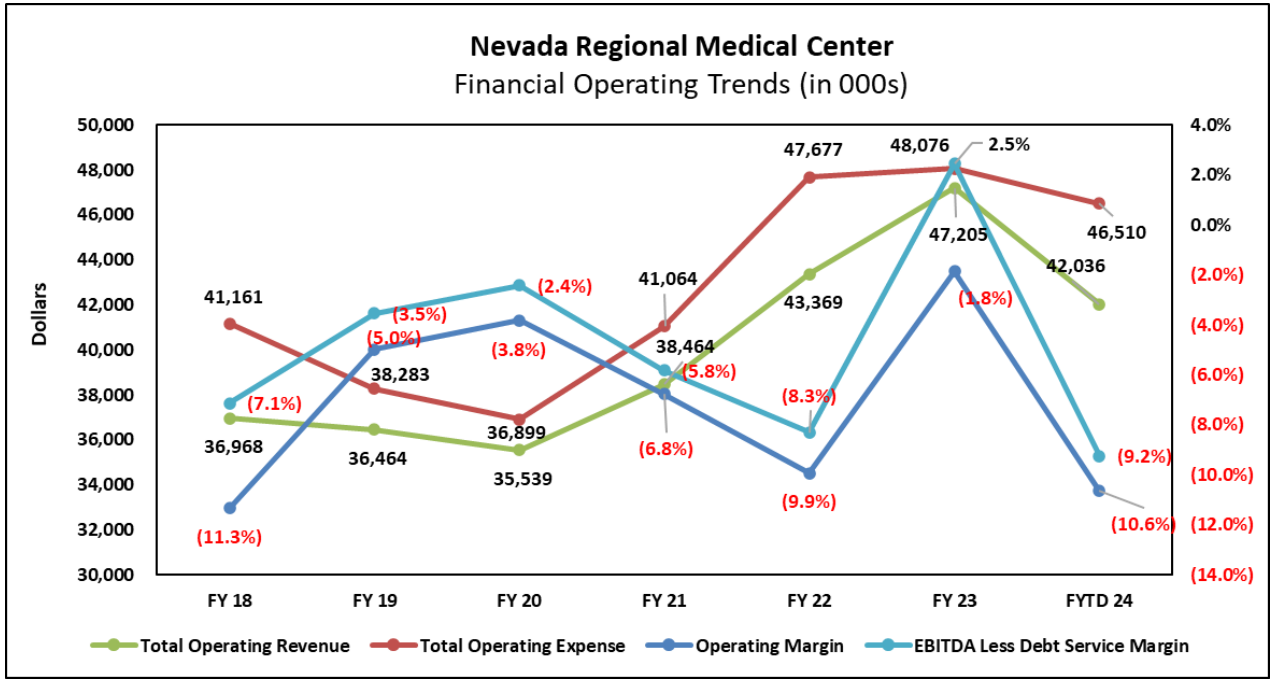
- **Operating revenue** increased 13.7% from FY 18 to annualized FY 24 primarily due to growth in clinic and surgery volumes, as well as revenue growth from 340B proceeds and a recently implemented city sales tax
  - Clinic volume growth was largely due to expanded services, expansion of clinic locations which included acquisition of Nevada Medical Clinic in FY 22 as well as investments made to increase access to providers for patients
- **Operating expense** increased 12.7% from FY 18 to annualized FY 24 primarily due to labor shortages, resulting in an increased reliance on costly agency staffing, costly ED provider coverage, and continued facilities maintenance cost generated by an aging facility



- Operating expenses increased 33% within the “other professional services” line item which is largely attributed to the cost of professional fees to cover the Emergency Department and the cost of agency staff
- In response to the increasing operating expenses, management led efforts to significantly reduce expenses by changing EMRs, a reduction in force (RIF), reducing agency staffing, and reviewing professional service contracts to optimize value for NRMC
- Due to a significant focus on operating expenses, NRMC leadership was able to reduce expenses below operating revenue for annualized FY 24; however, a focus solely on operational expenses will not position NRMC to thrive in the Future of Rural Healthcare
  - Best practice peer rural hospitals focus on growth of volume and enhanced reimbursement, otherwise known as abundance, to carry operations forward rather than focusing solely on the reduction of expenses

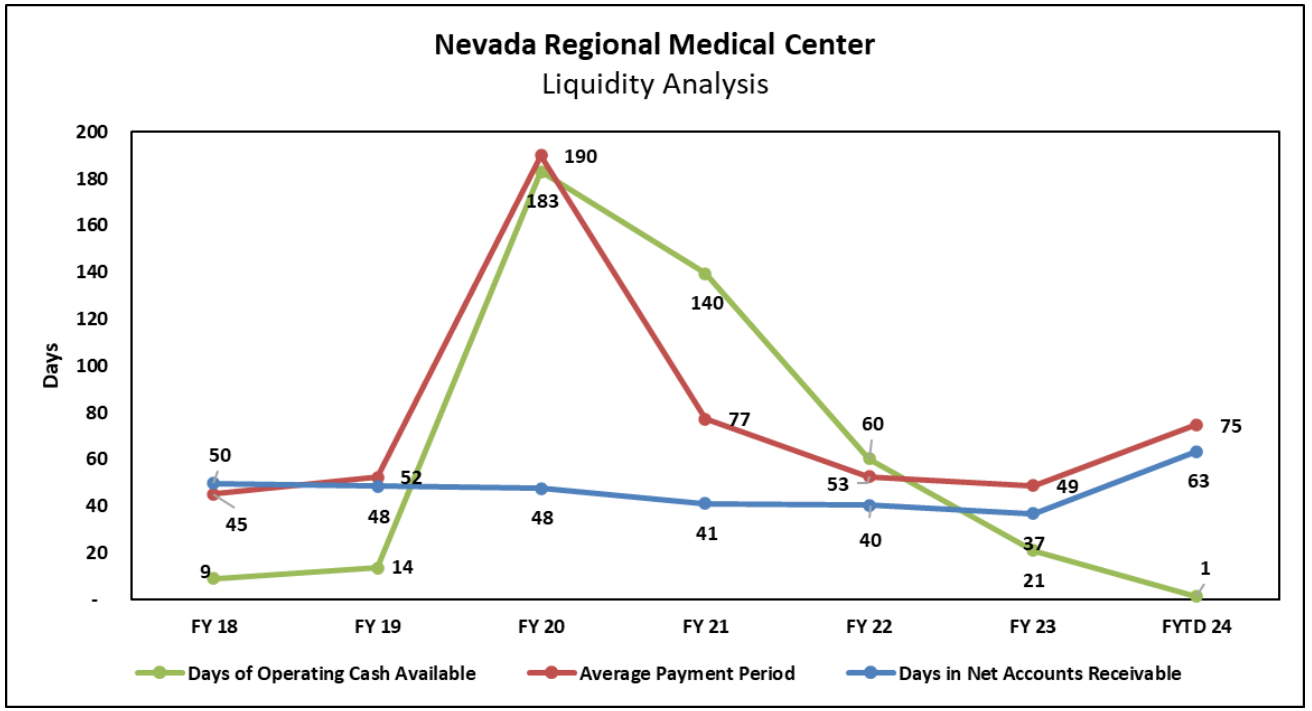
PROFITABILITY ANALYSIS

- **Operating margin** was negative between FY 18 and FY 23 and is continuing to decline into annualized FY 24
  - Operating margin increased initially from a low point of **(11.3%)** in FY 18 to **(3.8%)** in FY 20 due to increased volumes from the COVID-19 pandemic but subsequently fell to **(9.9%)** in FY 22
  - Between FY 22, operating margin improved considerably, growing from **(9.9%)** in FY 22 to **(1.8%)** in FY 23; however, into annualized FY 24 show a significant decline in operating margin
- **Earnings before Interest, Taxes, Depreciation and Amortization (EBITDA) less debt service** is a way to assess financial performance with consideration to an increase in non-cash depreciation expense
  - NRMC's financial performance is declining with a substantial change from **(7.1%)** in FY 18 to **(10.6%)** in annualized FY 24



LIQUIDITY ANALYSIS

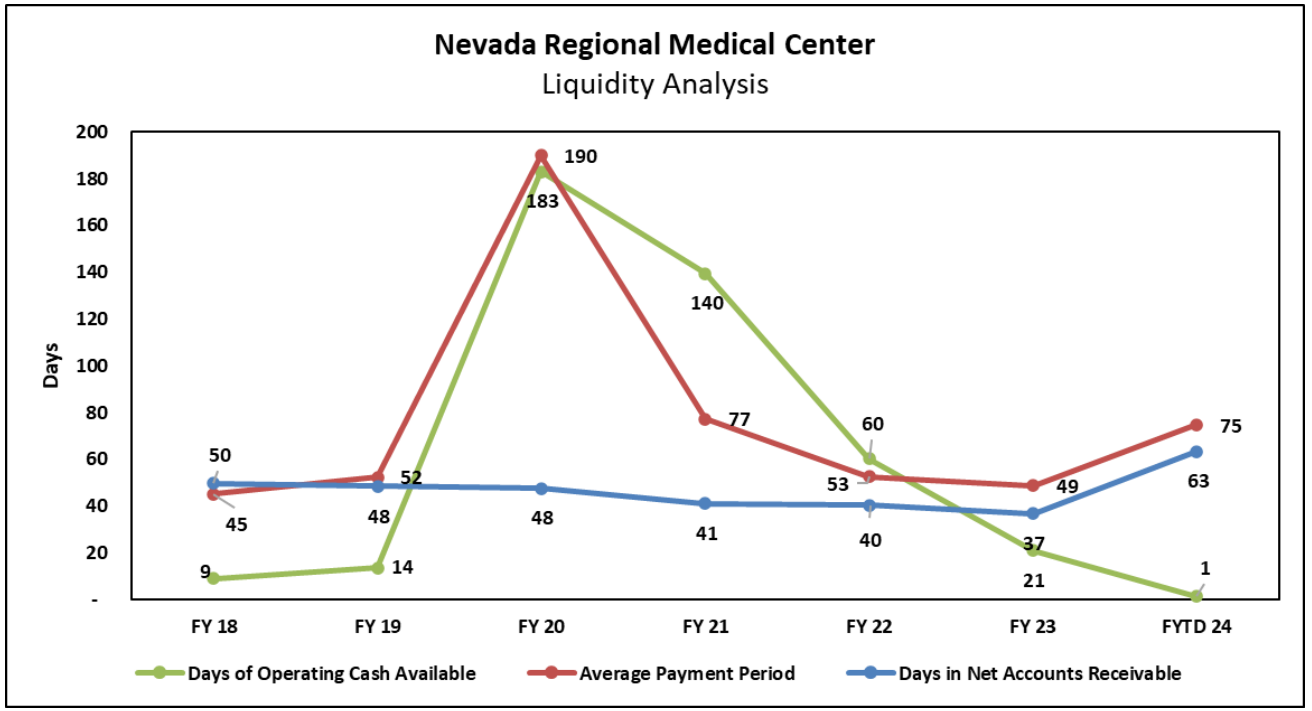
- **Days cash on hand (DCOH)** increased significantly from 9 days in FY 18 to 190 days in FY 20 due to receipt of approximately $13.0M in relief funding related to the COVID-19 pandemic
  - DCOH subsequently decreased to 1 in FY 24 due to use of COVID-19 relief funding to respond to the demands of the pandemic, significant negative cash flows from operations, payback of Medicare advance payments, and repayments of debt service and DSH
  - NRMC experienced a decrease in operating cash of approximately $7M in FY 22, $5.0M in FY 23, and $2.4M in FY 23; an infusion in cash would allow NRMC to focus on continued operational improvement and assist leadership in continuing to improve NRMC's overall financial position



- **Average payment period (APP)** increased from 45 in FY 18 to 183 in FY 20 due to an increase in COVID-19 funding liabilities on the balance sheet
  - The APP subsequently decreased to 49 in FY 23 primarily due to recognition and/ or repayment of COVID-19 relief funding in FY 21 & FY 22 but subsequently increased in FY 24 to 75 days primarily due to NRMC's unfavorable cash position, forcing NRMC to begin deferring payments on bills

LIQUIDITY ANALYSIS

- **Days in net A/R** declined steadily between FY 18 and FY 23 from 50 days to 37 days but increased in FY 24 to 63 days due to constraints within the revenue cycle generated by the new EMR system and no bills currently being written off
  - Best practice peer rural hospitals target a days in net AR of fewer than 45 days



FINANCIAL STATEMENT CONCLUSIONS

- **Findings and Analysis**
  - NRMC's operating margin was negative between FY 18 and FY 23 and is projected to be negative for annualized FY 24 with no further significant opportunities for reduction of expenses, indicating growth is required to improve operating margin
  - Overall DCOH increased significantly from 9 days in FY 18 to 190 days in FY 20 due to receipt of approximately $13.0M in relief funding related to the COVID-19 pandemic
    - DCOH subsequently decreased to 1 in FY 24 due to the use of COVID-19 relief funding to respond to the demands of the pandemic, significant negative cash flows from operations, payback of Medicare advance payments, and payments to reduce overall organizational debt
  - Days in net A/R decreased slightly between FY 18 at 50 days to 37 days in FY 23 but subsequently increased to 63 days due to changes in EMR impacting the revenue cycle and lack of writing off bills, leaving them to accrue on the balance sheet
    - Before the recent increase, NRMC was within the best practice benchmark of days in Net AR being lower than 45 days
  - NRMC leadership has made substantial progress in improving NRMC's financial position, both from a profitability and liquidity perspective; however, without a substantial influx of cash, NRMC will be limited in its ability to invest in operations and grow services

FINANCIAL STATEMENT CONCLUSIONS

- **Findings and Analysis (cont.)**
  - Stroudwater has developed a two-pronged approach for a financial turnaround
  - **Liquidity**
    - The first and most critical area to address is NRMC's deteriorating cash position; to address this, NRMC has multiple options
      - Request the City's approval and execution of a forbearance agreement from the City council which includes a subordinate loan provided by Build America Mutual (BAM) upwards of $1.2M in which $800K can be accessed immediately and an additional $400K can be accessed at BAM's discretion provided NRMC's financial performance is improving; this will provide organizational liquidity to NRMC to allow focus on investment and growth
        - In addition to BAM's willingness to provide a subordinate loan, the county is providing funding via an APRA grant to NRMC
        - If feasible, seek a $1M line of credit or another source of funding from the City of Nevada that is contingent on the establishment of a quantifiable turnaround plan or pledge of future sales tax revenue; given the economic impact of the hospital on the city, there is a shared incentive for the success of the hospital
      - NRMC is anticipating between $1.6M-$2.8M in FEMA reimbursement; NRMC leadership should work with state and federal agencies to expedite the process of getting the FEMA funding reimbursed

FINANCIAL STATEMENT CONCLUSIONS

- **Findings and Analysis (cont.)**
  - **Medium/Long-Term Financial Sustainability (cont.) Medium/Long-Term Financial Sustainability**
  - Listed below are several of the most impactful financial opportunities for NRMC to address, which will complement efforts already taken and currently underway by NRMC management to improve financial performance
    - Service growth strategy – One key component of the strategic plan is the growth strategy for both inpatient and outpatient services; there is an opportunity to look into the growth potential of volumes for NRMC, assess the market, and seek to grow volumes based on this analysis
    - Opportunities include expansion into the Fort Scott market, growth within surgical services, and improving community experience within the ED in addition to other recommendations listed throughout this report
      - Under the current payment system, generally the best way for a rural hospital to become more efficient and improve financial performance is to grow volumes as opposed to fixating on expense reductions; therefore, the growth strategy is a key input to organizational strategic planning
    - Measurement culture – NRMC could increase the use of measurement to drive organizational effectiveness
    - Point-of-service (POS) collections – reported that NRMC does not have consistent POS collections, creating a significant opportunity to develop a consistent process
    - Third-party contracts – there are several concerns around third-party payers' reimbursement; there is an opportunity to inventory NRMC's third-party payer contracts, compare reimbursement to cost and Medicare, and understand the implications of other areas such as the chargemaster on how NRMC is paid
    - Management accounting – managers currently have limited involvement in budgeting, financial reporting and variance analysis; departmental manager involvement is considered best practice, and there is an opportunity to implement this structure
    - Capital investments – NRMC has opportunities to invest in capital to improve the overall employee and patient experience, which will drive increased volumes
    - Seek to increase Nevada City sales tax proceeds from ½ a percent to 1% and expand the tax to the county of Nevada

FINANCIAL STATEMENT CONCLUSIONS

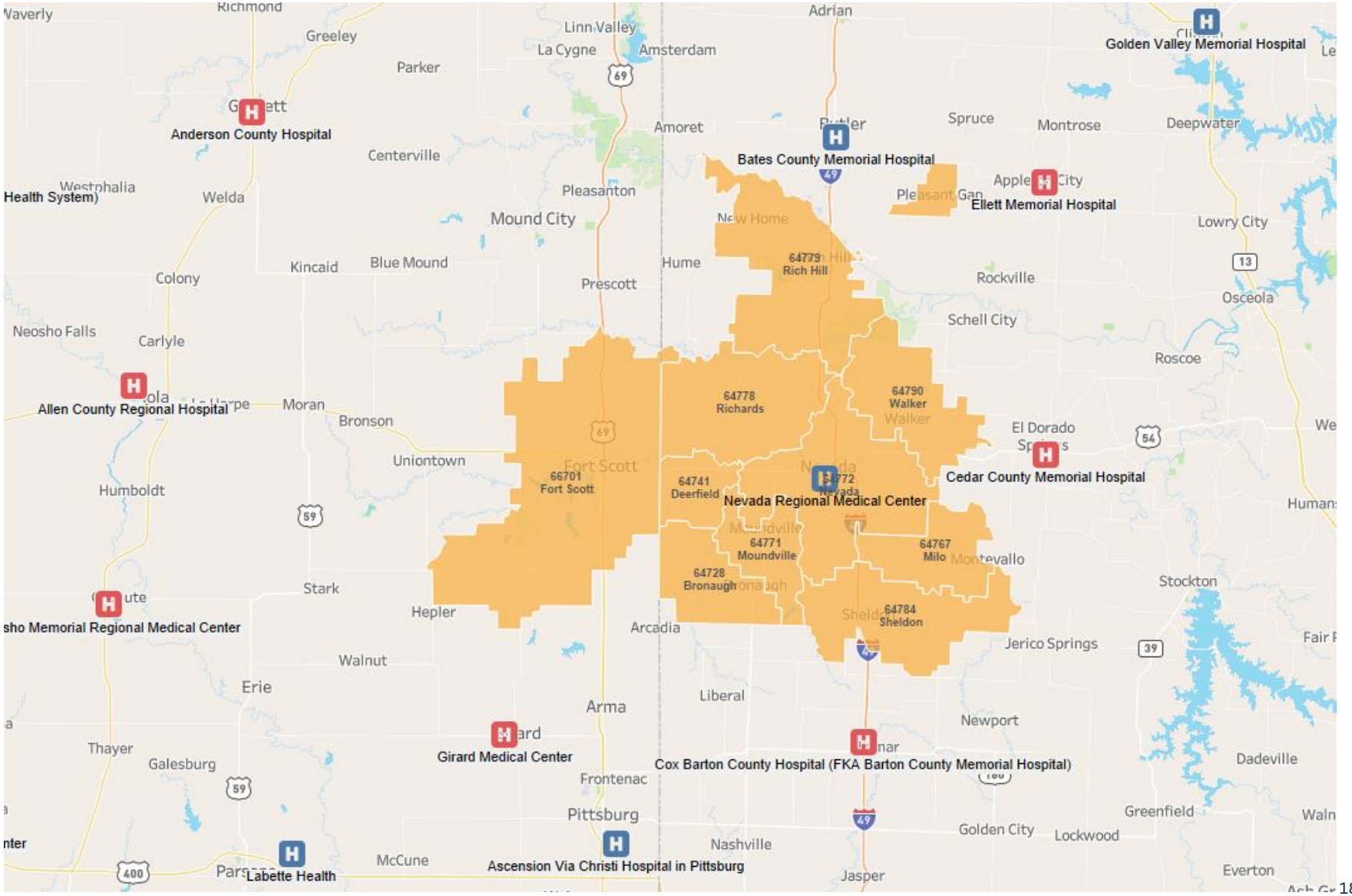
- **Recommendations**
  - NRMC should consider the recommendations below to act as complements to efforts already underway to improve financial performance as well as prior consultant reports that detail opportunities for NRMC
    - Work with the city of Nevada to agree to execute a forbearance agreement which includes the subordinate loans to increase immediate cash flow
      - Work to secure a $1M line of credit from the city to act as a financial stimulus to allow NRMC to focus on growth
    - Work with BAM and bondholders to provide solutions for necessary short-term liquidity in addition to a city-backed line of credit
    - Consistently follow up with FEMA for payment of funds
    - Work with the city and county to expand the sales tax to 1% and include the full county rather than just the city of Nevada
    - Revenue cycle improvement, including, but not limited to, continued expansion of a measurement culture through the reimplementation of a KPI dashboard, improvement of consistency regarding POS collection, and maintaining third-party contracts (see Revenue Cycle)
    - Focus on engaging managers in service growth and participation in budget preparation (see Management Accounting)
    - Development of an inpatient and outpatient growth strategy that includes the communities of Fort Scott and Deerfield as strategic priorities for the organization
    - Strategic investment in capital to ensure the highest quality patient care is delivered

SERVICE AREA

SERVICE AREA OVERVIEW

Nevada Regional Medical Center's Primary Service Area (PSA) is comprised of 10 ZIP codes.

