Is the hospital appropriation request going to grow each year? Or is there some plan to address this?

There is not a clear cut answer at this point. The hospital’s request is for the county’s 2012 fiscal budget. As with any county funding an annual review will be conducted and presented to the commissioners along with a reconsideration of the future needs.

I want to know what is paid to Quorum and what kind of return do we get on that investment.

- The latest public IRS Form 990 shows $391,295 paid to QHR in Fiscal Year 2010. This figure represents all payments made to QHR in the fiscal year 2010. $137,000 was for the management fee. The remainder includes the salaries and benefits paid to the CEO and CFO. Those expenses are “pass through” expenses that the hospital would experience whether those positions are employed directly by AMH or are contracted through QHR.
- Also included in that amount are the many, many management services provided by QHR. During the year in question, AMH turned to QHR to provide counsel on Case Management Studies, Healthcare Finance And Reimbursement monthly analysis, Cost Report Protocol review, Revenue Cycle Procedures, Coding Compliance Review, etc. All hospitals need these types of consulting services to stay current in the ever-changing world of healthcare. In the past, AMH obtained these consulting services through piece meal arrangements with outside vendors, but at a greater cost than we are able to secure through QHR.
- Among the other benefits we receive through our engagement with QHR are educational opportunities for staff and board members, and participation in a large, national group purchasing organization. In 2011, the savings we achieved through participation in the QHR GPO topped $106,000. Taken in total, the benefits of our relationship with QHR returned back to AMH 1.4 times what the hospital paid to QHR.

I read a lot of negative things about QHR in the paper. Is the board aware of those issues? Is the board concerned?

With all due respect to the letter writer in the local paper, the issues facing AMH have nothing to do with QHR and the allegations he brings up in his letter do nothing but detract from the real challenge facing our community hospital. **AMH does not have the resources to continuing paying for medical care of the County’s uninsured population.**

The board is confident the hospital is being run efficiently and in compliance with the many rules and regulations that govern it. But we simply cannot afford to continue
operating in an environment in which we collect on 52 cents for every $1 of services we provide.

We have done our homework on QHR. QHR has been around for more than 30 years and has helped several hundred hospitals in that time. Many of their clients come to QHR in a state of distress resulting from operational challenges, financial challenges, regulatory issues, labor problems, medical staff issues, or all of the above. In a litigious industry like healthcare, it is not surprising that they would experience lawsuits from time to time. Our experience with QHR has been positive and productive. As we look ahead to the increasing uncertainties of healthcare reform and economic challenge, it is imperative for AMH to have the resources and professional guidance of QHR.

- Does the board have any concerns that QHR could be misleading the hospital?

If you review the Myths & Facts document that we recently prepared, you will see that the hospital is being managed very well. AMH is lean, it’s efficient, and it performs better than most of its peers. In addition to QHR resources, we have a great team of local employees, and together, they are doing their very best for the community. But efficiencies cannot correct the fact that too many of our patients are not paying for the bills they incur at the hospital, and AMH does not have the resources to continuing paying for medical care of the County’s uninsured population.

What has been done to cut costs thus far?

<table>
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<th>Operating expense per equivalent discharge:</th>
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<tr>
<td>• AMH provided care to equivalent patients for significantly less expense than comparable hospitals*:</td>
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<tr>
<td>- AMH $4,976 (well below other facilities)</td>
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<td>- 50th Percentile Benchmark $7,017</td>
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<td>- 75th Percentile Benchmark $5,309</td>
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*Benchmarks based on national performance of 55 CAH facilities

This is showing a standardized performance benchmark for all hospitals across the nation. Overall it supports that AMH is a very efficiently run facility. Over the course of several years AMH has instituted several cost cutting efficiency measures. For example, the facility converted to Critical Access designation in Feb. 2005 to maximize reimbursement with Medicare and Medicaid. We conduct ongoing service line analysis. For example that analysis forced a decision to close the Community Assistance Program (CAP) service line and the Obstetrics (OB) service line in 2004, as opposed to some of our service line developments such as the Pulmonary Rehab and MRI. As with any business salary, wages
and benefits are the biggest expense. As with all businesses AMH conducts a monthly budget and productivity review and each and every department is scrutinized.

Ashe Hospital has been experiencing some of the same fiscal problems as Alleghany. It has sold its nursing home beds and, I believe, instituted across-the-board salary reductions for full-time staff.

Does Alleghany Memorial Hospital have any underperforming assets it can sell or close to improve its fiscal situation?

