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**STRATEGIC RISK:  
WHAT RURAL HEALTHCARE  
LEADERS NEED TO KNOW**

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# MEET THE SPEAKER



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Stroudwater is a leading national healthcare consulting firm specializing in mission-critical strategic, operational, and financial opportunities for healthcare leaders' most pressing challenges



# WHAT DO RURAL LEADERS NEED TO KNOW?



For the 60% of rural hospitals in a partnership, most systems miss critical aspects of rural value and add a new element to strategic risk



For independent rural hospitals, the key risk mitigation strategy is improving operating results



Know your risk profile: look at 5–7-year trends across key financial, operating, clinical and market data once per year



There are no risk-free options: independence and partnering each have their own inherent risks



The Four Know/Nos:  
- **Know your risk profile**  
- **Know your value**  
- **No one else will promote your value**  
- **No risk-free options**



# COMMON OUTCOMES FOR RURAL HOSPITALS



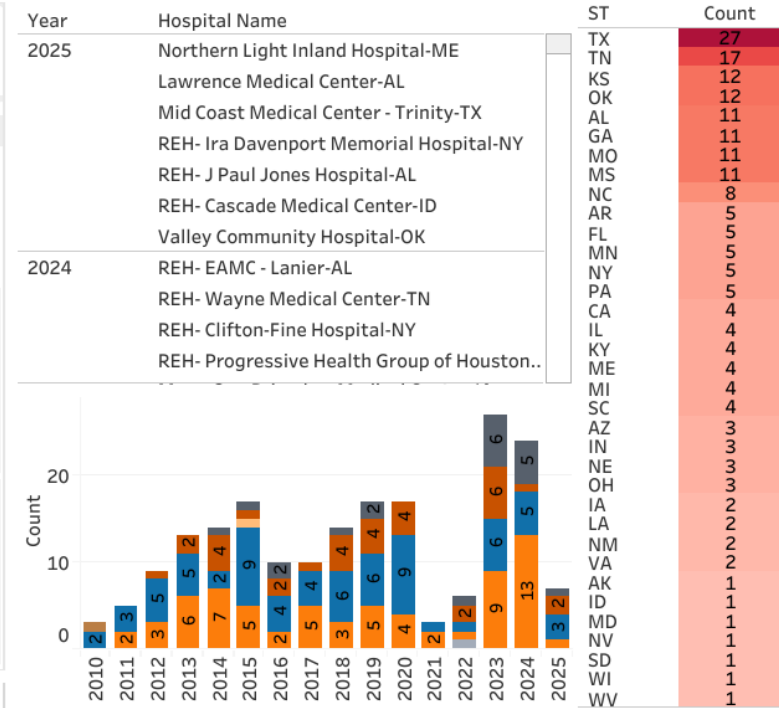
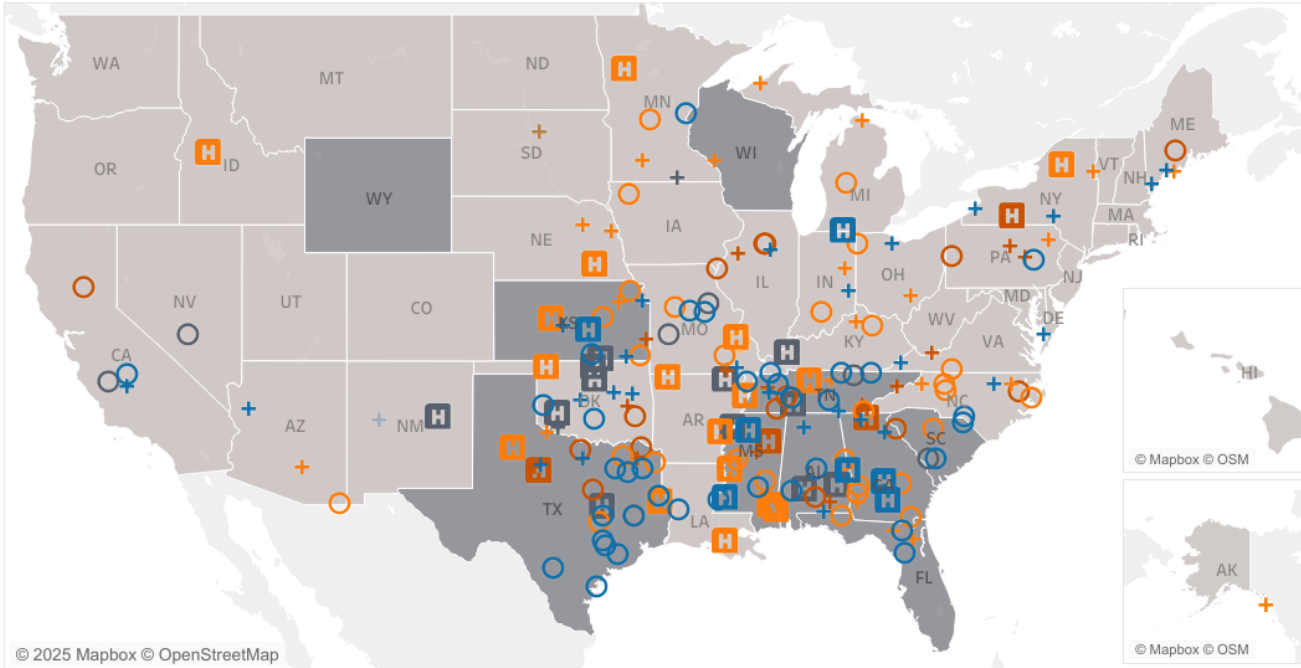
90%+/- of hospitals are within these three options



