OCH REGIONAL MEDICAL CENTER

RESPONSE

TO

STROUDWATER OPTIONS ASSESSMENT

DECEMBER 14, 2016

An executive summary of this report is available at och.org. Click on "Your Hospital" link.

OCH REGIONAL MEDICAL CENTER

RESPONSE

TO

STROUDWATER OPTIONS ASSESSMENT

EXECUTIVE SUMMARY

OF

10/17/2016

INFORMATION PROVIDED HEREIN IS IN RESPONSE TO THE EXECUTIVE SUMMARY:

- **THAT EITHER DID NOT INCLUDE INFORMATION PROVIDED BY OCH TO CONSULTANTS, OR**
- **INFORMATION PRESENTED BY THE CONSULTANTS NOT PROVIDED BY OCH, AND**
- **SUPPLEMENTAL INFORMATION FROM OCH THAT THE PUBLIC NEEDS TO HAVE IN ORDER TO HAVE A FULL UNDERSTANDING OF OCH AND SUPPORT OF MEDICAL STAFF IN OCH PERFORMING AS A SELF-GOVERNING STAND ALONE COMMUNITY HOSPITAL**

"THE REST OF OCH & MEDICAL STAFF STORY"

from

BOARD OF TRUSTEES, MEDICAL STAFF & ADMINISTRATION

DECEMBER 14, 2016

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No additional information is needed for clarification to pages 2 - 4 of the Stroudwater Report.

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Key Industry Trends:

Inpatient Service Demand Annual Rate Decline 2% since 2008 Page 6
Outpatient Service Demand Annual Rate Increase 3% as of 2008 Page 7

Source: Avalere Health Analysis of American Hospital Association Annual Survey Data, 2013

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The historical trending below shows that outpatient utilization is continually increasing with the exception of therapy visits while inpatient utilization is decreasing because of the third party payors' mandates to provide more outpatient services. OCH's trend data is consistent with third party payor initiatives for their network members.

Generally accepted practice to look at changes over a 5 year period
(To level out unusual annual increases or decreases)

OCH Actual Experience: **(See more comments on pages 13 &14 of this response regarding IP trend down)**

Inpatient / Outpatient Utilization

	FY 2011	FY 2015	5 Year Change	% Change
Inpatient -				
# of Available Beds	96	96	0	0.0%
Admissions	3,101	2,505	-596	-19.2%
Newborns	936	905	-31	-3.3%
Pt Days of Care	11,610	9,854	-1,756	-15.1%
Length of Stay	3.72	3.80	0.08	2.2%
Occupancy	33.08%	28.10%	-4.98%	-15.1%
See staffing note on next page.				
IP/OP & Ancillary Proc				
IP Surgical	711	1,018	307	43.2%
OP Surgical	4,099	4,252	153	3.7%
Total Surgical	**4,810**	**5,270**	**460**	**9.6%**
IP Endoscope	111	141	30	27.0%
OP Endoscope	1,618	2,183	565	34.9%
Total Endoscope	**1,729**	**2,324**	**595**	**34.4%**
ALL Procedures				
Total IP	82,291	77,925	-4,366	-5.3%
Total OP	117,902	156,596	38,694	32.8%
Total IP & OP	**200,193**	**234,521**	**34,328**	**17.1%**

Therapy Visits				
IP Therapy Visits	38,817	46,412	7,595	19.6%
OP Therapy Visits	76,516	69,067	-7,449	-9.7%
Total Therapy Visits	**115,333**	**115,479**	**146**	**0.1%**
OP Registrations / ER Visits	**FY 2011**	**FY 2015**		
OP Registrations	**30,985**	**35,529**	**4,544**	**14.7%**
ER Visits	**25,206**	**29,425**	**4,219**	**16.7%**
Total	**56,191**	**64,954**	**8,763**	**15.6%**
ER Visits Admit IP	**1,320**	**775**	**-545**	**-41.3%**
ER Visits Admit Observation	**587**	**1,550**	**963**	**164.1%**
ER Visits Surgical OP	**119**	**167**	**48**	**40.3%**

Staffing Note -
October 10, 2016

Currently, OCH is staffing 68 beds concerning our Inpatient census count and Outpatient Nursing services. Outpatient care rendered by nursing staff in the medical unit, surgical unit, ICU, and labor & delivery are:

- **Observation patients**
- **Swing bed patients**
- **Blood transfusions**
- **Labor monitoring**
- **Specialty injections**
- **Specialty infusions**

The outpatient services listed above are not a part of our daily census reported by the HIM department.

In addition to caring for patients in the Nursing units listed above, Nursing is also responsible for staffing for the following outpatient areas:

- **Ambulatory surgery**
- **Pain management**
- **GI Lab (endoscopy and colonoscopy)**
- **Emergency room**
- **Emergency medical services**

On any given day there will be 40 to 50 patients and on other rare occasions, OCH will be full, whether they be inpatients, outpatients, or observation patients.

On a daily basis, the Nursing House Manager utilizes a staffing tool for accuracy and the nursing employees are managed accordingly. When the census justifies more staff, the PRN pool is accessed. With low patient census, staff is sent to assist in a busier unit or sent home. This process is continuous and on-going since no two shifts are the same.

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Key Industry Trends:

System Activity in State of Mississippi - 63% in a System Page 8
Source: American Hospital Directory

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See Appendix 1 on page 67 for Spreadsheet Listing of Hospital Systems & Hospitals Providing Acute Medical/Surgical Care in the State of Mississippi by status: Non-Profit (NP), Governmental Non-State Owned (GNS), State (SH) & For Profit (FP)

In the State of Mississippi during 2015-16, there were 102 hospitals with acute care medical/surgical beds. A summary of the hospitals listing is provided below:

6 Non-Profit Systems (NP):		
System NP Hospitals	**25**	**24.5%**
Under Management Only	**1**	**1.0%**
Non-System NP Hospitals	**6**	**5.9%**
++		
5 Gov't Non State Systems (GNS):		
System GNS Hospitals	**7**	**6.9%**
Under Management Only	**5**	**4.9%**
Non-System GNS Hospitals	**23**	**22.5%**
++		
1 Gov't State System:		
3 State Hospitals	**3**	**2.9%**
++		
8 For Profit Systems (FP):		
System For Profit Hospitals	**24**	**23.5%**
Under Management Only FP	**1**	**1.0%**
Under Management Only GNS	**1**	**1.0%**
In Bankruptcy	**2**	
Looking for Buyer & previously sold 2nd time	**9**	
Recently Sold for 3rd Time	**3**	
Non-System FP Hospitals	**6**	**5.9%**
++		
Totals	**102**	**100.0%**
++		
MS Hospitals in Systems		**57.8%**
MS Hospitals in Non-Systems		**34.3%**
MS Hospitals under Management		**7.9%**

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Key Industry Trends:

What Does This Mean for Hospitals and Health Systems? Page 9

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- *Business as usual is out the window, and a new problem must be solved – learning to manage population health and justify your prices*

  OCH Trustees, Administration, Department Directors & Medical Staff are very well aware that health care is in a transitional process. Population Health Management has not been completely defined and many experimental programs are in process throughout the United States. The Medical Staff & OCH will work within the framework of Population Health Management for the primary and secondary service area of OCH as required by Medicare, Medicaid, and other commercial insurance payors. Networking with other systems will be an option for OCH in addition to what is being done and considered independently by OCH and the Medical Staff. OCH has approximately 80 programs aimed at improving the general health of the community and meeting some aspects of population management. OCH will collaborate with the Medical Staff regarding third party payors bundled payment programs and with other community providers when comprehensive episodic payments are put into place.

  With an incoming republican president elect and a republican controlled senate and house of representatives, there is much uncertainty as to what changes will be forthcoming with the Affordable Care Act and what the impact will be on hospitals and physicians. OCH and Medical Staff will make the proper adjustments to address any new medical/health care regulations as always.

- *More and bigger consolidation will be necessary to provide the needed care and services to the community, assemble the intellectual and financial capital required to succeed, and absorb and manage risk*

  This is an opinion expressed by Stroudwater. Bigger is not necessarily better. Hospital corporate systems have failed in the past, and there are some systems currently in financial trouble.

  OCH Trustees, Administration, Department Directors & Medical Staff have and will continue to work together to provide the needed care to the population within OCH's primary and secondary service areas. OCH will recruit needed physician specialists and other providers that can have sustainable viable practices within the population base of OCH's service area. Startup costs and financial assistance have been provided in the past by OCH and will continue in recruiting needed physician specialists to Starkville who can have sustainable practices. OCH's recruitment efforts must be compliant with Federal Stark Rules and Regulations and Anti-Kickback Laws as well state laws and/or State of Mississippi Attorney General opinions regarding non-state owned governmental and non-profit hospitals. In certain situations affiliation, not involving either a sale or lease of OCH, with other hospitals or systems may be a viable option in

achieving certain strategic objectives. OCH is an investor with 61 other hospitals in MississippiTrue, a developing network, for becoming a viable Medicaid Managed Care Company in the State of Mississippi as 1 of 3 vendors that will be seeking approval from the Division of Medicaid.

- *Hospitals and physicians must increase collaboration*

  OCH and the Medical Staff are very much aware of the future requirements for collaboration and clinical integration. OCH will work with the Medical Staff and use collective efforts to structure those collaborative and clinical integrated processes that will have a positive impact as the market changes for the delivery of health care in OCH's primary and secondary market.

- *Big investments in IT and care management will be essential*

  OCH and Medical Staff understand the importance of having appropriate investments in IT for the electronic health record (EHR) and hardware for appropriate software applications for running the clinical and administrative operations of the Hospital as well as having effective care management. The Board of Trustees and Administration will respond to the demands of these components as needed. In April 2016, the current EHR system of OCH was certified by HIMSS Analytics Healthcare for Stage 6 Meaningful Use for the Electronic Medical Record Adoption Model. As of November 11, 2016, there were only 23 hospitals in the State of Mississippi certified for Stage 6 Meaningful Use. Only 29% (1,601) of the hospitals in the United States achieved this recognition as of award date to OCH. The current certification requirement of CMS (Medicare) is for Stage 3 Meaningful Use. Stroudwater declined to interview OCH's CITO/ITS Director regarding the Hospital's IT capabilities which obviously exceeds current governmental requirements.

  OCH has an outstanding IT staff of analysts and programmers for data exchange of users throughout the Hospital. OCH has continuously invested in IT infrastructure with current networking capabilities that comply with all federal and state requirements and cybersecurity protection from external and internal threats. OCH's CITO/Director is 1 of 7 advisory members selected throughout the State of Mississippi by Blue Cross Blue Shield of Mississippi for participation in its CIO Collaborative Committee to establish "Minimum Data Security Standards" for Blue Cross Network Hospitals throughout the State and has also been an IBM Global Mid-Market Board Advisor for IBM Product Offerings.

- *Core competencies will need to evolve along with the market*

  As always, OCH will continue to adapt to the ongoing changes regarding clinical core competencies.

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Stakeholder Perspectives:

Stakeholder Interview Highlights – Perceived Strengths Page 11
Stakeholder Interview Highlights – Challenges Pages 12 - 13

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Perceived Strengths:

- *OCH Regional Medical Center enjoys good community support for basic healthcare services*
- *Primary service area (Starkville/Oktibbeha County) is a vibrant, growing community*
- *Loyal/committed medical staff, allied health professionals and nursing staff*
- *OCH Regional Medical Center provides quality, patient centered and personalized care*
- *Obstetrics/Women's health/Pediatrics are regionally recognized services*
- *OCH Regional Medical Center has up to date equipment and technology for diagnostic and surgical care*

OCH agrees with the strengths cited above but would like to call attention to the additional honors and accolades that OCH has received over the years. Visit och.org for details.

Challenges:

- *Lots of anxiety and uncertainty inside the hospital about the future of OCH Regional Medical Center*

We respond to this statement with a resounding "yes"! High anxiety has been brought on again by this assessment process with the decision that rests in the hands of the Board of Supervisors to sell or lease OCH to an unknown entity. Employees wonder what impact a sell/lease could have on them and their families since they know that it is a common practice with such transactions for basic core administrative/clinical administrative like functions to be centralized to corporate headquarters. OCH employees do not deserve to have their morale negatively impacted from the discussions that have occurred by some of the Supervisors since 2012. Listed below are the represented responses received from OCH Department Directors regarding comments from their line staff.

- **Concern that their jobs will be lost or change in responsibility**
- **Repeating a merger from prior job experience – very painful**
- **Good employees left OCH for more stable opportunities**
- **Recruitment and retention has been compromised**
- **Uncertainty of OCH's future in the hands of a new owner and changes**
- **Nurses worried about increased nurse/patient ratios -- having less employees with heavier workloads impacting quality of care**

- **Loss of benefits, accrued leave, reduced contributions to retirement, reduced leave time accrual, increased cost of benefits, etc.**
- **Salaries lowered or full-time employees will be made part-time**
- **Effect of patients' perception on quality – already has occurred because of the rampant rumors OCH is being sold/leased**
- **No say in type of equipment for purchase**
- **Going from "state-of-the art" to "hand-me-downs"**
- **Loss of feel of community pride in ownership of OCH**
- **Loss of seniority**
- **Loss of sovereign immunity**
- **Loss of community services being provided**
- **Adverse changes in physician staff**
- **Loss of autonomy with leadership and upper management regarding patient care**

Other hospitals in the State have made contacts with some members of OCH Medical Staff for recruitment to their community because of the perceived instability from the Stroudwater Report, and potential recruits have declined to relocate to Starkville.

This is a representative sample of the comments which were voiced time and time again. No workforce should have to go through this anxiety when OCH has been functioning well and has the ability of continuing in the future.

- *Not enough patient volume to demonstrate a need for development of higher acuity services*

The volume is not likely to change enough to make a difference. The population of the primary and secondary service area of OCH is not large enough to support the "super specialties" like cardiology, neurosurgery, oncology, etc. for the higher acuity patients for inpatient admissions because of the proximity of Baptist Memorial Hospital – GT (23 miles to the east) and North Mississippi Medical Center (60 miles to the north) which is a tertiary care facility and the largest rural hospital in the United States. Baptist Memorial Hospital – GT is 3 times larger and NMMC is 6 times larger than OCH in bed size. OCH and Medical Staff want these higher acuity patients to go tertiary care facilities like UMMC – Jackson and NMMC – Tupelo. The super specialties cannot be recruited to Starkville because the physicians cannot have a sustainable practice. Also, the certificate of need (CON) regulations from the Mississippi State Board of Health and the current state health plan will not allow issuance of a CON for open heart cardiac surgery and a linear accelerator with supporting services for heart and cancer patients respectively.

- *Surgery volumes are mostly ambulatory*

This is a true statement and is not a challenge. OCH is appreciative of its Medical Staff for their clinical expertise and willingness to practice medicine in Starkville and provide their services to the community in a lower cost outpatient setting which is the industry trend. This should not be listed as a challenge at all, but a positive strength and ongoing

opportunity. (See page 6 of this response for IP & OP Surgery and OP Endoscopic Procedures.)

- *Declining occupancy & inpatient volumes*

OCH is in line with this national trend that began in the 1980s. In 1983, IP Revenues were 95% of OCH's gross revenues. Currently IP Revenues are 24.2% of Gross Patients Revenues based on unaudited numbers at September 30, 2016. The 5 year trend from FY 2011 at 29.8% reduced to 26.4% of Gross Patient Revenues in FY 2015 according to audited data.

Inpatient admissions have declined because of the 2 midnight final rule sent to hospitals in 2013. This means that Medicare patients have to be admitted either in an outpatient observation or inpatient status depending on admitting physician anticipation of the length of stay being longer than 2 midnights and patient meeting medical necessity under Interqual Criteria. In these situations the admitting physician must document appropriately for justifying the patient stay as an inpatient discharge for DRG classification and reimbursement.

Medicare, Medicaid, Blue Cross, State of Mississippi, and Commercial Insurance Payors have historically, through managed care and Interqual Admission Criteria shifted patient services to be provided in an outpatient setting. OCH has met those regulatory challenges with OP Revenues growing from 5% in 1983 to 70.2% in FY 2011 and 73.6% in FY 2015. OCH has consistently responded to inpatient shift to outpatient services and will continue to respond appropriately to future changes within the healthcare system.

The goal through federal and state policies for Medicare/Medicaid and other third party payors is to keep patients out of the inpatient setting.

While occupancy and inpatient volumes have declined, the demand for use of patient rooms and beds, beyond the daily census count, has been unchanging. (See page 7 of this response for OCH's fixed staffing methodology.) In addition to daily inpatients, 40 to 50 outpatients occupy beds with no room charges for the reasons below:

1. **Observation patients**
2. **Swing bed patients**
3. **Blood transfusions**
4. **Labor monitoring**
5. **Specialty injections**
6. **Specialty infusions**

OCH and the Medical Staff have responded to outpatient third party payor initiatives while providing comprehensive quality outpatient services.

Important to Note: Neither OCH nor any other hospital in the State of Mississippi or the United States can guarantee that a hospital's patient case mix and volume of services will be the same or grow from year to year. There are numerous variables that

come into play as it relates to patients and what medical conditions that they have or the decision making process relative to elective surgeries.

- *Competition in the community for diagnostic and post-acute services (urgent care, imaging, skilled nursing, physical therapy, rehabilitation services, home infusion, etc.)*

  Starkville is a community with a major university presence. There is strong economic development in the Starkville proper are, and as a result, competition with OCH has occurred. OCH cannot predict:

  - **Where patients will be referred to except for non-sustainable specialty services**
  - **Where patients tell their attending physician where they want to go**
  - **Where patients self-select their providers**

  OCH is keenly aware of competition for key services and will continue to actively promote what needs to be offered.