The service area was derived by looking at ZIP codes where Nevada Regional Medical Center had 10% or better Medicare market share in 2022 OR had a significant amount of Medicare cases for FY2021 or FY2022.

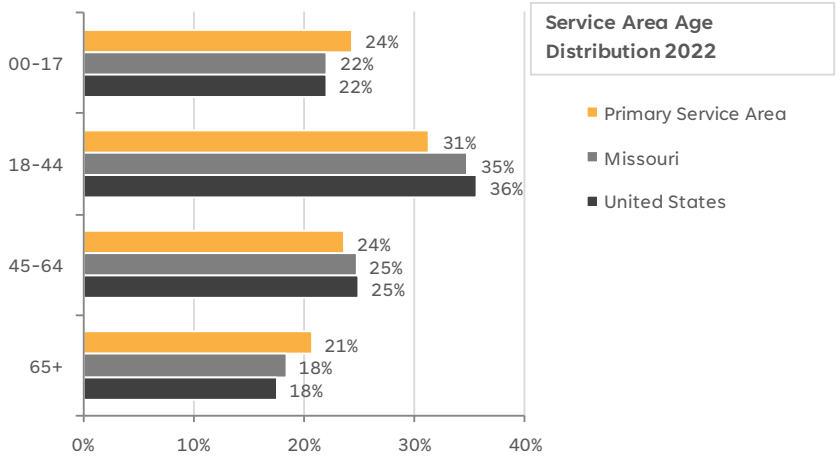


SERVICE AREA OVERVIEW

2022 Population Estimates

Primary Service Area	Name	00-17	18-44	45-64	65+	Total	%of PSA
64772	Nevada	3,014	4,064	3,200	2,765	13,043	40%
64778	Richards	163	204	156	122	645	2%
64771	Moundville	135	172	154	123	584	2%
64767	Milo	193	251	221	168	833	3%
64790	Walker	218	241	193	162	814	3%
64728	Bronaugh	132	173	149	113	567	2%
64784	Sheldon	390	473	396	297	1,556	5%
66701	Fort Scott	2,982	3,737	2,504	2,417	11,640	36%
64741	Deerfield	79	104	100	73	356	1%
64779	Rich Hill	536	678	534	423	2,171	7%
	PSA Total	*7,842*	*10,097*	*7,607*	*6,663*	*32,209*	*100%*
	Total Service Area	**7,842**	**10,097**	**7,607**	**6,663**	**32,209**	
	Total Service Area	24%	31%	24%	21%	100%	
	Missouri	22%	35%	25%	18%	100%	
	United States	22%	36%	25%	18%	100%	

Source: Merative



- The Total Service Area population was approximately 32,209 in 2022
- Fifty-five percent (55%) of the total population is younger than 45 years of age
- The under 18 age cohort has a larger percentage of people (24%) compared to the State (22%) and the United States (22%)
- The 18-44 age cohort has a smaller percentage of people (31%) than the State (35%) and the United States (36%)
- The 45-64 age cohort has a smaller percentage of people (24%) compared to the State (25%) and the United States (25%)
- The 65+ age cohort has a larger percentage of people (21%) compared to the State (18%) and the United States average (18%)
- Forty percent (40%) of the population resides in Nevada which is the home ZIP code for Nevada Regional Medical Center

SERVICE AREA POPULATION GROWTH BY ZIP CODE

Primary Service Area	Name	2022 Estimate	2027 Projection	2022-2027 % Change	2022-2027 Ab. Change
				2022-2027 Change	
64772	Nevada	13,043	12,903	-1%	-140
64778	Richards	645	634	-2%	-11
64771	Moundville	584	574	-2%	-10
64767	Milo	833	827	-1%	-6
64790	Walker	814	796	-2%	-18
64728	Bronaugh	567	556	-2%	-11
64784	Sheldon	1,556	1,546	-1%	-10
66701	Fort Scott	11,640	11,609	0%	-31
64741	Deerfield	356	351	-1%	-5
64779	Rich Hill	2,171	2,119	-2%	-52
	PSA Total	*32,209*	31,915	*-1%*	*-294*
	Total Service Area	32,209	31,915	-1%	-294
	Missouri	6.17	6.2	1%	
	United States	334	345	3%	

State and US in Millions

Source: Merative

- The Total Service Area population is projected to decrease by 1% (294 people) over the next five years
- The hospital's home ZIP code of Nevada is expected to decrease by 1% (140 people) over the next five years

POPULATION CHANGE BY AGE

2022-2027 Change

Total Service Area	2022 Estimate	2027 Projection	Absolute Change	Percent Change	Share of Growth
00-17	7,842	7,607	-235	-3%	0%
18-44	10,097	10,170	73	1%	12%
45-64	7,607	6,936	-671	-9%	0%
65+	6,663	7,202	539	8%	88%
Total	32,209	31,915	-294	-1%	100%

Source: Merative

- Eighty-eight percent (88%) of growth in the total service area is projected to come from those 65 years and older
- The 65+ age cohort is projected to increase by 8% (539 people)
- The 45 – 64 age cohort is projected to decrease by 9% (671 people)
- The 18 – 44 age cohort is projected to increase by 1% (73 people)
- The 0 – 17 age cohort is projected to decrease by 3% (235 people)

2022-2027 Change

Primary Service Area	Name	00-17	18-44	45-64	65+	Total
64772	Nevada	(98)	10	(267)	215	(140)
64778	Richards	(5)	3	(26)	17	(11)
64771	Moundville	(4)	2	(11)	3	(10)
64767	Milo	(4)	4	(29)	23	(6)
64790	Walker	(2)	0	(24)	8	(18)
64728	Bronaugh	(4)	(2)	(17)	12	(11)
64784	Sheldon	(10)	9	(38)	29	(10)
66701	Fort Scott	(81)	49	(183)	184	(31)
64741	Deerfield	(6)	(1)	(8)	10	(5)
64779	Rich Hill	(21)	(1)	(68)	38	(52)
PSA Total		*(235)*	*73*	*(671)*	*539*	*(294)*
Total Service Area		**(235)**	**73**	**(671)**	**539**	**(294)**

Source: Merative

POPULATION HOUSEHOLD INCOME

2022 Median Household Income

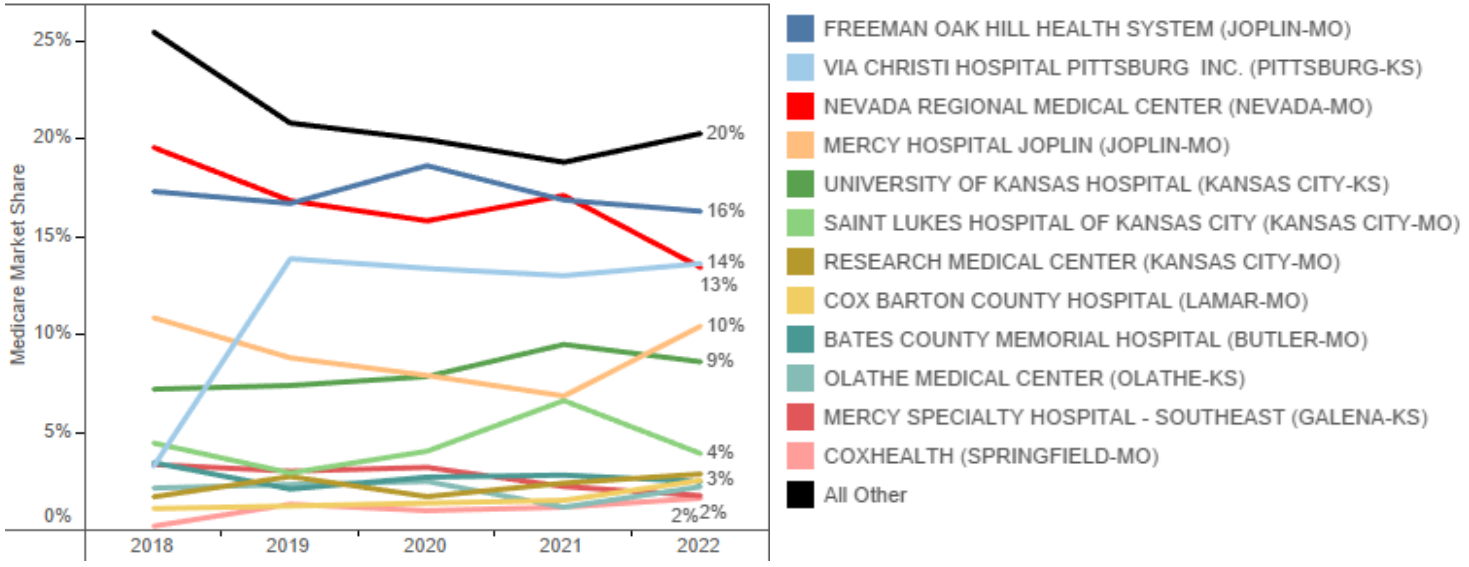
Primary Service Area	Name	Median Household Income	% of State	% of US
64772	Nevada	$44,440	75%	66%
64778	Richards	$59,565	100%	88%
64771	Moundville	$57,917	97%	86%
64767	Milo	$54,138	91%	80%
64790	Walker	$46,635	78%	69%
64728	Bronaugh	$56,800	95%	84%
64784	Sheldon	$53,200	89%	79%
66701	Fort Scott	$47,676	80%	71%
64741	Deerfield	$66,875	112%	99%
64779	Rich Hill	$48,631	82%	72%
PSA Weighted		*$47,634*	*80%*	*71%*
Total Weighted Service Area		**$47,634**	**80%**	**71%**
Missouri		$59,623	100%	88%
United States		$67,463		

Source: Merative

- Median household incomes for the service area are 80% of the State of Missouri median and 71%of the US median
- The weighted median household income for the service area is the sum of each ZIP code income times the ZIP code population divided by the total service-area population

MEDICARE MARKET SHARE 2018-2022

	Medicare Market Share					Total Cases				
	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022
FREEMAN OAK HILL HEALTH SYSTEM (JOPLIN-MO)	17%	17%	19%	17%	16%	346	366	337	288	250
VIA CHRISTI HOSPITAL PITTSBURG INC. (PITTSBURG-KS)	3%	14%	13%	13%	14%	65	304	242	222	209
NEVADA REGIONAL MEDICAL CENTER (NEVADA-MO)	20%	17%	16%	17%	13%	391	369	286	292	206
MERCY HOSPITAL JOPLIN (JOPLIN-MO)	11%	9%	8%	7%	10%	217	193	143	117	160
UNIVERSITY OF KANSAS HOSPITAL (KANSAS CITY-KS)	7%	7%	8%	9%	9%	144	162	142	162	132
SAINT LUKES HOSPITAL OF KANSAS CITY (KANSAS CITY-MO)	4%	3%	4%	7%	4%	89	64	73	113	60
RESEARCH MEDICAL CENTER (KANSAS CITY-MO)	2%	3%	2%	2%	3%	34	60	31	41	44
COX BARTON COUNTY HOSPITAL (LAMAR-MO)	1%	1%	1%	2%	3%	22	27	25	26	39
BATES COUNTY MEMORIAL HOSPITAL (BUTLER-MO)	3%	2%	3%	3%	2%	69	46	49	48	38
OLATHE MEDICAL CENTER (OLATHE-KS)	2%	2%	2%	1%	2%	43	51	45	20	34
MERCY SPECIALTY HOSPITAL - SOUTHEAST (GALENA-KS)	3%	3%	3%	2%	2%	67	66	58	38	27
COXHEALTH (SPRINGFIELD-MO)	0%	1%	1%	1%	2%	4	29	18	20	25
All Other	25%	21%	20%	19%	20%	509	456	361	321	311
Grand Total	100%	100%	100%	100%	100%	2,000	2,193	1,810	1,708	1,535



- Nevada Regional Medical Center's inpatient Medicare market decreased from 20% in 2018 to 13% in 2022
- Freeman Oak Hill Health System captured 16% Medicare market share in 2022
- Via Christi Hospital in Pittsburg(KS) had 14% Medicare market share in 2022
- Total Medicare discharges decreased by 23% (465 cases) since 2018

MARKET SERVICE AREA CALCULATION

- **Market Service Area**
  - To plan for needed services and to avoid developing excess capacity, total population of the service area is adjusted down based on the market and service area analysis
  - Current adjusted market service area, as defined below, is 24,193: this is based on 2022 population estimates and is projected to decrease by 1% over the next 5 years with a 2027 estimate of 23,957

Primary Service Area	Zip Code	2022 Actual Population	2022 CMS Market Discharges	2022 CMS NRMC Discharges	2022 CMS NRMC Market Share	Inpatient Hospital Service Area	Primary Care Service Area	Market Service Area Weighting*	2022 Weighted Population	2022-2027 Population Growth	2027 Est. Service Area Population
Nevada	64772	13,043	611	128	21%	Nevada	Nevada	100%	13,043	-1%	12,903
Richards	64778	645	28		36%	Nevada	Fort Scott	100%	645	-2%	634
Moundville	64771	584	21		24%	Nevada	Nevada	100%	584	-2%	574
Milo	64767	833	42		24%	Nevada	Nevada	100%	833	-1%	827
Walker	64790	814	44		23%	Nevada	Nevada	100%	814	-2%	796
Bronaugh	64728	567	38		16%	Nevada	Fort Scott	75%	427	-2%	419
Sheldon	64784	1,556	73		15%	Nevada	Nevada	72%	1,119	-1%	1,112
Fort Scott	66701	11,640	528	16	3%	Fort Scott	Fort Scott	50%	5,820	0%	5,805
Deerfield	64741	356	8		0%	Fort Scott	Fort Scott	50%	178	-1%	176
Rich Hill	64779	2,171	142		7%	Butler	Rich Hill	34%	730	-2%	713
PSA Total		32,209	1,535	206	13%			75%	24,193	-1%	23,957
Weighted Service Area		**32,209**	**1,535**	**206**	**13%**	**-**	**-**	**75%**	**24,193**	**-1%**	**23,957**

* CMS Suppression policy states no cell with a value less than 11 be directly reported

- Quantitative: Inpatient Medicare market share
- Qualitative: Hospital Service Area (Nevada, Fort Scott), Primary Care Service Area (Nevada, Fort Scott) proximity of competitors, services offered at Nevada Regional Medical Center, and field experience of Stroudwater consultants

MARKET SERVICE AREA CONCLUSIONS

- **Findings and Analysis**
  - The primary service area (PSA) weighted population of 24,193 is an adequate population base to support a rural hospital
    - PSA weighted population is projected to decrease by 1% over the next five years
  - The 65+ age cohort is expected to grow 8% from 2022 to 2027, gaining 539 people and comprising 88% of the service area growth during that period
    - The 65+ age cohort is typically the most frequent user of rural hospital services
    - The 18- to 44-year-old age cohort is also expected to increase between 2022 and 2027, representing the remaining 12% of growth within the service area
      - This indicates an opportunity for primary care providers to capture a younger population that may be relocating to Nevada and surrounding communities to help generate community and generational wellness
  - Median household incomes for the service area are 80% of the State of Missouri median and 71% of the US median
  - Total Medicare discharges in the service area decreased 23% (465 cases) from 2018 to 2022
  - NRMC's inpatient Medicare market share decreased from 20% in 2018 to 13% in 2022 primarily due to organizational decisions that impacted community perception of NRMC such as the implementation of the provider contract within the Emergency Department, lack of community engagement, and options for care within adjacent markets
    - NRMC maintained only 21% inpatient Medicare market share in 2022 in their home zip code of Nevada, which is below best-practice rural hospital benchmark
      - Peer best-practice rural hospitals target an inpatient market share of 35%-40% within their home ZIP code

MARKET SERVICE AREA CONCLUSIONS

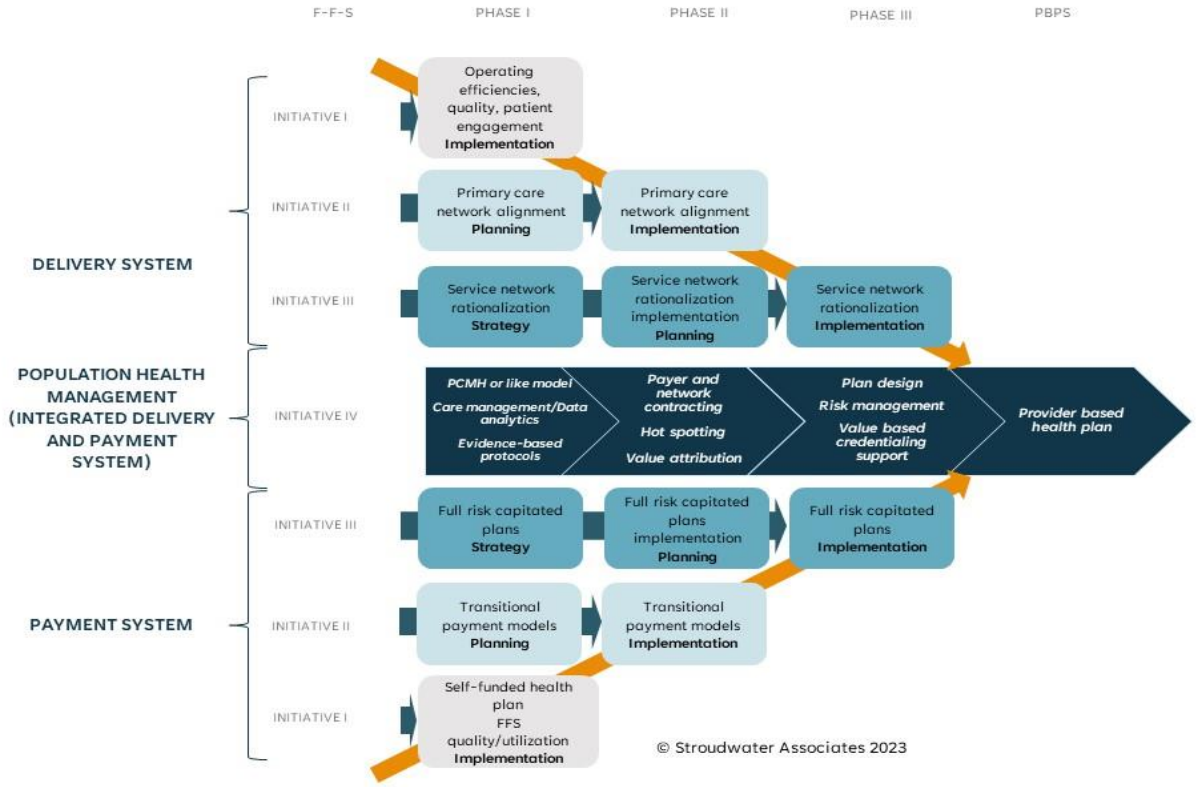
- **Findings and Analysis (cont.)**
  - Reported that an opportunity exists to further expand into the Fort Scott market due to the recent closure of a freestanding ED
    - The community of Fort Scott has contacted NRMC leadership seeking NRMC's services within the community; furthermore, the community of Fort Scott has offered to fund the operating losses for NRMC should they take over ED and clinic operations within the community; reported that this is being further explored through an organization called Amberwell
    - Best practice peer rural hospitals look for opportunities to expand their service area, whether it be through service area rationalization efforts or opening practices in emerging or underserved markets
- **Recommendations**
  - Target growth efforts to increase inpatient market share in NRMC's home ZIP code to 40% through the following (see Inpatient section for additional detail):
    - Expand utilization of consistent inpatient admission criteria such as InterQual or Milliman
    - Look for opportunities to improve the current contract for provider services within the ED whether it be termination of the existing contract or renegotiation of the contract
    - Prioritize the development of a "Care Spectrum" at NRMC, engaging relevant clinical and non-clinical leadership
    - Seek to grow swing bed program through proactive outreach to tertiary hospitals
    - Seek to optimize the EMR to effectively capture referrals to understand where patients are going for care and what care they are seeking
  - Work with the City of Nevada and Fort Scott to review options that will allow NRMC to begin providing care to residents of Fort Scott and Deerfield, which represent a community that is equivalent in terms of population to the city of Nevada

OPPORTUNITIES

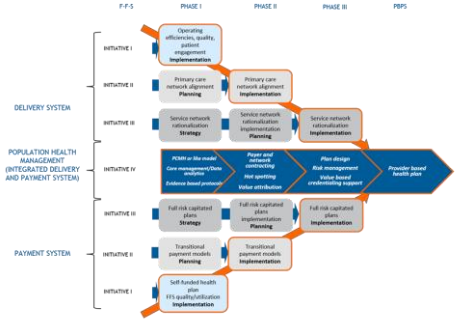
Utilization Volume Charts
Provider Complement
Operations

FUTURE OF RURAL HEALTHCARE

- The Transition Framework helps organizations through the transition from a fee-for-service (FFS) payment system to a population-based payment system
  - *Delivery system* addresses strategic imperatives for providers to transform their delivery system
  - *Payment system* addresses strategies for providers to influence the evolution of the payment system
  - *Population health/care management* requires the creation of an integrating vehicle so that providers can contract for covered lives, create value through active care management, and monetize the creation of that value
- Strategic imperatives drive the initiatives that must be designed and implemented to make the transition
  - Each initiative is developed in phases that correspond to the evolution of the payment models
  - Work on each initiative needs to begin now so they will be ready to implement when required
- Increasingly, board and leadership should be aware of the transitions occurring in the healthcare industry and incorporate new strategies into their organizations