# RURAL HOSPITAL CLOSURES SINCE 2010

**196** Closed or Converted Rural Hospitals

There have been 196 Rural Hospital closures or conversions since 2010 and 239 since 2005, these numbers include forty (40) REH Conversions since 2023



Year	Prospective Payment System	Critical Access Hospital	Medicare Dependent Hospital	Sole Community Hospital	IHS	Re-based Sole Community Hospital	Rural Referral Center	Total
2010	2	2				1		3
2011	3	3						6
2012	5	5	1					11
2013	5	6	2					13
2014	4	7	4	1				16
2015	4	5	1	1				11
2016	4	2	2	2			1	11
2017	4	1	1					6
2018	6	5	4	1				16
2019	6	5	4	1				16
2020	9	4	4	2				19
2021	11	2	4					17
2022	11	1	2	1	1			16
2023	6	9	6	1				22
2024	5	13	1	5				24
2025	1	2	1	1				5
<b>Total</b>	<b>71</b>	<b>68</b>	<b>34</b>	<b>20</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>196</b>

**Medicare Payment Type**

- Prospective Payment System
- Critical Access Hospital
- Medicare Dependent Hospital
- Sole Community Hospital
- Re-based Sole Community Hospital
- Rural Referral Center
- IHS

**Current Status**

- REH
- Complete Closure
- Convert to Other

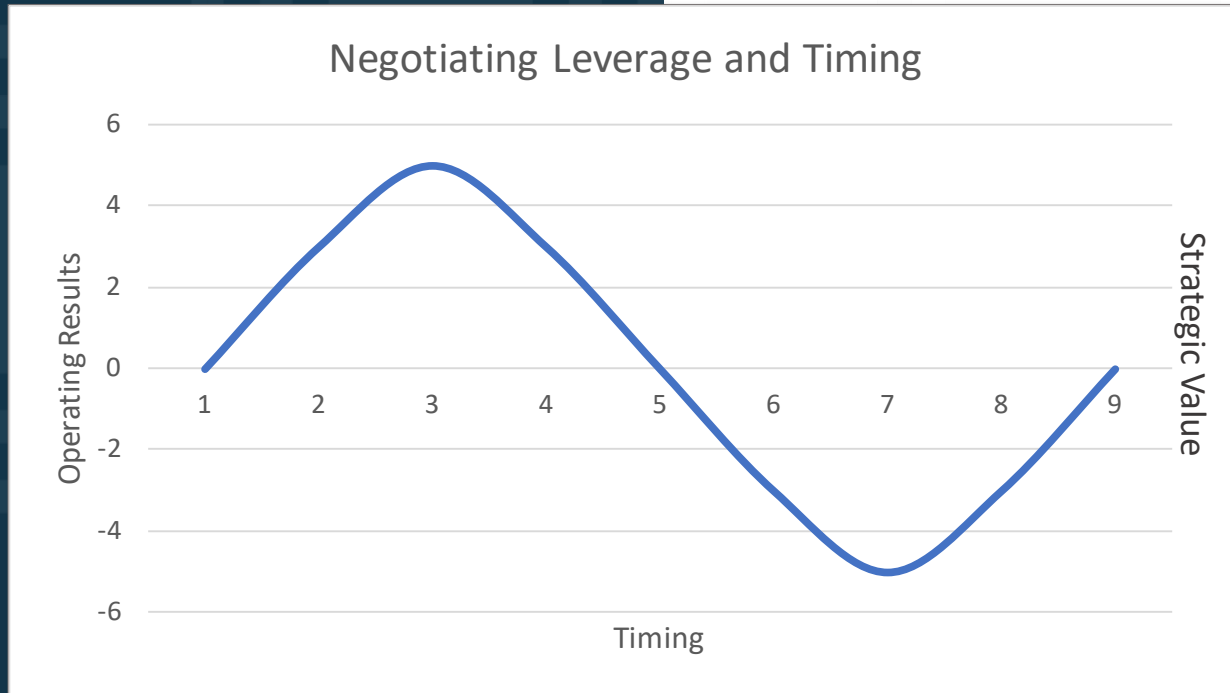
**Current Status of Medicaid Expansion Decision**

- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Updated:6/10/2025  
Sources: The North Carolina Rural Health Research Program (NC RHRP) at the Cecil G. Sheps Center for Health Services Research & kff.org



# TIME IS NEVER A NEUTRAL FACTOR



When weighing strategic options, a rural hospital must weigh the pros and cons of the following timing factors:

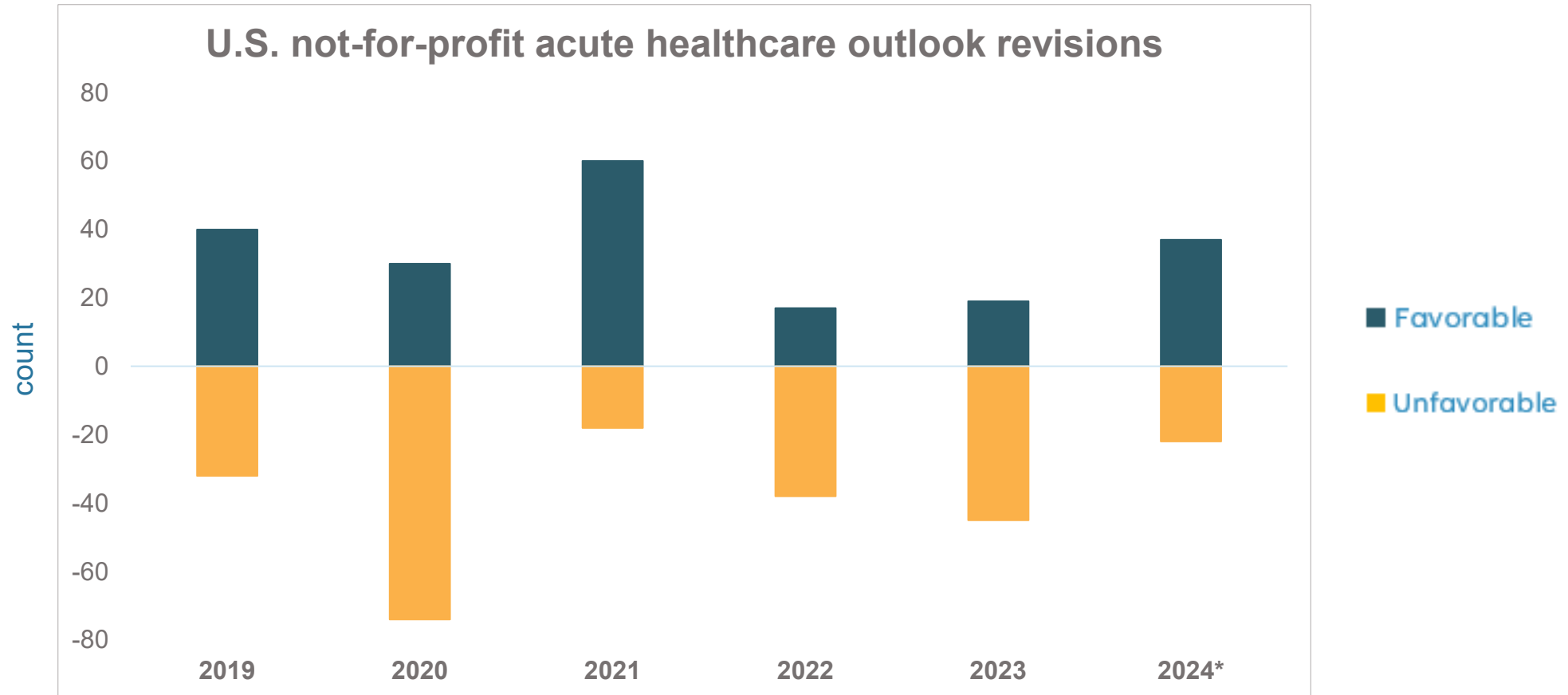
Time to demonstrate results from a performance improvement plan

Time for major developments

Time for adverse market developments to have an effect (state and federal budgets, competitor response, etc.)



# 2025 STATISTICAL ANALYSIS BASED ON 2024 DATA



\*Data as of Oct. 32, 2023. Data is for all outlook changes unaccompanied by a rating change. Favorable outlook revisions include stable to positive and negative to stable. Unfavorable outlook revisions include positive to stable and stable to negative. Excludes outlook revisions to developing and ratings that were removed from CreditWatch.

Source: S&P Global Ratings.

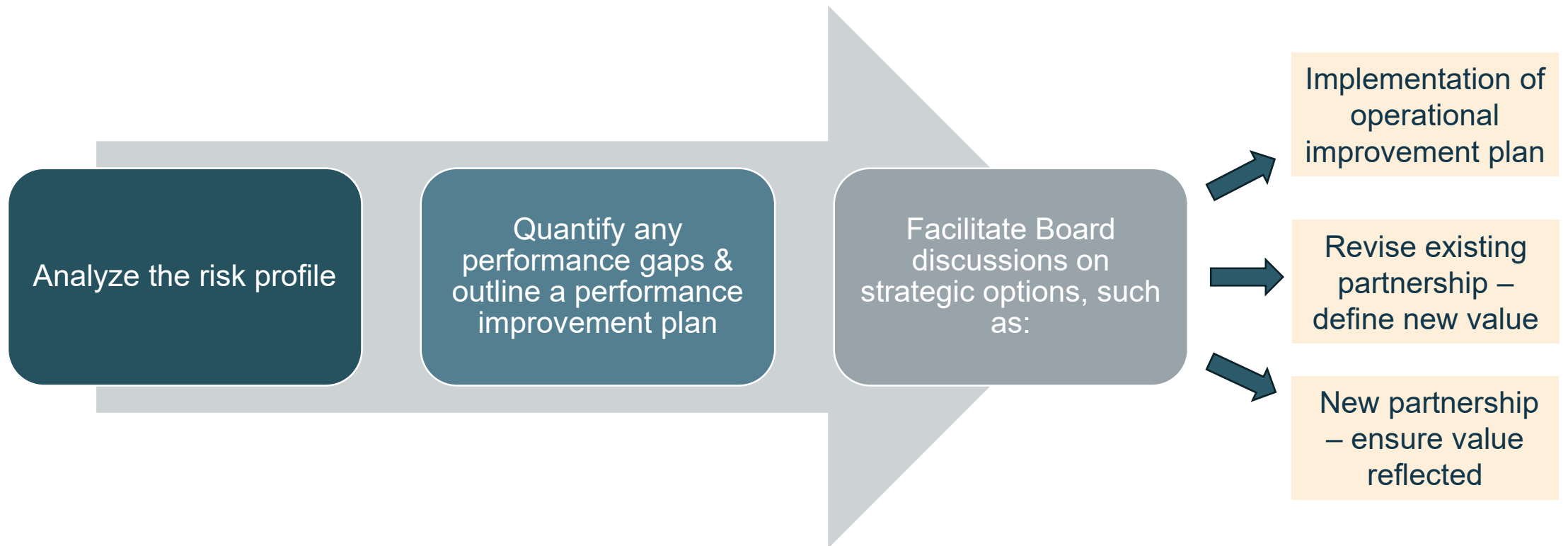
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# KEY POINT: OPERATING RESULTS AND STRATEGIC RISK

- Our focus is on mitigating strategic risks.
- Sound operating results are foundational to any strategic option.
- It is critical to understand the organization's strategic risk profile, key risk trends, and the extent of performance gaps between the current trend and a sustainable trajectory.