  Local competition includes the following:

  - **Urgent care centers:**
    These have had limited impact on the Emergency Room of OCH for lesser intensive walk-in patient services. Even with the urgent care presence, OCH had 29,425 in FY 2015 and that number is down to 28,238 for FY 2016. (See stats on page 7 of this response.) This is a good thing. It saves community members money and frees up ER Staff to take care of emergency patients.
    Providers are:
    - **Clinic at Elm Lake**
    - **Fast Care**
    - **Golden Triangle Urgent Care**
    - **Starkville Urgent Care**
    - **State Urgent Care**
  - **Imaging:**
    - **Premier**
  - **Physical Therapy and Rehab Services:**
    - **Bulldog Physical Therapy**
    - **Drayer Physical Therapy**
    - **Encore Rehab**
    - **Kids Therapy**
    - **Longest Student Health Center**
    - **Magnolia Outpatient Rehabilitation**
    - **Starkville Physical Therapy**
  - **Swingbed Programs:**
    - **Carrington Nursing Center**
    - **Starkville Manor Nursing Home**
    - **Vicker's Personal Care Home**

- *High nurse turnover rate primarily among younger / new graduate nurses (MSU transient effect) 19% v. 16% nationally*

Listed below is benchmarking for RN turnover and 1st year turnover with 25 LA/MS Hospitals who are participants with Vizient Gulf States. When looking at benchmark comparisons below, this a across the board trend.

OCH REGIONAL MEDICAL CENTER
Key Performance Indicator Report
25 LA / MS Hospitals **Vizient Gulf States**
Workforce Measures

	RN Turnover	1st Yr. Turnover
OCH 1st Qtr Jan-Mar 2015	**4.0%**	**10.4%**
VHA Gulf States Median	**4.3%**	**10.2%**
OCH 2nd Qtr Apr-Jun 2015	**8.0%**	**13.3%**
VHA Gulf States Median	**4.7%**	**9.3%**
OCH 3rd Qtr Jul-Sep 2015	**6.9%**	**9.8%**
VHA Gulf States Median	**4.4%**	**9.8%**
OCH 4th Qtr Oct-Dec 2015	**2.0%**	**8.5%**
VHA Gulf States Median	**4.0%**	**9.1%**
OCH 1st Qtr Jan-Mar 2016	**1.3%**	**14.9%**
VHA Gulf States Median	**3.9%**	**9.9%**

OCH has not experienced a historical problem in hiring nurses. Agency nurses are an option for OCH if there should ever be a problem. Students rotating through OCH are candidates for employment recruitment. See listing below.

Training facility for: Nurse Practitioner Students, Nursing & Exercise Programs, Nurse Practitioners, RN, LPN, EMT & Paramedic, Graduate Assistant Sports Medicine, Dietetic Intern Rotation, Undergraduate Fitness Management, Sports Administration & Kinesiology, Graduate Health Promotion Exercise Physiology, Physical Therapy & Physical Therapy Assistant Internships, Occupational Therapy, Respiratory Therapy, Health Information Management (HIM) Intern, Operating Room Tech Program, Radiology Technology, Social Work Intern, Surgical Technician and Student Shadowing for community colleges, colleges and universities below.

Alfred State University
Delta State University
East Mississippi Community College
Hinds Community College

Holmes Community College
Itawamba Community College
Meridian Community College
Millsaps College
Mississippi State University
Mississippi University for Women
Pear River Community College
Tennessee State University
University of Alabama in Birmingham
University of Mississippi Medical Center
University of South Alabama
University of Tennessee Health Services Center
University of West Alabama

- *Starkville and Oktibbeha County need access to more primary care/family practice physicians*

  There is a shortage of primary care physicians in the State of Mississippi. Family practice and internal medicine specialties have been a high priority for recruitment efforts for several years. Administration keeps the Board of Trustees and Medical Staff updated monthly with ongoing recruitment efforts of needed physicians for the community.

  Realizing the need for more primary care providers, OCH opened OCH Family Health Clinic on October 17, 2016. Another recruited family practice physician will commence practice in August 2018.

  Recruitment efforts are ongoing for: 2 family practice, 1 gastroenterologist, 2 hospitalists, 2 internists, 1 neurologist, 1 otolaryngologist (ENT) and 1 urologist for clinic practices with inpatient and/or outpatient privileges.

- *There is significant outmigration / transfers of patients to competing facilities for more specialized / higher acuity services*.

  There is no reason to think that this will change if OCH is sold or leased. (See pages 24 - 35 of this response for data and comments.)

- *Communications between the Board of Supervisors and the Board of Trustees historically have been very limited*

  Historically, the Board of Supervisors have not wanted periodic board meetings with the Board of Trustees. Supervisors relied on their appointed Trustees in operating and governing OCH. Trustees/Supervisors would communicate with each other at any time they should so desire. The Board of Trustees is willing to meet with the Board of Supervisors in any joint meetings that are needed.

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Review of Inpatient Facility Needs: ***Page 15***

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Inpatient Facility Needs

- *OCH Regional Medical Center made significant capital investments in its facility:*
  - *Between 2002 and 2006 the hospital added approximately 109,000 square feet of new space and renovated 56,000 existing square feet*

    New emergency room, lab, outpatient surgery, surgical suites, central power plant, new three-story tower and connection to existing hospital, renovation of three existing hospital floors
  - *Between 2010 and 2012, the hospital added another 87,000 square feet of new space and renovated approximately 29,000 existing square feet*

    Larger patient rooms, new Women's Center, improved ICU, new front entrance, new HVAC, new parking garage
- *The expansion and renovations have improved the patient care setting, improved patient flow, and created more efficient ambulatory care space*

No additional information is needed for clarification to page 15 of the Stroudwater Report.

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Historical Revenue Mix Trends: ***Page 16***

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2010 to 2016 GAGR:

IP Gross Revenue	*1.8%*
OP Gross Revenue	*7.1%*
Total Net Revenue	*3.7%*

Generally accepted practice to look at changes over a 5 year period
(To level out unusual annual increases or decreases)

	(Audited Million)							Unaudited	
	FY10	FY11	FY12	FY13	FY14	FY15	5 Yr.	FY16	5 Yr.
IP Revenue	44.8	48.8	49.3	47.2	44.8	52.0	6.5%	45.4	-7.9%
OP Revenue	96.9	103.6	114.8	124.8	136.1	144.5	39.4%	141.8	23.5%
Gross Revenue	141.7	152.4	164.1	172.0	180.9	196.5	28.9%	187.2	14.0%
Net Revenue	55.7	58.3	60.2	61.0	64.3	70.9	21.6%	71.6	18.9%
Cash Receipts	56.8	58.1	60.6	59.7	62.3	69.1	18.9%	68.7	13.3%

OCH has experienced very good revenue and cash receipts growth for the comparative 5 year periods from FY 2011 to FY 2015 and FY 2012 to FY 2016 except for the downward trend for inpatient revenues, which was expected due to patient/payors shifting to outpatient services.

Inpatient admissions have declined because of the 2 midnight final rule sent to hospitals in 2013. This means that Medicare patients have to be admitted either in an outpatient observation or inpatient status depending on admitting physician anticipation of the length of stay being longer than 2 midnights and patient meeting medical necessity under Interqual Criteria. In these situations the admitting physician must document appropriately for justifying the patient stay as an inpatient discharge for DRG classification and reimbursement. This accounts for a declining effect on inpatient revenues.

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Inpatient Volume Trends: ***Page 17***
Historical Inpatient Admissions Trend downward
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- *Though decreasing inpatient admissions are a national trend, OCH's decline is steeper, creating operating and financial risk for the hospital*

  OCH does not agree with the conclusion drawn with this comment. Trending away from inpatient admissions is the desired goal in health care. It is not an operational and financial risk as long as the outpatient trend is going up, which is the case for OCH.

- *More services are moving to an ambulatory setting*

  OCH is in agreement.

- *Many inpatient hospital facilities reflect prior-era service line strategies*

  OCH is in agreement.

- *OCH needs to find opportunities that will increase throughput in a high fixed-cost business (i.e., expanded swing bed programs, residential behavioral health, hospice care, etc.)*

  OCH is always open to expanding its opportunities with programs and services to meet community needs pending CON approval when required.

  OCH currently has 10 swing beds and can evaluate justification of adding swing beds when volume is sufficient which will require approval from the Mississippi State Board of Health.

  Within the past 2 years, OCH conducted research to consider adding geri-psych beds. Although OCH is open for seeking approval for geri-psych beds from the Mississippi State Board of Health, our present facility layout presents many logistic problems in trying to provide geri-psych care and meeting the regulatory requirements. If OCH should proceed to provide geri-psych services, the Medical Staff will need to approve for clinical endorsement and appropriate physician credentialing for patient care case management.

  In regard to hospice care, OCH has a contract with Gentiva Hospice for providing services for patients.

  OCH is at all times open to adding and/or expanding services for the benefit of the community as well as to improve its bottom line. Examples of such services recently include the new wound care center and new primary care clinic.

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Inpatient v. Observation Admissions ***Page 18***
Emergency Department Admissions

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Generally accepted practice to look at changes over a 5 year period
(To level out unusual annual increases or decreases)

Admissions by Type:

	FY11	FY12	FY15	5 Year Change	FY16	5 Year Change
Total Admissions	3,101	2,859	2,505	-19.2%	2,381	-16.7%
Total OP Observations Admits (1)	451	662	1,268	181.2%	1,046	58.0%
Inpatient Medicare Admits	1,266	1,082	1,065	-15.9%	838	-22.6%
Inpatient Medicaid Admits	1,589	1,498	1,222	-23.0%	1,310	-12.6%
Newborn Admits	936	964	905	3.3%	929	3.6%
ER Visits Admitted as IP	1,320	990	775	-41.3%	648	-34.5%
ER Visits OP Observation Admits (1)	587	878	1,550	164.1%	1,404	60.0%

The 5 year change above from FY 2011 to FY 2015 as compared to FY 2012 to FY 2016 shows the dramatic impact that federal and state policies have had on shifting hospital care from inpatient admissions to outpatient status. Blue Cross, State of Mississippi and other commercial insurance payors have adopted similar managed care policies that case managers have to use in justifying inpatient admissions.

It is easy to see the correlation in the decrease of inpatient admissions and increase of outpatient observation.

(1) Note: The difference in data reported above as "Total OP Observation Admits" & "ER Visits OP Observation Admits" is due to the case managers changing the status of the "ER Observation Admit" to an "Inpatient Admit" when patients meeting Interqual Admission Criteria after transfer from the ER.

(See outpatient utilization data on pages 6 & 7 of this response for the ongoing growth of services as hospital/medical care has continued to shift to the outpatient environment.)

- *The growth in observation stays poses a challenge for OCH. This trend has an adverse effect on the hospital's revenues and poses new challenges for care management.*

  This statement is the same for all hospitals in the United States--regardless of the type of ownership. The federal and state policies for Medicare and Medicaid as well as the commercial payors managed care policies affect all hospitals, not just OCH. These are not new challenges. Case management requires complying with the payors policies for being reimbursed appropriately or facing no reimbursement if patients are not in the correct admission status.

  Inpatient admissions have declined because of the 2 midnight final rule sent to hospitals in 2013. This means that Medicare patients have to be admitted either in an outpatient observation or inpatient status depending on admitting physician anticipation of the length of stay being longer than 2 midnights and patient meeting medical necessity under Interqual Criteria. In these situations the admitting physician must document appropriately for justifying the patient stay as an inpatient discharge for DRG classification and reimbursement.

- *Inpatient admissions are reimbursed at a higher rate than an observation patient. Lower revenue observation stays have also become a greater share of the cost of services.*

  Inpatient admissions are reimbursed by Medicare Severity Diagnosis Related Groups (MS DRG) or flat rate reimbursement while observation patients are only reimbursed if there are procedures involved such as IV infusions, etc. These patients occupy patient rooms in beds that have to be monitored by floor nurses. (See staffing note on page 7 of this response.) All acute care medical/surgical hospitals are subject to these same reimbursement rules. Regardless of who owns OCH, these same reimbursement rules apply.

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Historical Surgical Volumes ***Page 19***

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Generally accepted practice to look at changes over a 5 year period
(To level out unusual annual increases or decreases)

Surgical Procedures	FY11	FY12	FY15	5 Year Change	FY16	5 Year Change
Inpatient	711	983	1,018	43.2%	984	.1%
Outpatient	4,099	4,005	4,252	3.7%	4,081	1.9%
Total	4,810	4,988	5,270	9.6%	5,065	1.6%

- *Inpatient surgical volumes have experienced year-over-year growth until 2014, but have since started a downward trend due to the industry-wide movement of procedures from inpatient to an ambulatory setting.*

  The 5 year change above from FY 2011 to FY 2015 as compared to FY 2012 to FY 2016 shows the impact of shifting hospital care from inpatient to outpatient admissions; however, the number inpatient cases are being maintained at FY 2012 levels.

  Inpatient admissions have declined because of the 2 midnight final rule sent to hospitals in 2013. This means that Medicare patients have to be admitted either in an outpatient observation or inpatient status depending on admitting physician anticipation of the length of stay being longer than 2 midnights and patient meeting medical necessity under Interqual Criteria. In these situations the admitting physician must document appropriately for justifying the patient stay as an inpatient discharge for DRG classification and reimbursement.

- *OCH's OP surgical volumes are flat and are starting a downward trend. The service interruption in Winston County and the first two years of ACA insurance coverage 2014 & 2015 may have temporarily boosted OCH O/P surgery volume. Whether OCH is now reverting to its longer-term trend line must be monitored.*

  Stroudwater used a 3 year trend line versus a 5 year trend line that OCH is showing above. OCH employs board certified anesthesiologists for anesthesia monitoring. Winston Medical Center does not have board certified anesthesiologists on their Medical Staff. The interruption identified by Stroudwater has had very little impact on OCH due to the historical referral pattern for higher acuity surgical cases. FY13, 14, 15 & 16 OP surgical volumes exceed FY11 & 12 with or without a 5 year trend, contrary to the Stroudwater report.

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Key Findings ***Page 20***

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Key Findings

- *Low and declining occupancy at OCH poses financial and operating challenges*
- *The shift from inpatient to outpatient care will continue, creating new competitive and service delivery challenges*
- *Changes in the care delivery and payment will continue to pose challenges; for example, the shift to observation stays has impacted OCH admission volume and revenue*

These key findings are consistent with what many rural and metropolitan hospitals are experiencing throughout the United States. These are not unique findings for only OCH and are not alarming with OCH's growth in outpatient revenues and total cash receipts.

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OCH Service Area: PSA ***Page 22***

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OCH's Primary Service Area (PSA) is defined as Oktibbeha County and does not include Pheba (Clay County) and Crawford (Lowndes County) contrary to Stroudwater report.

OCH's Secondary Service Area includes partial county areas of: Choctaw, Clay, Lowndes, Noxubee, Webster & Winston.

It is important to note that Mississippi State University students with Oktibbeha County residence usually go to their parents' place of residency for elective inpatient hospital services.

The 3 tables on pages 25 & 26 of this response show where residents of Oktibbeha County (OCH's Primary Service Area) were discharged by patient types: IP-inpatients, OP-outpatients or ER-emergency room for CYs 15, 14 & 13.

From CY 13 to 14 and CY 14 to 15, OCH had an inpatient increase from the PSA for inpatients, outpatients and emergency room patients with the exception for inpatients from CY 13 to 14.

Total PSA Admission % Increase/Decrease

	CY15-IP	CY15-OP	CY15-ER
OCH RMC	1,756	18,788	18,364
CY 14 to CY 15	7.8%	0.4%	4.4%

	CY14-IP	CY14-OP	CY14-ER
OCH RMC	1,629	18,715	17,590
CY 13 to CY 14	-6.5%	5.3%	3.5%

	CY13-IP	CY13-OP	CY13-ER
OCH RMC	1,742	17,775	16,997
CY 12 not available			

Three years of data is insufficient to establish a trend. OCH's market share by zip code has remained steady. In addition, discharges by zip code alone are not sufficient to determine market share. (See pages 24 - 35 for additional information.)