Again, we continuously look at service lines and cost/benefit analysis just as we had to do with CAP and OB.

Have salary or benefits adjustments been explored or implemented?

Yes. We do benefits reviews annually and salary reviews every three years. Just like other surrounding business we have had to increase employees’ out-of-pocket costs for premiums, deductibles and co pays. In the most recent salary survey in 2011 of 52 positions 44 were below the 50th percentile of other hospitals in NC. In the last five years we have only had one merit increase that equated to an average of 2%.

We hear a lot about productivity gains in various businesses. Have efforts been made to streamline departments such the same work can be done by fewer people? I certainly don't take staff cuts or wage reductions lightly, but they may be necessary for the institution to survive.

Yes. We have found several opportunities for cross training in areas that we can, such as dietary and environmental services among many others. We also have matrices so that departments know when to flex up and down based on volumes. Again, we are a hospital and cannot compromise patient care. To accommodate this we have employed the practice of minimum staffing in certain clinical departments, for example we have to have at least one nurse in the ER at all times.

In the past our doctors made rounds in the am. And took turns in the ER. Now all of that is farmed out at what has to be a major cost. Why the change?

There has been a practice change in medicine developing over the last several years. More and more primary care physicians are pulling away from doing Inpatient medicine. Two main reasons for this are; (1) long hours/hard work (being on-call 24/7) and (2) shrinking reimbursements. The physicians are managing their outpatient clinics and opting to hand off their patients to a “Hospitalist”. A “Hospitalist” is a doctor (usually an Internal Medicine or Family Practice) who acts as the attending physician responsible for the oversight of the patients while they are an inpatient in the hospital. AMH implemented the hospitalist program in Jan 2011. We are fortunate to have 2 out of 6 Primary Care Physicians who participate in the program; Drs. Beres and Arocha.
Why call people who have insurance and demand they bring the money they are responsible for up front. That does not make sense when you are having as much bad debt as you do. Also it offends people, the same people who you want to bail you out now.

Up-front collections is a customer service to the patient to let the patient know prior to elective services how much they should expect to have to pay. Most patients with insurance still have out-of-pocket monetary reasonability, such as deductibles and co pays. This is a standard and proven best practice across all hospitals nationwide. If these amounts are not collected they increase the bad debt that the hospital absorbs.

It appears than the inpatient program, and the ER both operate at a huge loss, when the rest of the hospital does rather well, is a solution available?

In all due respect, to summarize the inpatient and ER as loss leader is not accurate. Actually, our analysis for the hospital has shown that our Inpatient (IP) service-line generates the most cash ($2.6 M) and then secondly, the ER (0.4M), with Surgical Services last at (0.3M).

To maintain an acute care hospital status, certain elements feed into the functioning of the ER and IP unit. For example, respiratory, lab, radiology, and pharmacy must be at access 24/7. While these individual dept are within budget they depend on these two hubs to provide their volumes.

One comment as a taxpayer I know how important the hospital is to the county, but where does it end how do we know you won’t ask for 75000.00 a month next year? Sometimes the solution requires less spending not more money.

There is not a clear cut answer at this point. The hospital’s request is for the county’s 2012 fiscal budget. As with any county funding an annual review will be conducted and presented to the commissioners along with a reconsideration of the future needs.

Has any thought been given to asking a larger hospital, such as Baptist or Forsyth if they are interested in taking this hospital over as an extension of their facility?

Partnership with a larger health system has been a strategic goal for AMH for the past six years. In that time, the AMH board has had both formal and informal communications with multiple healthcare systems. To date, no official offers have been made by interested parties, but AMH continues efforts to entertain partnership opportunities.

The following is a question I have in regards to AMH and QHR and the financial situation being currently discussed amongst our county and town officials. What steps have been taken to align doctors with patients and to keep patients from having to go out of town for treatment?
We fully agree and are committed that this is a key strategic focus of the business plan for the hospital. As most of you know Alleghany Memorial has partnered with the Health Department on our Golden Leaf proposal that addresses this issue. We also continue to look for opportunities to add specialty services locally. One example is adding Orthopedics to our service lines. Dr. Snyder travels from Elkin to perform surgeries Tuesday mornings and provides a clinic on Tuesday afternoons and all day Thursday with Michael Beres, Nurse Practitioner. Another example is Dr. Wells Stewart who performs cataract surgeries here. Yet another example is we were able to successfully add MRI access in the county bi-weekly. This has been very successful and has fulfilled a requested service need of the medical staff and the community.