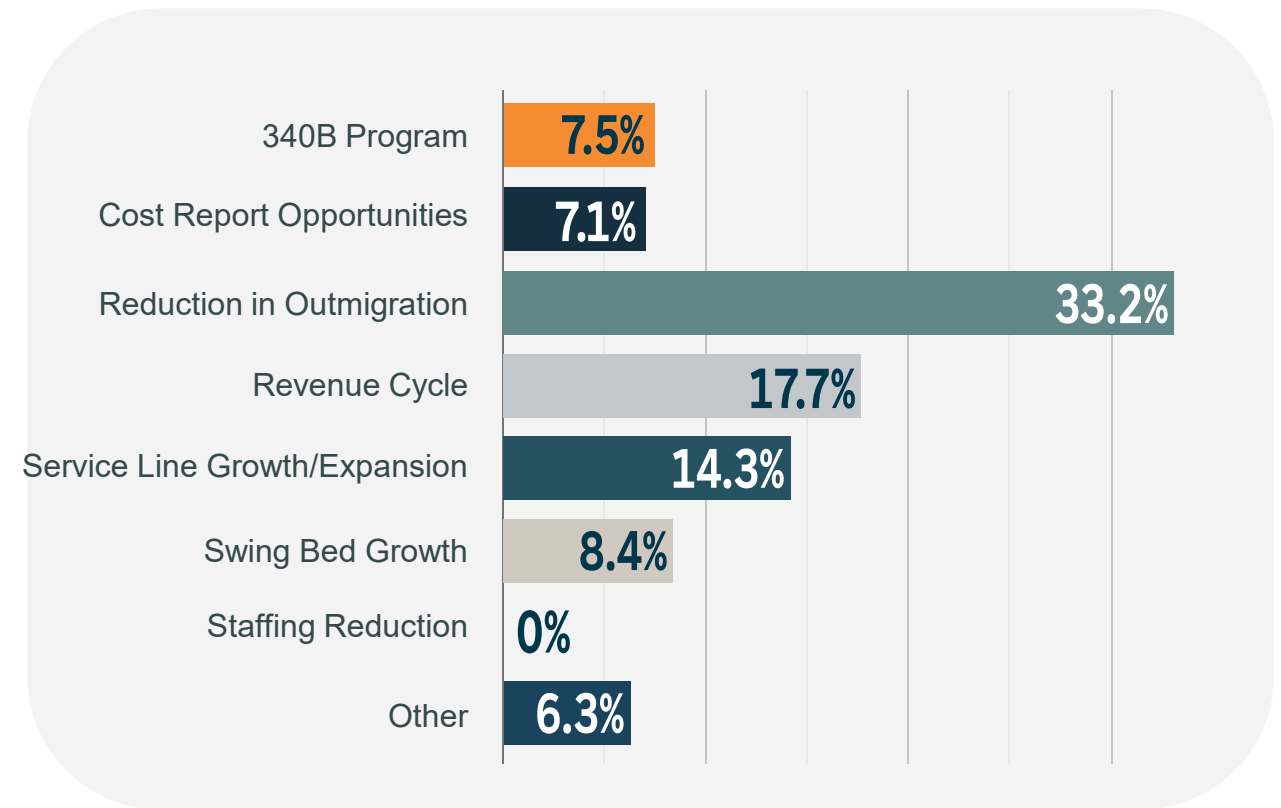
# RISK MITIGATION VIA IMPROVED PERFORMANCE

- Nearly 30 rural performance improvement projects led by Stroudwater over a 30-month period delivered a median of \$1.7M in financial improvement per organization, equating to nearly 8% of net patient revenue per organization.

Total Estimated Impact	
25th	\$ 1,300,000
Median	\$ 1,700,919
75th	\$ 3,727,000

Impact % of Net Pt Revenue	
25th	4.1%
Median	7.8%
75th	11.1%

- These engagements spanned an array of functional areas, with the average share of total improvement realized broken out as follows:





# RISKS FROM MISUNDERSTANDING YOUR VALUE

# MONEYBALL: WHAT CAN IT TELL US?

- The central premise of Moneyball (2003, Michael Lewis) is that the collective wisdom of baseball insiders over the past century is outdated, subjective, and often flawed.
- The best-known Moneyball theory was that on-base percentage was an undervalued asset and sluggers were overvalued.
- At the time, protagonist Billy Beane was correct. Jahn Hakes and Skip Sauer showed this in a very good economics paper.
- From 1999 to 2003, on-base percentage was a significant predictor of wins, but not a very significant predictor of player salaries.
- **The takeaway: players who draw a lot of walks were cheap relative to their actual value.**



# WHAT ARE WE GETTING WRONG?



- “Rural healthcare is a dumpster fire”
- “With fully allocated costs, the result is clear: the economics are unsustainable and dilutive”
- “We need to shut down or curtail rural operations to reduce costs and conserve resources”
  - These statements confirm what many believe they know
    - **But are these statements correct?**
    - **What are they getting wrong or missing?**



# AFFILIATE ACCRETIVE VALUE

- Our client was a Northeastern seven-hospital system, including a 120-bed community hospital affiliate
- System allocates \$25M of overhead to the affiliate's general ledger, resulting in a **\$13M operating loss**
  - As a result, the system slashed capital investment at the affiliate
  - The operating loss included \$7M in non-cash depreciation expense and excluded \$3M in non-operating income
- Of the \$25M in system-allocated overhead costs, only 20% were estimated to be variable (or incremental) while the remaining were estimated to be fixed (reallocation of existing costs)
  - The fixed portion should not have been considered when evaluating the contribution margin of the affiliate
- Actual contribution margin to the system, before considering the value of incremental patient volume from the affiliate service area, was \$17M
- The affiliate provided \$22M in incremental contribution margin to the system from additional service area referrals
- **Total contribution margin to the system from the rural affiliate: \$39M**



# RISKS FROM MISALIGNED RURAL PARTNERSHIPS

The accretive value of existing and prospective rural affiliates is almost always misunderstood or absent from negotiations or management decision-making.