Where Oktibbeha County Residents Received Care CY 15

Primary Service Area Facility Discharges	CY15-IP	CY15-OP	CY15-ER
OCH RMC	1,756	18,788	18,364
BMH-GT	649	2,935	1,812
NMMC-TUPELO	344	1,149	181
NMMC-EUPORA	91	961	662
NMMC-WEST POINT	146	662	560
UMMC-JACKSON	202	1,605	98
OTHER	436	1,859	554
Total Discharges PSA	3,624	27,959	22,231
Market Share	**CY15-IP**	**CY15-OP**	**CY15-ER**
OCH RMC	48.5%	67.2%	82.6%
BMH-GT	17.9%	10.5%	8.2%
NMMC-TUPELO	9.5%	4.1%	0.8%
NMMC-EUPORA	2.5%	3.4%	3.0%
NMMC-WEST POINT	4.0%	2.4%	2.5%
UMMC-JACKSON	5.6%	5.7%	0.4%
OTHER	12.0%	6.6%	2.5%
Total	100.0%	100.0%	100.0%

Where Oktibbeha County Residents Received Care CY 14

Primary Service Area Facility Discharges	CY14-IP	CY14-OP	CY14-ER
OCH RMC	1,629	18,715	17,590
BMH-GT	614	3,030	1,477
NMMC-TUPELO	303	1,053	121
NMMC-EUPORA	116	753	628
NMMC-WEST POINT	150	620	516
UMMC-JACKSON	193	1,506	91
OTHER	440	1,421	536
Total Discharges PSA	3,445	27,098	20,959
Market Share	**CY14-IP**	**CY14-OP**	**CY14-ER**
OCH RMC	47%	69%	84%
BMH-GT	18%	11%	7%
NMMC-TUPELO	9%	4%	1%
NMMC-EUPORA	3%	3%	3%
NMMC-WEST POINT	4%	2%	2%
UMMC-JACKSON	6%	6%	0%
OTHER	13%	5%	3%
Total	100.0%	100.0%	100.0%

Where Oktibbeha County Residents Received Care CY 13

Primary Service Area Facility Discharges	CY13-IP	CY13-OP	CY13-ER
OCH RMC	1,742	17,775	16,997
BMH-GT	564	2,709	1,177
NMMC-TUPELO	328	950	126
NMMC-EUPORA	136	621	596
NMMC-WEST POINT	154	588	456
UMMC-JACKSON	202	205	12
OTHER	378	1,504	542
Total Discharges PSA	3,504	24,352	19,906
Market Share	**CY13-IP**	**CY13-OP**	**CY13-ER**
OCH RMC	50%	73%	85%
BMH-GT	16%	11%	6%
NMMC-TUPELO	9%	4%	1%
NMMC-EUPORA	4%	3%	3%
NMMC-WEST POINT	4%	2%	2%
UMMC-JACKSON	6%	1%	0%
OTHER	11%	6%	3%
Total	100.0%	100.0%	100.0%

Source: Discharge data submitted by hospitals in Mississippi electronically to the Mississippi State Department of Health

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The 9 tables on pages 28 - 30 of this response show where residents of OCH's Secondary Service Area were discharged by patient types: IP-inpatients, OP-outpatients or ER-emergency room for CYs 15, 14 & 13. A summary of the data from the 9 tables are listed below.

SSA Inpatient Admission % Increase/Decrease

	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total
CY 15	124	142	402	236	166	72	1,142
	4.2%	26.8%	-5.2%	11.3%	-11.2%	-38.5%	-2.5%
CY 14	119	112	424	212	187	117	1,171
	-25.6%	-17.0%	12.2%	-22.6%	3.3%	33.0%	-3.7%
CY 13	160	135	378	274	181	88	1,216

CY12 not available

Inpatient admissions have declined because of the 2 midnight final rule sent to hospitals in 2013. This means that Medicare patients have to be admitted either in an outpatient observation or inpatient status depending on admitting physician anticipation of the length of stay being longer than 2 midnights and patient meeting medical necessity under Interqual Criteria. In these situations the admitting physician must document appropriately for justifying the patient stay as an inpatient discharge for DRG classification and reimbursement.

SSA Outpatient Admission % Increase/Decrease

	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total
CY 15	2,146	2,753	4,445	3,012	2,584	832	15,772
	-0.4%	16.0%	16.5%	1.5%	-0.2%	0.5%	7.1%
CY 14	2,155	2,373	3,817	2,967	2,588	828	14,728
	12.9%	23.0%	27.7%	18.9%	9.8%	17.4%	18.9%
CY 13	1,909	1,930	2,989	2,496	2,356	705	12,385

CY 12 not available

Three years of data is insufficient to establish a trend. OCH's market share by zip code has remained steady. In addition, discharges by zip code alone are not sufficient to determine market share. (See pages 31 - 35 for additional information.)

Where Secondary Service Area Residents Received Inpatient Care CY 15

CY 2015-Inpatient	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total	SSA Market Share
OCH	124	142	402	236	166	72	1,142	6.5%
BMH-GT	506	5,176	179	117	99	714	6,791	38.6%
NMMC-TUPELO	510	377	51	336	87	45	1,406	8.0%
NMMC-EUPORA	8	0	3	533	80	0	624	3.5%
NMMC-WEST POINT	1,357	574	82	897	196	74	3,180	18.1%
UMMC - Jackson	74	246	215	64	56	49	704	4.0%
Other Hospitals	245	695	1,252	150	333	1,072	3,747	21.3%
Totals	2,824	7,210	2,184	2,333	1,017	2,026	17,594	100.0%
	16.1%	41.0%	12.4%	13.3%	5.8%	11.5%	100.0%	

Where Secondary Service Area Residents Received Outpatient Care CY 15

CY 2015-Outpatient	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total	SSA Market Share
OCH	2,146	2,753	4,445	3,012	2,584	832	15,772	12.4%
BMH-GT	2,643	31,663	919	415	388	2,726	38,754	30.4%
NMMC-TUPELO	1,697	1,641	131	1,242	327	175	5,213	4.1%
NMMC-EUPORA	111	26	48	5,045	853	3	6,086	4.8%
NMMC-WEST POINT	7,473	993	74	225	78	149	8,992	7.1%
UMMC	633	1,759	1,835	501	487	457	5,672	4.5%
Other Hospitals	1,100	2,789	21,049	1,573	7,345	12,968	46,824	36.8%
Totals	15,803	41,624	28,501	12,013	12,062	17,310	127,313	100.0%
	12.4%	32.7%	22.4%	9.4%	9.5%	13.6%	100.0%	

Where Secondary Service Area Residents Received ER Care CY 15

CY 2015-ER	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total	SSA Market Share
OCH	987	1,114	1,542	1,032	686	387	5,748	6.3%
BMH-GT	2,406	48,136	257	109	113	3,288	54,309	59.6%
NMMC-TUPELO	500	279	11	113	21	31	955	1.0%
NMMC-EUPORA	25	11	15	3,205	487	1	3,744	4.1%
NMMC-WEST POINT	7,035	858	17	120	21	77	8,128	8.9%
UMMC	41	109	165	44	37	31	427	0.5%
Other Hospitals	452	982	9,896	388	2,338	3,719	17,775	19.5%
Totals	11,446	51,489	11,903	5,011	3,703	7,534	91,086	100.0%
	12.6%	56.5%	13.1%	5.5%	4.1%	8.3%	100.0%	

Source: Discharge data submitted by hospitals in Mississippi electronically to the Mississippi State Department of Health

Where Secondary Service Area Residents Received Inpatient Care CY 14

CY 2014 - Inpatient	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total	SSA Market Share
OCH	119	112	424	212	187	117	1,171	7.7%
BMH-GT	458	5,372	190	101	86	726	6,933	45.8%
NMMC-TUPELO	493	328	35	325	99	43	1,323	8.7%
NMMC-EUPORA	8	0	6	786	124	2	926	6.1%
NMMC-WEST POINT	1,151	232	26	50	19	19	1,497	9.9%
UMMC	66	190	251	55	66	68	696	4.6%
Other Hospitals	232	611	1,099	159	233	270	2,604	17.2%
Totals	2,527	6,845	2,031	1,688	814	1,245	15,150	100.0%
	16.7%	45.2%	13.4%	11.1%	5.4%	8.2%	100.0%	

Where Secondary Service Area Residents Received Outpatient Care CY 14

CY 2014-Outpatient	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total	SSA Market Share
OCH	2,155	2,373	3,817	2,967	2,588	828	14,728	14.8%
BMH-GT	2,503	30,884	1,046	465	344	2,452	37,694	37.9%
NMMC-TUPELO	1,652	1,541	98	1,315	316	123	5,045	5.1%
NMMC-EUPORA	50	9	40	3,752	604	4	4,459	4.5%
NMMC-WEST POINT	7,357	947	78	194	85	109	8,770	8.8%
UMMC	541	1,713	1,728	478	433	451	5,344	5.4%
Other Hospitals	1,019	1,820	12,322	1,599	4,867	1,702	23,329	23.5%
Totals	15,277	39,287	19,129	10,770	9,237	5,669	99,369	100.0%
	15.4%	39.5%	19.3%	10.8%	9.3%	5.7%	100.0%	

Where Secondary Service Area Residents Received ER Care CY 14

CY 2014-ER	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total	SSA Market Share
OCH	894	1,009	1,796	908	669	304	5,580	6.6%
BMH-GT	2,012	47,242	207	109	90	3,088	52,748	62.2%
NMMC-TUPELO	446	293	14	91	22	31	897	1.1%
NMMC-EUPORA	25	7	12	3,003	520	1	3,568	4.2%
NMMC-WEST POINT	7,117	757	12	111	15	83	8,095	9.6%
UMC	27	107	129	40	49	26	378	0.4%
Other Hospitals	589	790	8,814	485	2,464	330	13,472	15.9%
Totals	11,110	50,205	10,984	4,747	3,829	3,863	84,738	100.0%
	13.1%	59.2%	13.0%	5.6%	4.5%	4.6%	100.0%	

Source: Discharge data submitted by hospitals in Mississippi electronically to the Mississippi State Department of Health

Where Secondary Service Area Residents Received Inpatient Care CY 13

CY 2013 - Inpatient	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total	SSA Market Share
OCH	160	135	378	274	181	88	1,216	7.7%
BMH-GT	486	5,649	152	102	70	704	7,163	45.5%
NMMC-TUPELO	497	330	46	308	0	0	1,181	7.5%
NMMC-EUPORA	3	1	1	848	110	5	968	6.2%
NMMC-WEST POINT	1,283	275	26	79	38	32	1,733	11.0%
UMC	64	208	179	79	50	75	655	4.2%
Other Hospitals	225	586	1,219	167	367	246	2,810	17.9%
Totals	2,718	7,184	2,001	1,857	816	1,150	15,726	100.0%
	17.3%	45.7%	12.7%	11.8%	5.2%	7.3%	100.0%	

Where Secondary Service Area Residents Received Outpatient Care CY 13

CY 2013-Outpatient	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total	SSA Market Share
OCH	1,909	1,930	2,989	2,496	2,356	705	12,385	13.7%
BMH-GT	2,332	31,148	977	466	320	2,396	37,639	41.6%
NMMC-TUPELO	1,581	1,499	128	335	257	97	3,897	4.3%
NMMC-EUPORA	52	11	33	3,134	455	4	3,689	4.1%
NMMC-WEST POINT	7,535	975	76	211	78	109	8,984	9.9%
UMC	84	239	220	62	75	63	743	0.8%
Other Hospitals	1,049	1,781	13,004	1,733	4,088	1,549	23,204	25.6%
Totals	14,542	37,583	17,427	8,437	7,629	4,923	90,541	100.0%
	16.1%	41.5%	19.2%	9.3%	8.4%	5.4%	100.0%	

Where Secondary Service Area Residents Received ER Care CY 13

CY 2013-ER	Clay	Lowndes	Winston	Webster	Choctaw	Noxubee	Total	SSA Market Share
OCH	885	1,054	1,272	876	657	341	5,085	6.2%
BMH-GT	1,795	43,343	146	114	45	2,918	48,361	58.6%
NMMC-TUPELO	534	288	11	114	26	24	997	1.2%
NMMC-EUPORA	23	8	21	3,250	561	2	3,865	4.7%
NMMC-WEST POINT	7,303	707	9	117	10	61	8,207	9.9%
UMC	7	17	25	9	7	3	68	0.1%
Other Hospitals	591	752	10,993	604	2,702	327	15,969	19.3%
Totals	11,138	46,169	12,477	5,084	4,008	3,676	82,552	100.0%
	13.5%	55.9%	15.1%	6.2%	4.9%	4.5%	100.0%	

Source: Discharge data submitted by hospitals in Mississippi electronically to the Mississippi State Department of Health

OCH REGIONAL MEDICAL CENTER
RESPONSE TO
STROUDWATER OPTIONS ASSESSMENT: EXECUTIVE SUMMARY 10/17/2016

Key Findings ***Page 24***

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Key Findings

- *OCH loses significant market share from its PSA to two major competitors*

Stroudwater cannot accurately draw this conclusion with their responses on pages 22 and 23 of their report just on the basis of using the zip code analysis for the reasons as explained below. OCH agrees that there is some market share loss, but it is not significant. OCH does not lose significant market share for competitive reasons. The responses below will address the primary reason for outmigration.

The inpatient outmigration to Baptist Memorial Hospital – GT and to tertiary care hospitals of North Mississippi Medical Center - Tupelo and UMMC – Jackson is primarily related to specialty services that are not sustainable in Starkville. The recapture of most of the outmigration cannot be reasonably realized until the population base of OCH's PSA and SSA grows significantly to support financially the physician specialties providing such services.

First, see outmigration of "MS DRG Discharges by Hospitals Other than OCH for Oktibbeha County Residents CY 2015" on page 32 of this response.

- **This table is representative of 756 possible MS DRGs for inpatient coding that have been summarized by 38 general product/service line descriptions.**
- **Of the 38 listed general/service line descriptions, 20 general/service line items have 1,067 (57%) discharges that in most cases could not be admitted for required inpatient care at OCH because of the population comments outlined in the second paragraph above.**
- **Data for CY 2014 and 2013 is not provided because the results are not significantly different than CY 2015.**

MS DRG Discharges by Hospital Other than OCH for Oktibbeha County Residents CY 15

(Inpatient Outmigration)	BMH -GT Columbus	CY 2015 NMMC Eupora	MS DRG - UMC Jackson	Service NMMC Tupelo	Line NMMC WP	Oth Hosps	Total	%
1: Neurosurgery	3	0	6	13	1	7	30	1.6%
2: Neurology	19	5	15	40	2	24	105	5.6%
4: Thoracic Surgery	8	0	6	4	0	1	19	1.0%
5: Vascular Surgery	9	0	5	9	0	0	23	1.2%
6: Infectious Diseases	39	3	18	19	4	12	95	5.1%
7: Ophthalmology	0	0	1	0	0	0	1	0.1%
8: Otolaryngology	2	0	6	2	1	0	11	0.6%
9: Plastic Surgery	0	0	2	3	0	5	10	0.5%
10: Pulmonary Medicine	20	27	11	18	7	27	110	5.9%
11: Oncology	5	0	7	4	0	1	17	0.9%
13: General Surgery	18	1	24	23	3	26	95	5.1%
14: Gastroenterology	23	14	14	16	7	10	84	4.5%
15: Oral Surgery	0	0	1	1	0	0	2	0.1%
16: Orthopedics	49	0	18	22	1	16	106	5.7%
18: Dermatology	2	4	7	3	0	9	25	1.3%
19: Gynecology	12	0	0	0	9	6	27	1.4%
20: Endocrinology	4	10	4	6	5	8	37	2.0%
21: Urology	4	0	4	5	0	1	14	0.7%
22: Nephrology	20	10	1	15	0	11	57	3.0%
23: Obstetrics	49	0	9	15	54	15	142	7.6%
25: Neonatology	7	0	12	14	24	6	63	3.4%
26: Newborn	40	0	0	4	23	12	79	4.2%
27: Hematology	11	5	4	1	0	1	22	1.2%
28: Psychiatry	112	1	4	2	0	177	296	15.8%
29: Substance Abuse	49	0	0	0	0	20	69	3.7%
30: Adverse Effects	4	0	2	2	0	3	11	0.6%
31: Burns	0	0	0	0	0	1	1	0.1%
32: Rehabilitation	0	0	0	4	0	1	5	0.3%
33: Signs & Symptoms	1	0	0	1	0	0	2	0.1%
34: Other	3	0	2	4	0	5	14	0.7%
35: HIV Infection	0	0	0	1	0	0	1	0.1%
37: Back & Spine	36	2	8	12	0	6	64	3.4%
51: Cardiac Surgery	7	0	4	20	0	0	31	1.7%
52: Electrophysiology/Devices	4	0	0	6	0	1	11	0.6%
53: Invasive Cardiology	39	0	2	18	0	1	60	3.2%
54: General Cardiology	24	8	4	36	4	10	86	4.6%
56: Vascular Diseases	0	1	1	1	1	0	4	0.2%
SNF/Swing - Ungrouped	26	0	0	0	0	15	41	2.2%
Total	649	91	202	344	146	438	1,870	100.0%
	34.7%	4.9%	10.8%	18.4%	7.8%	23.4%	100.0%	

Source: Discharge data submitted by hospitals in Mississippi electronically to the Mississippi State Department of Health

Second, see outmigration of APG/APC Outpatients by Hospital Other than OCH for Oktibbeha County Residents CY 15 on page 34 of this response.