The following is a question I have in regards to AMH and QHR and the financial situation being currently discussed amongst our county and town officials. What other alternative revenue streams have the Board Members considered?

As part of strategic planning practices, alternative revenue streams, including service line considerations, improvements to existing service lines and cost benefit analysis of current service lines is conducted in detail every three years and reevaluated every quarter. The full strategic planning session includes a cross representation of community members to participate and give input on community healthcare needs.

The following is a question I have in regards to AMH and QHR and the financial situation being currently discussed amongst our county and town officials. What qualifications do the Board Members have to represent the Hospital’s best interest?

AMH’s governance structure is made up of a 15-member volunteer Board of Trustees that represents a cross section of the hospital’s primary service areas. To become a member of the Board, the nominee should be a resident of Alleghany or Grayson County; be at least 21 yrs. of age and have a good reputation within the community. A physician who is a member of the Medical Staff may hold an administrative position within the hospital and may retain his position on the MS. A physician may also hold a seat on the BOT with full voting privileges.

The Board of Trustees works collaboratively with the senior management and the Medical Staff for the operation of the organization. The Board of Trustees is educated on a monthly basis in regards to national healthcare current events and regulations, as well as, specific education on AMH departmental, financial and clinical performance. They are also offered educational opportunities regarding trustee responsibilities and current issues in healthcare throughout the year.

The following is a question I have in regards to AMH and QHR and the financial situation being currently discussed amongst our county and town officials. Thank you for your time. Has the Board thought about having a Hospital week where donations and fundraising events occur to help aid the hospital financially?

We really appreciate this suggestion and will relay that to the hospital Foundation Board. The Alleghany Memorial Hospital Foundation currently holds several fundraising events
throughout each year, as well as, an annual campaign where letters go out to the community. We welcome contributions to that organization anytime throughout the year and they are tax deductible. We also have the Alleghany Memorial Hospital Thrift Shop that readily accepts donations. So if you are working on your spring cleaning, it is the perfect time to take items out to the Thrift Shop in Roaring Gap. The monies raised and collected directly benefit the consumer in that they are usually used to upgrade and purchase medical equipment, such as, the CT scanner.

In regards to funding assistance the following questions have been posed
A. What percentage of the total patient services provided are provided to residents of Grayson County, VA?
   Approximately 15%-17%
   This number is pulled using zip codes which included Galax and White Top that spill into other counties so the number is likely inflated.

B. What percentage of the total annual debt is related to Grayson County usage?
   Grayson County residents accounted for 20% of our Net Bad Debt and 15% of our charity care in FY11.
   This number is pulled using zip codes which included Galax and White Top that spill into other counties so the number is likely inflated.

C. What percentage of the total hospital staff are residents of Grayson County?
   20%. We hire the best candidates without discrimination of their county residency.

D. Is there the intent to request financial assistance from the Grayson County Board of Commissioners?
   Again, 76% of the total registrations come from Alleghany County Residents, which is why our initial request is to Alleghany County.

Since Sparta is the commercial center for the county and the loss of the hospital would financially affect local business, does the hospital intend to request funds from the town council?

AMH has made annual requests to the Town Council over the last several years and in the most recent budget we received $7,000 to go toward an FDA required equipment upgrade for our Operating Room used to sterilize equipment.

What would be the economic effects of the loss of hospital services to businesses dependent on those services? For example: assisted living and retirement community.
   We will have defer that analysis to those businesses of which would be affected by the hospital.

When most corporations face poor earnings or potential losses, they look at restructuring...ie..downsizing...yes... that means staff reductions and possibly closing part of the facility. Decreasing head count adds directly to the bottom line. Nobody wants to lose their job but sometimes it is necessary.
Seems like these options need to be strongly considered until the economy picks up at which time the hospital can again be expanded.

You are exactly right. Just like with all businesses the greatest expense to consider is Salary Wage and Benefits of the employees. The hospital is no different and we underwent a full-scale organization workforce reduction in 2004, 2006, 2008 and most recently with our fiscal year 2011 budget. This resulted in not only a reduction of full time and part time staff, but as well we implemented a staffing matrix (or plan) in which every department on a daily basis adjusts their staffing hours according to fluctuating patient volume. On a monthly basis each dept is scrutinized on performance benchmarks and is held accountable to meeting those benchmarks. (If for example, a department did not flex appropriate to a low census an action plan is expected.) Something to keep in mind concerning the high standards that we expect is that we utilize a national productivity vendor, Vantage LMS. This company gauges our performance using national standards and we have outperformed 90% of the database participants.