Adverse Outcome #1: Key deal terms that would reinforce long-term value creation for the rural affiliate and system are absent



Adverse Outcome #2: Systems with rural affiliates miss value-added opportunities and fail to account for rural accretive contribution margin when evaluating performance and allocating resources



Adverse Outcome #3: Chronic underinvestment in rural affiliates



Adverse Outcome #4: System and rural affiliate long term performance is diluted and suboptimized



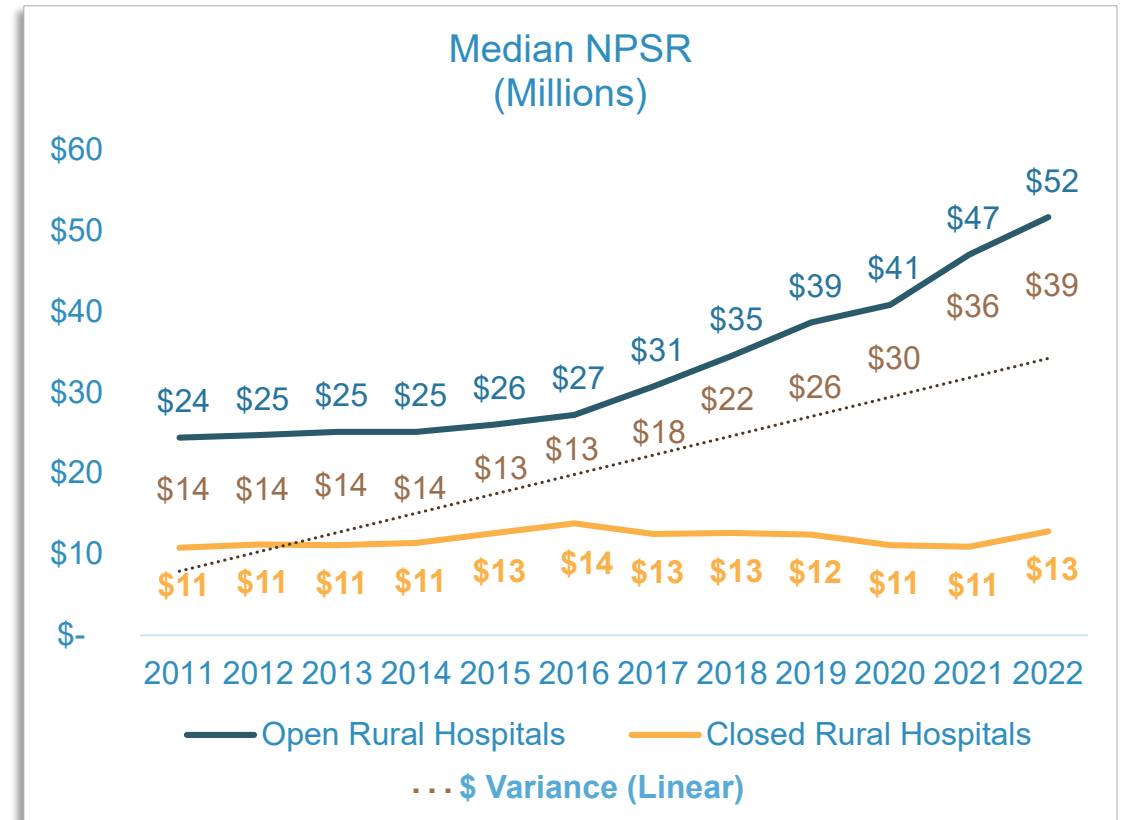


# HOSPITAL CLOSURE OVERVIEW

# OPEN RURAL HOSPITALS DEMONSTRATE SIZE & GROWTH DISPARITY

## RURAL HOSPITALS

- The median net patient service revenue (NPSR) for open rural hospitals is more than 2 times the median NPSR for closed rural hospitals in 2011 and has grown to be 4 times the median NPSR of closed hospitals in 2022.
- Open rural hospitals reveal a significant increase in median NPSR from 2011 through 2022 (7% CAGR), whereas closed hospital median NPSR shows minimal changes with a CAGR of 1.5%.
- Hospital size, as measured by NPSR, was determined to be a factor that predicts the future risk for financial distress and closure in UNC closure studies.\*
- **Smaller size and the absence of growth are both foundational to the inherent lack of financial flexibility in rural hospitals.**
- **Rural hospital growth supports long-term sustainability.**



\*North Carolina Rural Health Research Program/University of North Carolina (UNC) at Chapel Hill published 4 articles and/or findings brief from 2016 to 2024