- **This table is representative of 584 possible APGs for outpatient coding that have been summarized by 28 general product / service line descriptions.**
- **Of the 28 listed general/service line descriptions, 3 general / service line items (shaded in gray) have 12,054 (45%) of APG classifications that are either inconclusive or un-coded because commercial payor rules for outpatient billing are not required.**
- **Of the 38 listed general/service line descriptions, 8 general/service line items have 5,926 (22%) APG classification that in most cases could not be admitted for required outpatient care at OCH because of the described population comments in second paragraph on page 31 of this response.**
- **In this table each line does not represent the actual number of patients because patients can be assigned more than 1 APC. Line item #50: Observation is the one exception.**
- **Because of these limitations, no definitive conclusions regarding PSA outpatient outmigration can be made from either the zip code or the APG data compilations.**
- **Data for CY 2014 and CY 2013 is not provided because the data results are not significantly different than CY 2015.**

APG/APC Outpatients by Hospital Other than OCH for Oktibbeha County Residents CY 15

(Outpatient Outmigration)	BMH –GT Columbus	CY 2015 NMMC Eupora	APG or UMC Jackson	APC - NMMC Tupelo	Service NMMC WP	Line Oth Hosps	Total	%
Other outpatient	229	148	356	121	107	320	1,281	4.8%
Outpatient (Lab/Radiation)	1,667	764	1,090	823	440	1,101	5,885	21.9%
01: Skin and integumentary system & proc	54	3	30	38	1	70	196	0.7%
02: Breast procedures	5	0	2	13	0	13	33	0.1%
03: Musculoskeletal system procedures	26	0	13	9	7	40	95	0.4%
04: Respiratory procedures	59	0	34	24	7	36	160	0.6%
05: Cardiovascular procedures	261	0	1	64	0	68	394	1.5%
06: Hematologic. Lymphatic & Endoc Proc	53	1	2	6	4	16	82	0.3%
07: Gastrointestinal system procedures	66	0	23	64	43	71	267	1.0%
08: Genitourinary system procedures	22	0	1	11	1	7	42	0.2%
09: Male Reproductive system & Proc	13	0	7	3	0	1	24	0.1%
10: Female Reproductive system & Proc	15	0	2	6	9	10	42	0.2%
11: Neurologic system procedures	62	0	5	20	0	105	192	0.7%
12: Ophthalmologic system procedures	1	0	12	0	0	4	17	0.1%
13: Otolaryngologic system procedures	26	0	50	3	1	6	86	0.3%
14: Rehabilitation	22	0	7	0	4	29	62	0.2%
15: Radiologic procedures	37	0	8	9	4	47	105	0.4%
17: Nuclear Medicine	0	0	0	3	0	8	11	0.0%
18: Radiation Oncology	16	0	0	0	0	0	16	0.1%
19: Dental procedures	15	0	1	0	0	40	56	0.2%
20: Anesthesia	0	0	1	62	30	51	144	0.5%
21: Pathology	91	0	86	194	2	119	492	1.8%
22: Laboratory	756	0	181	227	50	525	1,739	6.5%
23: Other ancillary tests & Proc	668	0	40	111	22	317	1,158	4.3%
24: Chemotherapy and other drugs	2,513	1	307	597	327	1,369	5,114	19.0%
25: Radiology	348	1	21	83	11	97	561	2.1%
30: Incidental procedures and ser	869	0	51	271	71	411	1,673	6.2%
50: Observation	366	248	13	151	311	231	1,320	4.9%
60: Diseases & Disorders Skin/Subcut	0	0	0	0	0	2	2	0.0%
99: No EAPG assigned	2,198	1	471	365	132	1,721	4,888	18.2%
Therapy only (PT/OT)	500	37	38	3	22	189	789	2.9%
Total	10,958	1,204	2,853	3,281	1,606	7,024	26,926	100.0%
	40.7%	4.5%	10.6%	12.2%	6.0%	26.1%	100.0%	

Source: Discharge data submitted by hospitals in Mississippi electronically to the Mississippi State Department of Health

Other examples of outmigration:

- **CMS rules and regulations of where Medicare patients must go**
- **Trauma rules and regulations requiring where trauma patients must go depending on the severity of trauma medical/surgical need**
- **Physicians referring out of market due to patient clinical history**
- **Patient self-selection**

Of these examples patient selection is OCH's greatest opportunity for outmigration improvement.

- *OCH is not currently well positioned to grow market share in the SSA*
  - *Larger competitors and systems*
  - *Lack of satellite clinics and dispersed primary care base (with exception of primary care clinic in Choctaw County)*
  - *Incumbent hospitals located in each SSA population center*

OCH and Medical Staff do not agree with Stroudwater's comment that OCH is not well positioned to grow market share in SSA. Through collaboration, OCH and the Medical Staff can effectively grow its SSA market share. Staff physicians currently have satellite clinics in Eupora, Louisville, West Point and Kosciusko which lead to admissions at OCH, and future clinics will be considered when appropriate.

It is important to note, OCH and Medical Staff are in a unique position with Mississippi State University's (MSU) presence in its PSA. MSU is a strong economic development driver for Oktibbeha County. It, combined with the region's potential growth, provide a solid foundation and bright future for the medical community and patients served.

Likewise, OCH and the Medical Staff have a strong impact on economic development in Oktibbeha County. In 2015, the Mississippi Hospital Association commissioned an economic impact study of the hospitals in the State of Mississippi with the results for OCH as follows:

TOTAL Economic Impact Spending	**$118,239,739**
▪ **Capital Expenditure Economic Impact**	**$ 4,279,719**
▪ **Total Payroll Expenditure Economic Impact**	**$ 66,233,186**

Total economic impact increased by 11.2% from the 2011 amount of $106,329,000.

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Balance Sheet Strength ***Page 26***

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See page 26 of the Stroudwater Report for selected balance sheet ratio information referenced in bullet points below:

- *Adjusted balance sheet ratios assumes that the $24.8M of general obligation bonds on the county balance sheet are included on the hospital's balance sheet*

  Placing the $24.8M of county general obligation bonds on OCH balance sheet for ratio comparison is not compliant with Generally Accepted Accounting Principles (GAAP).

- *2015 BBB- are median balance sheet ratios for Standard & Poor rated stand alone acute care hospitals – Lowest investment grade debt*

- *Green ratios exceed medians and indicate relative strength compared to medians*

- *Red ratios are medians and indicate risk or relative weakness compared to median*

It would be more appropriate to compare OCH Regional Medical Center to other Mississippi hospitals of similar bed size and service lines. OCH is unaware of any rural hospital, less than 100 beds, in the State of Mississippi that has a BBB- bond rating.

When reviewing the ratios provided by Stroudwater, OCH is providing for comparison the ratios below and on page 38 of this response that were presented by Watkins, Ward and Stafford, CPAs as a part of the FY 2015 annual audit report to the Board of Trustees.

One ratio presented by Stroudwater below the median was the Average Age of Net Fixed Assets. Although OCH Average Age of Net Fixed Assets is slightly higher than the 2015 BBB- median ratio, it is not because of the lack of funds to purchase assets. The annual capital equipment budget takes recommendations of physicians and department directors, who only recommend replacing an asset if it is at the end of life, quality of care will be impacted, or the asset would provide a new service to the community.

For FY 2015 Watkins Ward and Stafford calculated a ratio value of 12.1 for Average Age of Plant. The median values based on the Vizient Gulf States Audited Financial Report of its members (21 Mississippi & Louisiana Hospitals) FY 2011 - 2015 by operating expenses are listed below:

	Ave Age of Plant	
$71.5M Operating Expenses	12.1	OCH
	Median	
$ 49M - $120M Operating Expenses	12.7	7 Hospitals
$143M - $265M Operating Expenses	15.1	8 Hospitals
$339M - $ 1.1B Operating Expenses	11.7	6 Hospitals

OCH is performing favorably with Vizient (21 hospitals) comparison.

The days in Accounts Receivable is above the 2015 BBB- median ratios for Standard & Poor. OCH's goal is to work with the patients as much as possible for establishing payment plans. The gross days for third party payors and commercial insurance categories are at an average of 45 days. This average is consistent with other benchmark comparisons. The gross days for self-pay accounts averages 100+ days.

Self pay accounts receivable include accounts that have no insurance and accounts balances for patients after third party payors and insurance payments (copays, deductibles and co-insurance). Billing policies allow patients to make payments over time.

Many hospitals, with average days less than 45, will sell off their accounts after insurance has paid. OCH is a community-oriented hospital, and its long established culture is to work with patients for self-pay balance payoff. This long term policy will most likely go away with a sale/lease of OCH.

OCH's 5 year-trend for gross gays in AR by payors' financial class are listed below. OCH is performing very well and in the norm for Medicare, Medicaid & Commercial Insurance financial classes for benchmark comparisons.

	DAYS IN AR AT 9/30/2016	DAYS IN AR AT 9/30/2015	DAYS IN AR AT 9/30/2014	DAYS IN AR AT 9/30/2013	DAYS IN AR AT 9/30/2012
Blue Cross Blue Shield	35.1	42.2	35.0	36.1	33.9
State of MS	43.7	33.6	36.1	34.6	32.1
Workers Comp	67.2	85.7	144.6	93.8	107.4
Commercial Insurance	74.6	71.1	60.9	61.5	55.5
Medicare	39.2	33.8	44.4	53.7	44.7
Medicaid	43.9	40.7	46.4	56.1	39.1
Total Insur + Workers Comp	44.9	42.1	45.9	51.2	42.8
All Other FC - Self Pay	113.5	105.7	107.7	109.9	97.9
Total AR	76.0	71.0	71.7	71.5	64.9

Although OCH debt service ratio is below the BBB- rating, take a look at OCH's benchmark performance below with 20 other Vizient Gulf States Hospitals by range of 3 operating expense groups. Debt service ratios are influenced by current portion of long term debt, profit margins and depreciation either being high or low.

	Debt Service Ratio	
$71.5M Operating Expenses	3.25	OCH
	Median	
$ 49M - $120M Operating Expenses	4.06	6 Hospitals
$143M - $265M Operating Expenses	3.60	8 Hospitals
$339M - $ 1.1B Operating Expenses	4.63	6 Hospitals

During previous annual audit presentations, Watkins, Ward and Stafford, CPA representatives reported the ratios below and commented that OCH is in good financial position. The 2 highlighted ratios below are Stroudwater calculations.

Ratios	FY 2015	FY 2014	FY 2013	FY 2012
Key Liquidity Ratios				
Current Ratio	2.62	2.69	2.26	2.29
Quick Ratio	2.22	2.22	1.88	1.91
Days Revenue in Accounts Receivable				
Gross	77	79	74	69
Net	93	92	84	79
Days Cash on Hand-without funds restricted for Capital Improvement	36	32	21	30
Days Cash on Hand-with funds restricted for Capital Improvement	179.79	171.32	161.13	179.56
Average Payment Period	62	58	57	60
Key Capital Structure Ratios				
Equity Financing	78.94%	78.04%	76.33%	76.57%
Cash Flow to Total Debt	35.26%	27.88%	14.26%	31.63%
Unrestricted cash/Long-term debt	47.98%	34.44%	19.55%	25.42%
Long-Term Debt to Equity	14.53%	17.18%	20.27%	20.39%
Times Interest Earned	7.11	2.92	(1.37)	4.55
Key Profitability Ratios				
Markup Ratio	277.20%	274.46%	260.18%	267.64%
Deductible Ratio	63.88%	63.37%	63.11%	61.68%
Operating Margin Ratio	3.84%	2.18%	-1.95%	4.97%
Return on Equity	3.34%	1.29%	-2.34%	3.37%
Other Ratios				
Total Asset Turnover	63.64%	59.42%	56.63%	55.22%
Average Age of Plant	12.14	10.93	9.83	9.04
Viability Ratio	0.28	0.3	0.45	0.33
Cushion Ratio	1.69	1.3	1.11	1.04
Debt Service	3.52	2.97	1.77	2.63

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Comparison to Standard & Poor's Median Ratios Page 27

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Sources of risk for OCH Regional Medical Center: i) a lack of scale, as measured by net patient revenue; ii) higher staffing costs; iii) lower debt service coverage; iii) lower cash flow, operating and total margins; iv) higher days in A/R. Strengths relative to the medians include solid liquidity (days cash on hand) and modest leverage (long term debt to total capitalization). OCH Regional Medical Center's balance sheet is enhanced by the support of the County's balance sheet, which puts the county at financial risk.

Higher staffing costs – the salaries and benefit expense for FY 2015 was 59.74%. OCH's goal is to staff in order to meet the acuity of the patients and the volume of inpatients that are being treated. Also, OCH has staffed according to the need for using rooms with beds occupied by patients classified as outpatients. (See page 7 for staffing methodology.)

OCH is the second largest employer in the community and is proud to provide as many jobs as possible for the benefit of the local economy.

When Stroudwater calculated the Operating Margin Ratio, the electronic health record revenue (EHR) was excluded and interest expense included. Based on OCH FY 2015 Audit report prepared by Watkins, Ward and Stafford, EHR revenue should be included in the Operating Revenue, and interest expense is not considered an Operating Expense. EHR revenue is provided in order to cover the cost of implementing an EHR. See Operating Margin Ratio presented on page 38 of this response.

(See previous comments on pages 36 - 38 regarding all financial ratios.)

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Financial & Operating Results Summary Page 28

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Top line revenue growth has moderated when TTM 2016 results are included, falling behind the expense growth trend line. As a result, margins have declined over the same timeline.

Liquidity as measured by days cash on hand has decreased while decreased leverage has allowed debt service coverage to modestly increase.

Stroudwater restated the audited Operating Statements from FY 2010 - 15 on page 28 of their report which will understate some of the percentages. This restatement by Stroudwater does not follow Generally Accepted Accounting Principles (GAAP) in red font below.

	(000)					Unaudited	
	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016
Stroudwater Error	57,591	60,279	62,640	63,291	66,610	72,231	71,715
Total Operating Revenue	57,591	60,278	64,528	64,829	67,395	73,734	71,600
Stroudwater Error	57,805	59,664	62,289	67,236	66,511	71,390	72,713
Total Operating Expenses	56,900	58,865	61,323	66,091	65,924	70,905	72.052
Stroudwater Error	(214)	615	2,239	(2,407)	884	2,345	(831)
Income from operations	691	1,413	3,205	(1,262)	1,471	2,829	(452)
Stroudwater Error	0	0	0	0	0	0	0
Nonoperating Rev (Exp)	1,135	(175)	(369)	(758)	(374)	117	257
Excess of Rev over (under) Exp Before Minority Interest	1,826	1,238	2,836	(2,020)	1,097	2,946	(195)
Minority Interest				(70)	(70)	(70)	(70)
Excess Rev over (under) Exp After Minority Interest				(2,090)	1,027	2,876	(265)

SOURCE: Audited Statements Prepared by Watkins Ward and Stafford, PLLC, Certified Public Accountants

OCH has minimized the amount of available cash on hand to cover each bi-weekly payroll period and vendors' invoices for each accounts payable run. Cash from operations are first used to each payroll period and operational expenses through accounts payable. This allows OCH to maximize investment earnings on excess cash.

The Board of Trustees' policy is to keep minimum cash available. The ability to transfer cash from restricted funds has not impacted OCH's liquidity position for meeting payroll, operational expenses or other disbursements.

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OCH Historical Operating Cash Flow ***Page 29***

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For FY 2015, OCH had $12.3 million in restricted funds that were designated by the Board of Trustees to be used specifically for capital improvements.

- **In FY 2016 the Hospital acquired $2.4 million in capital assets. These purchases were made either from the unrestricted cash account or through very favorable debt financing.**
- **In FY 2015 the Hospital acquired $2.6 million in capital assets. $2.3 million of the unrestricted operating funds was used for these acquisitions. The remainder was debt financed.**
- **In FY 2014 the Hospital purchased $1.9 million in capital assets. $154,771 was used from cash restricted for capital improvements for these acquisitions. The remainder was paid from unrestricted cash.**

Although OCH has purchased some capital assets using the restricted cash Account, the restricted cash account currently has a balance of $12.3 million (20.1% increase) compared to a balance of $9.6 million at 09/30/12. Since OCH has been able to increase this restricted cash balance, it is an indication that OCH can make capital improvements when needed. OCH uses operational cash receipts and/or debt financing when needed as debt service ratios will allow without being in violation of any OCH bond covenants.

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Operating Margin ***Page 30***

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Historically, OCH has not been in the business to drive a high bottom line at the cost of the community it serves. Charges in the charge master are maintained at a rate to be sufficient for meeting allowable charges with Medicare, Medicaid, Blue Cross, State of Mississippi and other commercial insurance payors. The OCH goal is to have enough operating margin to cover debt service and capital improvements.

The Board of Trustees has had a long standing culture, as a community hospital owned by residents of Oktibbeha County, to provide affordable healthcare to its patients while trying to minimize the amount of out-of-pocket exposure for self-pay balances after third party and insurance payments. OCH provides over 80 programs that are community beneficial. Many of these programs are offered at no charge or at or less than costs for making the programs and services available.

OCH has completed its internal FY 2016 year-end review in preparation for the annual audit by Watkins Ward & Stafford, CPAs. From that staff review OCH posted the remaining accounts payable and payroll accruals, adjusted depreciation to the year-end depreciation schedule and other necessary adjustments for review during the audit. After these adjustments were made, Stroudwater reported operational income loss of $831,000 was reduced to $452,000. The audit is ongoing, and the final results may bring additional audit adjustment entries having a positive impact on OCH's bottom line.

OCH has recently completed its periodic review of the charge master for any charges that may be under the allowable charges for reimbursement from the third party payors. From this review OCH has conservatively determined that by adjusting those charges to the recognized third party allowable amounts, OCH will realize an additional $800,000 in net reimbursement during FY 2017.

OCH has invested in the future of the community and hospital through its ongoing physician recruitment program. Having physicians on OCH's Medical Staff is the only way to generate inpatient/outpatient operating revenues. Without physician orders, third party payors will not reimburse for billable services provided.

Medical Staff ***Page 31***

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Medical Staff

- *Approximately 170 physicians are currently on the OCH Regional Medical Center staff, with an average age of 48 years*
    - *Approximately 60 physicians are considered "active staff"*
    - *16 physicians are employed by the hospital*
        - *3 anesthesiologists*
        - *7 ER physicians*
        - *1 general surgeon*
        - *1 orthopedic*
        - *1 pain management*
        - *1 internal medicine*
        - *2 pulmonologists*
- *19 physician "extenders" are employed by the hospital*
        - *10 CRNA*
        - *9 Nurse Practitioners*
- *The remaining physicians in the community are either in private practice or employed or affiliated with competing hospitals from Columbus, Tupelo and Jackson*

As of September 30, 2015, supplemental information regarding active specialties on the Medical Staff is listed below. These specialties (all board certified physicians) are considered as the daily primary admitting medical staff:

Medical Specialty	Total
Chronic Pain Management	1
Dental	2
Family Physician	5
Gastroenterology	1
General Surgery	4
Internal Medicine	2
Internal Medicine Hospitalist	7
Obstetrics/Gynecology	6
Ophthalmology	1
Oral & Maxillofacial Surgery	1
Orthopedic Surgery	3
Otolaryngology	1
Pediatrics	4
Pulmonology/Sleep Medicine/Critical Care	2
Urology	2
Total	42

Hospital Based Physicians	Total
Anesthesiology	3
Emergency Medicine	6
Radiology	2
Total	11

OCH is unaware of any rural hospitals of less than 100 beds in its PSA & SSA that have board certified physicians in anesthesiology supervising anesthesia care delivery and in emergency medicine covering the ER. OCH has 3 board certified anesthesiologists and 5 board certified emergency medicine specialists. Through their specialized training, these physicians provide quality care available to the patients they serve.

