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WELCOME

Rural Health Executive Educational Series

Please visit **NRHASC.com**

to see a complete list of our upcoming educational presentations as well as Case Studies, Toolkits, Partner lists and other valuable resources.

House Keeping Items

- We like to get through our presentations in about 45 minutes, offering time at the end for questions to the presenter
- All attendees are muted during the webinar
- If you have a question for the presenter, please type it into the question section of your GOTO webinar control panel. We will cover it at the end.
- This event is being recorded. You will receive an email before the end of the day with a link to the recording.

Maximizing Rural Hospital Value: The Strategic Risks That Can Kill Success

April 2025

Jeff Sommer, Managing Director
Clare Kelley, Senior Consultant

STROUDWATER

Meet the Speakers

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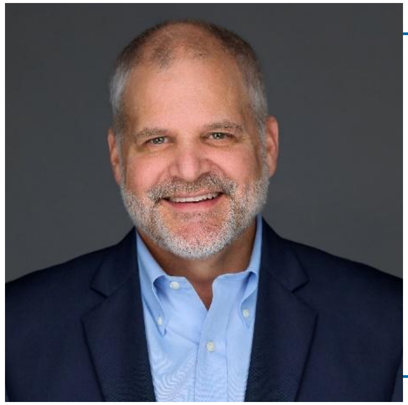

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Stroudwater is a leading national healthcare consulting firm specializing in mission-critical strategic, operational, and financial opportunities for healthcare leaders’ most pressing challenges

Key Point: Sound Operations Underpin All Options

When we talk to a rural client about strategic options, we focus on mitigating strategic risks. Sound operating results are foundational to those efforts regardless of the strategic option selected. From there, we can evaluate strategic options to find the right strategy based on the organization's risk profile.

1. Analyze the risk profile
2. Quantify any performance gaps & outline a performance improvement plan
3. Facilitate Board discussions on strategic options, such as:
   - Implementation of operational improvement plan
   - Revise existing partnership – define new value
   - New partnership – ensure value reflected

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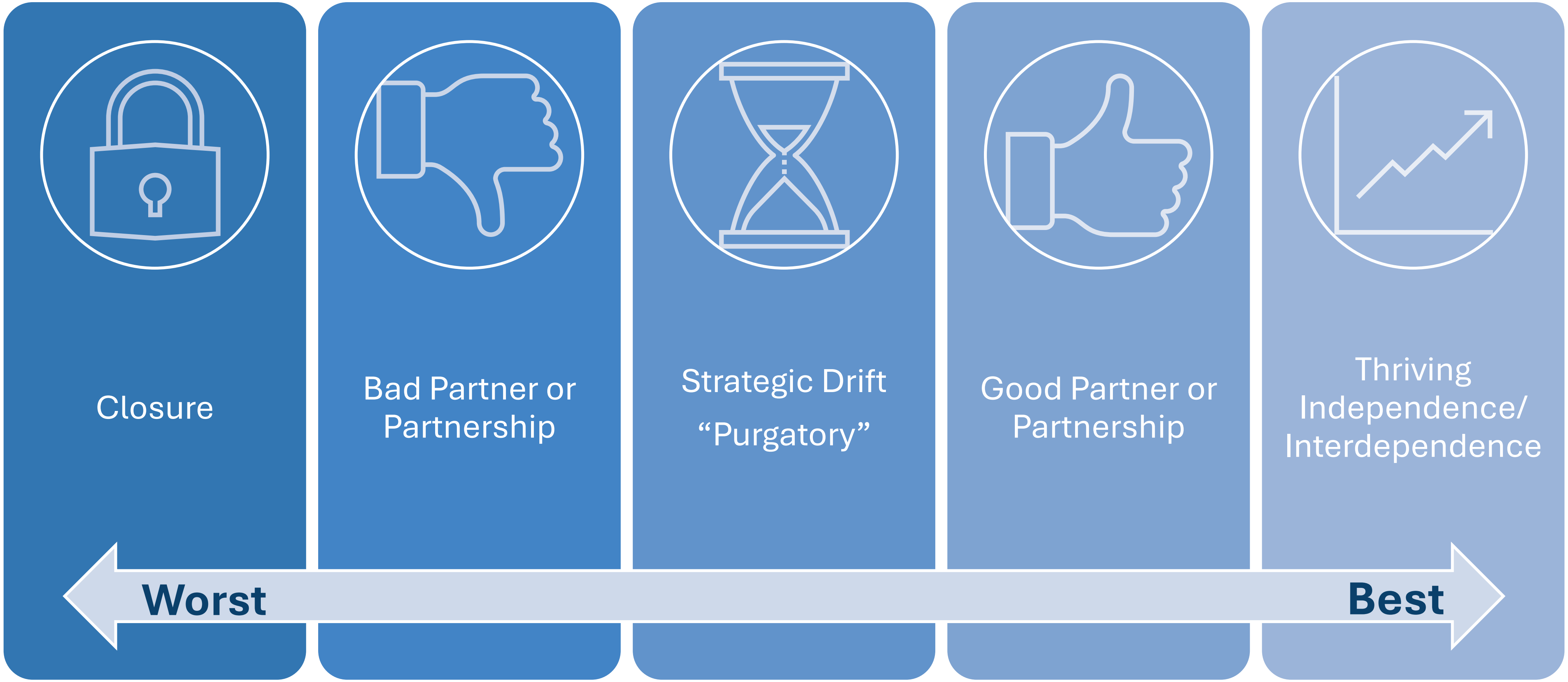
Common Outcomes for Rural Hospitals