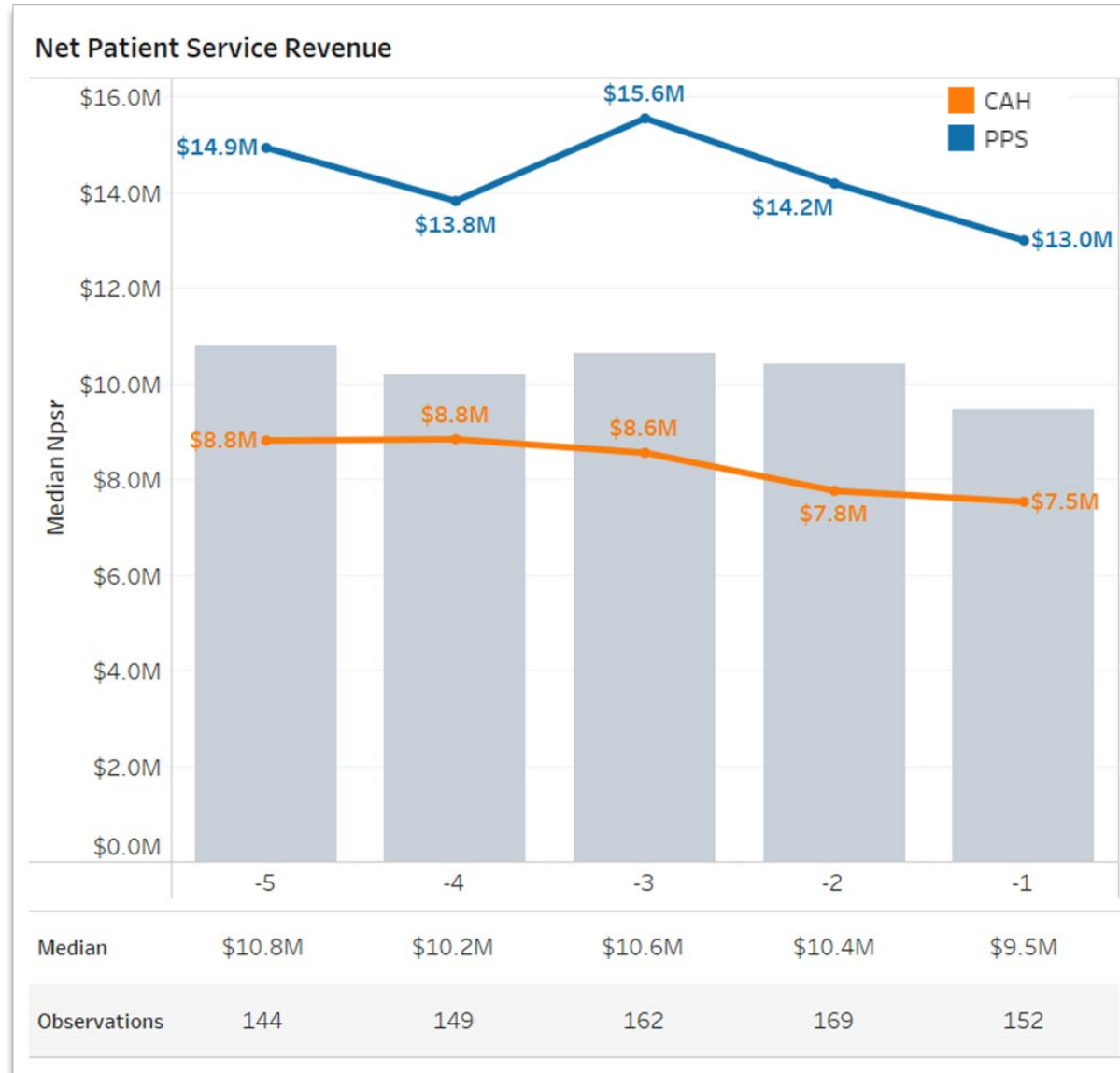
Data source: HCRIS Medicare Cost Report data



# JOURNEY TO HOSPITAL CLOSURE: NO REVENUE GROWTH

## CLOSED RURAL HOSPITALS

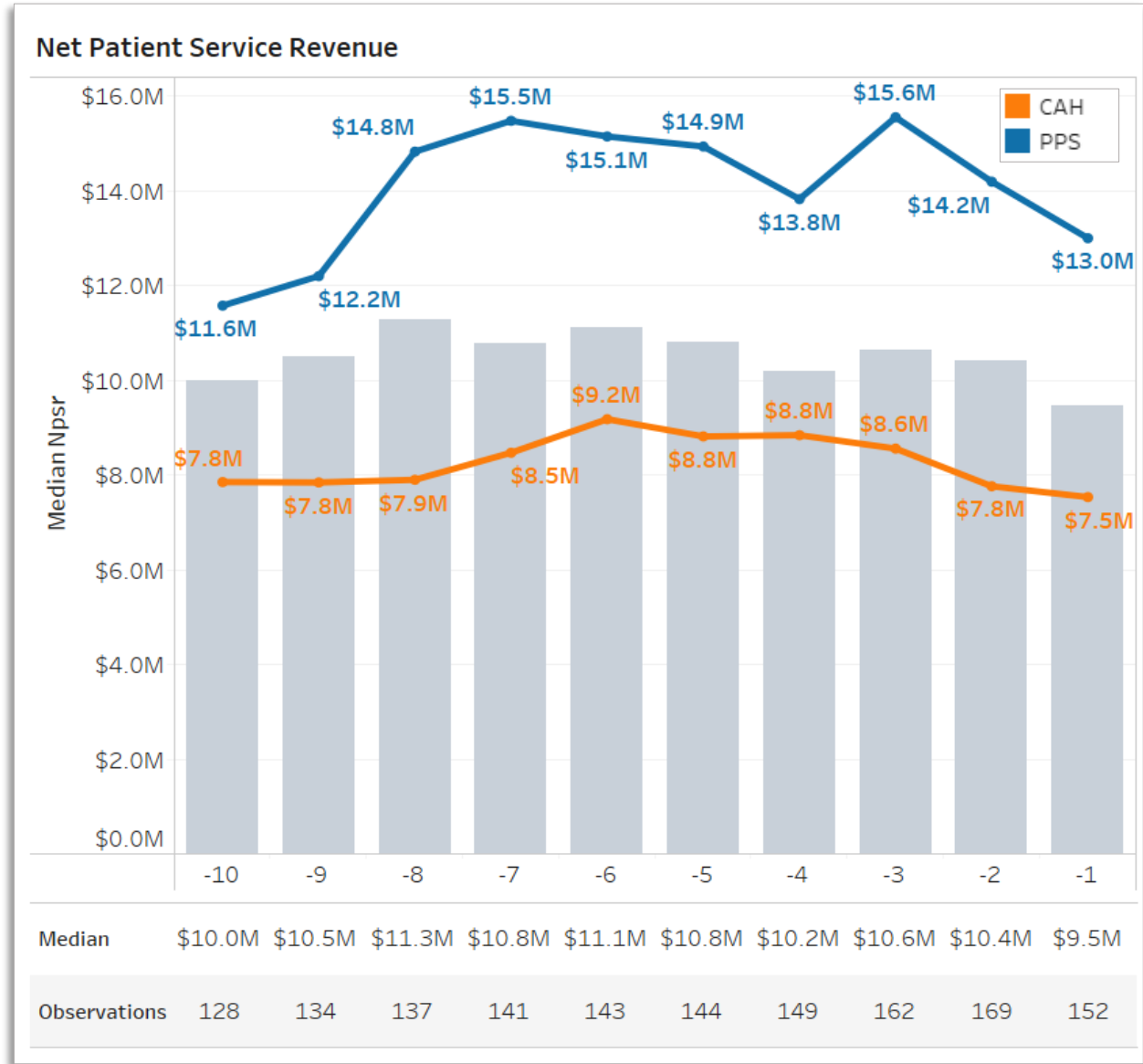
- Median net patient service revenue (NPSR) for all closed rural hospitals declined by 12% in the 5 years before rural hospital closure.
  - This trend produces a CAGR of -2.9% in the five years before closure.
- The Median NPSR for closed Rural PPS hospitals declined by 12.6% in the five years before closure.
  - This trend produces a CAGR of -3.0% in the five years before closure.
- Median NPSR for closed Rural CAHs decreased by 14.8% with a CAGR of -3.5% in the five years before closure.
- **The absence of revenue growth is an indicator of closure risk.**