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Key Findings – Relative Strengths ***Page 32***

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Relative Strengths:

- *OCH has a sound liquidity position and modest leverage*
- *OCH has made significant investments to its acute care campus*
- *A loyal and committed medical staff, predominately board-certified with an average age < 50*
- *Growing/dynamic primary service area with stable major employers*
    - *OCH Regional Medical Center needs to be able to match that growth and demand*

OCH agrees with very broad strengths cited above but would like to call attention that these can be greatly expounded upon.

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STROUDWATER OPTIONS ASSESSMENT: EXECUTIVE SUMMARY 10/17/2016
Key Findings: ***Page 33***
Sources of Risk:
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- *Weak cash flow and operating margins*
  - *Since 2013, OCH has lagged behind the "sustain" threshold of performance by $3M annually on average, excluding debt service on GO bonds*

	(Audited Million)						Unaudited		
	FY10	FY11	FY12	FY13	FY14	FY15	5 Yr.	FY16	5 Yr.
Cash Receipts	56.8	58.1	60.6	59.7	62.3	69.1	18.9%	68.7	13.3%

OCH's actual cash receipts position with 5 year trending from FY 2011 to FY 2015 is an increase of 18.9% while from FY 2012 to FY 2016 is an increase of 13.3%. This trending of cash receipts is not weak as suggested.

  - *2016 TTM performance indicates an approximately $4M "gap" between operating results and desired level of performance excluding debt service on GO bonds*

FY 2016 OCH's operating results were impacted by the start-up of the Wound Care Center. With the unexpected delay in recruitment of the Center's medical director, the program did not ramp up as quickly as anticipated.

Also, reduced patient volumes, directly related to the mild "cold & flu" season, adversely impacted the Hospital's bottom line.

- *Operating costs per adjusted admission are too high for the reimbursements being realized*

OCH recognizes that Medicare cost differential is slightly above Medicare payments as shown in the bullet point below on the next page. On page 43 of the Stroudwater Report, they made reference to "Lack of Scale". This means that more volume is needed to cover OCH's fixed costs for "Medicare Costs per Patient" and other non-Medicare patient costs. Also, an increase in scale volume would impact the Medicare "Efficiency Index Ratio" on page 48 of this response. The other way to close the payment/cost differential is to decrease cost which OCH can achieve as a part of its operating strategy when determining what services will be either eliminated or reduced and how this decision would impact personnel costs. These efforts would be a matter of consideration within OCH's strategic planning or annual budgetary processes.

Medicare reimbursement only represents 36% of OCH's Gross Patient Revenues. This payment/cost differential below is not the same for the non-Medicare financial classes.

One example is that certain Medicare surgical procedures require implantable devices that often costs more than what Medicare is willing to pay. The vendors supplying the implantable devices are reluctant to lower their billing invoices to OCH. These are factors OCH has to consider when offering services. If OCH does not offer such services patients would have to seek care elsewhere, which would result in outmigration. This another example of OCH operating as a community patient focused facility.

- *At an annualized rate, costs per adjusted admission are growing at a slightly higher rate than reimbursements*

	FY 2015 Medicare Payments Per Patient	Medicare Costs per Patient
Baptist Memorial Hospital GT	**$ 9,959**	**$10,434**
North Mississippi Medical Center	**$11,100**	**$10,734**
OCH Regional Medical Center	**$ 9,360**	**$11,052**

Source: Calculations from CMS using Hospitals Cost Reports

This is a true statement and related to the explanation provided in the second bullet point of this section.

- *Significant investments will be required in service line development and IT*

OCH has met the IT needs historically and will continue to meet those future needs. Additionally, OCH has exceeded the current meaningful use stage 3 certification by qualifying for stage 6 meaningful use in April 2016.

- *New quality and outcome reporting requirements for physicians will create incentives for unaligned private practice physicians to be more integrated with hospital providers that can provide them with access to needed resources and technology*

OCH and the Medical Staff currently work together and will continue to maximize incentive opportunities for private and public practices through appropriate clinical integration and the provision of needed resources and technology that do not violate any federal and state laws, rules and regulations.

OCH is preparing for the change to the risk base reimbursement program in regards to the Final Rule issued by CMS on October 14, 2016, for the Medicare Access and CHIP Reauthorization ACT of 2015 (MACRA) and how this will impact physicians and OCH.

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Value Comparison of MS Hospitals ***Page 35***

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Only 9 of 65 hospitals scored by CMS in July 2016 performed better than OCH on core measures. OCH received 3 stars which is ranked with almost 50% of the hospitals in the United States and on par with Baptist Memorial Hospital-Gt and North Mississippi Medical Center Tupelo.

The data below from the CMS Website shows the most recently reported "Medicare Hospital Spending per Patient Score" for selected Mississippi Hospitals in the left column with the Efficiency Index Ratio (EIF) and quality scoring on right side.

EIF Index *			CMS Quality Stars	Leapfrog Safety Grades	Consumer Reports Grades
.91	South Central Regional Medical Center	Laurel	★	C	39
.96	Baptist Memorial Hospital	Oxford	★★★★	A	49
.96	Magnolia Regional Health Center	Corinth	★★	A	48
.97	Baptist Memorial Hospital New Albany	New Albany	★★★★	A	56
.98	Merit Health Biloxi	Biloxi	★★	C	41
.98	Singing River Hospital	Pascagoula	★★	C	38
.98	Southwest Mississippi Regional Med Ctr	McComb	★	C	50
.99	Baptist Memorial Hospital GT	Columbus	★★★	A	53
.99	Forrest General Hospital	Hattiesburg	★★	B	41
.99	Kings Daughter Hospital	Brookhaven	★★★★	A	52
.99	Merit Health Rankin	Brandon	★★	C	NR
1.00	Clay County Medical Center	West Point	★★★	NR	49
1.00	St Dominic Hospital	Jackson	★★★	A	52
1.00	University of MS Medical Ctr Grenada	Grenada	★★	C	NR
1.01	Baptist Memorial Hospital Desoto	Southaven	★★	B	47
1.01	Merit Health River Oaks	Flowood	★★★★	B	49
1.01	North Mississippi Medical Center	Tupelo	★★★	C	49
1.02	Mississippi Baptist Medical Center	Jackson	★★★	B	51
1.02	Greenwood Leflore Hospital	Greenwood	★★	C	46
1.02	OCH Regional Medical Center	Starkville	★★★	A	48
1.02	University of MS Medical Center	Jackson	★	F	37
1.04	Memorial Hospital at Gulfport	Gulfport	★★	C	37
1.05	Merit Health Central	Jackson	★★	C	45
1.07	Anderson Regional Medical Center	Meridian	★★★	B	44
1.07	Delta Regional Medical Center	Greenville	★★	F	41
1.20	Rush Foundation Hospital	Meridian	★★	C	38

The selected hospital listing above consist of mostly larger hospitals in bed size than OCH. In regards to the "EIF Index Ratio", OCH is within reach of its nearest competitors, as well as most of the hospitals listed. Adding to scale by increasing volume or decreasing costs can lower OCH's ratio.

Many factors have to be taken into consideration when comparing hospitals to the types of patients within the hospitals Case Mix Index (CMI).

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Patient Satisfaction Scores – HCAHPS ***Page 36***

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Stroudwater noted that OCH is 4 Star Rated Hospital for patient satisfaction scores. OCH has consistently demonstrated HCAPHS Scores to be equal to or higher than the National and Mississippi Averages. The CMS scores below indicate that OCH's survey results show patients report having a better overall experience.

HCAHPHS Ratings (out of 5 stars)

OCH Regional Medical Center	**Starkville**	★★★★
Baptist Memorial Hospital-GT	**Columbus**	★★★
North Mississippi Medical Center	**Tupelo**	★★★

SOURCE: Hospital Compare

OCH REGIONAL MEDICAL CENTER
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Findings and Analysis (continued) ***Pages 37 - 38***
Core Measures

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- *U.S. Department of Health and Human Services Hospital Compare website data comparing HMH and competitor hospitals on publicly-reported core measures scores*

  Stroudwater, during their oral presentation on October 17, 2016, acknowledged that the comparative Core Measures on pages 37 and 38 of their report were old data.

  The Institute of Medicine defines health care quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

  For more than 60 years, efforts have been ongoing to define what quality is as it relates to medical/health care. The Centers for Medicare and Medicaid (CMS) has been in an evolving process for performance measurement through their established "Core Measures Program" for federal Medicare patients while the State of Mississippi is in the developmental process for measuring performance for Medicaid patients. Hospital participation in the "Core Measures Program" is voluntary; however, participation is mandatory in order to qualify for CMS "Value Based Payment Program" incentives. Other commercial insurance payors are either adopting existing methodology or developing their quality initiatives for payment.

  What are Core Measures? "Core Measures are standardized best practices designed to improve patient care. ..." Core Measures are for hospitals self-reporting their results to CMS on Medicare patients.

  For FY 2016, Medicare is 36.3% while Medicaid is 20.7% of OCH's Gross Patient Revenue billings. It is desirable for hospitals to have low Medicare and Medicaid percentage to gross billings like OCH.

  In October 2013, the Hanys Quality Institute "HQI" released a report entitled "Hanys' Report on Report Cards – Understanding Publicly Reported Hospital Quality Measures". Hanys' report listed the 10 entities below:

  - **The Joint Commission Quality Check**
  - **DOH Hospital-Acquired Infection Report**
  - **CMS Hospital Compare**
  - **DOH Hospital Profile Quality Section**
  - **Niagara Health Quality Coalition New York State Hospital Report Card**
  - **Leapfrog Hospital Safety Score**
  - **Truven Health Analytics 100 Top Hospitals**
  - **Healthgrades America's Best Hospitals**

- Consumer Reports Hospital Safety Ratings
- U.S. News and World Report

HQI noted that "health care providers and patients face a proliferation of publicly available reports rating the quality of health care provided in hospitals. Supporters of hospital 'report cards' promote them as a means to improve the overall quality of care and help people make more informed health care choices. However, these goals are thwarted by multiple reports with conflicting information and dramatically different ratings. Despite the confusion that contradictory reports create, hospital report cards continue to garner attention from consumers and hospitals engaged in quality improvement efforts." The fact that all of these entities use different methodologies for scoring results create confusion for both providers and consumers.

Surprisingly, Stroudwater did not ask OCH's Administrator/CEO any questions or request information about participation in any quality programs including Core Measures.

OCH voluntarily participates with the Leapfrog Group.

"The Leapfrog Hospital Safety Grade was created and is administered by The Leapfrog Group, a national leader and advocate in hospital transparency. The Leapfrog Group is an independent, national not-for-profit organization founded more than a decade ago by the nation's leading employers and private health care experts… With our goal of saving lives by reducing errors, injuries, accidents, and infections, The Leapfrog Group focuses on measuring and publicly reporting hospital performance through the annual Leapfrog Hospital Survey. The survey is a trusted, transparent and evidence-based national tool in which more than 1,800 hospitals voluntarily participate free of charge."

The Leapfrog Hospital Survey is about performance reporting on all hospital patients. Leapfrog does take into account the Core Measures as developed by CMS for Medicare.

OCH's Leapfrog Safety Grade performance results and comparison to its closest competitors with higher bed size along with other hospitals in the United States are as follows:

		Hospitals United States		
OCH Regional Medical Center	Fall 2016 "A"	A	844	32.0%
Baptist Memorial Hospital GT	Fall 2016 "A"	B	658	25.0%
North Mississippi Medical Center	Fall 2016 "C"	C	954	36.2%
		D	157	6.0%
		F	20	.8%
		Total	2,633	

		Hospitals United States		Hospitals State of MS	
OCH Regional Medical Center	Spring 2016 "A"	A	797	A	12

Also, see pages 48 and 55 - 58 of this response for OCH's benchmark quality scores to "CMS Quality Safety Stars," "Leapfrog Safety Grades" and "Consumer Reports Grades." OCH performs very well when benchmarked with these larger Mississippi hospitals.

The Joint Commission and DNV–GL Healthcare are independent, not-for-profit organizations accredit and certify health care organizations in the United States. While accreditation is technically a voluntary process, through which accrediting bodies like The Joint Commission and DNV–GL Healthcare visit facilities to perform quality and process checks, it is also relied upon by state agencies in all 50 states in lieu of state licensure requirements. Consequently, if an organization fails to achieve accreditation, through either The Joint Commission or DNV–GL Healthcare, the state licensure is much more difficult, if not impossible, to achieve. Without state licensure, a healthcare facility cannot legally keep its doors open.

OCH chose DNV-GL Healthcare in November 2009, previously accredited by The Joint Commission, because of their noticeably different approach to achieving "deemed status" from CMS. DNV offer accreditation built on 2 components:

- **A set of hospital standards, National Integrated Accreditation for Healthcare Organizations (NIAHO), a requirement of CMS**
- **Additional requirement to achieve ISO 9001 certification, or at least ISO 9001 compliance within the first 3 years**

OCH became ISO 9001:2008 eligible for compliance in November 2009 and compliant in 2012. OCH achieved full 3 year certification in June 2016 and was awarded Management System Certificate #133409-2013-AQ-USA-RvA for conforming to the Quality Management System of ISO. OCH is the only hospital in Northeast Mississippi achieving a full certification from ISO 9001:2008. Receiving this certification means that OCH is CONTINUALLY seeking quality care improvement.

The NIAHO standards are basically the Medicare Conditions of Participation (CoPs). The ISO 9001 standards are a broader framework and set of principles for operating an effective organization, much like the Baldrige framework for performance excellence. The ISO 9001 standards focus on 3 major components:

- **Alignment with strategy**
- **Clear and effective quality management system**
- **Consistent process execution**

OCH has obtained the following ongoing certifications:

- **Gold Seal in mammography from the American College of Radiology (ACR) to the Center for Breast Health & Imaging**
- **Gold Seal in MRI Imaging from the American College of Radiology**
- **Gold Seal in computed tomography from the American College of Radiology**

- **Full accreditation from the American Academy of Sleep Medicine for the OCH Center for Sleep Medicine**
- **American Association of Cardiovascular and Pulmonary Rehabilitation**
- **Certified Quality Breast Center of Excellence**
- **IBCLC Care Award for Excellence in staffing lactation consultants (only hospital in Mississippi to receive this award for 2016)**
- **CHAMPS hospital since 2015**
- **Level III Adult Trauma Center and Primary Pediatric Trauma Center**
- **Additional awards cited at och.org**

In October 2016, OCH was chosen by Sunovion Pharmaceuticals, the manufacturer of Brovana, to participate in a pilot program that supports the continuity of care. Sunovion selected OCH because our respiratory staff proactively works to better the health of its patients. Brovana is a long-acting bronchodilator used for the treatment of chronic obstructive pulmonary diseases, including chronic bronchitis and emphysema. OCH was chosen as a direct result of the Respiratory Department's initiation of reversible obstructive airway disease (ROAD) program during the past year. The free two-week supply of Brovana will aid in decreasing the length of stay in the hospital and avoid readmissions. These outcomes are in line with mandates set by the Affordable Care Act. This pilot program will run through March 2017 helping a better quality of life for those patients.

- *Best-practice hospitals track MBQIP data and use the information to make systematic and operational changes to improve overall quality and patient outcomes*

  "The Medicare Beneficiary Quality Improvement Project (MBQIP) is a quality improvement activity under the Medicare Rural Hospital Flexibility (Flex) grant … designed for Critical Access Hospitals. The Federal Office of Rural Health Policy (FORHP) and its partners are charged with increasing current critical access hospitals (CAHs) Hospital Compare participation rates, and CAH dedication to quality improvement initiatives. While participation in the project is voluntary, Medicare Beneficiary Quality Improvement Program (MBQIP) seeks to increase attention on quality healthcare to all CAH Medicare beneficiaries, both inpatient and outpatient."

  Participating in MBQIP is voluntary and is not the only quality improvement tracking methodology available for hospitals to use. OCH does not participate in MBQIP; however, OCH is participating in other acceptable quality initiatives for quality improvement and patient outcomes as previously explained on pages 51 and 52 of this response.

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Key Findings ***Pages 39***

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- *OCH performs well on patient satisfaction but below MS averages on core measures*

Core Measures are just one part of OCH's journey to providing safe, high-quality healthcare for the seven-county service area. The Core Measures for HF, PN, and SCIP (listed on pages 37 and 38 of the Stroudwater report) have not been required since 9/30/2015 and are outdated. A Stroudwater consultant even acknowledged this saying, "the data was old data" during the October 17, 2016, presentation.

In addition to the required CMS Core Measures listed for the CY 2016 time periods below, OCH audits all available Core Measures for benchmark comparison for its continuing quality improvement process. OCH's Quality Department has continued to monitor past Core Measures, as well as the present required measures. OCH believes in continually monitoring performance in order to improve the care and safety of patients; therefore, the measures that did not meet OCH threshold or benchmarks are audited each quarter whether required by CMS or not.