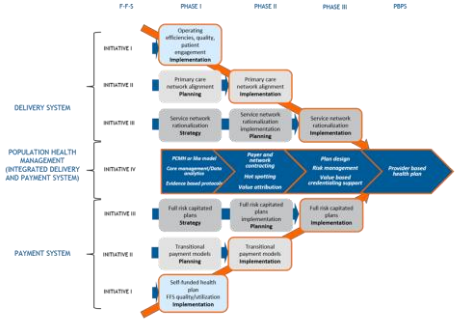


FUTURE OF RURAL HEALTHCARE



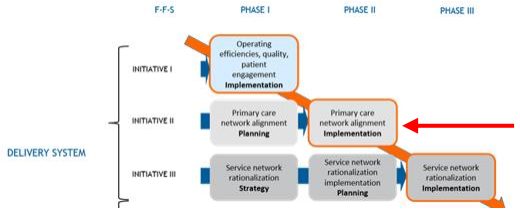
- **Findings and Analysis**
  - NRMC has a Management Action Plan that serves as its strategic plan and focuses on financial viability, physician alignment, organizational culture, community perception, facility improvement, and quality and safety
    - Best practice peer rural hospitals prioritize strategic planning and create a written strategic plan that includes quantifiable goals, target dates, and ownership
    - Best practice peer rural hospitals consider the evolving care delivery and payment system when developing a strategic plan and associated priorities
  - Healthcare reform has created new market competition on patient value, which is especially relevant to rural hospitals like NRMC
    - Important strategic opportunities that must be proactively addressed include:
      - Recognizing the evolving payment system from FFS to population-based payment, and the impact this has on functional imperatives for rural healthcare providers
      - Improving operational efficiencies and financial viability
      - Evaluating new models of care delivery, and associated financial implications, that are primary care and outpatient-focused
      - Recognizing quality and patient safety as a competitive advantage
      - Medical staff recruitment, retention, and alignment
      - Development of care management strategies to address population health
      - Effective utilization of patient demographic and utilization data to inform decision-making
      - Consideration of strategic partnership opportunities

FUTURE OF RURAL HEALTHCARE



- **Recommendations**
  - Utilize this report to update and revise the existing strategic plan, considering the following:
    - The evolving payment system as a key driver of organizational strategy
    - Development of a robust measurement culture in revenue cycle
    - Expansion and optimization of the 340B program
    - Development of an inpatient and outpatient growth strategy
    - Strong management accounting systems
    - Strategic growth of NRMC's primary/specialty network, leveraging telehealth platforms as appropriate
    - Potential partnership opportunities that provide mutual value between NRMC and partner
    - Focus on patient-centric care delivery, borrowing concepts from the retail sector, to enhance patient access, convenience, and experience
    - Growth of comprehensive care management services in the clinics
    - Enhanced focus on alignment efforts with service area primary care providers
    - New service offering growth based on the assessment of demand within the community and initial feasibility modeling
    - Focus on data-driven decision-making, leveraging public and internal data resources
    - Quality improvement as a strategic advantage

PROVIDER COMPLEMENT: PRIMARY CARE

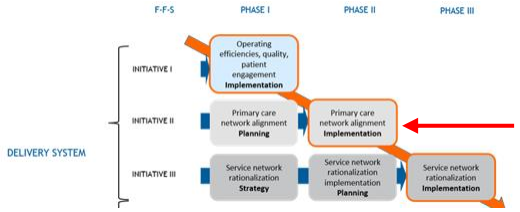


- **Findings and Analysis**
  - Primary Care Providers (PCPs) in the service area consist of the following:

Primary Care

Provider Name	Credentials	Specialty	Name of Practice	FTE
Sonja Albright	NP	Family Practice	NowCare Clinic	1.00
Jama Bogart	NP	Family Practice	Primary Care Center	0.50
Casey Brown	NP	Family Practice	Rich Hill Family Medical Clinic	1.00
Jennifer Conley	MD	Family Practice	Nevada Medical Clinic	0.80
Katelyn Erwin	NP	Family Practice	Nevada Medical Clinic	0.80
John Fox	MD	Internal Medicine/Pediatric	NRMC Professional Practice Clinic	1.00
Ricky Kellenberger	DO	Family Practice	Nevada Medical Clinic	0.60
Chelsay Langford	NP	Family Practice	NowCare Clinic	0.80
Byron L. Perkinson	MD	Family Practice	Nevada Medical Clinic	0.80
Teresa Reed	NP	Family Practice	Primary Care Center	1.00
Heather Russell	MD	Family Practice	Nevada Medical Clinic	0.80
Samantha Simpson	NP	Family Practice	Nevada Medical Clinic	0.80
Brandon Sohm	MD	Internal Medicine	NRMC Professional Practice Clinic	1.00
Jill Spangler	DO	Family Practice	Nevada Medical Clinic	0.80
Benjamin Wilson	MD	Family Practice	Primary Care Center	1.00
Sidney Zimmerman	NP	Family Practice	NowCare Clinic	0.90
Candice Moore	MD	Psychiatry	Primary Care Center	0.60
Susanne Platt	Other	LCSW	Primary Care Center	0.60
Mohammad Rasheed	MD	Psychiatry	Nevada Regional Medical Center	0.20
Mark Stewart	DO	Psychiatry	Nevada Medical Clinic	0.20
Vicki Sloniker	NP	Other	Nevada Medical Clinic	0.20

PROVIDER COMPLEMENT: SPECIALTIES



- **Findings and Analysis**
  - Specialty Care Providers in the service area consist of the following:

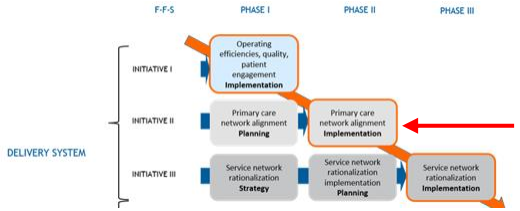
Medical Specialities

Provider Name	Credentials	Specialty	Name of Practice	FTE
David Zuehlke	MD	Cardiology	NRMC Specialty Clinic	0.20
Jacqueline Youtsos	MD	Dermatology	NRMC Specialty Clinic	0.20
Christopher Andrew	MD	Neurology	NRMC Specialty Clinic	0.10
Kent Cooper	MD	Neurology	NRMC Specialty Clinic	0.10
Shashank Radadiya	MD	Rheumatology	NRMC Specialty Clinic	0.10
Tannaz Montee	MD	Pulmonary	NRMC Specialty Clinic	0.10

Surgical Specialties

Provider Name	Credentials	Specialty	Name of Practice	FTE
Nathan Box	MD	ENT	NRMC Specialty Clinic	0.62
Joseph Dodd	MD	General Surgery	NRMC Professional Practice Clinic	0.80
Ralph Hall	DO	General Surgery	NRMC Professional Practice Clinic	0.80
Larry Seals	DO	OB/GYN	Nevada Regional Medical Center	0.00
Anton Galich	MD	Urology	NRMC Specialty Clinic	0.10
Caleb Pace	Other	Other	NRMC Professional Practice Clinic	0.60

PROVIDER COMPLEMENT: PROVIDER NEED



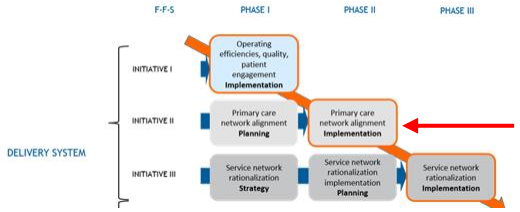
Physician Shortage/Surplus	Adjusted Service Area Population: 24,193						
Primary Care	Supply Study Range			Existing[1]	(Shortage)/Surplus Range[2]		
Family Practice	3.3	-	11.4	4.80	(6.6)	-	1.5
Internal Medicine	2.8	-	6.7	1.50	(5.2)	-	(1.3)
Pediatrics	1.9	-	2.9	0.50	(2.4)	-	(1.4)
Physician Primary Care Range	12.9	-	16.1	**6.80**	**(9.3)**	-	**(6.1)**
Non-Phys Providers	1.6	-	5.5	7.00	1.5	-	5.4
TOTAL Primary Care Range	16.1	-	21.6	**13.80**	**(7.8)**	-	**(2.3)**
Medical Specialties							
Allergy	0.2	-	0.3	0.00	(0.3)	-	(0.2)
Cardiology	0.7	-	0.9	0.20	(0.7)	-	(0.5)
Dermatology	0.4	-	0.6	0.20	(0.4)	-	(0.2)
Endocrinology	0.1	-	0.3	0.00	(0.3)	-	(0.1)
Gastroenterology	0.5	-	0.6	0.00	(0.6)	-	(0.5)
Hem/Oncology	0.5	-	0.6	0.00	(0.6)	-	(0.5)
Infectious Disease	0.1	-	0.2	0.00	(0.2)	-	(0.1)
Nephrology	0.3	-	0.4	0.00	(0.4)	-	(0.3)
Neurology	0.4	-	0.7	0.20	(0.5)	-	(0.2)
Pulmonary	0.2	-	0.5	0.10	(0.4)	-	(0.1)
Rheumatology	0.2	-	0.3	0.10	(0.2)	-	(0.1)
Surgical Specialties							
ENT	0.1	-	0.7	0.62	(0.1)	-	0.5
General Surgery	1.5	-	1.8	1.60	(0.2)	-	0.1
Neurosurgery	0.2	-	0.3	0.00	(0.3)	-	(0.2)
OB/GYN	1.9	-	2.6	0.00	(2.6)	-	(1.9)
Ophthalmology	0.9	-	0.9	0.00	(0.9)	-	(0.9)
Orthopedic	1.0	-	1.7	0.00	(1.7)	-	(1.0)
Plastic Surgery	0.3	-	0.5	0.00	(0.5)	-	(0.3)
Urology	0.6	-	0.7	0.10	(0.6)	-	(0.5)

1 Physician FTEs calculated as 5 days per week = 1.0 FTE or 18 days per month = 1.0 FTE

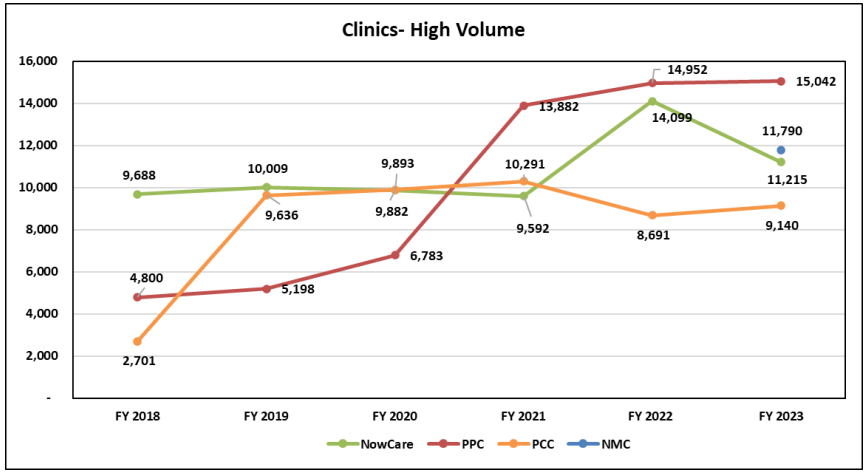
2 See Appendix for detail of Supply Studies.

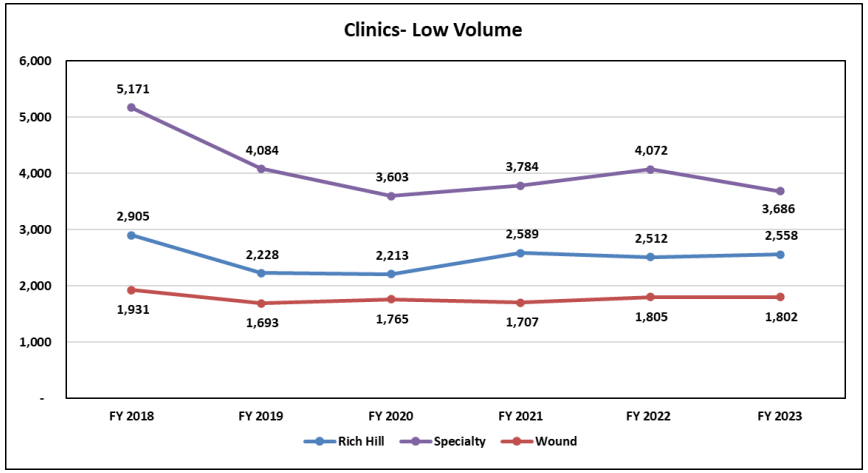
- **Findings and Analysis**
  - Primary care current needs analysis, based on adjusted Total Service Area population, indicates a range of potential shortage of **(2.3)** to **(7.8)** of primary care provider FTEs
    - Primary care physician range of potential **(6.1)** to **(9.3)** FTE shortage is only partially offset by 6.98 non-physician provider (APP) FTEs
    - Provider needs analysis suggests that NRMC has an opportunity to recruit additional primary care providers to meet community demand
    - Analysis does not account for providers within the Fort Scott community
  - Reported that NRMC is not currently recruiting primary care providers
    - Best practice peer rural hospitals establish robust primary care networks to position for emerging population-based payment models as primary care providers will be the future revenue centers
  - Specialty Care needs analysis suggests potential shortages in most medical and surgical specialties with some exceptions.
    - NRMC maintains three FP-OBs and one OB/GYN (used only for cesarean sections) that partially address the shortage in OB/GYN; additionally, efforts are underway to recruit an additional FP-OB and OB/GYN to further complement existing practices
    - NRMC has an orthopedic surgeon joining part-time in April 2024, which will address the orthopedic shortage within the community

PROVIDER COMPLEMENT/PRACTICE MANAGEMENT

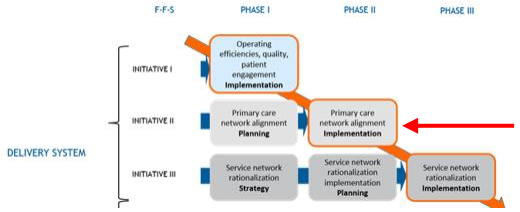


- **Findings and Analysis**
  - NRMC operates seven clinics – two specialty clinics, four rural health clinics, and one additional clinic within their clinic portfolio
    - Nevada Medical Clinic (NMC) is located at 900 S. Adams Street, Nevada, MO, and is open Mon-Fri 7:30am-5:30pm with walk-in availability Mon, Wed, Fri from 7-8:30am
    - NowCare Clinic is located at 345 S. Barrett Street, Nevada, MO, and is open 7 days a week from 7a-7p
    - Primary Care Center (PCC) is located at 627 S. Ash Street, Nevada, MO, and is open from 8am-5pm Mon-Fri
    - Professional Practice Clinic (PPC) is located at 800 S. Ash Street, Nevada, MO, and is open Mon-Fri 8:30am-4:30pm
    - Rich Hill Family Medical Clinic is located at 320 N. 14th Street, Rich Hill, MO, and is open from 8am-5pm Mon-Thu
    - Specialty Clinic located at 800 S. Ash Street, Nevada, MO and is open Mon-Fri 8am-5pm
    - Wound Care Clinic located at 800 S. Ash Street, Nevada, MO and is open Mon-Fri 8:30am-4:30pm



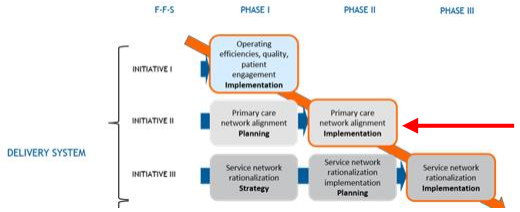


PROVIDER COMPLEMENT/PRACTICE MANAGEMENT



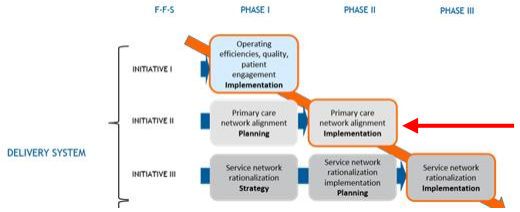
- **Findings and Analysis (cont.)**
  - Overall clinic volumes increased by 50% from FY 18 to FY 23 due expansion of services through the onboarding of providers and increasing access by extending hours and increasing days of operation
    - While volumes have increased overall, volumes within the specialty care clinic have decreased by 29% due to the loss of high-performing specialists (urology, pulmonology, cardiology) who have been replaced with providers who are working to regain volume. Growth is slow due to a lack of community awareness, insurance barriers, and suboptimal workflows decreasing patient throughput
    - Reported that provider volumes are limited by the current amount of support staff allocated to each provider – this is especially apparent for higher volume providers with a desire to further grow volumes
      - Best practice peer rural hospitals invest in support staff within clinics to allow providers to spend more time with patients while support staff handle administrative functions and can work to proactively reach out to patients
  - Reported that Dr. Box (ENT) has expressed a desire to start an Allergy Clinic due to his status as the only allergy provider within a large service area extending beyond the PSA
    - Best-performing rural hospitals look for opportunities to offer new services to their service area and communities beyond the service area to drive incremental revenue
  - Third-party payers, such as Blue Cross Blue Shield, appear to be paying at rates significantly below Medicare-allowed amounts which indicates an opportunity for all third-party contracts to be reviewed to ensure commercial payers are paying appropriate amounts
    - Best practice rural hospitals and affiliated clinics monitor their charges in the context of third-party contracts and cost to ensure favorable reimbursement

PROVIDER COMPLEMENT/PRACTICE MANAGEMENT



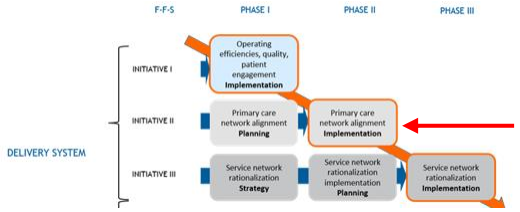
- **Findings and Analysis (cont.)**
  - The clinics are currently conducting and billing for Medicare annual wellness visits (AWV) but significant opportunity exists to grow this service through proactive patient outreach and external partnership(s)
    - Reported that the organization could benefit from a better understanding of the AWV standards and requirements, as well as financial benefits
      - Best practice peer rural hospitals with affiliated clinics conduct proactive outreach to patients eligible for Medicare AWVs, targeting an established percentage of the total patient panel as determined by organizational leadership
  - Reported that NRMC has an established CCM program, but an opportunity exists to expand
    - Reported that NRMC has plans to engage Chart Span to help build a CCM program (see Population Health Management)
    - Best practice peer rural hospitals seek to bolster CCM enrollment for eligible patients when feasible due to the opportunity for improved care and additional financial benefit to the hospital

PROVIDER COMPLEMENT/PRACTICE MANAGEMENT



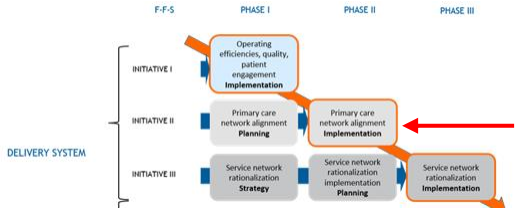
- **Recommendations**
  - Work with Dr. Box to develop and implement an Allergy practice that can pull from a wide service area and differentiate NRMC from other organizations within the market
  - Increase the amount of support staff available to providers, especially high-volume providers such as ENT to increase access and the number of patients that can be seen
  - Continue to offer expanded hours in the NowCare Clinic and look for opportunities to expand hours and services within the other clinics
  - Work with third-party payers to ensure that NRMC is receiving adequate payments relative to Medicare-allowed amounts
  - Create a focus to grow AWVs through proactive outreach to Medicare patients and greater education for both administrators and providers on the value of these visits
  - Seek to increase the number of enrolled CCM patients to support enhanced care coordination and realize financial benefits (see Population Health Management)
    - Consider expansion of current relationship with Chart Span as it relates to growth of CCM program

PROVIDER ALIGNMENT



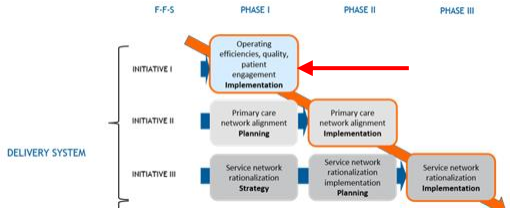
- **Findings and Analysis**
  - NRMC has invested in developing a strong network of primary care providers, with an emphasis on FP-OBs, which is a strong strategic advantage for NRMC
  - Given the functional imperatives of the changing payment system from fee-for-service (FFS) to value-based payment, and the moderate shortage of primary care (see Provider Needs Analysis), it is imperative that NRMC continue to invest in primary care and prioritize alignment with employed and contracted physicians
    - NRMC currently employs 13 primary care providers and is working to recruit an additional FP-OB to the community
    - ER providers are a contracted service provided by an external organization
    - Best performing peer rural hospitals develop alignment strategies with local primary care providers as the future success of rural hospitals will be directly related to the strength of these relationships
  - NRMC currently has Dr. Jennifer Conley serving as President of the Medical Staff but does not have a formal CMO role
    - Further alignment with primary care providers will require developing interdependencies through contractual, functional, and governance relationships with current NRMC providers as follows:
      - Functional Alignment (shared medical records, joint development of evidence-based protocols)
      - Contractual Alignment (employment, contracted management services)
      - Governance Alignment (Board, executive leadership, planning committees, etc.)
        - Best performing peer rural hospitals develop alignment strategies with local primary care providers as the future success of rural hospitals will be directly related to the strength of these relationships