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

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What Do Rural Leaders Need to Know?

For the 60% of rural hospitals in a partnership, most systems miss critical aspects of rural value

No one is going to stumble across your value if you do not quantify it and show the path to operationalizing it

Identify win-wins with existing partners – it's about making better decisions and better allocating scarce resources

Does a partner understand your value?

Variable vs fixed costs

Contribution margin vs. fully allocated costs

Incremental cost vs. reallocated costs

The value of incremental referrals

The Four Know/Nos:

Know your risk profile

Know your value

No one else will promote your value

No risk-free options

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Better Decisions for Better Rural Healthcare

Our Objective: Improve decisions about resource allocation and performance evaluation to enhance system performance and optimize access to needed healthcare services sustainably

These decisions should be based upon:

- Variable/incremental costs (20%) not reallocated fixed costs (80%)
- Contribution margin – after variable costs are considered – 80%
- Cost-based payment (for CAHs) is unique and should inform management decisions

Access to unique rural-based programs; don't take conventional wisdom as definitive

Value should include contribution margin from incremental referrals, aligned primary care base with positive cash flow, 340B, and swing bed opportunities

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Our Agenda

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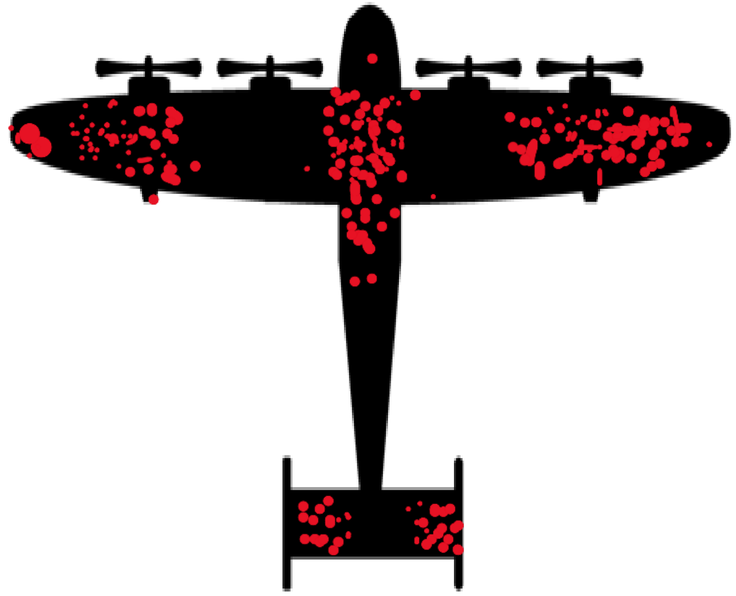
What Are We Getting Wrong?