From October 1, 2015 through June 30, 2016, CMS required reporting on:

AMI -- Fibrinolytic given within 30 minutes
Sepsis -- All measures
SCIP -- For cardiac surgery, obtain blood sugar
VTE -- Monitor prophylaxis, overlap therapy, discharge instructions, and hospital-acquired VTE

Stroke -- Monitor VTE, anti-thrombotic therapy, a-fib, thrombotic statin, patient education, and PT
Patient immunization/vaccinations

From July 1, 2016 through December 31, 2016, CMS requires reporting on:

Sepsis -- All measures (13)
VTE -- Discharge instructions and hospital-acquired VTE
Stroke -- Thrombolytic therapy within 30 minutes of arrival
Patient immunization/vaccinations

The website for Hospital Compare: https://www/medicare.gov/HospitalsCompare/profile.html

As of November 22, 2016, the data percentages recorded on Hospital Compare for OCH were:

AMI (OP) with the reporting period being 1/1/15 – 12/31/15:

- **Average # of minutes to get an EKG in ER:**

  OCH 25 minutes*
  MS 9 minutes
  US 7 minutes

  ***There is a discrepancy between Hospital Compare data and OCH actual 2015 and 2016 respiratory department documentation, which shows the average time to be 7 and 6 minutes respectively.**

  OCH's Respiratory Therapy Department monitors EKG performance time on a monthly basis.
  - **In 2015 the average # of minutes from the time of the EKG tech being called until the time the EKG is printed off was 7 minutes.**
  - **In 2016 the average # of minutes from the time of the EKG tech being called until the time the EKG is printed off is 6 minutes.**
    (See page 71 of Appendix 2 of this response for graphs.)

- **Aspirin given within 24 hours of arrival:**
  OCH 93%
  MS 95%
  US 96%

LVS evaluation with the reporting period being 1/1/15 – 9/30/15:
OCH 97%
MS 93%
US 96%

Pneumonia antibiotic with reporting period being 1/1/15 – 9/30/15:
OCH 84%
MS 88%
US 92%

SCIP with the reporting period being 1/1/15 – 9/30/15:

- **Antibiotic within 1 hour of surgery:**
  OCH 89%
  MS 99%
  US 98%

- **Antibiotic stopped at 24 hours post-op:**
  OCH 96%
  MS 96%
  US 98%

- **VTE treatment within 24 hours before/after:**
  OCH 100%
  MS 100%
  US 99%

- **Beta Blocker given before/after surgery:**
  OCH 82%
  MS 95%
  US 97%

- **Right antibiotic given:** OCH 93%, MS 98%, US 99%

- **Foley removed 1-2 days post-surgery:** OCH 99%, MS 98%, US 98%

12/15/15 - A FTE Quality Care Coordinator was hired to work with the medical staff and the hospital staff on a daily basis for continual improvement in the CMS required core measures, Leap Frog and other continuing quality program initiatives.

Concurrent Core Measures for the first quarter, second quarter, and third quarter of 2016. OCH collects data according to the timeframe identical to CMS schedule (1/1/2016 – 12/31/2016). (See pages 72 - 75 of Appendix 2 of this response for the graphs below.)

AMI (Aspirin):

Benchmark	= 98%
1st Q sample size	0 = 0% (1)
2nd Q sample size	2 = 68% (2)
3rd Q sample size	5 = 75%

(1) No samples required for reporting.
(2) Sample size per CMS must be 5+ for benchmark comparison.

CHF (LVS):

Benchmark	= 98%
1st Q sample size	8 = 100%
2nd Q sample size	39 = 83%
3rd Q sample size	25 = 100%

Pneumonia (Appropriate antibiotic):

Benchmark	= 98%
1st Q sample size	33 = 100%
2nd Q sample size	56 = 100%
3rd Q sample size	22 = 87%

SCIP (Antibiotic within 1 hour):

Benchmark	= 98%
1st Q sample size	88 = 90%
2nd Q sample size	105 = 99%
3rd Q sample size	46 = 100%

SCIP (Antibiotic stopped appropriately):

Benchmark	= 98%
1st Q sample size	76 = 99%
2nd Q sample size	105 = 98%
3rd Q sample size	46 = 99%

SCIP (VTE):

Benchmark	**= 98%**
1st Q sample size	**76 = 100%**
2nd Q sample size	**105 = 100%**
3rd Q sample size	**46 = 100%**

SCIP (Beta blockers):

Benchmark	**= 98%**
1st Q sample size	**76 = 100%**
2nd Q sample size	**105 = 98%**
3rd Q sample size	**46 = 100%**

SCIP (Right antibiotic):

Benchmark	**= 98%**
1st Q sample size	**76 = 90%**
2nd Q sample size	**105 = 96%**
3rd Q sample size	**46 = 100%**

SCIP (Foley removal):

Benchmark	**= 98%**
1st Q sample size	**76 = 100%**
2nd Q sample size	**105 = 100%**
3rd Q sample size	**46 = 100%**

Patient quality and safety is a continuous on-going process. In pursuit of fostering a culture of safety and improvement, OCH is committed to making patient care safer, thereby improving patient outcomes.

- *OCH has an overall rating of 3 of a possible 5 stars*
  - *Approximately 40% of hospitals receive 3 stars / 20% 4 stars / 2% 5 stars*

CMS released star rating as of July 2016 on Core Measures Results

	United States		Mississippi	
5 Stars	**102**	**2.8%**	**0**	**0%**
4 Stars	**934**	**25.7%**	**9**	**13.8%**
3 Stars	**1,770**	**48.8%**	**29**	**44.6%**
2 Stars	**701**	**19.3%**	**23**	**35.4%**
1 Star	**121**	**3.4%**	**4**	**6.2%**
Total	**3,628**		**65**	
Not Enough Data to Rate:	**937**		**33**	

3 Stars issued to:

OCH Regional Medical Center	**Starkville**
Baptist Memorial Hospital – Golden Triangle	**Columbus**
North Mississippi Medical Center	**Tupelo**

Also, see pages 48 & 52 of this response for other OCH quality benchmark comparison.

- *OCH is a higher cost and average quality provider using CMS cost and quality data*

  OCH has received the same "3" Star Rating from CMS that Baptist Memorial Hospital-GT and NMMC Tupelo received. Also, OCH received an "A" Grade from Leapfrog as did Baptist Memorial Hospital-GT, while NMMC Tupelo received a "C" Grade.

  OCH "Medicare Hospital Spending per Patient Score" is 1.02. See page 48 of this response for benchmark comparison with larger hospitals in Mississippi. See previous comments in this response regarding quality data and information.

- *Why is quality of care important?*
  - *Reimbursement is now tied to reported quality and core measure scores, making quality a financial issue*

    OCH and the Medical Staff concur with this statement.

  - *All reported CORE Measures are designed around accepted best practices nationally*

    OCH and the Medical Staff concur with this statement. OCH has received the same 3 Stars Score from CMS as: Baptist Memorial Hospital-GT and North Mississippi Medical Center.

  - *Every hospital board member should be familiar with its hospital's quality reports and holding the administrative team accountable for agreed upon acceptable levels of quality.* ***Quality is the Board's responsibility.***

    The Board of Trustees is familiar with the hospital's quality reports. Quarterly update reports are presented by the Chief Nursing Officer. One Trustee serves annually on the Quality Outcomes Committee which meets quarterly.

    The Board of Trustees of OCH Regional Medical Center has, pursuant to Article VII, and Article VIII of the Bylaws of OCH, delegated the authority and responsibilities to the Medical Staff to establish the Bylaws, Rules, Regulations and Policies for the purpose of creating an effective administrative unit to discharge the functions and responsibilities for providing the appropriate quality professional care rendered to Hospital patients and the community.

    It is a collaborative team effort of the Board of Trustees, Medical Staff, Administration, Department Directors, Department Supervisors and line employees to be a continuing ongoing quality improvement program. This is an absolute essential compliance requirement for full certification under ISO 9001:2008.

NO hospital will achieve absolute final quality. Hospitals have to show that their facility is in an ongoing quality improvement process. OCH has and will continue to seek ways for demonstrating quality improvement.

- *Consumerism and transparency*

In regards to transparency there is much information on OCH and hospitals throughout the State of Mississippi and United States in the CMS Compare Website and in the Leapfrog Safety Grade Website as well as the web sites of other publicly quality reporting entities. OCH's website also features an entire section dedicated to transparency (och.org/accountability-and-transparency).

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The Outlook for Not-for-Profit Hospitals	***Page 41***
Weighing Execution Risk & Transaction Risk	***Page 42***

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No additional information is needed for clarification to pages 41 & 42 of the Stroudwater Report.

OCH REGIONAL MEDICAL CENTER
RESPONSE TO
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Strategic Questions for OCH ***Pages 43 - 46***

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Some of the questions presented below by Stroudwater are Strategic Planning Initiatives that will need to be considered annually by the Board of Trustees, Administration and Medical Staff as OCH prepares to move forward as a "stand alone" facility. Consideration of these questions deserves careful evaluation and planning on an annual basis by OCH and the Medical Staff and to consider what impact any final decisions will have on OCH's culture in the delivery of medical/health care to the community that the Hospital and Medical Staff are serving.

- *What sources of risk are most significant to OCH's ongoing viability and success?*
  - *Lack of scale*
  - *Inadequate operating margins*
  - *Outmigration from PSA and low occupancy*
  - *Weak market position in SSA*
  - *Quality scores and cost position*
- *What strategies can be employed to mitigate those risks?*
  - *Investment in satellite clinics and aligned primary care base*
  - *Development of aligned clinical services in cardiology, cancer, etc.*
  - *Investment in IT and systems needed for new payment models*
  - *Operational improvement*
- *Is OCH well positioned to achieve its mission and objectives independently?*
  - *Weak margins, lack of scale, outmigration, weak market position in the SSA and quality scores all compromise OCH's future trajectory*
- *How large is the "performance gap" between the resources generated by current operating results and projected investment needs?*
  - *An annual gap of $3M-$4M exists between current operating results and needed levels of performance (excluding GO Bond debt service) before the need for strategic capital is considered*
- *How critical are additional scale, capital and operational resources to the future success of OCH?*
  - *Scale is vital given growing regulatory and operating complexity and high fixed costs for community hospitals*
  - *Operational improvement of $3M-$4M annually is required (excluding GO Bond debt service)*
  - *Additional strategic capital is needed for satellite clinic development, primary care alignment, developing high priority clinical services and IT investment*
- *What strategies and/or strategic options address these constraints?*
  - *Operational improvement is a prerequisite under any scenario*
  - *Strategic investment to reduce outmigration from the PSA and improve OCH's position in the SSA*

- *How well could a transaction with another healthcare provider organization sustain OCH's mission and achieve its strategic objectives?*
    - *We cannot say until transaction options have been explored*
    - *To provide the Supervisors with the information needed to make an informed decision would require that transaction options be explored*
    - *affiliation options against a potentially improved operating trajectory*
- *What type of transaction is best suited for OCH and the community's needs?*
    - *For a transaction to adequately address OCH's operating and strategic risks, OCH requires a "tight model" of sale or lease*
    - *A management agreement, service-line-specific arrangements, or joint operating agreements, while meeting some of OCH's needs, would not create opportunities for significant needed investment and sharing of resources at OCH*
    - *The best structure for OCH cannot be identified until the specifics are available*
- *If a sale or lease is an appropriate option for OCH, how does OCH best mitigate the inherent risks of a transaction?*
    - *A competitive process would help to ensure that:*
    - *All options are explored*
    - *A successful lessee or acquirer is best equipped to meet OCH's and the communities needs*
    - *Alternative transaction structures are vetted*
    - *Potential suitors are evaluated for fit, strategic alignment and capabilities*
    - *Negotiating leverage is enhanced for appropriate, contractually binding terms*

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Stroudwater Recommendation ***Page 47***

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- *OCH needs to improve its operating results to achieve the following goals:*
  - *Ensure that its services are high quality and meet the needs of the community, regardless of future strategic direction*
  - *Enhance the quality and variety of OCH's sale or lease options*
  - *Enhance OCH's negotiating position with potential suitors*
  - *Improve the probability of a sustainable independent path should an acceptable sale or lease option not be available*
- *The Supervisors should explore transaction options as soon as is practical*
  - *This exploration will arm decision makers with additional information*
- *Once transaction options have been vetted, the Supervisors should evaluate the quality and responsiveness of the options against their stated transaction criteria and strategic objectives for OCH*
- *As an exercise of the Supervisors' fiduciary duties, they should understand the benefits and risks associated with all strategic options, including sale or lease options and OCH's potentially improved stand-alone operation*

Some of the above recommendations are strictly for the Board of Supervisors as representatives of the citizens of Oktibbeha County. Other recommendations directly fall on the Board of Trustees, as appointees by the Board of Supervisors, to faithfully carry out their fiduciary responsibilities and duties as required by Mississippi Code Ann. §41-13-1, etc. and subsequent amendments under Senate Bill No. 2407 signed into law in 2015 regulating governmental community, non-state owned hospitals.

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Historical Transaction Multiples ***Page 48***

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No additional information is needed for clarification to page 48 of the Stroudwater Report.

OCH REGIONAL MEDICAL CENTER
RESPONSE TO
QUESTIONS REGARDING READMISSION AND VALUE BASE PENALTIES DURING PUBLIC HEARING 12/06/2016

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Supervisor Bricklee Miller asked about OCH's readmission and value base payment penalties during the public hearing on December 6, 2016.

READMISSION PENALTY - FY 2017

		Rate	Amount
OCH Regional Medical Center	Starkville	.00460	($ 29,234)
Baptist Memorial Hospital-GT	Columbus	.00860	($230,674)
North Mississippi Medical Center	Tupelo	.00610	($637,646)

SOURCE: Advisory Board August 4, 2016

According to the Advisory Board, 2,597 hospitals face readmission penalties for FY 2017 based on data released by CMS on August 2, 2016. These latest penalties are based on readmissions between July 2012 and June 2015. The penalties result from higher-than-expected number of Medicare readmissions within 30 days of discharge for six conditions:

- **Chronic lung disease**
- **Coronary artery bypass graft surgery**
- **Heart attacks**
- **Heart failure**
- **Hip and knee replacements**
- **Pneumonia**

The penalties are not adjusted for socioeconomic factors, which are beyond the control of any hospital after patients are discharged. Medicare is disproportionately penalizing hospitals such as OCH that serve disadvantaged patients and communities.

PAY FOR PERFORMANCE (P4P) ESTIMATED NET IMPACT - FY 2017

		Rate	Amount
OCH Regional Medical Center	Starkville	-.00020397	($ 1,773)
Baptist Memorial Hospital-GT	Columbus	-.00598121	($204,159)
North Mississippi Medical Center	Tupelo	-.00355409	($480,801)

SOURCE: Advisory Board August 4, 2016

The P4P estimated impact rate penalty for OCH is less than the rates for Baptist Memorial Hospital-GT and North Mississippi Medical Center Tupelo.

This data indicates that readmission penalties and P4P estimated net impact for 2017 will lead to minimal reductions to OCH's bottom line.

In regards to Hospital Acquired Conditions (HAC), OCH has no estimated penalty reductions flagged for FY 2017 as reported directly to OCH from CMS in September 2016. OCH does not have access to the comparable reports that were provided to Baptist Memorial Hospital-GT and North Mississippi Medical Center Tupelo.