# JOURNEY TO HOSPITAL CLOSURE: 10 YEARS PRIOR

## CLOSED RURAL HOSPITALS

- Median net patient service revenue (NPSR) for all rural closed hospitals declined by 5% in the 10 years before closure.
- Median NPSR for all closed rural hospitals increased 11% between 10 and 6 years before closure for a CAGR of 2.9%.
- In contrast, median NPSR for all closed rural hospitals during the five years before closure declined by 12% with a CAGR of -2.9%.
- **The absence of sustained growth over the 10 years before closure, with a marked fall-off in the five years before closure, affirms flat or declining top-line revenue as an indicator of closure risk.**



# RELATIVE SIZE & GROWTH ARE IMPORTANT

## SUMMARIZED

- Median revenue size varies amongst closed rural hospitals between \$10M and \$15M annually, with a substantial variance in Open PPS hospital revenue of nearly 7 times that of open CAHs.
- Annual revenue growth for open hospitals is 5.5 percentage points higher than for closed hospitals.
- Average daily census (ADC) declined for all hospitals except open rural PPS hospitals and declined less for open rural CAH hospitals compared to closed rural CAH hospitals.
- **ADC Compound Annual Growth Rate (CAGR) declined for closed rural hospitals at substantially higher rates than open rural hospitals.**

Metric	All Open Rural Hospitals	All Closed Rural Hospitals	Open Rural CAH	Closed Rural CAH	Open Rural PPS	Closed Rural PPS
2022 Median NPSR	\$52M	\$13M	\$24M	\$10M	\$168M	\$15M
<b>2011 to 2022 Median NPSR CAGR</b>	<b>7.0%</b>	<b>1.5%</b>	<b>4.2%</b>	<b>2.3%</b>	<b>10.0%</b>	<b>0.4%</b>
2022 Median ADC	9.4	3.2	4.9	2.3	44.9	4.9
<b>2011 to 2022 Median ADC CAGR</b>	<b>-0.4%</b>	<b>-7.1%</b>	<b>-1.9%</b>	<b>-4.5%</b>	<b>6.1%</b>	<b>-6.0%</b>



# OPERATIONAL & FINANCIAL PERFORMANCE

## SUMMARIZED

- Median operating margins (Op Margin) are consistently negative for closed hospitals with a substantial declining compound annual change rate.
- Median Days Cash on Hand (DCOH) for closed rural hospitals is below open hospitals overall and substantially lower than open CAHs and the national average for CAHs.
- **Benchmarking financial performance provides valuable insights into the financial risks associated with hospital closure.**

Metric	All Open Rural Hospitals	All Closed Rural Hospitals	2022 Open Rural CAH Hospital Benchmark*	Open Rural CAH	Closed Rural CAH	Open Rural PPS	Closed Rural PPS
2022 Op Margin	2%	-10%	3%	3%	-5%	1%	-11%
2022 Op Margin CAGR	2%	-15%	--	11%	-13%	-10%	-15%
2022 DCOH	131	22	126	159	30	93	17



# CLOSURE RISK FACTORS



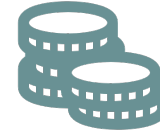
Size of organization



Top line revenue growth



Operating margin



Adequate liquidity



Size of market





# STRATEGIC RISK ANALYSIS

# UNDERSTANDING THE RISKS

What is the best strategy to achieve mission and vision?