When Preconceptions and Bias Misinform

- 60% of the Allies' bomber crews were being killed (46%), wounded (7%), or taken prisoner (8%) during bombing runs over Germany in WW2
- Researchers at the Center for Naval Analysis knew they needed hard data to solve this problem
- After each mission, the damage from each bomber was painstakingly reviewed and recorded
- The data began to show a clear pattern: most damage was to the wings and body of the plane
- The solution was clear: increase the armor on the plane's wings and body
- But the analysis was completely wrong. Why?
- Every plane that had been shot down was missing from the data collected
- **The researchers' data had created a map of the places where the bomber could be shot and still survive**
- **In our opinion, something similar is happening frequently regarding rural healthcare affiliates**



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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

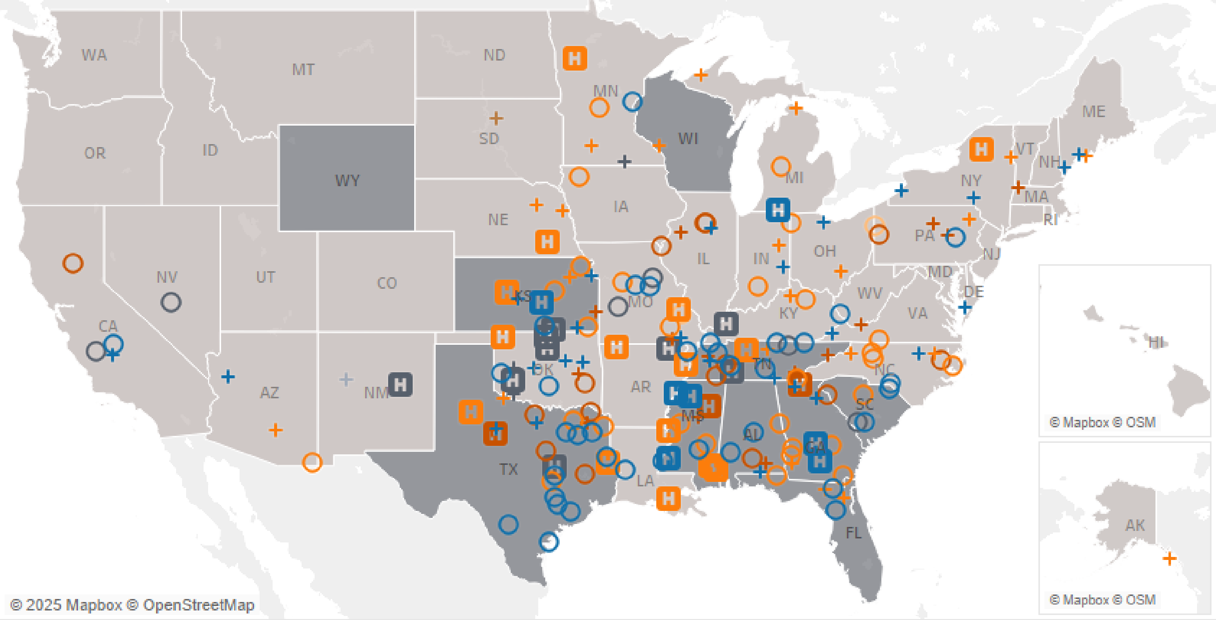
- Northeastern seven-hospital system, including a 120-bed community hospital affiliate
- System allocates $25M of overhead to the affiliate's general ledger, resulting in a **$13M operating loss**
    - As a result, the system slashed capital investment at the affiliate
    - The operating loss included $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**

Health Industry Factors Increasing Strategic Risk

Rural Hospital Closures Since 2010

191 Closed or Converted Rural Hospitals

There have been 191 Rural Hospital closures or conversions since 2010 and 230 since 2005, these numbers include **thirty-four (34) REH Conversions since 2023**



Year	Hospital Name
2025	Valley Community Hospital-OK
	Sharon Regional Health System-PA
2024	REH- Wayne Medical Center-TN
	REH- Clifton-Fine Hospital-NY
	REH- Progressive Health Group of Houston..
	MercyOne Primghar Medical Center-IA
	Thomasville Regional Medical Center (TRM..
	REH- Elkview General Hospital-OK
	REH- Taylor Regional Hospital-GA
	REH- Sharkey Issaquena Community Hospit..
	Community Memorial Hospital-OH