APPENDIX 1

SPREADSHEET LISTING

OF

HOSPITAL SYSTEMS & HOSPITALS

PROVIDING ACUTE MEDICAL / SURGICAL CARE

IN

STATE OF MISSISSIPPI

STATE OF MS HOSPITALS SELECT COMPARATIVE DATA

SOURCE: MISSISSIPPI HOSPITAL ASSOCIATION 2015 - 2016 DESK DIRECTORY & REFERENCE GUIDE

	City / Town	County	Name	Type	Ser-vice	CAH	Acute Beds	Psych Beds	LTC Beds	Rehab Beds	
			Systems & Non-Profit Hospitals								
1	Meridian	Lauderdale	AND - Anderson Regional Medical Center	NP	M / S	No	260	16	0	20	
2	Meridian	Lauderdale	AND - Anderson Regional Medical Center - South	NP	M / S	No	120	0	0	20	
3	Booneville	Prentiss	Baptist Memorial Hospital - Booneville	NP	M / S	No	58	15	0	0	In merger discussions.
4	Southaven	Desoto	Baptist Memorial Hospital - Desoto	NP	M / S	No	309	0	0	30	In merger discussions.
5	Columbus	Lowdnes	Baptist Memorial Hospital - Golden Triangle	NP	M / S	No	285	22	0	0	In merger discussions.
6	Oxford	Lafayette	Baptist Memorial Hospital - North Ms	NP	M / S	No	204	0	0	13	In merger discussions.
7	New Alabany	Union	Baptist Memorial Hospital - Union County	NP	M / S	No	153	0	0	0	In merger discussions.
8	Calhoun City	Calhoun	Calhoun Health Services	NP	M / S	No	25	0	0	0	In merger discussions.
9	Yazoo City	Yazoo	MB - Baptist Medical Center - Yazoo, Inc	NP	M / S	Yes	25	0	0	0	In merger discussions.
10	Kosciusko	Attala	MB - Baptist Medical Center Attla	NP	M / S	Yes	25	0	0	0	In merger discussions.
11	Carthage	Leake	MB - Baptist Medical Center Leake	NP	M / S	Yes	25	0	0	0	In merger discussions.
12	Jackson	Hinds	MB - Mississippi Baptist Medical Center	NP	M / S	No	541	23	0	0	In merger discussions.
13	Jackson	Hinds	MB - Mississippi Hospital for Restorative Care	NP	LT	Yes	20	0	0	0	In merger discussions.
14	Tupelo	Lee	NM - North Mississippi Medical Center	NP	M / S	No	554	33	0	30	
15	Eupora	Webster	NM - Webster Health Services	NP	M / S	No	38	36	36	0	
16	Iuka	Tishomingo	NM - Tishomingo Health Services	NP	M / S	No	48	0	0	0	
17	Pontotoc	Pontotoc	NM - North Mississippi Medical Center - Pontotoc	NP	M / S	Yes	25	0	44	0	
18	West Point	Clay	NM - Clay County Corporation	NP	M / S	No	60	0	0	0	
19	Quitman	Clarke	RUSH - H.C. Watkins Memorial Hospital	NP	M / S	Yes	25	0	0	0	
20	De Kalb	Kemper	RUSH - John C. Stennis Memorial Hospital	NP	M / S	Yes	25	0	0	0	
21	Union	Newton	RUSH - Laird Hospital	NP	M / S	Yes	25	0	0	0	
22	Meridian	Lauderdale	RUSH - Rush Foundation Hospsital	NP	M / S	No	215	0	0	0	
23	Morton	Scott	RUSH - Scott Regional Hospital	NP	M / S	Yes	25	0	0	0	
24	Meridian	Lauderdale	RUSH - Specialty Hospital of Meridian	NP	LT	No	49	0	0	0	
25	Jackson	Hinds	STDOM - St Dominic - Jackson Memorial Hosp	NP	M / S	No	417	83	0	0	
			Non -System & Non-Profit Hospitals								
26	Magnolia	Pike	Beachum Memorial Hospital	NP	M / S	No	37	0	0	0	
27	Magee	Simpson	Magee General Hospital	NP	M / S	No	64	0	0	0	
28	Olive Branch	De Soto	Methodist Healthcare Olive Branch Hospital	NP	M/S	No	67	0	0	0	
29	Jackson	Hinds	Methodist Rehabilitation Center	NP	Rehab	No	44	0	0	80	
30	Mendenhall	Simpson	Simpson General Hospital	NP	M / S	Yes	25	10	0	0	
31	Louisville	Winston	Winston Medical Center	NP	M / S	No	27	14	120	0	
			Systems & GNS or State Hospitals								
32	Hattiesburg	Forrest	FH - Forrest General Hospital	GNS	M / S	No	400	80	0	24	
33	Picayune	Pearl River	FH - Highland Community Hospital	GNS	M / S	No	60	0	0	0	
34	Prentiss	Jeff Davis	FH - Jefferson Davis Community Hospital	GNS	M / S	Yes	25	10	0	0	
35	Columbia	Marion	FH - Marion General Hospital	GNS	M / S	No	49	0	0	0	
36	Tylertown	Walthall	FH - Walthall County General Hospital	GNS	M / S	Yes	25	0	0	0	
37	Bay Saint Louis	Hancock	OCHSNER - Hancock Medical Center	GNS	M / S	No	102	0	0	0	Under Management
38	Centreville	Wilkinson	QHR - Field Memorial Community Hospital	GNS	M / S	Yes	25	0	0	0	Under Management
39	Brookhaven	Lincoln	QHR - King's Daughter Medical Center	NP	M / S	No	122	0	0	0	Under Management
40	Corinth	Alcorn	QHR - Magnolia Regional Health Center	GNS	M / S	No	181	19	0	0	Under Management
41	Ocean Springs	Jackson	SING - Ocean Springs Hospital	GNS	M / S	No	136	0	0	0	
42	Pascagoula	Jackson	SING - Singing River Health System	GNS	M / S	No	385	30	0	20	
43	McComb	Pike	SWHS - Southwest Mississippi Reg Med Ctr	GNS	M / S	No	160	0	0	0	Under Management
44	Monticello	Lawrence	SWHS- Lawrence County Hospital	GNS	M / S	Yes	25	0	0	0	Under Management
45	Grenada	Grenada	UMMC - Grenada Lake Medical Center	ST	M / S	No	156	14	0	0	
46	Lexington	Holmes	UMMC - Holmes County Hospital & Clinics	ST	M / S	Yes	25	0	0	0	
47	Jackson	Hinds	UMMC - University Hospitals & Health System	ST	M / S	No	664	33	20	25	

STATE OF MS HOSPITALS SELECT COMPARATIVE DATA

SOURCE: MISSISSIPPI HOSPITAL ASSOCIATION 2015 - 2016 DESK DIRECTORY & REFERENCE GUIDE

	City / Town	County	Name	Type	Ser-vice	CAH	Acute Beds	Psych Beds	LTC Beds	Rehab Beds	
			Non-System & GNS Hospitals								
48	Port Gibson	Caliborne	Claiborne County Medical Center	GNS	M / S	No	32	0	0	0	
49	Collins	Covington	Covington County Hospital	GNS	M / S	Yes	25	10	0	0	
50	Greenville	Washington	Delta Regional Medical Center	GNS	M / S	No	58	9	40	24	
51	Meadville	Franklin	Franklin County Mermorial Hospital	GNS	M / S	Yes	25	0	10	0	
52	Lucedale	Jackson	George Regional Health system	GNS	M / S	Yes	22	0	0	0	
53	Leaksville	Greene	Greene County Hospital	GNS	M / S	Yes	3	0	0	0	
54	Greenwood	Leflore	Greenwood Leflore Hospital	GNS	M / S	No	188	0	0	20	
55	Hazlehurst	Copiah	Hardy Wilson Memorial Hospital	GNS	M / S	Yes	25	0	0	0	
56	Bay Springs	Jasper	Jasper General Hospital	GNS	M / S	Yes	16	0	110	0	
57	Fayette	Jefferson	Jefferson County Hospital	GNS	M / S	No	30	0	0	0	
58	Gulfport	Harrison	Memorial Hospital at Gulfport	GNS	M / S	No	303	89	0	33	
59	Philadelphia	Neshoba	Neshoba County General Hospital	GNS	M / S	No	49	0	160	0	
60	Ruleville	Sunflower	North Sunflower Medical Center	GNS	M / S	Yes	25	10	0	0	
61	Macon	Noxubee	Noxubee General Hospital	GNS	M / S	Yes	25	0	0	0	
62	Starkville	Oktibbeha	OCH Regional Medical Center	GNS	M / S	No	96	0	0	0	
63	Poplarville	Pearl River	Pearl River County Hospital	GNS	M / S	Yes	24	24	0	0	
64	Rolling Fork	Sharkey	Sharkey - Issaquena Community Hospital	GNS	M / S	Yes	19	10	0	0	
65	Laurel	Jones	South Central Regional Medical Center	GNS	M / S	No	275	18	260	0	
66	Indianola	Sunflower	South Sunflower County Hospital	GNS	M / S	No	49	0	0	0	
67	Charleston	Tallahatchie	Tallahatchie General Hospital	GNS	M / S	Yes	18	0	0	0	
68	Winona	Mongomery	Tyler Holmes Memorial Hospital	GNS	M / S	Yes	25	0	0	0	
69	Waynesboro	Wayne	Wayne General Hospital	GNS	M / S	No	80	0	0	0	
70	Water Valley	Yalobusha	Yalobusha General Hospital	GNS	M / S	No	26	0	0	0	
			Systems & For Profit Hospitals								
71	Gulfport	Harrison	HCA- Garden Park Medical Center	FP	M / S	No	130	0	0	0	
72	Cleveland	Bolivar	LIFEPOINT - Bolivar Medical Center	FP	M / S	No	165	0	35	0	
73	Batesville	Panola	Merit - Natchez Batesville	FP	M / S	No	77	25	0	0	Sold to Curae.
74	Biloxi	Harrison	Merit Health Biloxi	FP	M / S	No	153	45	0	0	Financial Issues - seeking buyer.
75	Jackson	Hinds	Merit Health Central	FP	M / S	No	415	47	0	0	Financial Issues - seeking buyer.
76	Amory	Monroe	Merit Health Gilmore	FP	M / S	No	95	0	0	0	Sold to Curae.
77	Canton	Madison	Merit Health Madison	FP	M / S	No	67	0	0	0	Financial Issues - seeking buyer.
78	Natchez	Adams	Merit Health Natchez	FP	M / S	No	147	12	0	20	Financial Issues - seeking buyer.
79	Clarksdale	Coahoma	Merit Health Northwest	FP	M / S	No	181	0	0	14	Sold to Curae.
80	Brandon	Rankin	Merit Health Rankin	FP	M / S	No	114	20	0	0	Financial Issues - seeking buyer.
81	Flowood	Rankin	Merit Health River Oaks	FP	M / S	No	130	0	0	0	Financial Issues - seeking buyer.
82	Vicksburg	Warren	Merit Health River Region	FP	M / S	No	261	40	0	0	Financial Issues - seeking buyer.
83	Hattiesburg	Forrest	Merit Health Wesley	FP	M / S	No	211	0	0	0	Financial Issues - seeking buyer.
84	Flowood	Rankin	Merit Health Woman's Hospital	FP	OB/GYN	No	60	0	0	0	Financial Issues - seeking buyer.
85	Aberdeen	Monroe	PI - Pioneer Community Hospital of Aberdeen	FP	M / S	Yes	14	6	0	0	**In Bankruptcy.**
86	Newton	Newton	PI - Pioneer Community Hospital of Newton	FP	M / S	Yes	21	9	0	0	**In Bankruptcy.**
87	Forest	Scott	PI - S.E. Lackey Memorial Hospital	NP	M / S	Yes	15	10	20	10	
88	Ripley	Tippah	PI - Tippah County Hospital	GNS	M / S	Yes	25	0	40	0	**Under Management**
89	Vicksburg	Warren	Promise Hospital of Vicksburg	FP	LT	No	33	0	0	0	
90	Hattiesburg	Forrest	SELECT - Regency Hospital of Hattiesburg	FP	LT	Yes	8	0	0	0	
91	Jackson	Hinds	SELECT - Regency Hospital of Jackson	FP	LT	No	36	0	0	0	
92	Meridian	Lauderdale	SELECT - Regency Hospital of Meridian	FP	LT	No	40	0	0	0	
93	Gulfport	Harrison	SELECT - Select Specialty Hospital - Gulf Coast	FP	LT	No	61	0	0	0	
94	Jackson	Hinds	SELECT - Select Specialty Hospital - Jackson	FP	LT	No	53	0	0	0	
95	Houston	Chickasaw	SUNLINK - Trace Regional Hospital	FP	M / S	No	66	18	0	0	**Under Management**
96	Ackerman	Choctaw	Triology - Choctaw Regional Medical Center	GNS	M / S	Yes	25	0	0	0	
			Non-System & For Profit Hospitals								
97	Greenwood	Leflore	LTAC Hospital of Greenwood	FP	LT	No	40	0	0	0	
98	Senatobia	Tate	North Oak Regional Medical Center	FP	M / S	No	53	0	0	0	
99	Belzoni	Humphreys	Patients Choice Medical Center	FP	M / S	No	34				
100	Richton	Perry	Perry County General Hospital	FP	M / S	Yes	22	0	0	0	
101	Marks	Quitman	Quitman County Hospital	FP	M / S	Yes	25	8	60	0	
102	Wiggins	Stone	Stone County Hospital	FP	M / S	Yes	25	0	0	0	
			Totals - State of Mississippi				**10,600**	**848**	**955**	**383**	