Independence vs. Affiliation/Partnership



## How do you minimize Operating Risk?

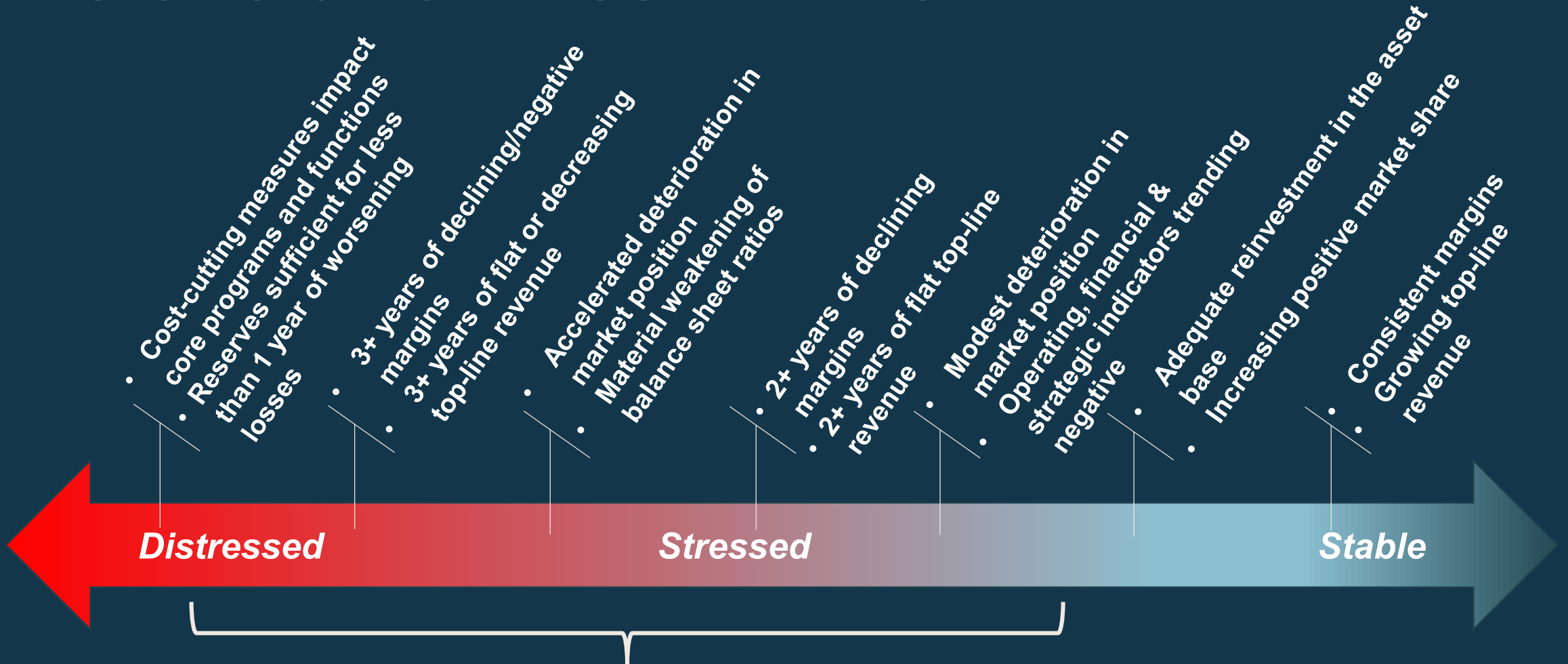
- **Accountability around strategic objectives** between the board, the management team, and the medical staff
- Maintain annual **operating cash flows** at least equal to debt service plus 120% of depreciation expense
- Create access to a **robust primary care base**
- Achieve required value metrics re: **quality and cost** and selectively assume risk
- Invest in a distributed and efficient **ambulatory network**

## How do you minimize Partner Risk?

- Design a well-structured affiliation process with clear objectives
- Select a **strategically aligned partner**
- **Vet alternative partners' track records and capabilities**
- Vet alternative **affiliation structures** for their fit with our strategic objectives
- **Contractually enforceable key terms**
- **Involve key stakeholders** from the beginning and emphasize communication
- **Make candidates earn the right to be your partner**



# SIGNS OF STRESS: ABRIDGED



# FACTORS THAT AFFECT RISK



- The four risk domains depicted to the left describe the major sources of strategic risk in today’s environment
- Poor performance in one domain will have collateral or “spillover” effects on one or more of the other domains
- Key trends within each risk category should be monitored annually, and long-term trends should be quantified. Over time, the cumulative impacts can be very significant.

**Boards may not appreciate the cumulative effects of changes in risk factors that can take place over several years.**



# QUESTIONS FOR RURAL HEALTHCARE LEADERS

- Do you ever play poker without knowing the rules of the game?
  - If so, how does that work out for you?
  - Not knowing your organizational risk profile is the same as playing poker and not knowing the rules of the game
- Do you ever make a bet in a poker game without knowing what is in your hand?
  - If so, how does that work out for you?
  - Not knowing your value is the same as not knowing what is in your hand.
- Don't gamble with the future of your hospital without knowing:
  - The rules of the game (your risk profile), or
  - What cards are in your hand (your value)





# KEY TAKEAWAYS

# THE KEY LESSONS LEARNED FROM HOSPITAL CLOSURES



**OPERATIONAL PERFORMANCE IS FOUNDATIONAL TO ANY STRATEGIC OPTION**



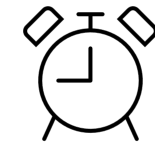
**TIME IS NEVER A NEUTRAL FACTOR; AT A MINIMUM, TWO YEARS IS NEEDED TO EXECUTE A TURN AROUND**



**KNOW YOUR VALUE AND RISK PROFILE; DO THE HOMEWORK**



**THERE ARE NO RISK-FREE STRATEGIC OPTIONS**



**EARLY ACTION SAVES HOSPITALS; THE SOONER YOU ALTER COURSE, THE LESS DRASTIC THE COURSE CORRECTION REQUIRED**





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THANK YOU



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