PROVIDER ALIGNMENT

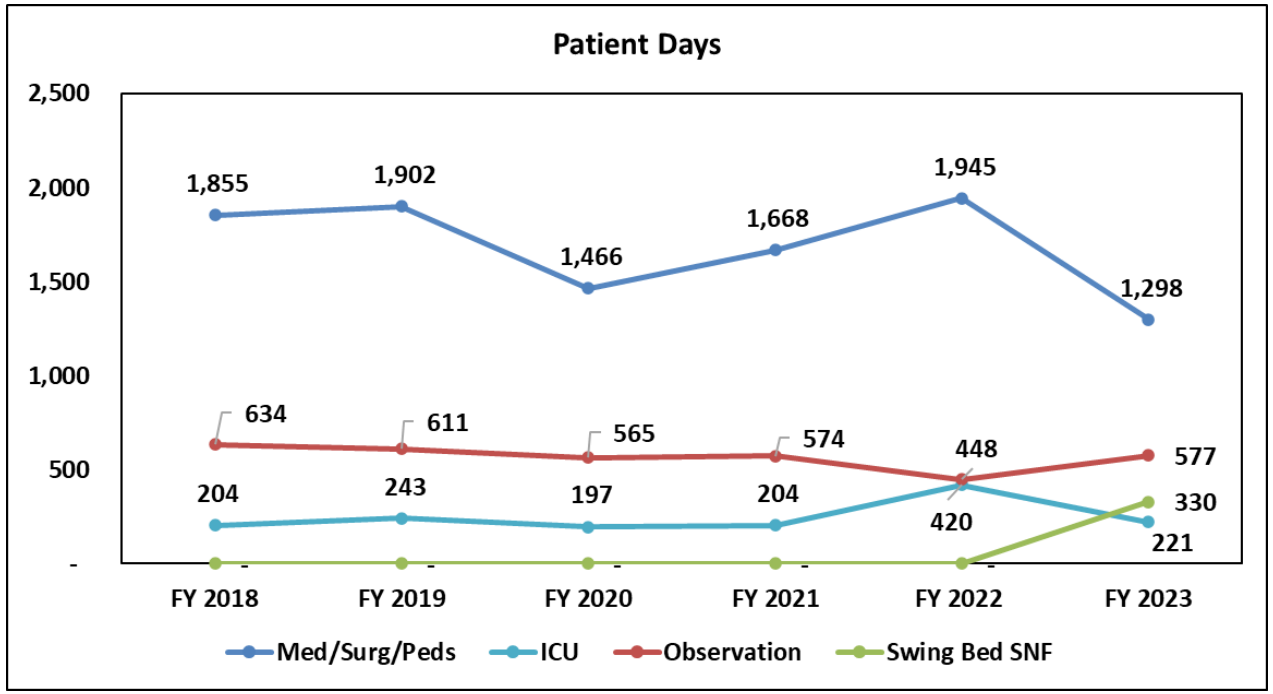


- **Recommendations**
  - Pursue greater alignment with all providers in the service area through functional, contractual and governance alignment strategies given the future importance of primary care network development to developing payment systems
    - Consider the development of a formal CMO role to provide the medical staff with a representative on the senior leadership team

INPATIENT SERVICES

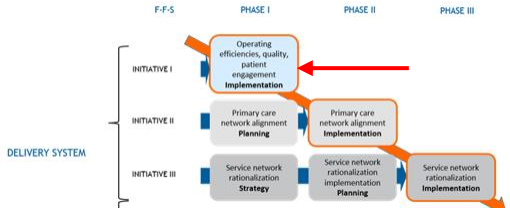


- **Findings and Analysis**
  - Overall patient days (Med/Surg, Swing Bed, and Observation) decreased 10% from FY 18 to FY 23 Annualized
    - Med/Surg volumes peaked in FY 22 at 1,945 due to COVID-19 surges and capacity constraints at larger tertiary hospitals, hindering the ability for NRMC to transfer patients; volumes then declined by 33% into FY 23 due to changes in provider groups and dysfunctions within ER operations causing fewer admissions into NRMC
    - ICU and Observation days decreased between FY 18 and FY 23 indicating a decreasing market position and patients choosing to go elsewhere for care



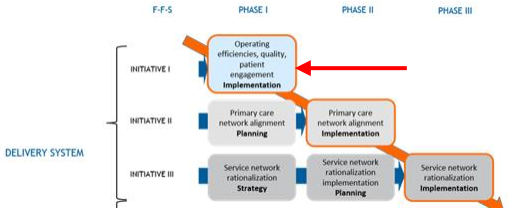
- NRMC has historically not invested in swing bed growth; however, based on recommendations from prior consultant reports NRMC grew the swing bed program to 330 days in FY 23; based on feedback from administration and prior consultant reports there is an additional opportunity to grow this program
  - NRMC has the opportunity to be more proactive in soliciting swing bed referrals from larger tertiary centers; the current administration is aware of the incremental benefit of swing bed growth and is investing in strategies to continue to grow the swing bed program
  - Swing bed services are important for rural hospitals as they allow the hospital to provide additional IP rehab services, generate increased reimbursement, and help to dilute fixed nursing unit cost

INPATIENT SERVICES



- **Findings and Analysis (cont.)**
    - Best practice rural hospitals elevate the development and promotion of the swing bed program as a strategic priority, targeting an Average Daily Census (ADC) of 3 patients per 10,000 population which equals an ADC goal of 7 for NRMC
        - Current ADC for skilled swing bed patients is 0.9
    - Observation days as a percentage of acute Med/Surg days were 34% in FY 18 and increased to 44% in FY 23 annualized which is above the target peer benchmark range of 20 – 30% of acute patient days, indicating a deference to observation status
        - Reported that InterQual criteria will be utilized for patients that providers are unsure about whether to admit or not, but it is not utilized consistently (inpatient vs. observation)
        - Best practice peer rural hospitals establish and actively manage to formal admission criteria (e.g., Milliman, InterQual, etc.) to determine appropriate admissions while targeting industry best practice of 20-30% observation days as a percentage of total acute days
    - Based on interviews NRMC does not have a defined “Care Spectrum” of patients that are most suitable for care; rural hospitals may experience increased utilization and greater collaboration after the “Care Spectrum” has been defined and communicated to applicable clinical staff
        - Best performing peer rural hospitals partner with primary care, ED, and hospitalist providers on an inpatient growth strategy that is guided by a defined care spectrum identifying patients most suitable for care
    - NRMC does not hold consistent multidisciplinary clinical huddles Monday through Friday including nurse managers, respiratory therapy, case management, radiology, pharmacy, and other clinical areas as necessary
        - Consistent operational huddles are considered best practice for peer rural hospitals

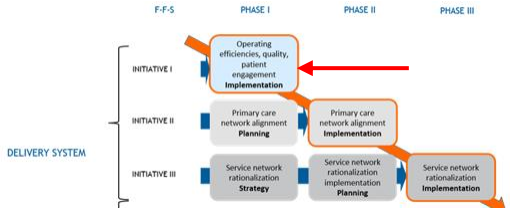
INPATIENT SERVICES - ACUTE



Contribution Margin Impact of Incremental Acute Volume		
	Low Growth	**High Growth**
Average Daily Census (M/S ADC) - FY 2023	6.1	6.1
Targeted Acute ADC	10.0	15.0
Incremental Acute ADC	3.9	8.9
Incremental Acute Days	1,434	3,259
Estimated Revenue per Acute Day	$ 3,624	$ 3,624
Estimated Incremental Daily Expense	(750)	(750)
Estimated Daily Acute Profit	$ 2,874	$ 2,874
Estimated Incremental Acute Contribution Margin	$ 4,121,301	$ 9,366,332

- **Findings and Analysis (cont.)**
  - Analysis indicates profit opportunity resulting from the following incremental inpatient acute volume growth scenarios over actual NRMC's FY 23 Med/Surg average daily census (ADC):
    - Low Growth census model – 10.0 Med/Surg ADC
    - High Growth census model – 15.0 Med/Surg ADC
    - Analysis assumes $3,624/day average reimbursement and $750/day average variable cost
      - Acute rate of $2,874/day was calculated based on the FY 23 Medicare cost report
    - Significant contribution margin opportunity exists from inpatient volume growth ranging from approximately $4.1M at low growth levels to $9.4M at high growth levels

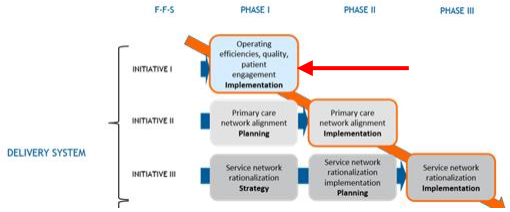
INPATIENT SERVICES – SWING BED



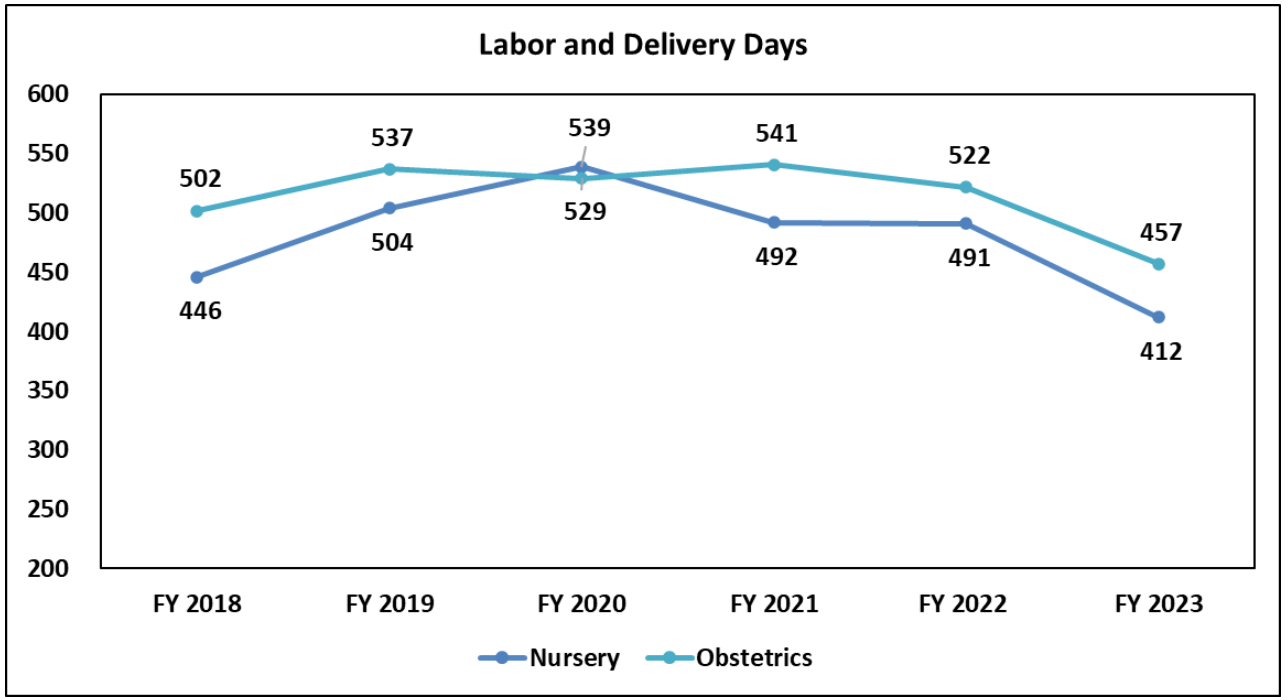
Contribution Margin Impact of Incremental Swing Bed Volume		
	Low Growth	**High Growth**
Average Daily Census (SWB ADC) - FY 2023	0.9	0.9
Targeted Swing Bed ADC	3.0	5.0
Incremental Swing Bed ADC	2.1	4.1
Incremental Swing Bed Days	766.5	1,497
Estimated Revenue per Swing Bed Day	$ 500	$ 500
Estimated Incremental Daily Expense	(200)	(200)
Estimated Daily Swing Bed Profit	$ 300	$ 300
Estimated Incremental Swing Bed Contribution Margin	$ 229,950	$ 448,950

- **Findings and Analysis (cont.)**
  - Analysis indicates profit opportunity resulting from the following incremental inpatient swing bed volume growth scenarios over actual NRMC's FY 23 swing bed average daily census (ADC):
    - Low Growth census model – 3.0 Med/Surg ADC
    - High Growth census model – 5.0 Med/Surg ADC
    - Analysis assumes $500/day average reimbursement and $200/day average variable cost
    - Significant contribution margin opportunity exists from inpatient volume growth ranging from approximately $230K at low growth levels to $449K at high growth levels

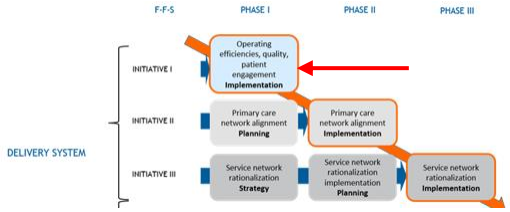
INPATIENT SERVICES



- **Findings and Analysis**
  - NRMC maintains an obstetric program providing both vaginal and Cesarean section (C-section) birth offerings in the community
  - Nursery patient days declined 8.25% from FY 18 to FY 23, and obstetric volumes have declined by 9.8% over the same period
    - Reported that the OB program is desperately needed within the community due to being one of the only delivery sites within a 60-mile area
    - Despite declines, NRMC maintains a strong program which is supported by two local FP-OBs and one OB/GYN; it was expressed that any changes in the status of the OB program at NRMC would detrimentally affect the city of Nevada and the surrounding community
    - In addition to the existing FP-OBs, NRMC is recruiting an additional 2 FP-OBs to further enhance the program

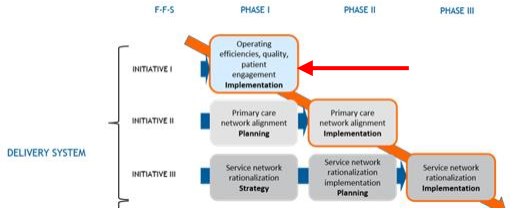


INPATIENT SERVICES

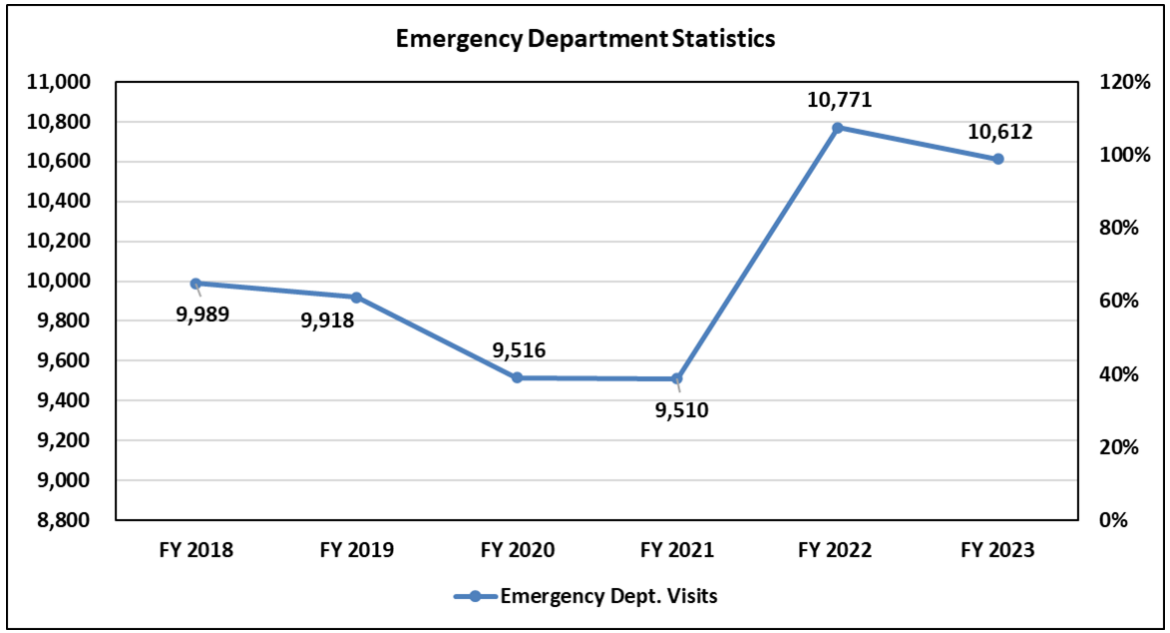


- **Recommendations**
  - Target growth in acute average daily census to at least 10.0 (Med/Surg), and a swing bed census of 5.0, to achieve 40% inpatient Medicare market share in the home zip code of Nevada via the following activities:
    - Expand utilization of consistent inpatient admission criteria via InterQual to drive consistency in inpatient admissions
    - Define the Care Spectrum (those patients able to receive care at your facility) as a collaborative, multi-disciplinary group inclusive of the following categories: Medical Staff, Nursing, Pharmacy, Medical Equipment, and Therapists
      - Establish a system to monitor patient disposition and periodically re-educate the medical staff on admission and observation status criteria to ensure the appropriate disposition of patients, as well as throughput efficiency
    - Better educate staff/providers on inpatient admission criteria to ensure optimal patient placement and level of care
    - Consider the development of a swing bed marketing plan including, targeting outreach to area hospital case managers, local area providers, and patient education on swing bed services and the program at NRMC
  - Expand the use of multidisciplinary clinical and operational huddles to improve internal communication and coordination
  - Consider expanding the employment of per-diem nurses to alleviate the use of agency nurses and reduce expenses
    - Consider outreach to former full-time employed nurses to gauge willingness to return to NRMC

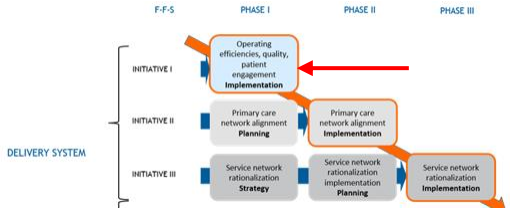
EMERGENCY DEPARTMENT



- **Findings and Analysis**
  - NRMC Emergency Department (ED) visits increased by 6% between FY 18 and FY 23 with much of the increase occurring between FY 21 and FY 22
    - Increase was primarily due to patient willingness to return to the ED post-pandemic as well as the closure of the Fort Scott freestanding ED which
  - NRMC's ED admission rate was reported to be 7% for the last 6 months with historical data unavailable
    - Best-performing peer rural hospitals have an ED admission rate between 10% and 12%
  - Reported that NRMC does utilize InterQual but not consistently throughout the hospital nor for every potential admission
    - Also reported that there are issues with consistent admission criteria due to a large number of ED providers working under the existing ED staffing contract
    - Best performing peer rural hospitals establish admission guidelines (e.g., Milliman, Interqual, etc.) that are consistently followed to ensure seamless coordination of care between hospitalists and ED providers and to reduce unnecessary transfers
  - NRMC's ED transfer rate was reported to be 4.91% primarily due to capacity constraints at tertiary hospitals and a majority of patients presenting as lower acuity and being discharged
    - Best practice peer rural hospitals target a transfer rate of less than 5%