ST	Count
TX	26
TN	17
OK	13
KS	12
GA	11
MO	11
MS	11
NC	8
AL	7
PA	6
FL	5
MN	5
AR	4
CA	4
IL	4
KY	4
MI	4
NY	4
SC	4
AZ	3
IN	3
ME	3
NE	3
OH	3
IA	2
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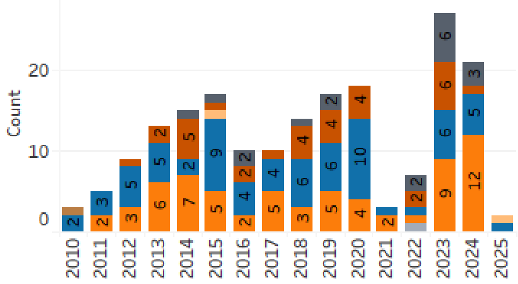
NM	2
VA	2
WV	2
AK	1
MA	1
MD	1
NV	1
SD	1
WI	1



Year	Prospective Payment System	Critical Access Hospital	Medicare Dependent Hospital	Sole Community Hospital	Rural Referral Center	IHS	Re-based Sole Community Hospital	Total
2010	2						1	3
2011	3	2						5
2012	5	3	1					9
2013	5	6	2					13
2014	2	7	5	1				15
2015	9	5	1	1	1			17
2016	4	2	2	2				10
2017	4	5	1					10
2018	6	3	4	1				14
2019	6	5	4	2				17
2020	10	4	4					18
2021	1	2						3
2022	1	1	2	2		1		7
2023	6	9	6	6				27
2024	5	12	1	3				21
2025	1				1			2
Total	70	66	33	18	2	1	1	191

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:2/3/2025

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

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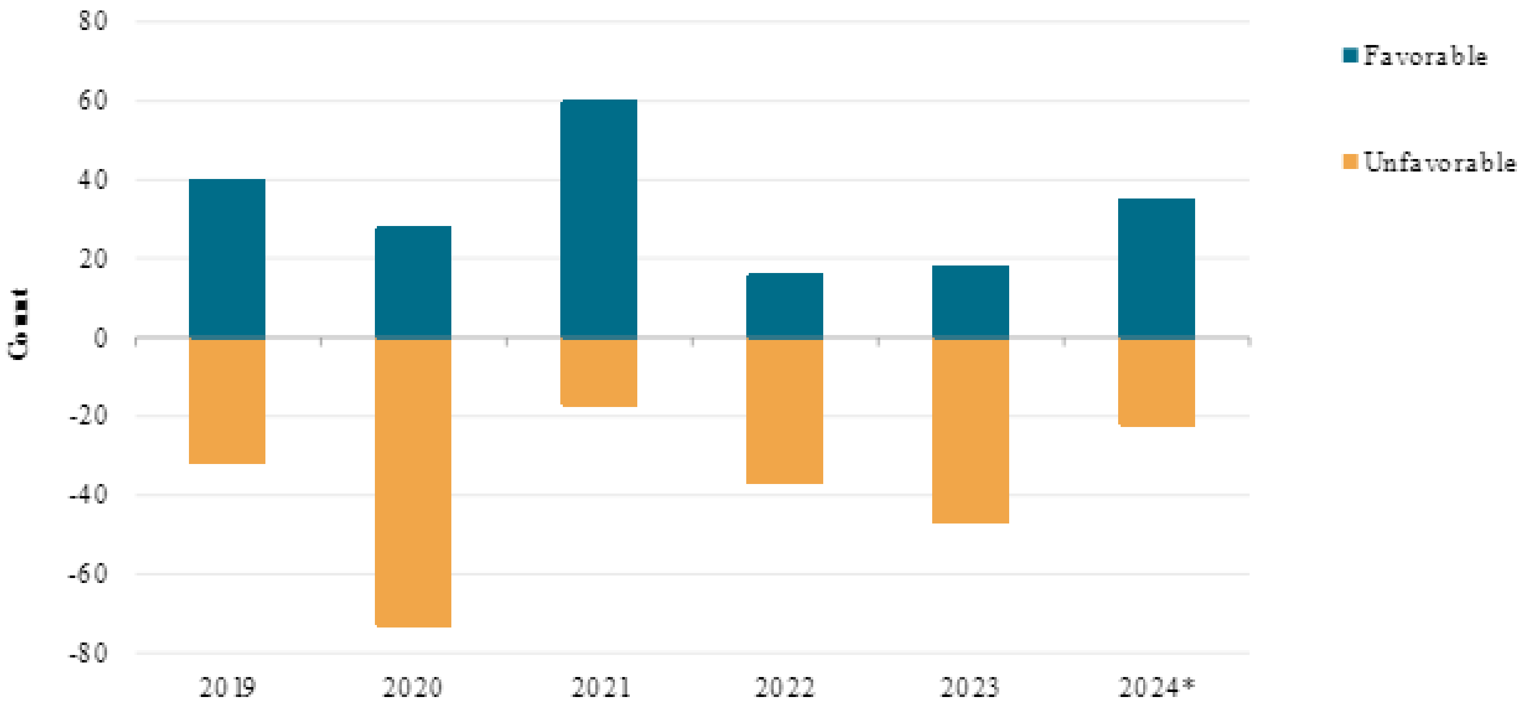
Favorable vs. Unfavorable Credit Ratings