As far as collecting 58 cents on the dollar, maybe some of the uninsured seeking services other than emergencies at AMH should be referred to other hospitals that are better able at absorbing these costs. If something is not done in this area, the 600K being asked for this year will be 1 million next year and on and on.

We are bound by the federally mandated EMTALA (Emergency Medical Treatment and Active Labor Act) law just like any other hospital across the nation. When a patient presents to our ER, regardless of citizenship, legal status or ability to pay, a doctor must assess them to r/o an emergency medical condition. Once that is completed, and should the patient need to be admitted to the hospital for further treatment, hospitals may only transfer once the patient is ‘medically stable’, ‘gives an informed consent’, and IF a ‘higher level of care service is required’ (that is defined as another hospital that is better equipped to administer necessary treatment, for example a patient who has had a heart attack and needs a cardiac catheterization). Were AMH to transfer patients to alternate facilities, when/if we were capable of handling the care needs with resources we already had available, that could be perceived as ‘dumping’ and would be in violation of federal law.

For non-emergent care needs, AMH employs financial counseling through it’s ‘Up Front’ collections practices, and if applicable, evaluates for the ‘Financial Assistance Program’.

Maybe changing to an urgent care center makes good sense until the economy or the collection rates improve.....everyone in the county that I know having elective but necessary surgery goes to another area hospital.

Clearly there are advantages to having better and broader spectrum of care access with a full scale hospital vs. a one-stop urgent care center with limited medical capability. But again, you are limited in what services, scope of treatment that a patient can receive in an
urgent care center. They are neither equipped nor able to provide serious emergency care that may be life threatening, nor are they able to observe patients over a period of time.

And to further answer your question, this has been a consideration that has been debated and analyzed over the course of the last several years, especially with the insult of dwindling reimbursement and whether or not the full hospital model can be sustained. That is an uncertainty that not only leadership is posed with, but many other rural facilities nationwide.

If I or my insurance is paying the ambulance or rescue squad bill, I should be taken to the hospital of my choice not to AMH first.

The Alleghany County EMS protocol directs all patient care to be transported to the nearest local hospital. There are specific exclusions, that being patients needing Obstetrics, obvious fracture, acute stroke, acute heart attack patients needing interventions (cardiac catheterizations, heart bypass surgery). These limited diagnosis groups would be outside of the scope of local available services. All other diagnoses are brought to the ER for immediate medical screening by the ER physician. The key of this is to ensure that the patient is stabilized FIRST and foremost. IF an emergency medical condition is present, and admission is recommended, and your local hospital has the resources to safely treat the patient. Clearly we would like to have the patient remain at AMH, however, patients can consent to be transferred elsewhere, if it’s not contraindicated.

11. Many people in the county do not have confidence in this Hospital and say I would not go there. How is AMH going to change this image? Are you rated as a Center of EXCELLENCE?

In all due respect, we can only gauge our image in the community based off our surveying of the patients that utilize our services. We work with a national vendor, Avatar, to aggregate survey data and our patient satisfaction scores are amongst the top performers. For example our Operating Room and Outpatient area has been labeled as a 5 Star performer for the past 5 years consecutively!

We also have an active customer service program throughout the hospital. Each and every employee signs an annual agreement recommitting to the service principles of achieving excellence in all hospital interactions.

Additionally we have a marketing team, whose mission is to promote community outreach, for example our surgery team has spoken to multiple civic groups recently to educate them, not only on various disease topics, but also to reinforce with them, the services available at AMH.

Do you have systems in place to track staff infections and ECT?

Like any other acute care hospital, AMH participates in the CMS public reporting initiatives, or core measures. These are standardized indicators of performance in many
areas such as the handling of heart attacks, heart failure, pneumonia patients, as well as, ER processing, throughput, etc…Hospital Data with regard to Hospital Acquired Conditions, such as pressure ulcers, falls with fractures, and then to, infection rates, etc…is reported routinely to CMS and can be seen displayed on the CMS website. AMH is also fully accredited by The Joint Commission, a main regulatory organization who surveys healthcare facilities nationwide. They also have performance indicators and standards of care that we are held accountable to.

What is stopping AMH from paying for itself? Could you become more than a Hospital? Like an acute inpatient care wing. Home health care services and home P/T services. What areas cost the most to provide?

We constantly look at the model of our care delivery…service lines to keep, add to, new services and profitability.

How do you plan to increase your bed occupancy rate?