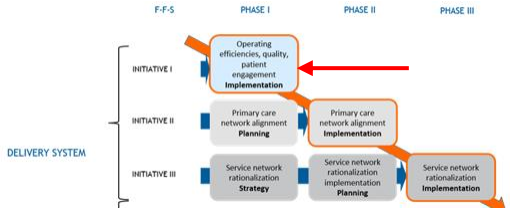


EMERGENCY DEPARTMENT

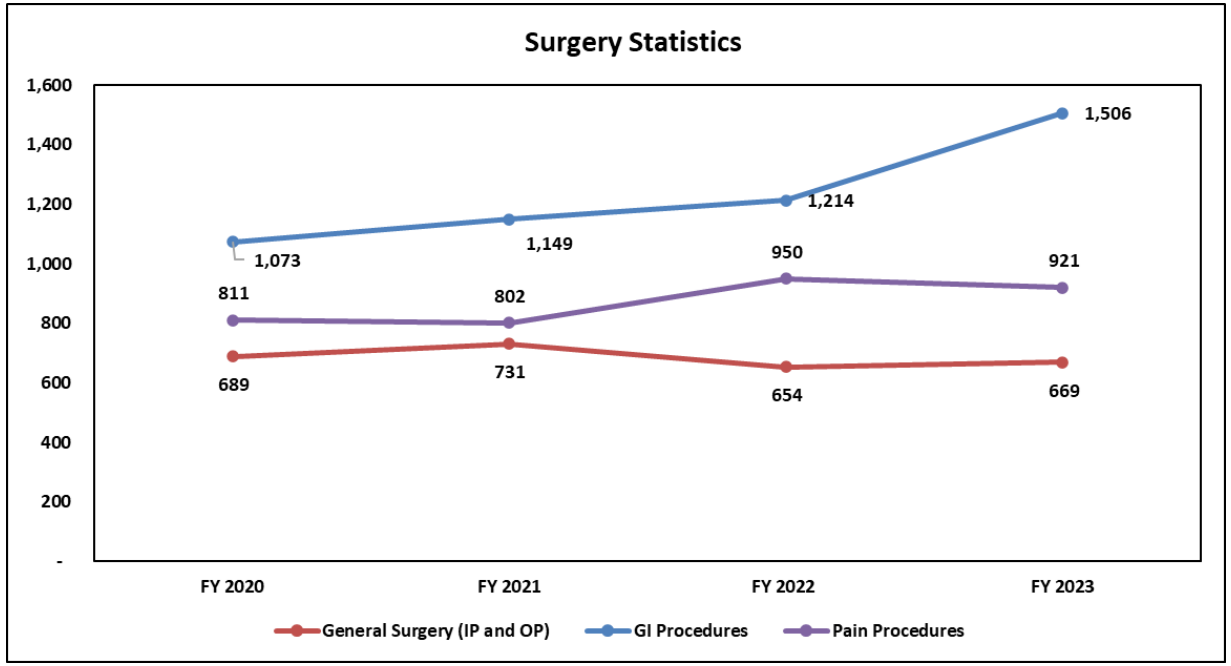


- **Findings and Analysis**
  - Due to the current functionality of the EMR, NRMC receives limited information about admissions and transfers by physician; additionally, ED patient experience scores are much lower than organizational targets
    - Best practice peer rural hospitals with contracted ED services host regular meetings between the hospital and the contract group to discuss performance and review identified metrics
  - Reported that there may be an opportunity to look into shared responsibility between other nurses within the facility to increase overall efficiency
  - ER providers are a contracted service provided by an external organization
    - Reported that this contract has caused dysfunction amongst the medical staff due to a lack of consistent providers staffing the ED; this has decreased ED performance and lessened community trust within the ED
      - Best practice peer rural hospitals recognize the ED as the window to their hospital and invest in provider solutions that are best for the medical staff and the community
- **Recommendations**
  - Ensure inpatient admissions and transfers from the ED are tracked and monitored consistently, targeting an admission rate of 12% of visits and a transfer rate of 5% or less
  - Prioritize expanded utilization of formal inpatient admission criteria, such as InterQual or Milliman, to ensure consistency in admission decisions
  - Develop a consistent meeting cadence between NRMC and the ED provider group to discuss performance as it relates to key indicators; if the ED provider group cannot meet NRMC set targets, consider alternative options for ED provider contractors
  - Evaluate the current nurse staffing model, potentially looking into cross-departmental nurse coverage between units

SURGICAL SERVICES

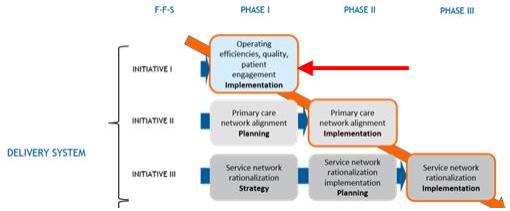


- **Findings and Analysis**
  - Overall, surgical volumes have increased 17% between FY 20 and FY 23
    - Increase was primarily due onboarding of additional surgical providers such as Dr. Hall and Dr. Box to grow volumes
  - NRMC currently has 2 operating rooms and one endoscopy suite
  - NRMC reported the opportunity and desire to increase its overall ENT surgical, general surgery, and orthopedic market share
    - Best practice peer rural hospitals market and promote services to the community to grow volumes in key departments



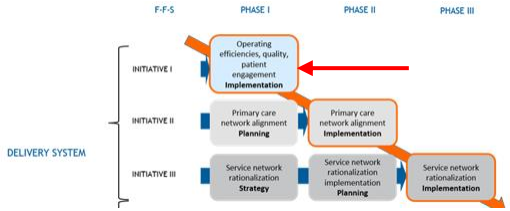
  - NRMC reports that the biggest barriers to enhanced operational efficiency within the department are the lack of CRNA/anesthesiologist coverage within the ORs and the current layout of the facilities with large amounts of space between all sections of the OR
- Surgery is staffed to ensure that the OR is open 24/7 to provide around-the-clock surgery for potential cesarean sections
  - Investment in recruitment is required to allow the surgical services department to continue to grow and meet the demands of a growing ENT practice and an incoming orthopedic provider

SURGICAL SERVICES

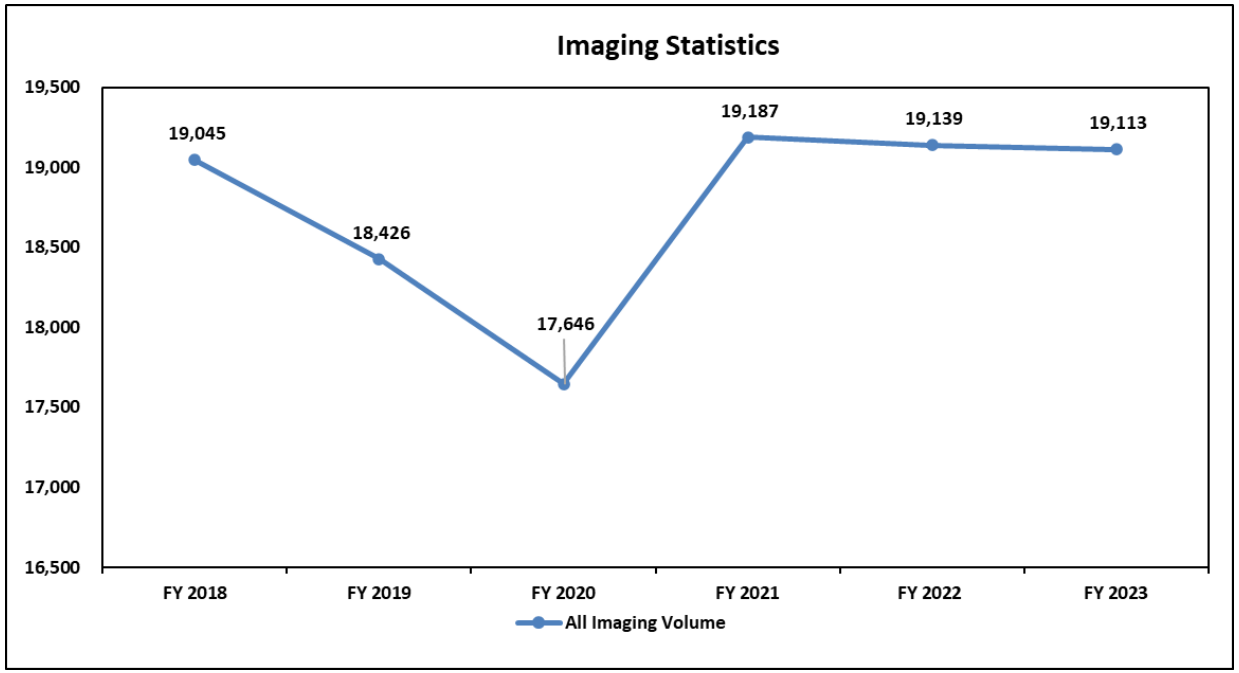


- **Findings and Analysis**
  - Reported that Dr. Hall is currently not accepting Blue Cross Blue Shield insurance due to delays in the credentialing process
    - Best practice peer rural hospitals ensure their providers are credentialed with all major insurers within their market
  - Reported that current EMR does not allow the functionality for referrals to be tracked
    - Best practice peer rural hospitals track referrals to understand where patients are coming from and where patients are going for their care
- **Recommendations**
  - Target continued growth in surgery as a strategic priority to increase revenue with a focus on orthopedics and ENT
  - Work with Dr. Box to grow ENT surgical volume by investing in an additional MA to increase clinic volumes, which will subsequently increase ENT surgical volumes
  - Work to accelerate Dr. Hall's insurance credentialing with BCBS to address the backlog of patients waiting for surgery and increase his efficiency
  - Continue to evaluate additional services that can be offered at NRMC
  - Promote current and new services to the community to increase referrals
  - Work with EMR to ensure that referrals can be tracked for all surgical patients

IMAGING

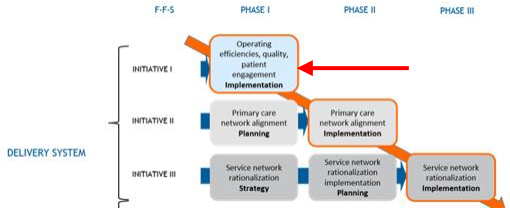


- **Findings and Analysis**
  - NRMC provides imaging services across the following modalities of the hospital: diagnostic X-ray, CT, MRI, bone density, and ultrasound
    - Currently MRI is only offered 1 day a week due to a lack of certified staff to operate the MRI
  - Imaging volumes declined 7.93% between FY 18 and FY 20 primarily due to the impact of the COVID-19 pandemic but subsequently increased 7.68% between FY 20 and FY 23 returning to pre-pandemic levels
    - Reported that some services may be lost due to the quality of equipment and overall cost of services versus freestanding imaging centers



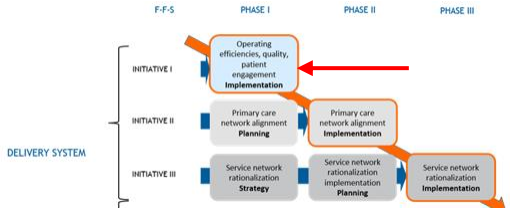
  - Reported that no radiology equipment was replaced during the COVID-19 pandemic and that significant investment must be made in the existing equipment such as ultrasound and CT
    - Best practice peer rural hospitals investment in imaging equipment to drive referral volumes from local primary care providers and radiologists
    - Best practice rural hospitals promote capital investments in the community to increase referrals

IMAGING

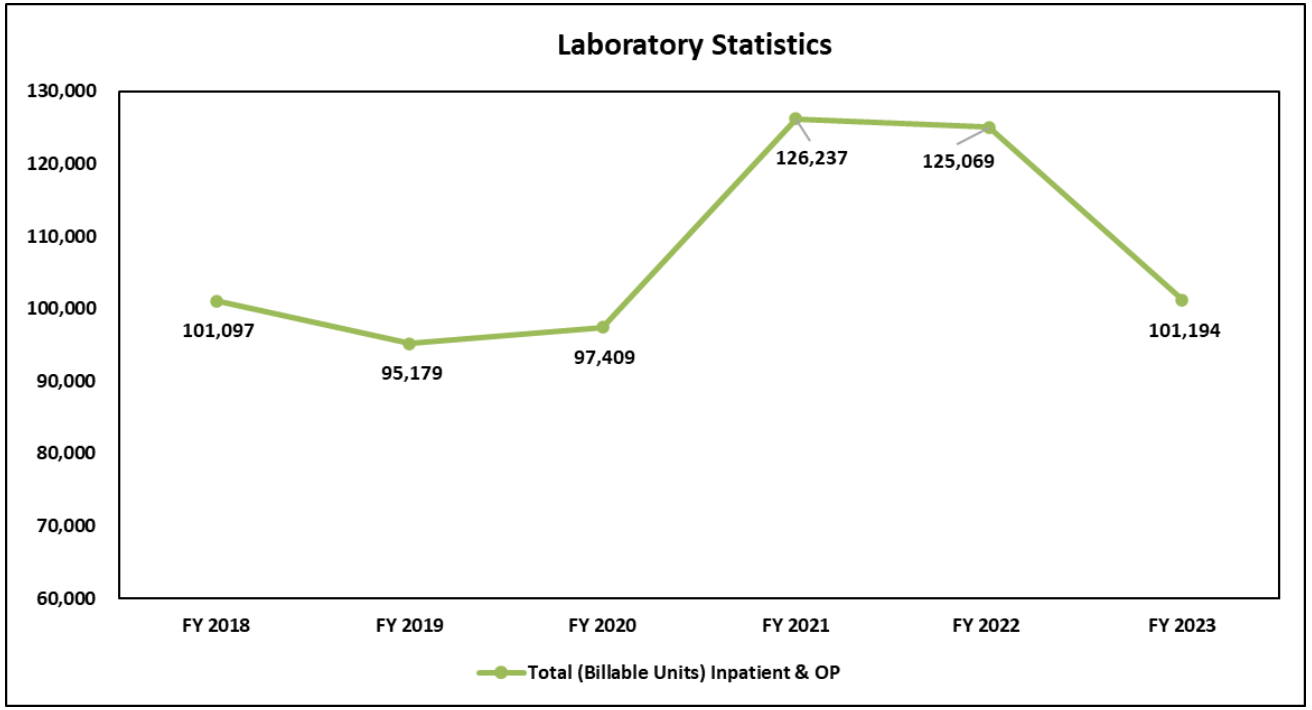


- **Findings and Analysis (cont.)**
  - The current MRI technician is PRN and only works one day a week, limiting the operational capacity of the MRI machine
  - Reported that NRMC utilizes Advanced Radiology as their Radiology group and reports that the practice is easy to work with and provides reads in a timely manner
    - Best practice peer rural hospitals with outsourced radiology departments provide timely feedback regarding radiology read turnaround times and ensure issues are addressed given the potential impacts to patients and referring physicians
  - Reported there is an opportunity to better promote imaging services to local providers and within the community
    - Best practice peer rural hospitals actively promote services to their communities and local service area providers
  - Reported that there is an opportunity to track imaging referrals; although NRMC believes that most physicians in the clinics are referring to NRMC for imaging services, it is unclear as referrals are not currently tracked
    - Best practice peer rural hospitals track referrals by provider and use the information to drive targeted outreach
- **Recommendations**
  - Ensure imaging referrals are tracked by provider to gain insight into service area market opportunities
  - Look for opportunities to invest in equipment and services such as new CT and ultrasound machines
  - Consider opportunities to cross-train current imaging staff or hire MRI certified technologist to increase MRI access to 5 days a week
  - Continue best practice of tracking radiology turnaround times and working with Advanced Radiology to ensure timely results are provided

LABORATORY

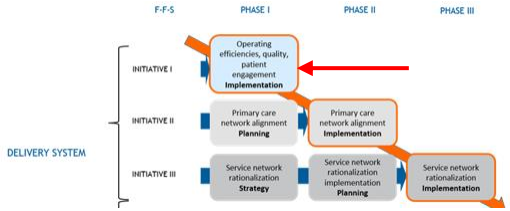


- **Findings and Analysis**
  - Outpatient lab volumes have remained stable only increasing from 101,097 in FY 18 to 101,194 in FY 23, or .10%
    - Lab volumes increased 22.84% between FY 20 and FY 21 due partially to an increase in COVID-19 testing throughout the pandemic, subsequently decreasing to historical levels after FY 2022 as the pandemic waned
    - In addition to COVID-19 volumes waning, NRMC also lost volume generated by the city-owned Nursing Home which discounted the use of NRMC services



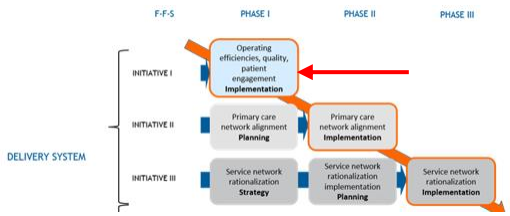
  - Reported that there is an opportunity to grow volumes even further through the promotion of services in the community or through locations such as Fort Scott
    - Best practice peer rural hospitals conduct frequent outreach visits to area providers to increase referrals and reduce service outmigration

LABORATORY

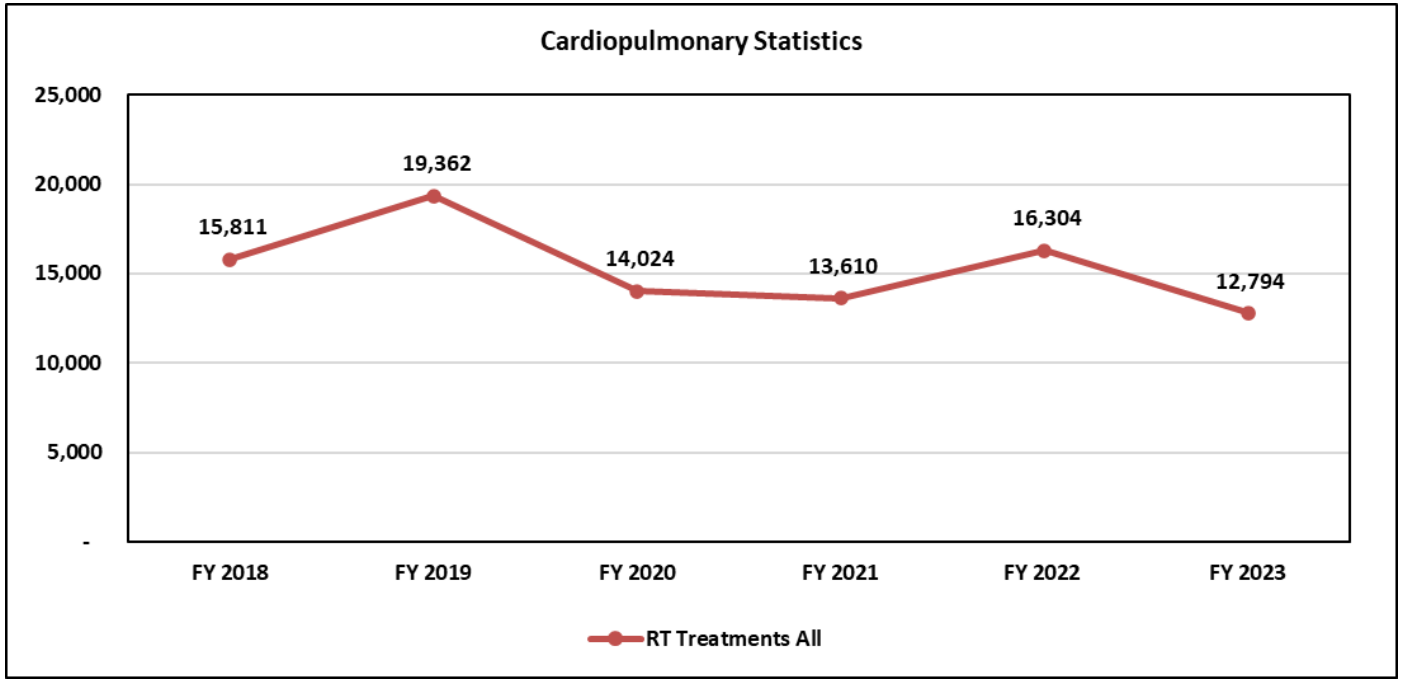


- **Findings and Analysis**
  - The NRMC lab reports that it does not use a separate fee schedule for hospital lab services versus clinic lab services
    - Reported that the community avoids utilizing the lab services at the clinics due to the higher price, thus choosing to go elsewhere for lab services
      - Best practice peer rural hospitals develop market competitive outpatient pricing, such as a separate discounted reference lab fee schedule, and actively promote lab services to area providers, nursing homes, healthcare facilities, schools, and employers
  - The department is generally staffed by 4 CSTs and 3 phlebotomists
- **Recommendations**
  - Initiate more frequent outreach/promotion of services with area providers and the community to drive greater utilization
  - Evaluate opportunities to create a separate reference lab fee schedule to make lab service pricing more attractive to the local community
  - Target growth in the Fort Scott community as a strategic priority
  - Work to restart providing lab services to the adjacent nursing home

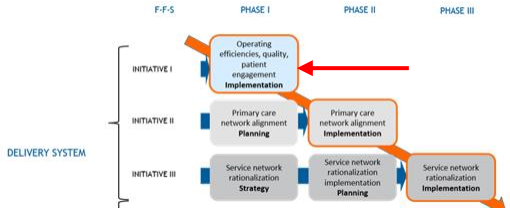
CARDIOPULMONARY



- **Findings and Analysis**
  - NRMC offers cardiopulmonary services including the following: Respiratory Therapy treatments, EKGs and Pulmonary function tests, sleep studies, Holter monitor tests, treadmill stress tests
  - Outpatient cardiopulmonary volumes have decreased by 23% from FY 18 to FY 23 despite slight growth between FY 20 and FY 22 during the COVID-19 pandemic
    - Decline in volumes has been driven by the departure of a well-respected pulmonologist and new operational practices such as clinic visits being required before certain tests causing patients to opt for care elsewhere
      - Reported that NRMC has hired a new pulmonologist who has struggled to build a full practice
        - Best practice peer rural hospitals actively market new providers to the community and set productivity incentives and targets for new providers
  - Currently NRMC is offering Phase II and Phase III services to the community
    - Reported there is an opportunity to consider offering additional procedural services should staffing levels allow
    - Best practice peer rural hospitals offer comprehensive respiratory and cardiopulmonary services