APPENDIX 2

GRAPHS

EKG PERFORMANCE TIMES 2015

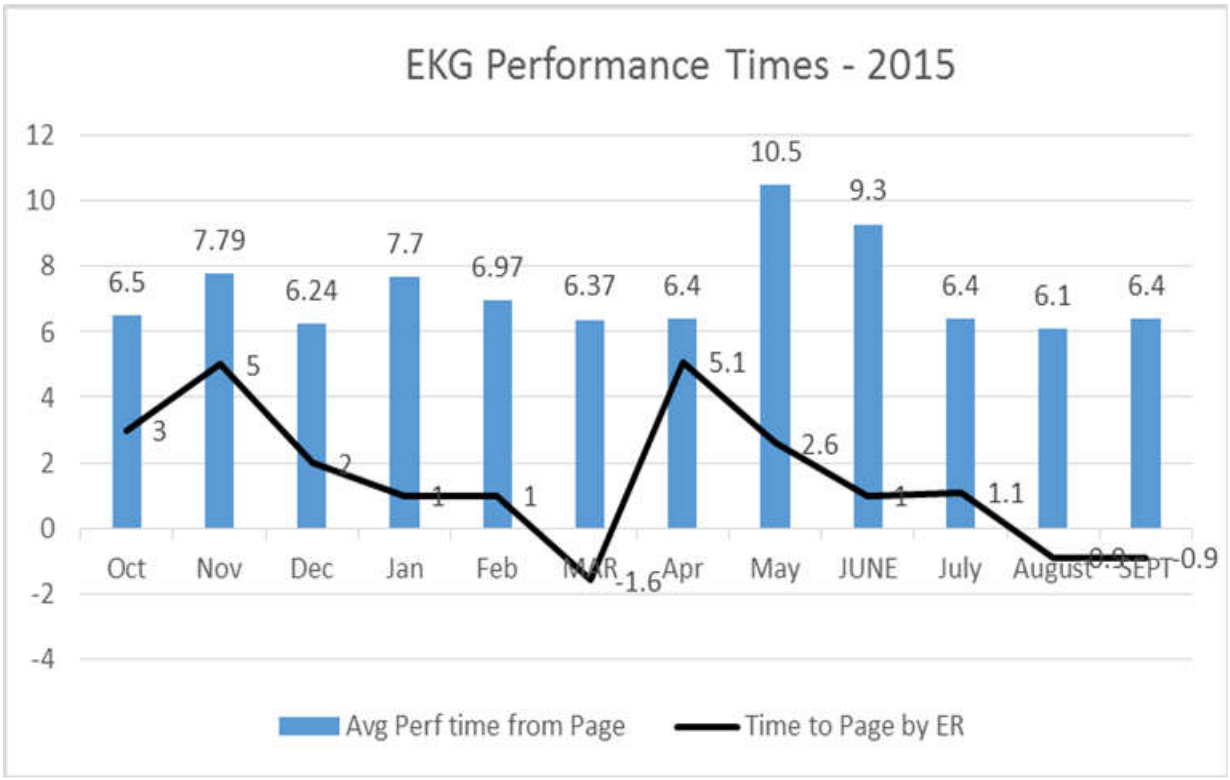
EKG PERFORMANCE TIMES 2016

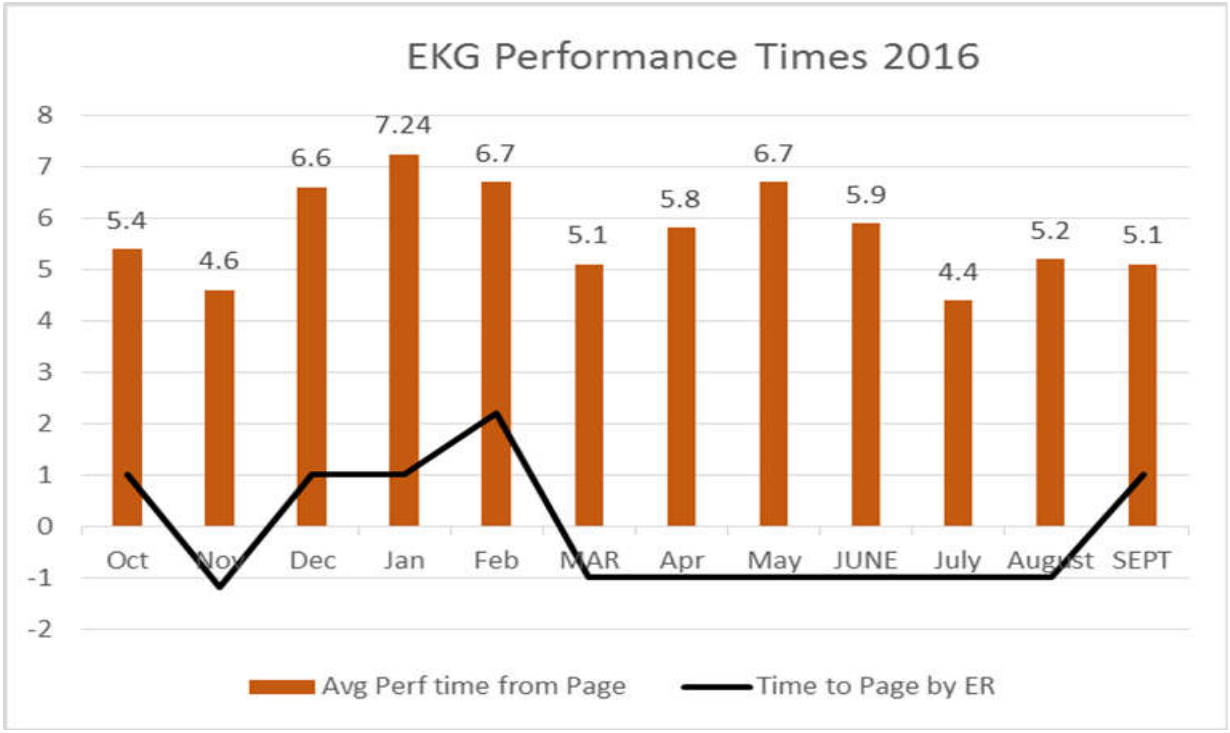
ACUTE MYOCARDIAL INFARCTION 2016

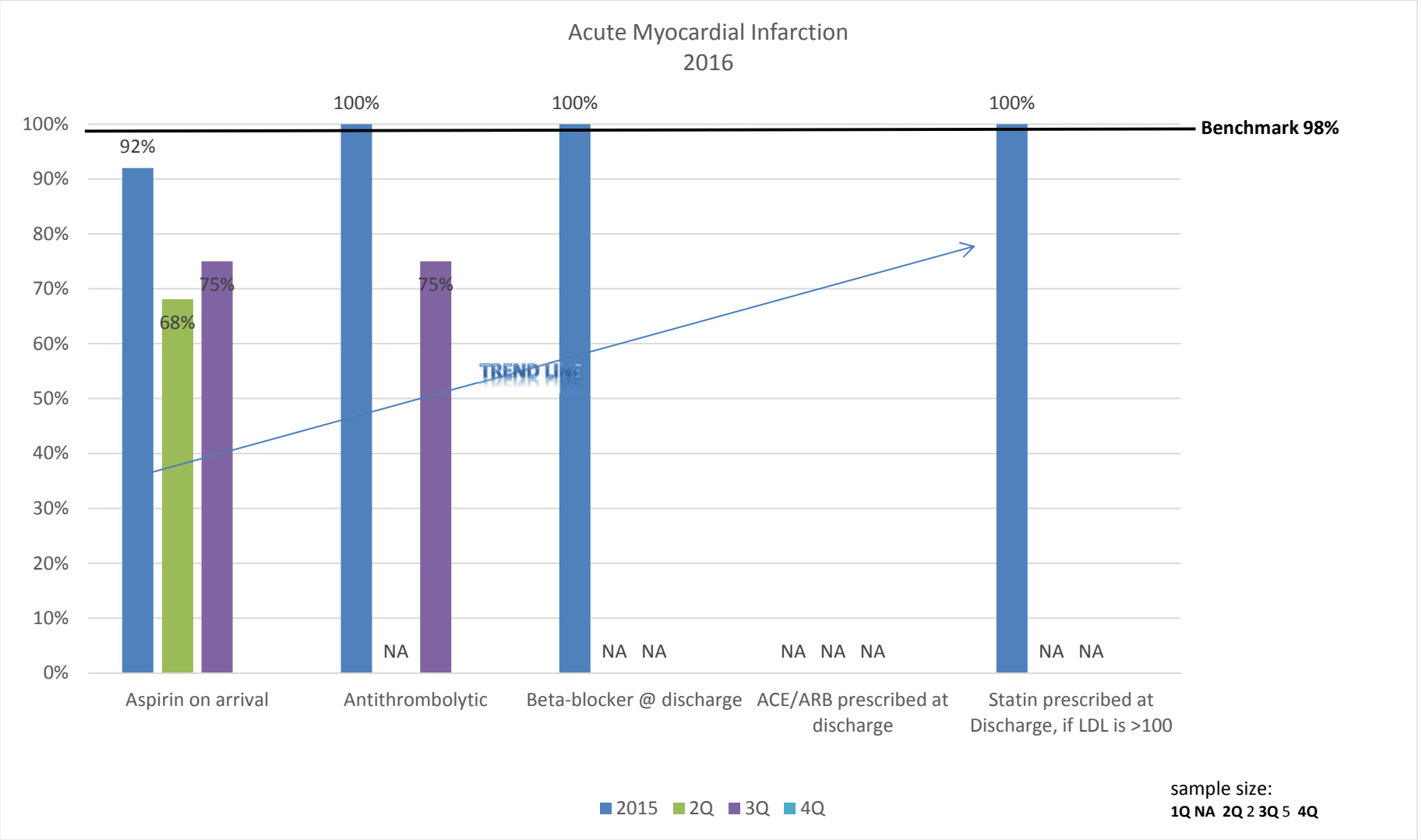
HEART FAILURE 2016

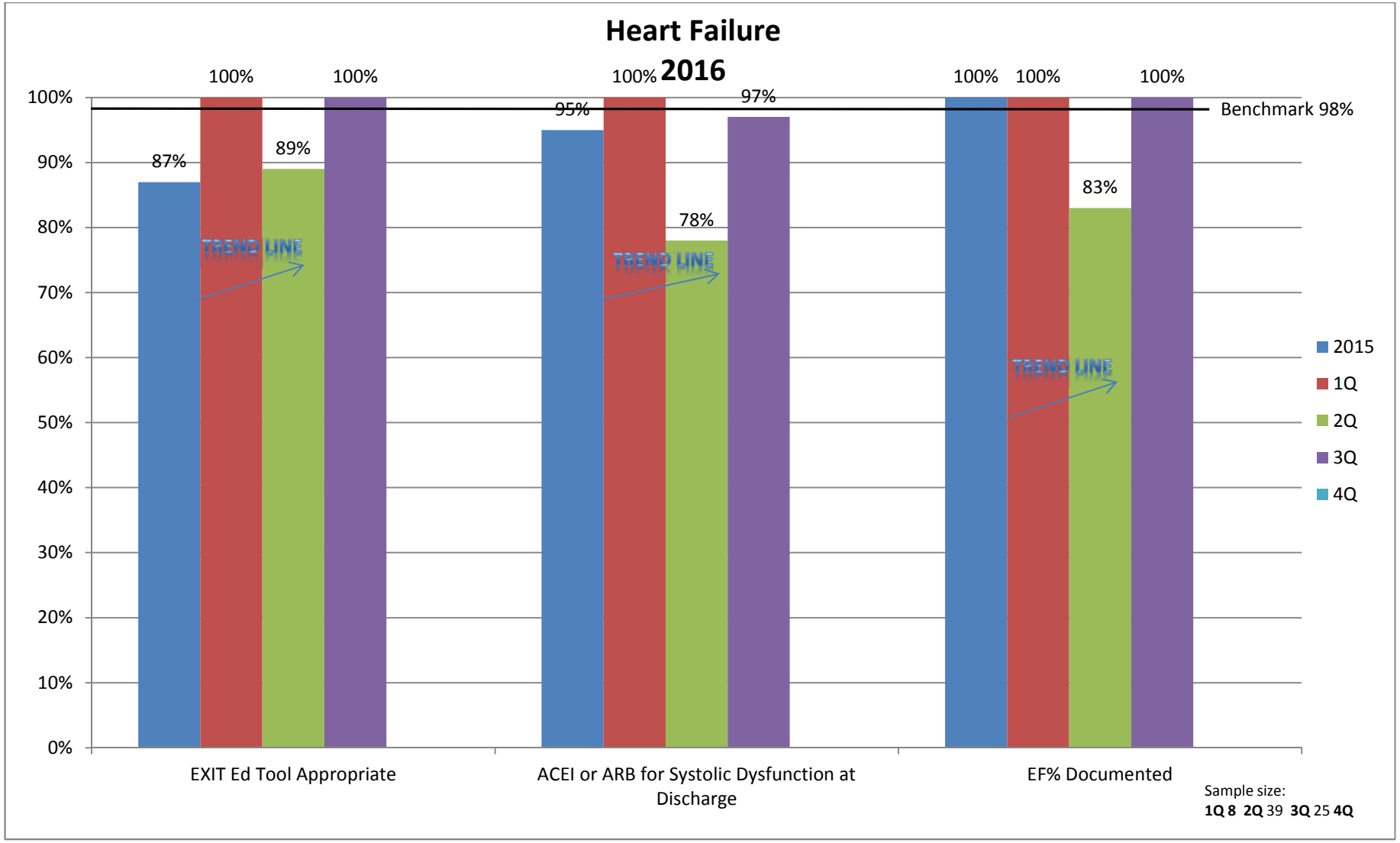
PNEUMONIA 2016

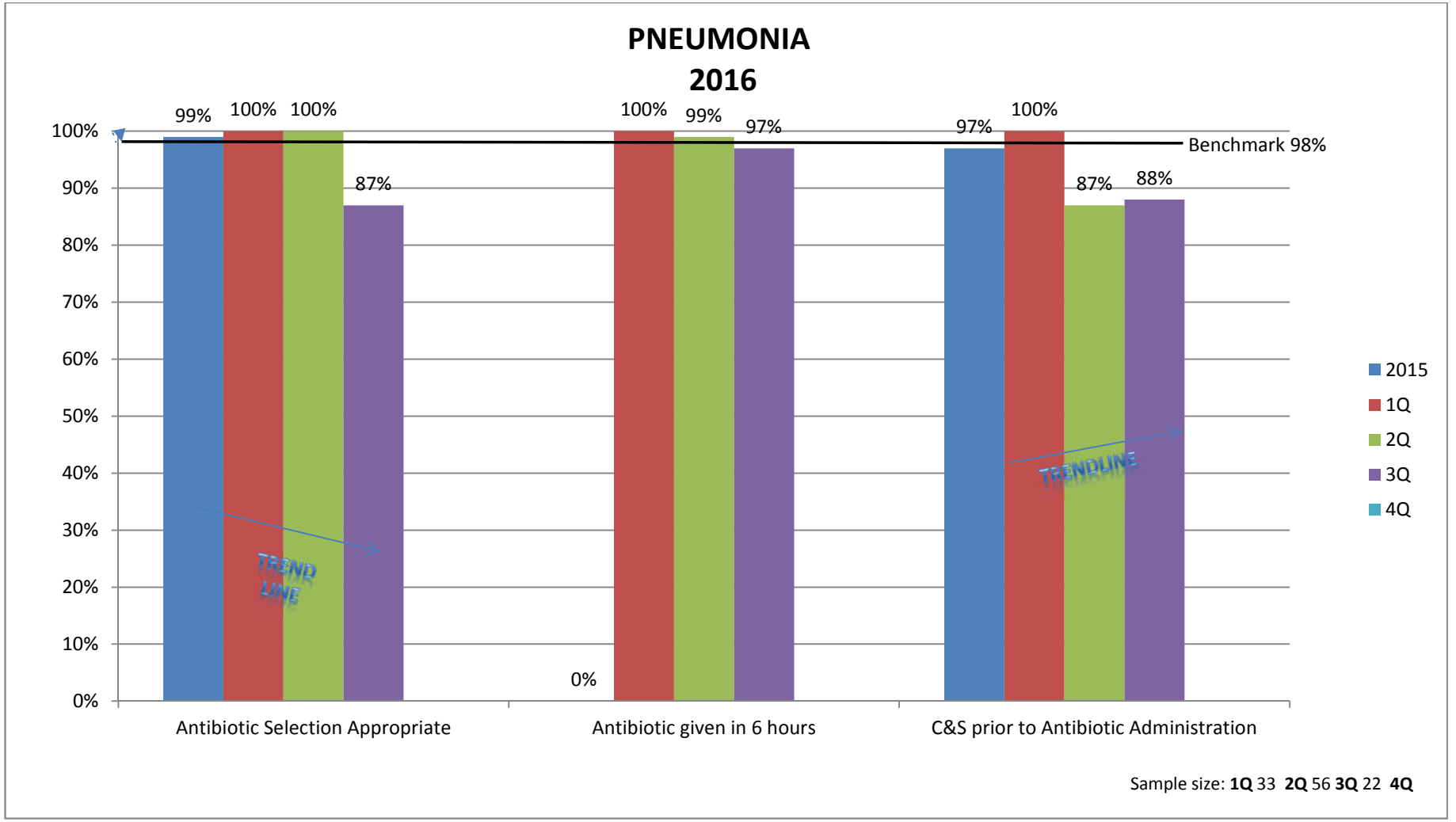
SURGICAL CARE IMPROVEMENT PROJECT (SCIP)

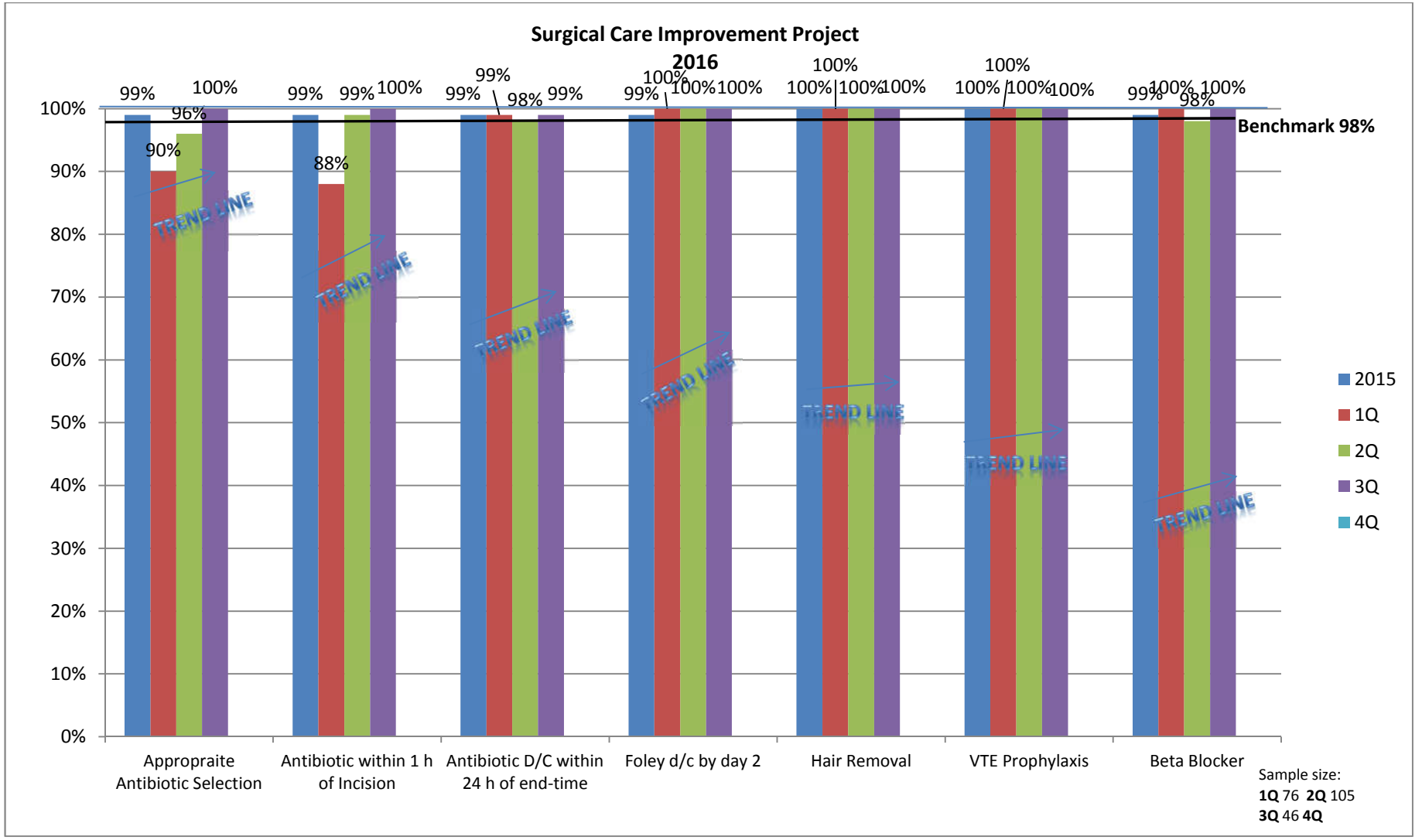

EKG Performance Times - 2015
12
10
8
6
4
2
0
-2
-4
6.5
7.79
6.24
7.7
6.97
6.37
6.4
10.5
9.3
6.4
6.1
6.4
3
5
2
1
1
-1.6
5.1
2.6
1
1.1
-0.9
Oct
Nov
Dec
Jan
Feb
MAR
Apr
May
JUNE
July
August
SEPT
Avg Perf time from Page
Time to Page by ER


EKG Performance Times 2016
8
7
6
5
4
3
2
1
0
-1
-2
5.4
4.6
6.6
7.24
6.7
5.1
5.8
6.7
5.9
4.4
5.2
5.1
Oct
Nov
Dec
Jan
Feb
MAR
Apr
May
JUNE
July
August
SEPT
Avg Perf time from Page
Time to Page by ER


Acute Myocardial Infarction
2016
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Benchmark 98%
92%
68%
75%
100%
NA
75%
100%
NA NA
NA NA NA
100%
NA NA
TREND LINE
Aspirin on arrival
Antithrombolytic
Beta-blocker @ discharge
ACE/ARB prescribed at discharge
Statin prescribed at Discharge, if LDL is >100
2015 2Q 3Q 4Q
sample size:
1Q NA 2Q 2 3Q 5 4Q


Heart Failure
2016
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
87%
100%
89%
100%
95%
100%
78%
97%
100%
100%
83%
100%
TREND LINE
TREND LINE
TREND LINE
Benchmark 98%
2015
1Q
2Q
3Q
4Q
EXIT Ed Tool Appropriate
ACEI or ARB for Systolic Dysfunction at Discharge
EF% Documented
Sample size:
1Q 8 2Q 39 3Q 25 4Q


PNEUMONIA
2016
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
99%
100%
100%
87%
0%
100%
99%
97%
97%
100%
87%
88%
Benchmark 98%
TREND LINE
TRENDLINE
Antibiotic Selection Appropriate
Antibiotic given in 6 hours
C&S prior to Antibiotic Administration
2015
1Q
2Q
3Q
4Q
Sample size: 1Q 33 2Q 56 3Q 22 4Q


Surgical Care Improvement Project
2016
Benchmark 98%
2015
1Q
2Q
3Q
4Q
Appropraite Antibiotic Selection
Antibiotic within 1 h of Incision
Antibiotic D/C within 24 h of end-time
Foley d/c by day 2
Hair Removal
VTE Prophylaxis
Beta Blocker
TREND LINE
Sample size:
1Q 76 2Q 105
3Q 46 4Q