Primary Care Physician Recruitment

Would it be cheaper to open a Clinic to take care of non-critical cases?

We are actually in current analysis of whether or not to reopen a “rural health clinic”. In the past this was a setting that handled non-critical cases. There are several regulatory requirements for this start-up.

Why did AMH missed the opportunity to be bought by DUKE? Instead they bought Galax Hospital.

They have not made any statements of interest.

How is AMH IT technologies compared to other hospitals and is this something that could be outsourced?

We were actually one of the first hospitals to achieve Meaningful Use designation, which means that we met the governments expectations for stage one for Electronic Health Records. (Among the first 10% to achieve and we are far ahead of some large tertiary systems in this respect.)

With the shortage of Doctors in the county have you sought out residents that want to be doctors and have completed their first 4 years. Why not develop a pay loan program in exchange for a number of years of service to the hospital?

This is our educational assistance program. We have provided educational loan assistance to physicians in the past and continue to work with the local school system.
Can the EMS team be used to handle some cases and workload?

We have a very good clinical relationship with Alleghany EMS and their skill set does allow them to implement many medical protocols outside of a hospital setting. We feel we are optimizing this relationship.

Will the Alleghany Memorial Hospital Board of Trustees, Warren Taylor, Chairman, immediately require an independent audit from a firm not associated with Quorum Health Resources and further require a full and complete financial statement, including all liabilities and all assets of Alleghany Memorial Hospital and make this information known to the Alleghany County Commissioners and the taxpayers of Alleghany County before any further county revenues are expended to address any financial requests made by the Alleghany Memorial Hospital?

We already undergo an annual Financial Audit by Dixon Hughes Goodman, LLC an independent third party. Like all not-for-profit 501(c)(3) hospital the audit will be attached to the IRS Form 990, which is a public document.

The Hospital is audited, and the community realizes this, but is it possible to have a copy of an audit going at least five years back? If so, how?

We welcome anyone who would like to review our audit reports or IRS filings. A simple document request can be made to the email address info@amhsparta.org. They clearly illustrate the hospital does not have the resources to continuing paying for medical care of the County’s uninsured population.

What type of power do the Board Members actually have and is QHR over them?

The governing board of trustees is the ultimate deciding body. QHR has no power over this body, but serves in an advisory role.

Why has AMH not provided a written laundry-list of things it will do to assure its situation does not deteriorate further; and especially what it will do with the money requested from Alleghany tax payers so that AMH does not become a permanent financial loss in which Alleghany tax payers are put into a position that will permanently burdened them with an organization, AMH, that runs gallons of red ink each year?

As discussed earlier, the hospital has a strategic business plan that is ever evolving. As part of that plan we attempt to anticipate the direction that healthcare delivery will go, but there are a lot of unknowns.
It is obvious, even to a casual observer that the convolution of fiscal and financial morass AMH is in did not come about over a short period of time. Why did the AMH board sit complacently by and do nothing to take positive corrective actions at least 2 years ago when AMH and Quorum Health Services had numerous and frequent audits, reports, consultant advisories, etc., which plainly showed and demonstrated things were patently in such a state that monumental problems were eminent which are inimical to proper management and health services?

The challenges and struggles that AMH is experiencing are not new or unique to any other hospital across the nation. We have addressed the effects of the difficult economy and shrinking reimbursements. Approaching the county with a budget request was last resort in a direct relation to the continued increase in uncompensated care (people that can’t or don’t pay their bill).

Why can’t a hybrid critical care facility work, where you would still have the helicopter pad in order to ferry emergencies to other area hospitals?

This again speaks to ensuring that patients receive a medical screening exam to ensure that the patient is stable and able to endure a transport to an alternate setting. In many cases the time of travel would jeopardize the patient’s medical state.

Just what is a hospitalist and why do we need it at AMH? How does it benefit us?

This has been a nationwide change in culture of medicine. Actually AMH was fortunate to maintain the old-school practice of primary care doctors rounding on their own patients a lot longer than most facilities. Because of declining reimbursement for the physicians to provide Inpatient care the standard of practice has transitioned primary care physicians into outpatient clinic services only. AMH implemented the hospitalist program in Jan 2011.

Can your family physician admit you?

We have 6 primary care physicians on medical staff who have active admitting privileges. Currently 2 of the 6 participate in the “hospitalist” program, Drs’ Arocha and Beres. The remainder of the medical staff admit to the hospitalist. We are fortunate that Dr. Arocha and Dr. Beres are local and have been active in our medical staff for several years. There is good communication between all of the Medical Staff.