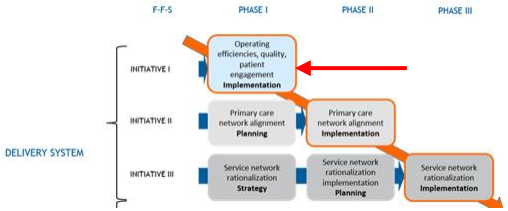


CARDIOPULMONARY



- **Findings and Analysis (cont.)**
  - Reported that there is an additional opportunity to educate providers on the cardiopulmonary services that NRMC offers to drive increased referrals – examples include increased collaboration with Mercy provider
    - Best practice peer rural hospitals conduct frequent outreach visits to area providers to increase referrals and reduce service outmigration
  - Reported that referrals are unable to be tracked within the current EMR system
    - Best practice peer rural hospitals track referrals by provider to understand the market opportunity and where patients are going for their care
  - Cardiopulmonary services at NRMC are provided via three full-time respiratory therapists which include the department manager
    - Volume-based benchmarks suggest that the department is well staffed, with the capacity for increased volume; this is ideal for NRMC given the opportunity to grow volumes
- **Recommendations**
  - Continue to evaluate additional cardiopulmonary services to grow volumes
  - Continue with frequent outreach/promotion of services with area providers and the community to drive greater utilization
  - Work to market the new pulmonologist to expand and build her practice

340B DRUG PRICING PROGRAM

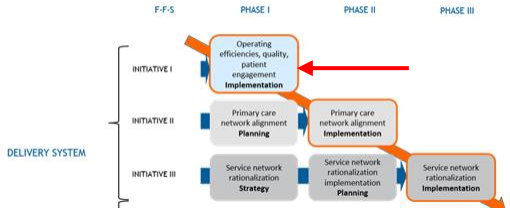


- **Findings and Analysis**
  - The 340B program has proven highly beneficial to rural hospital peers with outpatient clinics
    - The 340B Drug Pricing Program allows rural hospitals to benefit from reduced drug costs and profit from contracted retail pharmacy program revenues
    - For qualifying rural hospitals, the 340B program is available to provider-based entity (PBE) clinics and provider-based rural health clinics (PB-RHC)
  - Reported that NRMC has a robust 340B program that has performed successfully since the program was launched – however, since transitioning to CPSI NRMC's 340B program is not fully optimized
  - NRMC has the potential to generate an additional $400K to $450K in supplemental income for every 10K eligible Medicare and third-party visits, which is based on Stroudwater's experience with 340B program rural hospitals (use the estimate below as a guideline as 340B revenue forecasting is complex). Note that this estimate is based only on primary care visits and does not include other qualifying visits/treatments

JCH Clinic Visits	Est. Medicare and 3rd Party Payer %	340B Eligible Visits	Avg. RX per Visit	Total 340B RXs	Avg. per Rx 340B Increase	340B Incremental Benefit
55,233	85%	46,948	1.5	70,422	$35.00	$ 2,464,773

  - Reported that NRMC currently realized approximately $1.5-2.0M in 340B revenue and has the potential to realize approximately $2.5M in 340B revenue
    - Best practice peer rural hospitals often generate between $400K and $450K in supplemental income for every 10K eligible provider-based clinic visits
- **Recommendations**
  - Target 340B benefit within the estimated range by evaluating contract pharmacy arrangements and leveraging 340B opportunities
  - Work with CPSI to ensure functionality of the 340B program

QUALITY IMPROVEMENT: HCAHPS

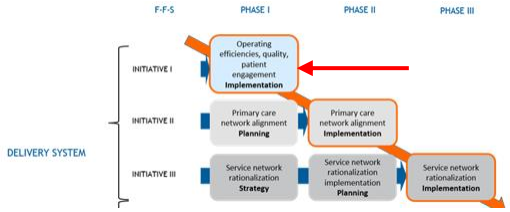


- **Findings and Analysis**
  - U.S. Department of Health and Human Services Hospital Compare website data compares hospitals on HCAHPS patient-satisfaction scores and assigns an overall star rating
    - NRMC is the lowest performing HCAHPS organization within the comparison below with 6 of 10 measures being worse than all other organizations in the comparison and only one measure being better than state and national averages

Best Score
Better than Nat.
Worse than Nat.
Worst Score
Source: www.hospitalcompare.hhs.gov
Date:10/1/2021-9/30/2022

U.S. HHS Hospital Compare Measures	National Avg.	MO Average	Nevada Regional Medical Ctr	Bates County Memorial Hosp	Cedar County Memorial Hosp	Cox Barton County Hosp	Freeman Health System-Freeman	Mercy Hospital Joplin
Patient Survey Summary Star Rating:			**3**			**5**	**3**	**3**
Patient Satisfaction (HCAHPS) Average:	**70%**	**69%**	**61%**	**71%**	**73%**	**83%**	**62%**	**64%**
Nurses "Always" communicated well:	79%	79%	74%	83%	83%	87%	71%	71%
Doctors "Always" communicated well:	79%	79%	75%	79%	87%	79%	75%	74%
"Always" received help when wanted:	66%	64%	64%	73%	79%	80%	47%	55%
Staff "Always" explained med's before administering:	62%	60%	48%	59%	59%	74%	51%	53%
Room and bathroom "Always" clean:	72%	72%	61%	72%	81%	95%	66%	63%
Area around room "Always" quiet at night:	62%	61%	72%	61%	76%	78%	52%	57%
YES, given at home recovery information:	86%	86%	79%	87%	82%	93%	85%	83%
"Strongly Agree" they understood care after discharge:	52%	51%	30%	51%	57%	64%	43%	45%
Gave hospital rating of 9 or 10 (0-10 scale):	71%	71%	59%	72%	61%	94%	65%	69%
YES, definitely recommend the hospital:	69%	68%	46%	72%	62%	84%	68%	69%

QUALITY IMPROVEMENT: CORE MEASURES



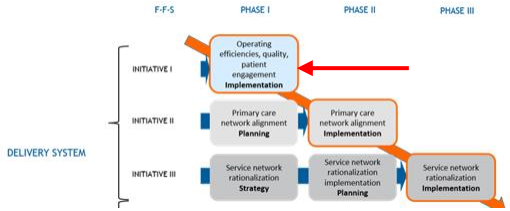
- **Findings and Analysis (cont.)**
  - U.S. Department of Health and Human Services Hospital Compare website data comparing NRMC and competitor hospitals on publicly-reported core measure scores
    - NRMC scored below the national average in two measures included below, including the worst score in COVID-19 vaccinations among competitors and only performed better than national and state averages in two measures below

Measure ID	Measure Name	National Avg.	MO Average	Nevada Regional Medical Ctr	Bates County Memorial Hosp	Cedar County Memorial Hosp	Cox Barton County Hosp	Freeman Health System-Freeman	Mercy Hospital Joplin
OP 2	Fibrinolytic Therapy Received within 30 Minutes of ED Arrival	50%	61%	NA	NA	NA	NA	NA	NA
OP 3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention	64	57	NA	NA	NA	NA	NA	NA
OP 18b	Avg. time patients spent in ED before being sent home	162	156	95	90	96	65	286	247
OP 22	Percentage of patients who left the emergency department before being seen	3%	4%	2%	0%	1%	0%	12%	8%
OP 23	Head CT results	69%	74%	NA	NA	NA	NA	24%	50%
COVID-19	Percentage of Healthcare personnel who completed COVID-19 vaccination series	90%	90%	71%	78%	74%	86%	80%	96%
IMM 3	Healthcare workers given influenza vaccination	81%	90%	69%	63%	74%	95%	62%	100%

Best Score
Better than Nat.
Worse than Nat.
Worst Score

Source: www.hospitalcompare.hhs.gov
Date:10/1/2021-9/30/2022

QUALITY IMPROVEMENT: CORE MEASURES



- **Findings and Analysis (cont.)**
  - U.S. Department of Health and Human Services Hospital Compare website data comparing NRMC and competitor hospitals on publicly-reported core measure scores
    - NRMC scored better than the state and national average for OP-29 and Sep-1

Measure ID	Measure Name	National Avg.	MO Average	Nevada Regional Medical Ctr	Bates County Memorial Hosp	Cedar County Memorial Hosp	Cox Barton County Hosp	Freeman Health System-Freeman	Mercy Hospital Joplin
OP 31	Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	97%	96%	NA	NA	NA	NA	NA	NA
OP 29	Endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients	92%	96%	100%	NA	NA	NA	92%	92%
SEP 1	Received appropriate care for severe sepsis and septic shock	60%	54%	69%	39%	NA	NA	65%	75%

Best Score
Better than Nat.
Worse than Nat.
Worst Score

Source: www.hospitalcompare.hhs.gov
Date:10/1/2021-9/30/2022

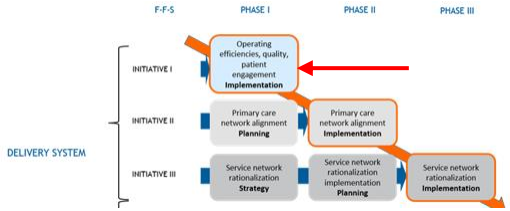
QUALITY IMPROVEMENT

- **Findings and Analysis (cont.)**
  - Reported that due to NRMC's declining financial position, quality improvement has not been a major focus of the organization post-COVID; currently, NRMC is ranked at the 1st percentile for the Recommend the Hospital metric indicating significant opportunity to improve community perception of the hospital as well as organizational quality and safety
    - Best practice peer rural hospitals actively engage their community through their senior leadership team by regularly rounding with patients and engaging in community activities to generate goodwill
    - Best practice peer rural hospitals elevate quality as a strategic imperative through establishing regular quality/patient satisfaction meetings with strong manager and medical staff engagement, utilizing performance dashboards to drive accountability for care quality, outcomes, and patient satisfaction across all staff, providers, and the Board of Directors
  - NRMC does not have an overarching Quality Improvement Committee but rather has multiple quality-sub committees such as utilization review, patient safety, quality outcomes, professional standards, etc.; the information from these committees is shared with the Board on an ad hoc basis
    - Best practice peer rural hospitals have at minimum, bi-monthly (every other month) overarching Quality Improvement Committee of the Board meetings which include Board members, members of the medical staff, hospital senior team, leadership, and front-line team members as necessary
  - Hospital Compare indicates that NRMC has an HCAHPS response rate of 17%, which is below best practice peer rural hospital targets of 30%
    - Best practice peer rural hospitals target a 30% HCAHPS survey response rate by promoting the hospital's services through various formats such as letters from the CEO, admission packets, business cards with reminders that patients will receive a survey, post-discharge phone calls, etc.

QUALITY IMPROVEMENT

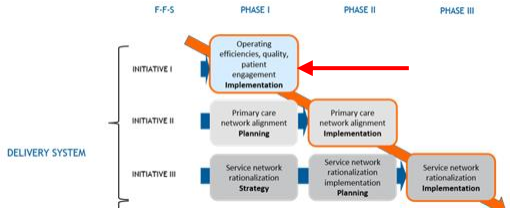
- **Findings and Analysis (cont.)**
  - Reported that only one member of NRMC leadership is trained in formal process improvement methodology
    - Best practice peer rural hospitals invest in professional development courses that teach their employees about process improvement methodology, so all members of the organization are engaged in problem-solving
- **Recommendations**
  - Ensure that quality is leveraged as a strategic priority for long-term growth
  - Implement an overarching Quality Improvement Committee that governs all quality activity throughout the organization and has representation from medical staff and the Board
  - Use quality and patient satisfaction data to target underperforming areas while promoting high quality in best practice areas
  - Evaluate current quality improvement infrastructure, seeking to create a culture of improvement in this area
  - Actively round with patients and engage with the community to seek feedback on opportunities for the hospital to improve
  - Consider development of a Patient Family Advisory Council to hear directly from those in the community
  - Work to increase HCAHPS survey response rates to 30% using rounding and reminders

HUMAN RESOURCES



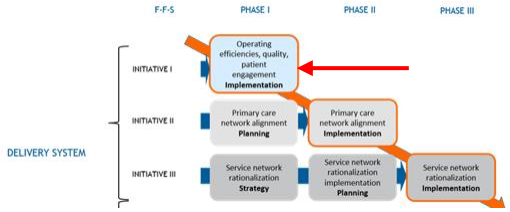
- **Findings and Analysis**
  - *Salaries and Wages*
    - Reported that NRMC has a wage scale system for entry-level positions but there are no established wage scales for all positions
      - Best practice peer rural hospitals implement appropriate pay scales based on position, education, and years of experience and conduct an annual evaluation of set pay scales to ensure the wages are competitive within the market and to attract/retain high-quality staff
    - NRMC has not provided any merit-based adjustments within the last 5 years, if not longer, due to the organization's declining financial performance
      - Wage increases have been granted but not in a uniform manner nor in a manner based on performance in which employees understand the required behaviors that merit wage increases
        - Best practice peer rural hospitals conduct annual performance appraisals that include merit-based incentives based on employee performance throughout the year
    - Reported that NRMC takes the average of the 25th percentile based on the MO Hospital Association wage indexes
      - Best practice peer rural hospitals review their wages against multiple scales to ensure they are competitive within their local market
  - *Benefits*
    - NRMC is self-insured for health insurance; this plan is further discussed in Payment System Transformation
    - NRMC offers a retirement plan option for eligible employees and matches employee contributions up to 4.1% of employee election after a 5-year employment
      - Best practice peer rural hospitals often include an employee matching provision in the retirement plan policy

HUMAN RESOURCES



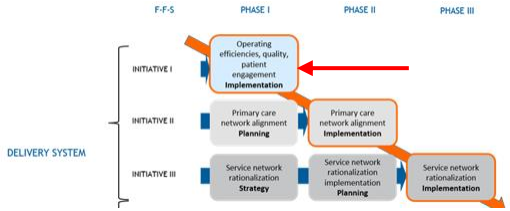
- **Recommendations**
  - Continue to utilize researched wage surveys to index employee salaries
    - Consider opportunities to increase employees to the 50th percentile (when financially feasible) to make NRMC more attractive as it relates to recruitment and retention
  - Look for opportunities to roll out a house-wide market increase to bring employees in line with current market demand
  - Work with the Board to implement merit-based incentives for employees based on an objective evaluation of employee performance
  - Continue the best practice of offering a robust insurance plan
  - Continue best-practice retirement plan matching

INFORMATION TECHNOLOGY



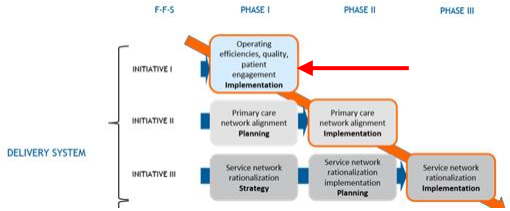
- **Findings and Analysis**
  - NRMC currently utilizes CPSI as their primary EHR – reported that NRMC recently converted to CPSI from Cerner within the last year as a cost-saving mechanism
    - Reported that the CPSI rollout has created multiple bottlenecks within operations with potential and known impacts on the development of dashboards, patient charting, utilization of evidence-based protocols, revenue cycle functions, etc.
      - Best practice peer rural hospitals leverage IT resources to deliver demonstrable quality, patient safety, and customer service in a secured network environment, understanding its importance for success in the evolving healthcare landscape
  - Reported that an opportunity exists to engage medical staff and the organization around the strategic vision and operational plan to achieve full functionality of CPSI
    - Best practice peer rural hospitals actively engage their medical staff in the development and optimization of their EMR
    - Best performing peer rural hospitals develop multi-year IT strategic plans that define how resources should be invested to develop integrated IT solutions that drive workflow efficiency and ensure seamless transfer of information across the care continuum
- **Recommendations**
  - Consider opportunities to re-evaluate the existing contract with CPSI to ensure NRMC is receiving optimal value
  - Work with CPSI to address known issues that have developed throughout the conversion to improve patient safety, employee morale, and revenue cycle performance

MANAGEMENT ACCOUNTING



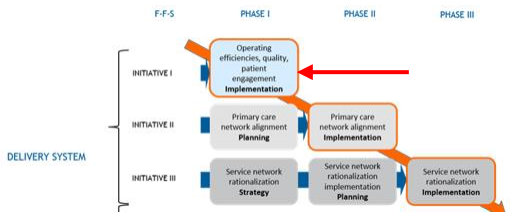
- **Findings and Analysis**
  - *Budget Preparation*
    - Reported that the CEO and CFO prepare the annual budget and budget updates are not discussed at the department level
      - Best practice peer rural hospitals engage managers in developing both revenue and expense budgets to foster ownership and accountability
      - Best practice peer rural hospitals educate all managers on the budget process and basic financial management principles
  - *Financial Statements*
    - Reported that department managers do not receive consistent financial statements, and are not responsible for variance analysis except on an ad-hoc basis
      - Best practice peer rural hospitals provide department managers with P&L statements, require variance analysis based on predetermined thresholds, and hold department managers accountable for both volume growth and expense management
- **Recommendations**
  - Prioritize the development of a measurement and accountability culture through the following:
    - Involve department managers in the budget preparation process and have them establish volume, revenues, and expenses to promote ownership and accountability
    - Require all department managers to provide variance analysis on a monthly or quarterly basis for pre-determined variances (e.g., +/- 10%) from the budget for revenues and expenses and plan monthly meetings with Controller/CFO for overall financial/business mentoring
    - Maintain a focus on revenue growth by encouraging departmental managers to build business cases for additional services and budget if adequate volume and revenue can be generated

COST REPORT OPPORTUNITIES

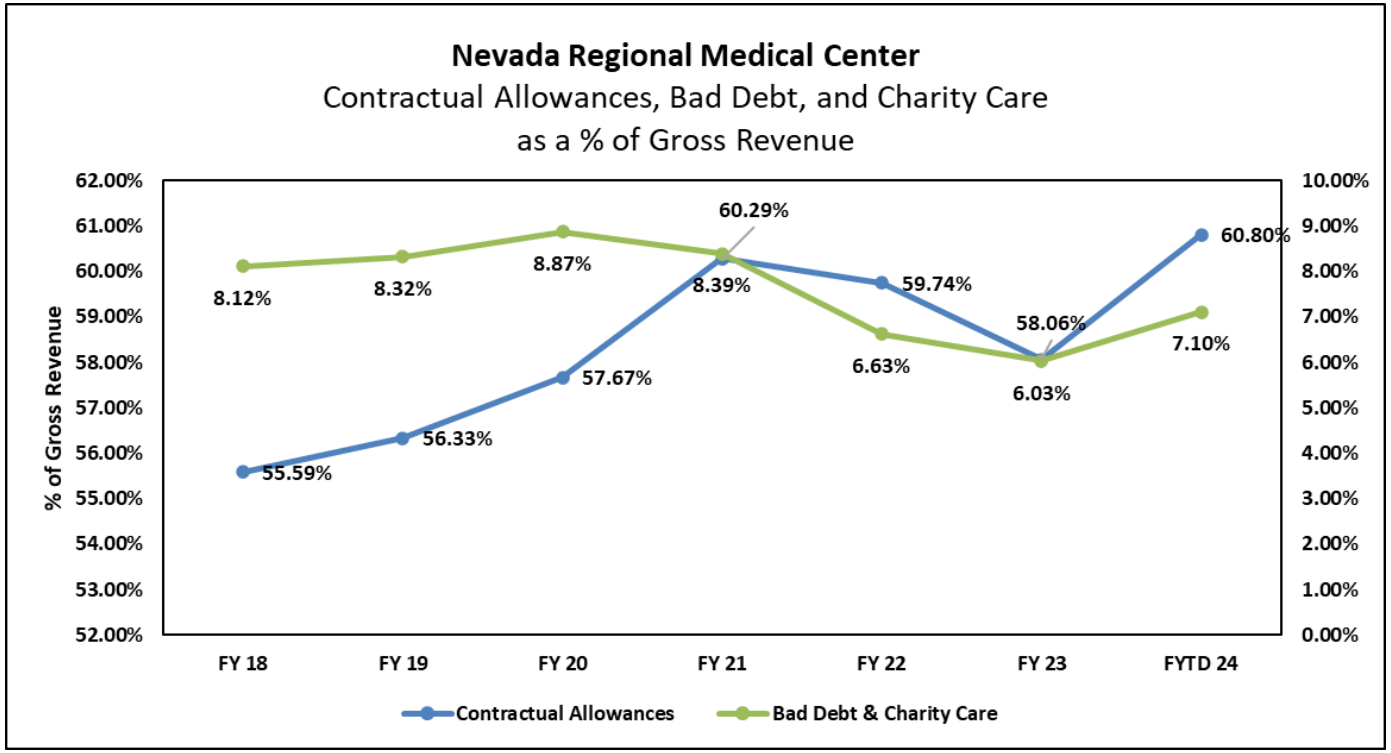


- **Findings and Analysis**
  - A review of the FY 23 filed Medicare cost report was completed to look for common errors in preparation, opportunities to enhance reimbursement, or potential ways to drive operational efficiencies; findings have been listed below
  - *RHC Productivity Waiver*
    - NRMC's cost per visit within the PB-RHCs exceeded the Upper Payment Limit (UPL) and upon a review of the 2020 cost report that established the UPL base rate, NRMC had not applied for nor received a public health emergency productivity waiver which has set the UPL lower than what it should be for years moving forward after 2020
      - During the Public Health Emergency (PHE), RHCs were eligible to file for productivity waivers, thus exempting them from the negative impact or productivity limits. The PHE did not expire until 5/11/2023.
- **Recommendations**
  - *RHC Productivity Waiver*
    - NRMC should immediately file for productivity waivers for their PB-RHCs that exceeded their Upper Payment Limits and actively pursue the processing of the refiled report

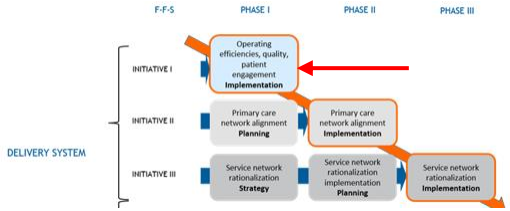
REVENUE CYCLE



- **Findings and Analysis**
  - *Performance Measures/Management*
    - Contractual Allowances as a percentage of gross revenue have increased from 55.6% in FY 18 to 60.8% in annualized FY 24
      - Increase in contractual allowances is primarily due to growth in clinic volumes for which third-party payers were paying a significant discount off charges in addition to CDM increases
    - Bad debt & charity care also has remained relatively stable over the period with a slight decrease from 8.12% in FY 18 to 7.10% in annualized FY 24, which is within range of best practice peer rural hospitals

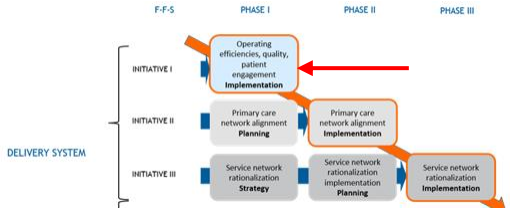


REVENUE CYCLE



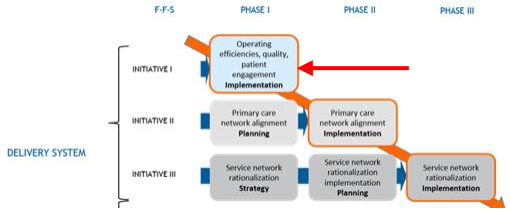
- **Findings and Analysis (cont.)**
  - *Performance Measures/Management (cont.)*
    - NRMC reported that historically a KPI dashboard that included multiple metrics and all key indicators was utilized but was discontinued when CPSI launched; currently, no KPI dashboard is being utilized to manage revenue cycle performance
      - NRMC also reports a revenue cycle committee that meets weekly
        - Best practice peer rural hospitals develop a measurement culture in revenue cycle, using KPIs to monitor performance and drive operational improvement
        - Best practice peer rural hospitals often form a designated revenue cycle committee whose responsibility is to monitor and improve revenue cycle performance
        - Best practice peer rural hospitals establish, target, track, and manage performance indicators in a revenue cycle dashboard, such as the following HFMA best-practice revenue-cycle metrics, to improve revenue cycle performance:
          - Cash collected and cash percentage of net revenue
          - Gross and Net A/R and A/R days
          - In-house and discharged not-final-billed receivables
          - Cost to collect
          - Bad debt and charity as a percent of gross charges
          - Denials as a fraction of gross charges
          - Point of service collections as a fraction of goal

REVENUE CYCLE



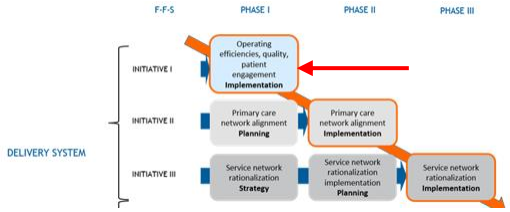
- **Findings and Analysis (cont.)**
  - *Patient Registration*
    - Reported that patient registration occurs before the patient visit through Central Scheduling in which patient financial responsibility is discussed; however this process is not consistently applied throughout the organization
      - Best practice peer rural hospitals create consistent registration and pre-registration processes whereby all scheduled patients are pre-registered, which includes a discussion of payment for patient responsibility amounts at the point of service
  - *Point of service collections (POS)*
    - Reported that NRMC has a POS collection process in place, but it is not consistently applied throughout the hospital or the clinics
      - Currently the goal within clinics for each registration staff member is to collect $1K a month which is significantly lower than industry targets
      - Best practice peer rural hospitals set POS goals for the ED, central registration, and other outpatient departments to collect co-payments and co-insurance at the time of service, targeting 1-3% of net patient revenue
    - It was unclear if NRMC has any type of discount for self-paying patients who pay at the time of service
      - Best practice peer rural hospitals often offer significant prompt pay discounts for self-pay patients to enhance the likelihood of collections
  - *Concurrent Review*
    - Reported that NRMC does not have a concurrent coding review process in place for acute care services
      - Best practice rural PPS hospitals have a concurrent coding review process to maximize charge capture, ensure coding compliance, and optimize revenue cycle

REVENUE CYCLE



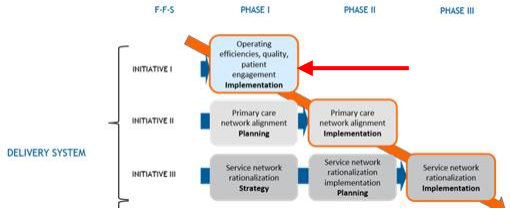
- **Findings and Analysis (cont.)**
  - *Third Party Contracts*
    - Reported that RHG reviewed third-party contracts with a focus on facility fees. RHG determined that the charges were reasonable but did not review the physician practice professional fees during this assessment
      - Based on analysis it does not appear that all third-party contracts for professional services have been updated in several years as indicated by BCBS allowing $67 for a 99213
        - Best practice peer rural hospitals routinely review physician practice professional fees
    - Reported that NRMC maintains an inventory of third-party contracts but does not have a consistent contract review process in place
      - Best practice peer rural hospitals will inventory/catalog insurance contracts and proactively negotiate when deemed favorable
    - Reported that there is a significant opportunity for NRMC to compare posted payments from third-party payers to payer contracts for accuracy; based on discussions with NRMC leadership, it is often unclear how much third parties pay for services based on how the payments are posted
      - Best practice peer rural hospitals review payments received for services for accuracy and challenge payment when necessary
    - Under the prior administration, NRMC negotiated with MA plans at a discounted rate from Medicare.
      - MA plans are required to pay Medicare equivalent rates unless the hospital has negotiated discounted rates.
  - *Denials Management*
    - Reported that NRMC has a robust process for reviewing denied claims and is generally able to overturn 50% of claims that were originally denied; however, reported that more staff are required to continue to manage this effectively
      - Best practice peer rural hospitals aggressively pursue denied claims, targeting best practice denial rate of 5% or less

REVENUE CYCLE



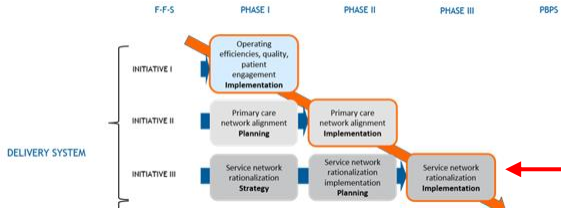
- **Findings and Analysis (cont.)**
  - *Charge Capture*
    - Reported that managers have limited involvement in reviewing charge capture and CPSI has impacted their ability to fully reconcile charges, which may be impacting charge capture for NRMC
      - Best practice peer rural hospitals require daily charge reconciliation with department manager input to ensure adequate charge capture
- **Recommendations**
  - *Performance Measures/Management*
    - Continue to ensure the revenue cycle committee meets weekly and is tasked to monitor and improve revenue cycle performance
    - Reinstate the list of KPIs that were in place before the implementation of CPSI, and monitor consistently, using these to inform revenue cycle committee meetings
    - Utilize the KPI dashboard that was discovered from the recently acquired clinic, and ensure this dashboard is widely disseminated to NRMC leadership and other key revenue cycle staff on at least a monthly basis
  - *Patient Registration*
    - Expand and standardize the pre-registration of all scheduled outpatient services at NRMC to verify insurance and patient information, and to discuss payment for services
  - *Point of service collections (POS)*
    - Create a POS collection process in all applicable areas of the hospital, targeting 3% of overall net patient revenues
    - Consider implementing a self-pay discount if paid at the time of service to 14 days after the date of service to encourage faster and more consistent payment
    - Consider a prompt pay discount for self-pay patients in the clinics, and monitor this discount as future pricing changes are adopted

REVENUE CYCLE



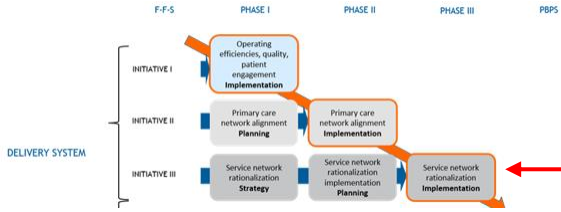
- **Recommendations (cont.)**
  - *Concurrent Coding Review*
    - Implement a concurrent coding review process for all acute care services
  - *Third Party Contracts*
    - Review all professional fees from third-party contracts
    - Develop a consistent review process to ensure contracts are reasonable, and that NRMC is being paid appropriately according to contracts
    - Work to renegotiate third part contracts with emphasis on the clinics
  - *Denials Management*
    - Consider recruiting additional staff to continue best practice denials management practice targeting a best practice denial rate of 5% or less
  - *Charge Capture*
    - Work with CPSI to make it easier for managers to perform daily charge reconciliation subsequently, require all department managers to perform a daily charge reconciliation
    - Ensure all department managers are educated on the importance of proper charge capture to overall financial performance

SERVICE AREA RATIONALIZATION



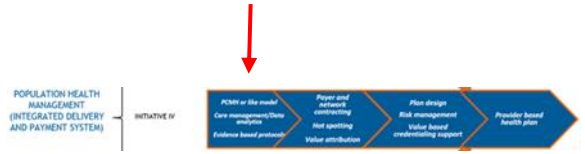
- **Findings and Analysis**
  - The functional imperatives of the current FFS payment system (managing organizational volumes, payment, and costs) do not require higher levels of alignment; however, higher levels of alignment will be required as future value-based payment systems emerge that establish new functional imperatives to manage the care and risk associated with populations of lives
    - Best-performing rural hospitals evaluate partnership opportunities with primary care practices, hospitals, and other health organizations/agencies, in terms of the following considerations:
      - Benefits to NRMC
      - Benefits to a partner
      - Continued control and decision rights of NRMC
      - Potential level of commitment and investment from a partner
  - NRMC does not have any formal management agreement or affiliation with any other organization
    - While not discussed, it appears that NRMC leadership is not opposed to evaluating partnership opportunities, including more formal arrangements if deemed to be advantageous
      - Best practice independent rural hospitals often explore strategic options inclusive of partnership/collaboration opportunities that generate mutual value
  - Stroudwater has developed the Affiliation Commitment Curve (Appendix II) as a tool to guide hospitals in maximizing their value, in conjunction with strategic partners, to better position themselves for changes in the healthcare environment
    - Best practice peer rural hospitals seek to develop operational efficiencies and maintain financial margin that allows for sustained operations before engaging in official partnership discussions

SERVICE AREA RATIONALIZATION



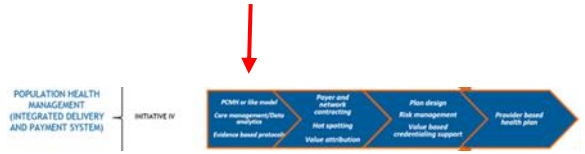
- **Recommendations**
  - Prioritize financial and operational improvement opportunities outlined in this report, seeking to generate enough margin to sustain operations
  - Once financial stability is achieved, consider performing a strategic options analysis to evaluate long-term strategic partnership opportunities with area providers that maximize NRMC's value with consideration of the following areas:
    - Primary care provider recruitment and alignment
    - Access to specialty care services, and potential growth in ancillary services supporting those specialists
    - Expanded care management capabilities and establishment of best practice, evidence-based medical protocols
    - Value-based payment arrangements, such as support for Accountable Care Organization (ACO) involvement (see Payment System Transformation)
    - Capital investments
    - Technological integration and support (e.g., shared EMR)
    - Additional expense reductions through further administrative integration, group purchasing, and shared service arrangements

POPULATION HEALTH MANAGEMENT



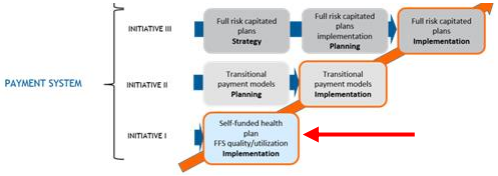
- **Findings and Analysis**
  - *Patient-Centered Medical Home (PCMH) Development*
    - NRMC RHCs are not designated as PCMH(s) but efforts are underway to obtain PCMH designation for all applicable clinics
      - PCMH recognition allows hospitals to be reimbursed at potentially higher levels for standard primary care through participation in Per Member Per Month (PMPM) or other payment incentives that some third-party payers have organized for PCMHs, or to negotiate such payment; it also provides clinics with the infrastructure to more effectively manage a patient panel, addressing both preventative and acute care needs
        - Best-performing peer rural hospitals that have PCMH-designated clinics negotiate with third-party payers to increase incentives and drive incremental revenues
  - *Team-Based Care*
    - NRMC has implemented some functions of team-based care but lacks the support staff to fully realize a team-based model of care in the clinics
      - Best practice peer rural hospitals seek to implement team-based care when appropriate to enhance primary care delivery
      - Best practice peer rural hospitals educate providers on the potential clinical, administrative, and financial benefits of a team-based model of care
  - *Claims/Analytic Capabilities*
    - Despite having a self-insured plan, NRMC currently does not utilize claims information to inform decision-making around plan design and areas to increase market capture
      - Best practice peer rural hospitals analyze claims data to better understand where opportunities may exist to improve the health of the workforce, gain efficiencies in plan design, and reduce service outmigration
      - Best practice peer rural hospitals utilize claims data from their self-insured plans to inform decisions surrounding the health of their workforce and the broader community

POPULATION HEALTH MANAGEMENT



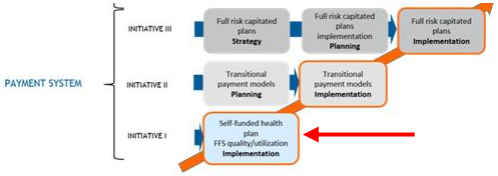
- **Recommendations**
  - *Patient-Centered Medical Home (PCMH) Development*
    - Expedite the pursuit of PCMH designation to access enhanced reimbursement and efficiency opportunities
    - Educate providers, clinic staff, and other key stakeholders on the PCMH model, such as potential opportunities for additional reimbursement associated with the designation, and potential opportunities for increased efficiency when implemented in conjunction with team-based care
  - *Team-Based Care*
    - Invest in support staff such as Medical Assistants within the clinics to diversify job roles and allow providers to spend more time with patients rather than performing administrative functions
    - Evaluate opportunities to further implement team-based care in NRMC primary care delivery settings, utilizing the Shared Principles of Primary Care compiled by the Primary Care Collaborative (See Appendix III) as a guide, to improve the efficiency of practice and patient experience
    - Educate providers and clinic staff on the benefits of a team-based care approach, such as potentially improved patient experience, enhanced capacity to support a greater patient panel size, and greater staff satisfaction as members of the care team can operate at the “top of their license”
  - *Claims/Analytic Capabilities*
    - Develop a consistent claims review process based on claims from NRMC’s self-insured plan to identify areas of opportunity for service growth, cost management of high dollar cases, reduced service outmigration, and other appropriate areas while also improving the health of the NRMC workforce

PAYMENT SYSTEM TRANSFORMATION



- **Findings and Analysis**
  - *Health Plan Design*
    - NRMC has a health plan in which enrollees are incentivized to utilize NRMC services via reduced deductible and maximum out-of-pocket in addition to a 20% premium increase for smoking
      - Best-performing peer rural hospitals are increasingly redesigning health plans with appropriate incentives/disincentives for a healthier workforce such as high deductible plans with employer-sponsored HSA, higher premiums for poor health choices (e.g., smoking), and establishing targets for improved health (See Appendix IV for top 5 Benefits of Population Health Management Model)
      - Best practice peer rural hospitals frequently offer significant discounts for employees to utilize their facilities, including heavily reduced, or 100% waived, co-payments, co-insurance, and/or deductibles, to reduce service outmigration
  - *Medicare Care Management Programs*
    - Reported that the NRMC RHC is performing, and being reimbursed for, Medicare Annual Wellness visits (AWVs) and Chronic Care Management (CCM) visits; NRMC recently began AWVs in the clinics, and there is a significant opportunity for additional growth and revenue capture
      - NRMC is currently in discussion with Main Street Health and Chart Span regarding potential partnership around the growth of the CCM program
      - Best-performing practices operated by rural hospitals consistently offer TCM, CCM, BHI, and CoCM services to all eligible patients, educate them on the benefits of such programs, and establish appropriate systems to ensure accurate coding and billing
      - Best practice peer rural hospitals have found success in utilizing organizations such as Main Street Health to act as a vehicle to receive advanced payments on their Medicare Advantage patient panels

PAYMENT SYSTEM TRANSFORMATION



- **Findings and Analysis (cont.)**
  - *Alternative Payment Model*
    - NRMC currently does not participate in an Accountable Care Organization (ACO); NRMC may have the opportunity to evaluate ACO participation after financial turnaround has been completed
      - In addition to assisting with growth in care management programs, Main Street Health also has an ACO option for hospitals to consider
      - Best-performing peer rural hospitals evaluate and actively participate in alternate payment models to include ACOs and CINs when it is demonstrated to be advantageous
- **Recommendations**
  - *Self-Insured Health Plan*
    - Consider increasing the financial benefit of utilizing NRMC services for care for those under the NRMC self-insured plan
  - *Medicare Care Management Programs*
    - Continue to grow Medicare AWV and CCM programs to drive increased reimbursement
    - Continue to evaluate and develop partnerships to grow care management and receive additional reimbursement
    - Consider opportunities with Main Street Health or expansion of Chart Span agreement to grow the CCM program
    - Evaluate the advantages of TCM and BHI programs
  - *Alternative Payment Model*
    - Evaluate potential opportunities to participate in an ACO through a partnership with a larger organization once other initiatives in this report have been undertaken and NRMC is in a position to sustain operations
      - Consider opportunities to participate in Main Street Health's ACO

RECOMMENDATIONS SUMMARY

RECOMMENDATIONS

- **Financial Performance**
  - NRMC should consider the recommendations below to act as complements to efforts already underway to improve financial performance as well as prior consultant reports that detail opportunities for NRMC
    - Work with the city of Nevada to agree to execute a forbearance agreement which includes the subordinate loans to increase immediate cash flow
      - Work to secure a $1M line of credit from the city to act as a financial stimulus to allow NRMC to focus on growth
    - Work with BAM and bondholders to provide solutions for necessary short-term liquidity in addition to a city-backed line of credit
    - Consistently follow up with FEMA for payment of funds
    - Work with the city and county to expand the sales tax to 1% and include the full county rather than just the city of Nevada
    - Revenue cycle improvement, including, but not limited to, continued expansion of a measurement culture through the reimplementation of a KPI dashboard, improvement of consistency regarding POS collection, and maintaining third-party contracts (see Revenue Cycle)
    - Focus on engaging managers in service growth and participation in budget preparation (see Management Accounting)
    - Development of an inpatient and outpatient growth strategy that includes the communities of Fort Scott and Deerfield as strategic priorities for the organization
    - Strategic investment in capital to ensure the highest quality patient care is delivered

RECOMMENDATIONS

- **Market Service Area Conclusions**
  - Target growth efforts to increase inpatient market share in NRMC's home ZIP code to 40% through the following (see Inpatient section for additional detail):
    - Expand utilization of consistent inpatient admission criteria such as InterQual or Milliman
    - Look for opportunities to improve the current contract for provider services within the ED whether it be termination of the existing contract or renegotiation of the contract
    - Prioritize the development of a "Care Spectrum" at NRMC, engaging relevant clinical and non-clinical leadership
    - Seek to grow swing bed program through proactive outreach to tertiary hospitals
    - Seek to optimize the EMR to effectively capture referrals to understand where patients are going for care and what care they are seeking
  - Work with the City of Nevada and Fort Scott to review options that will allow NRMC to begin providing care to residents of Fort Scott and Deerfield, which represent a community that is equivalent in terms of population to the city of Nevada

RECOMMENDATIONS

- **Future of Rural Healthcare**
  - Utilize this report to update and revise the existing strategic plan, considering the following:
    - The evolving payment system as a key driver of organizational strategy
    - Development of a robust measurement culture in revenue cycle
    - Expansion and optimization of the 340B program
    - Development of an inpatient and outpatient growth strategy
    - Strong management accounting systems
    - Strategic growth of NRMC's primary/specialty network, leveraging telehealth platforms as appropriate
    - Potential partnership opportunities that provide mutual value between NRMC and partner
    - Focus on patient-centric care delivery, borrowing concepts from the retail sector, to enhance patient access, convenience, and experience
    - Growth of comprehensive care management services in the clinics
    - Enhanced focus on alignment efforts with service area primary care providers
    - New service offering growth based on the assessment of demand within the community and initial feasibility modeling
    - Focus on data-driven decision-making, leveraging public and internal data resources
    - Quality improvement as a strategic advantage

RECOMMENDATIONS

- **Provider Complement/Practice Management**
  - Work with Dr. Box to develop and implement an Allergy practice that can pull from a wide service area and differentiate NRMC from other organizations within the market
  - Increase the amount of support staff available to providers, especially high-volume providers such as ENT to increase access and the number of patients that can be seen
  - Continue to offer expanded hours in the NowCare Clinic and look for opportunities to expand hours and services within the other clinics
  - Work with third-party payers to ensure that NRMC is receiving adequate payments relative to Medicare-allowed amounts
  - Create a focus to grow AWVs through proactive outreach to Medicare patients and greater education for both administrators and providers on the value of these visits
  - Seek to increase the number of enrolled CCM patients to support enhanced care coordination and realize financial benefits (see Population Health Management)
    - Consider Chart Span partnership as it relates to the growth of the CCM program
- **Provider Alignment**
  - Pursue greater alignment with all providers in the service area through functional, contractual and governance alignment strategies given the future importance of primary care network development to developing payment systems
    - Consider the development of a formal CMO role to provide the medical staff with a representative on the senior leadership team

RECOMMENDATIONS

- **Inpatient Services**
  - Target growth in acute average daily census to at least 10.0 (Med/Surg), and a swing bed census of 5.0, to achieve 40% inpatient Medicare market share in the home zip code of Nevada via the following activities:
    - Expand utilization of consistent inpatient admission criteria via InterQual to drive consistency in inpatient admissions
    - Define the Care Spectrum (those patients able to receive care at your facility) as a collaborative, multi-disciplinary group inclusive of the following categories: Medical Staff, Nursing, Pharmacy, Medical Equipment, and Therapists
      - Establish a system to monitor patient disposition and periodically re-educate the medical staff on admission and observation status criteria to ensure the appropriate disposition of patients, as well as throughput efficiency
    - Better educate staff/providers on inpatient admission criteria to ensure optimal patient placement and level of care
    - Consider the development of a swing bed marketing plan including, targeting outreach to area hospital case managers, local area providers, and patient education on swing bed services and the program at NRMC
  - Expand the use of multidisciplinary clinical and operational huddles to improve internal communication and coordination
  - Consider expanding the employment of per-diem nurses to alleviate the use of agency nurses and reduce expenses
    - Consider outreach to former full-time employed nurses to gauge willingness to return to NRMC

RECOMMENDATIONS

- **Emergency Department**
  - Ensure inpatient admissions and transfers from the ED are tracked and monitored consistently, targeting an admission rate of 12% of visits and a transfer rate of 5% or less
  - Prioritize expanded utilization of formal inpatient admission criteria, such as InterQual or Milliman, to ensure consistency in admission decisions
  - Develop a consistent meeting cadence between NRMC and the ED provider group to discuss performance as it relates to key indicators; if the ED provider group cannot meet NRMC set targets, consider alternative options for ED provider contractors
  - Evaluate the current nurse staffing model, potentially looking into cross-departmental nurse coverage between units
- **Surgical Services**
  - Target continued growth in surgery as a strategic priority to increase revenue with a focus on orthopedics and ENT
  - Work with Dr. Box to grow ENT surgical volume by investing in an additional MA to increase clinic volumes, which will subsequently increase ENT surgical volumes
  - Work to accelerate Dr. Hall's insurance credentialing with BCBS to address the backlog of patients waiting for surgery and increase his efficiency
  - Continue to evaluate additional services that can be offered at NRMC
  - Promote current and new services to the community to increase referrals
  - Work with EMR to ensure that referrals can be tracked for all surgical patients

RECOMMENDATIONS

- **Imaging**
  - Ensure imaging referrals are tracked by provider to gain insight into service area market opportunities
  - Look for opportunities to invest in equipment and services such as new CT and ultrasound machines
  - Consider opportunities to cross-train current imaging staff or hire MRI certified technologist to increase MRI access to 5 days a week
  - Continue best practice of tracking radiology turnaround times and working with Advanced Radiology to ensure timely results are provided
- **Laboratory**
  - Initiate more frequent outreach/promotion of services with area providers and the community to drive greater utilization
  - Evaluate opportunities to create a separate reference lab fee schedule to make lab service pricing more attractive to the local community
  - Target growth in the Fort Scott community as a strategic priority
  - Work to restart providing lab services to the adjacent nursing home
- **Cardiopulmonary**
  - Continue to evaluate additional cardiopulmonary services to grow volumes
  - Continue with frequent outreach/promotion of services with area providers and the community to drive greater utilization
  - Work to market the new pulmonologist to expand and build her practice

RECOMMENDATIONS

- **Staffing Benchmark Analysis**
  - Use volume-based staffing benchmarks, in addition to other available data sources, to evaluate departmental staffing levels with the goal of maintaining efficiency, understanding that, in a low-volume environment, attaining optimal efficiency in terms of staffing may not be feasible given minimum staffing requirements
- **340B Drug Pricing Program**
  - Target 340B benefit within the estimated range by evaluating contract pharmacy arrangements and leveraging 340B opportunities
  - Work with CPSI to ensure functionality of the 340B program
- **Quality Improvement**
  - Ensure that quality is leveraged as a strategic priority for long-term growth
  - Implement an overarching Quality Improvement Committee that governs all quality activity throughout the organization and has representation from medical staff and the Board
  - Use quality and patient satisfaction data to target underperforming areas while promoting high quality in best practice areas
  - Evaluate current quality improvement infrastructure, seeking to create a culture of improvement in this area
  - Actively round with patients and engage with the community to seek feedback on opportunities for the hospital to improve
  - Consider the development of a Patient Family Advisory Council to hear directly from those in the community
  - Work to increase HCAHPS survey response rates to 30% using rounding and reminders

RECOMMENDATIONS

- **Human Resources**
  - Continue to utilize researched wage surveys to index employee salaries
    - Consider opportunities to increase employees to the 50th percentile (when financially feasible) to make NRMC more attractive as it relates to recruitment and retention
  - Look for opportunities to roll out a house-wide market increase to bring employees in line with current market demand
  - Work with the Board to implement merit-based incentives for employees based on an objective evaluation of employee performance
  - Continue the best practice of offering a robust insurance plan
  - Continue best-practice retirement plan matching
- **Information Technology**
  - Consider opportunities to re-evaluate the existing contract with CPSI to ensure NRMC is receiving optimal value
  - Work with CPSI to address known issues that have developed throughout the conversion to improve patient safety, employee morale, and revenue cycle performance
    - If the current EMR cannot meet the needs of NRMC, consider opportunities to look for a new EMR provider

RECOMMENDATIONS

- **Management Accounting**
  - Prioritize the development of a measurement and accountability culture through the following:
    - Involve department managers in the budget preparation process and have them establish volume, revenues, and expenses to promote ownership and accountability
    - Require all department managers to provide variance analysis on a monthly or quarterly basis for pre-determined variances (e.g., +/- 10%) from the budget for revenues and expenses and plan monthly meetings with Controller/CFO for overall financial/business mentoring
    - Maintain a focus on revenue growth by encouraging departmental managers to build business cases for additional services and budget if adequate volume and revenue can be generated
- **Cost Report Opportunities**
  - *RHC Productivity Waiver*
    - NRMC should immediately file for productivity waivers for their PB-RHCs that exceeded their Upper Payment Limits and actively pursue the processing of the refiled report

RECOMMENDATIONS

- **Revenue Cycle**
  - *Performance Measures/Management*
    - Continue to ensure the revenue cycle committee meets weekly and is tasked to monitor and improve revenue cycle performance
    - Reinstate the list of KPIs that were in place before the implementation of CPSI, and monitor consistently, using these to inform revenue cycle committee meetings
    - Utilize the KPI dashboard that was discovered from the recently acquired clinic, and ensure this dashboard is widely disseminated to NRMC leadership and other key revenue cycle staff on at least a monthly basis
  - *Patient Registration*
    - Expand and standardize the pre-registration of all scheduled outpatient services at NRMC to verify insurance and patient information, and to discuss payment for services
  - *Point of service collections (POS)*
    - Create a POS collection process in all applicable areas of the hospital, targeting 3% of overall net patient revenues
    - Consider implementing a self-pay discount if paid at the time of service to 14 days after the date of service to encourage faster and more consistent payment
    - Consider a prompt pay discount for self-pay patients in the clinics, and monitor this discount as future pricing changes are adopted

RECOMMENDATIONS

- **Revenue Cycle, cont.**
  - *Concurrent Coding Review*
    - Implement a concurrent coding review process for all acute care services
  - *Third Party Contracts*
    - Review all professional fees from third-party contracts
    - Develop a consistent review process to ensure contracts are reasonable, and that NRMC is being paid appropriately according to contracts
    - Work to renegotiate third part contracts with emphasis on the clinics
  - *Denials Management*
    - Continue best practice denials management practice targeting a best practice denial rate of 5% or less
  - *Charge Capture*
    - Work with CPSI to make it easier for managers to perform daily charge reconciliation subsequently, require all department managers to perform a daily charge reconciliation
    - Ensure all department managers are educated on the importance of proper charge capture to overall financial performance

RECOMMENDATIONS

- **Service Area Rationalization**
  - Prioritize financial and operational improvement opportunities outlined in this report, seeking to generate enough margin to sustain operations
  - Once financial stability is achieved, consider performing a strategic options analysis to evaluate long-term strategic partnership opportunities with area providers that maximize NRMC's value with consideration of the following areas:
    - Primary care provider recruitment and alignment
    - Access to specialty care services, and potential growth in ancillary services supporting those specialists
    - Expanded care management capabilities and establishment of best practice, evidence-based medical protocols
    - Value-based payment arrangements, such as support for Accountable Care Organization (ACO) involvement (see Payment System Transformation)
    - Capital investments
    - Technological integration and support (e.g., shared EMR)
    - Additional expense reductions through further administrative integration, group purchasing, and shared service arrangements

RECOMMENDATIONS

- **Population Health Management**
  - *Patient-Centered Medical Home (PCMH) Development*
    - Expedite the pursuit of PCMH designation to access enhanced reimbursement and efficiency opportunities
    - Educate providers, clinic staff, and other key stakeholders on the PCMH model, such as potential opportunities for additional reimbursement associated with the designation, and potential opportunities for increased efficiency when implemented in conjunction with team-based care
  - *Team-Based Care*
    - Invest in support staff such as Medical Assistants within the clinics to diversify job roles and allow providers to spend more time with patients rather than performing administrative functions
    - Evaluate opportunities to further implement team-based care in NRMC primary care delivery settings, utilizing the Shared Principles of Primary Care compiled by the Primary Care Collaborative (See Appendix III) as a guide, to improve the efficiency of practice and patient experience
    - Educate providers and clinic staff on the benefits of a team-based care approach, such as potentially improved patient experience, enhanced capacity to support a greater patient panel size, and greater staff satisfaction as members of the care team can operate at the “top of their license”
  - *Claims/Analytic Capabilities*
    - Develop a consistent claims review process based on claims from NRMC’s self-insured plan to identify areas of opportunity for service growth, cost management of high dollar cases, reduced service outmigration, and other appropriate areas while also improving the health of the NRMC workforce

RECOMMENDATIONS

- **Payment System Transformation**
  - *Self-Insured Health Plan*
    - Consider increasing the financial benefit of utilizing NRMC services for care for those under the NRMC self-insured plan
  - *Medicare Care Management Programs*
    - Continue to grow Medicare AWV and CCM programs to drive increased reimbursement
    - Continue to evaluate and develop partnerships to grow care management and receive additional reimbursement
    - Consider opportunities with Main Street Health to grow the CCM program
    - Evaluate the advantages of TCM and BHI programs
  - *Alternative Payment Model*
    - Evaluate potential opportunities to participate in an ACO through a partnership with a larger organization once other initiatives in this report have been undertaken and NRMC is in a position to sustain operations
      - Consider opportunities to participate in Main Street Health's ACO

APPENDIX

APPENDIX I: PROVIDER SUPPLY STUDY BENCHMARKS

Provider Supply (FTEs) for Service Area of	24,193		
	Supply Indicators		
Primary Care	Kaiser	Group Health	Health Partners
Family Practice	3.3	11.4	5.4
Internal Medicine	6.7	2.8	6.6
Pediatrics	2.9	1.9	2.5
Subtotal	12.9	16.1	14.4
Non-Phys Providers	3.2	5.5	1.6
Primary Care Total	16.1	21.6	16.1
Medical Specialties			
Allergy	0.3	0.3	0.2
Cardiology	0.7	0.9	0.9
Dermatology	0.6	0.4	0.5
Endocrinology	0.3	0.1	0.2
Gastroenterology	0.5	0.6	0.5
Hem/Oncology	0.5	0.6	0.5
Infectious Disease	0.2	0.1	0.2
Nephrology	0.3	0.3	0.4
Neurology	0.4	0.5	0.7
Pulmonary	0.2	0.5	0.4
Rheumatology	0.2	0.3	0.3
Surgical Specialties			
ENT	0.6	0.7	0.1
General	1.5	1.6	1.8
Neurosurgery	0.2	0.3	
OB/GYN	2.6	1.9	2.2
Ophthalmology	0.9	0.9	0.9
Orthopedic	1.0	1.7	
Plastic Surgery	0.3		0.5
Urology	0.6	0.7	

Physician Need Calculations

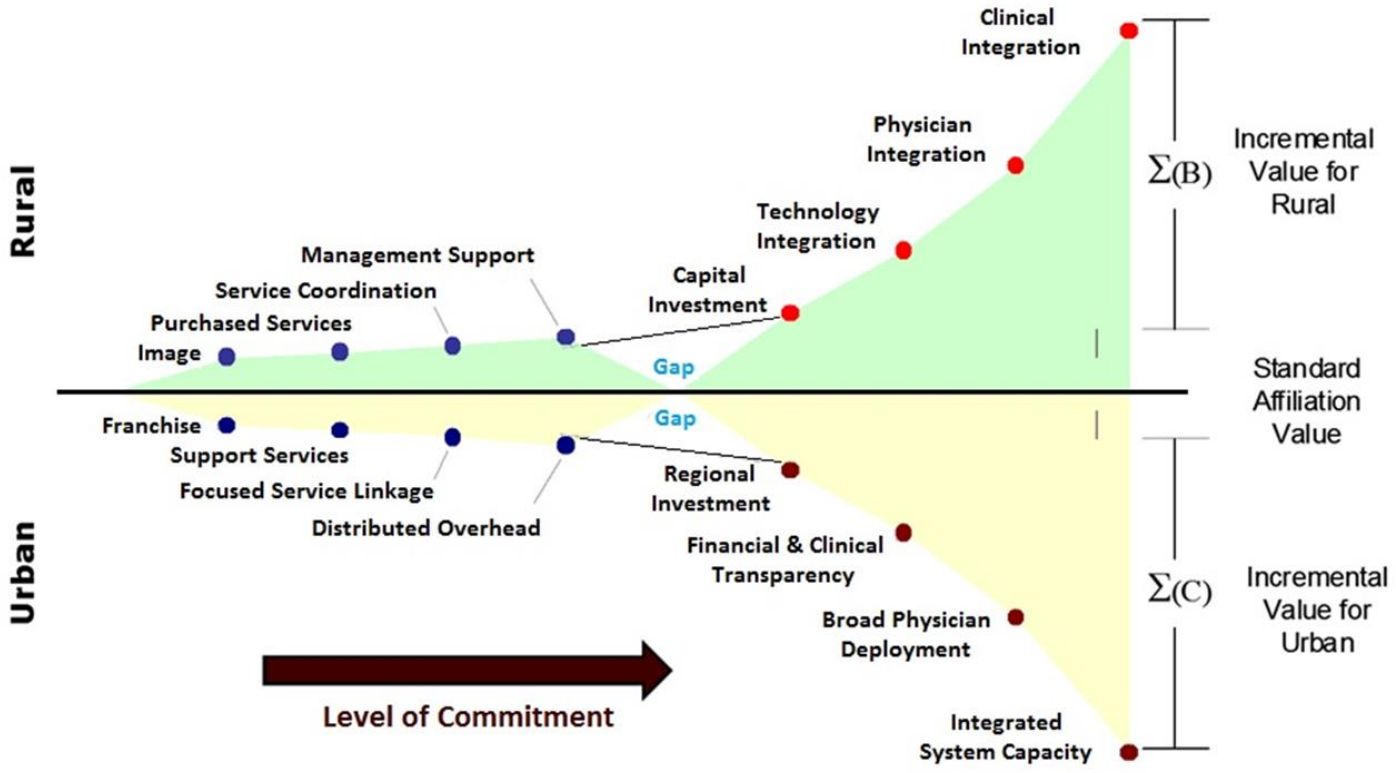
- Physician-to-population ratio data represents physician-to-100,000 population rates from three large prepaid group practices that serve over eight million consumers
  - Source: Weiner JP, Prepaid Group Practice Staffing and U.S. Physician Supply: Lessons for Workforce Policy, Health Affairs, 4 February 2004.
  - Calculated need values for Family Practice developed by averaging Weiner data (above) and a state-specific ratio of family/general practice physicians to population
    - Source: Flowers et al. State Profiles: Reforming the Health Care System. AARP Public Policy Institute. 12th Edition. 2003
  - Area physician FTEs calculated as 18 days per month = 1.0 FTE

Physician Shortage/Surplus Caveats

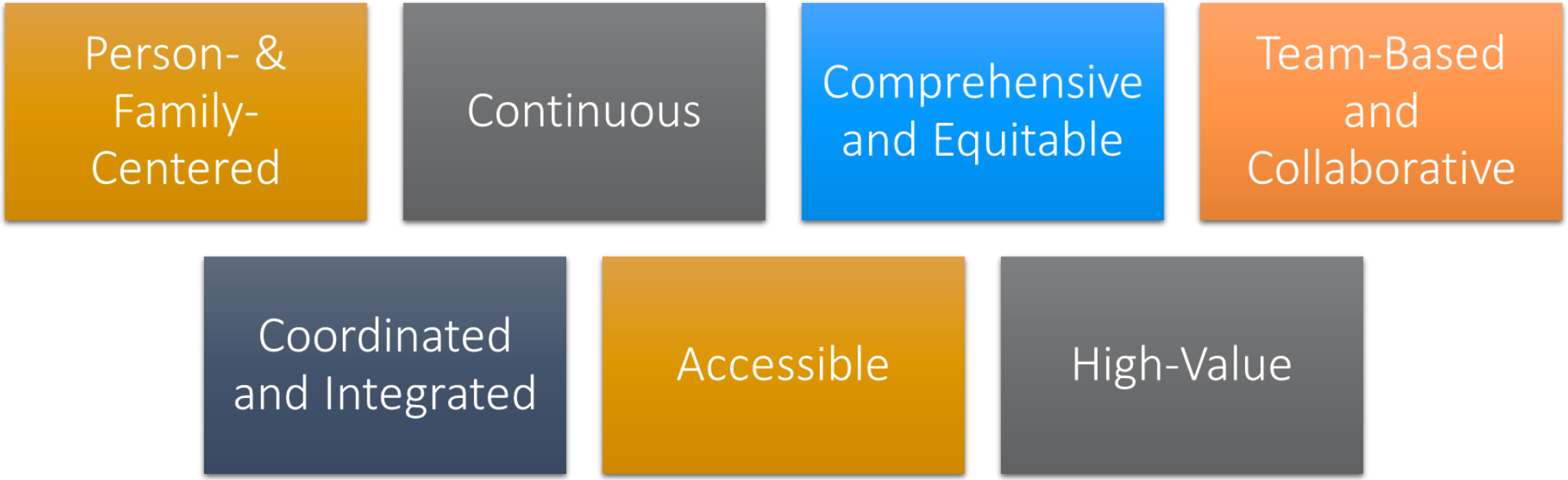
- Determination of physician shortage/surplus is much more complex than comparisons to national ratios
- Factors such as local access to care (e.g., delay for non-urgent appointments), community perceptions, current physician perceptions, projected service area change, etc., should be considered

APPENDIX II: AFFILIATION COMMITMENT CURVE

- Affiliation benefits are arranged along a diverse continuum and mutual commitment from both partners is required to yield maximum benefit from an affiliation



APPENDIX III: SEVEN SHARED PRINCIPLES OF PRIMARY CARE

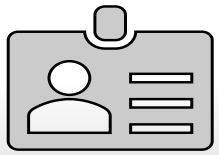


For additional information on the shared principles, go to https://www.pcpcc.org/about/shared-principles

APPENDIX IV: POPULATION HEALTH MANAGEMENT MODEL

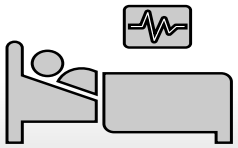
TOP 5 BENEFITS OF A POPULATION HEALTH MANAGEMENT MODEL

1. AVERAGE YEAR 1 INSURED GROUP SAVINGS OF 12.6% (source: RAND corporation)



2. EMPLOYEE CASE MANAGEMENT PROGRAMS (source: MD Anderson)

- 80% improvement lost workdays over 6 years
- 64% decline modified-duty days
- 50% reduction in workers' comp insurance premiums

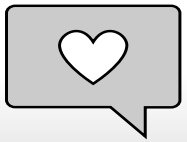


3. HIGH-RISK PATIENT MANAGEMENT (source: Harvard Business Review)

- 57% converted to low-risk over 6 months
- $1,421/participant claims reduction over 1 year
- $6 savings per $1 invested over 1 year

4. WELLNESS PROGRAMS (source: Johnson & Johnson)

- 67% reduction smoking
- 50% reduction hypertension
- 50% increase in physical activity
- $2.70 savings per $1 invested (5 years)



5. VOLUNTARY EMPLOYEE TURNOVER REDUCTION

- 9% vs. 15% (source: Towers Perrin study)
- 9% vs. 19% (source: Biltmore study)