U.S. not-for-profit acute health care outlook revisions



*Data as of Oct. 31, 2024. 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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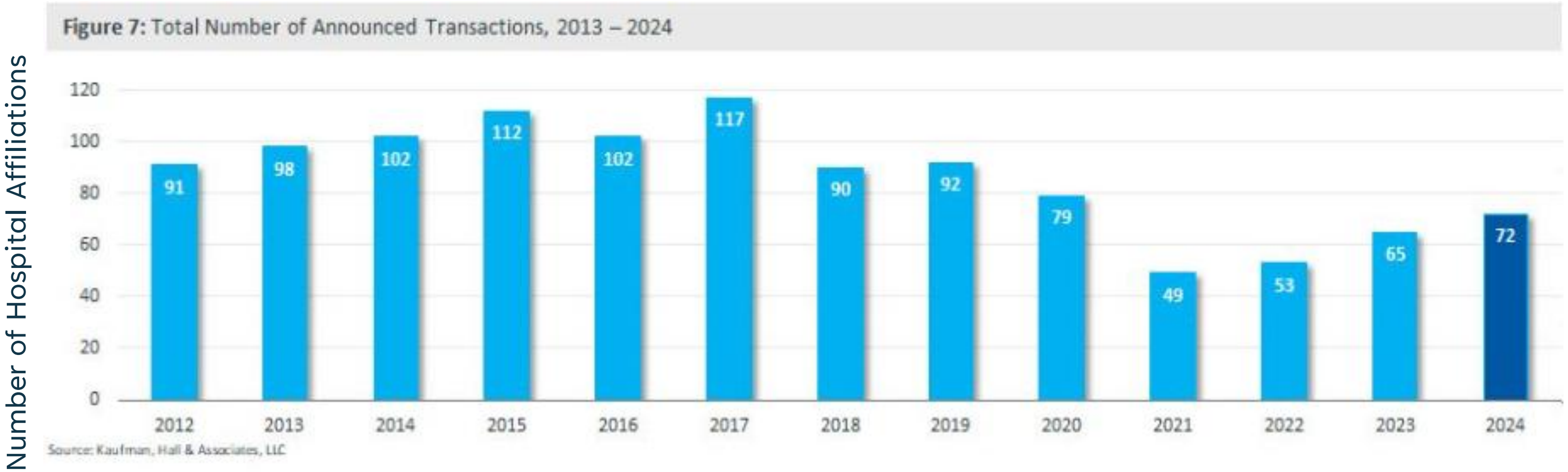
Rural Affiliation Drivers: Industry Consolidation



Catalysts:

- Margin pressure
- Heightened competition
- Staffing crisis
- Increasing bad debt from high-deductible health plans
- Medicare Advantage
- Declining inpatient admissions
- Changing payment models
- Quality initiatives
- Provider shortages
- Economies of skill

https://www.kaufmanhall.com/insights/research-report/hospital-and-health-system-ma-review-despite-industry-stabilization

Risk Mitigation via Improved Performance

- 27 rural performance improvement projects conducted by Stroudwater over the last 30 months yielded $93.8M in total improvements or 9.6% of operating revenue on average
- These engagements spanned an array of functional areas with the average share of total improvement realized broken out as follows:
    - Cost report opportunities – 7.1%
    - Revenue cycle – 17.7%
    - Service line growth/expansion – 14.3%
    - Swing Bed growth – 8.4%
    - Inpatient growth – 33.2%
    - 340B program – 7.5%
    - Other – 6.3%
- Across these 27 rural performance improvement engagements – the average benefit per organization was $3.5M or 9.6% of operating revenue

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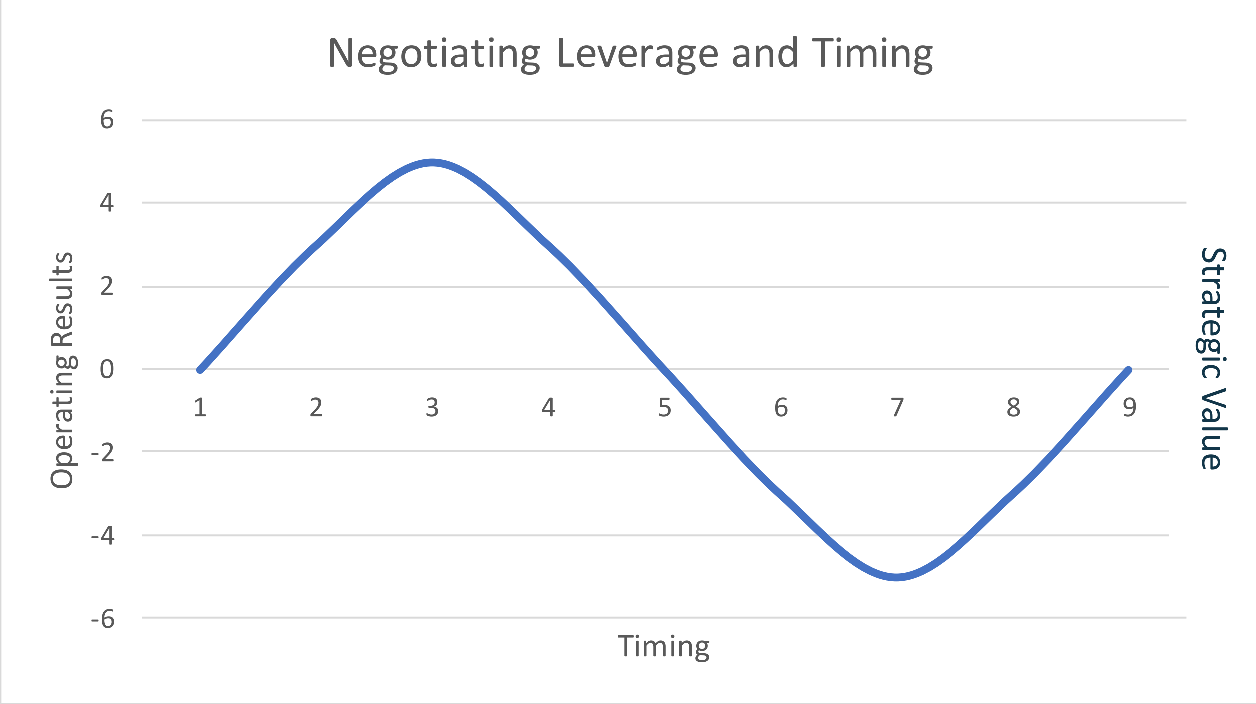
When to Think About Partnerships

Time Is Never a Neutral Factor

- A struggling 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.)



Signs of Stress: Abridged

- Cost-cutting measures impact core programs and functions
- Reserves sufficient for less than 1 year of worsening losses

- 3+ years of declining/negative margins
- 3+ years of flat or decreasing top-line revenue

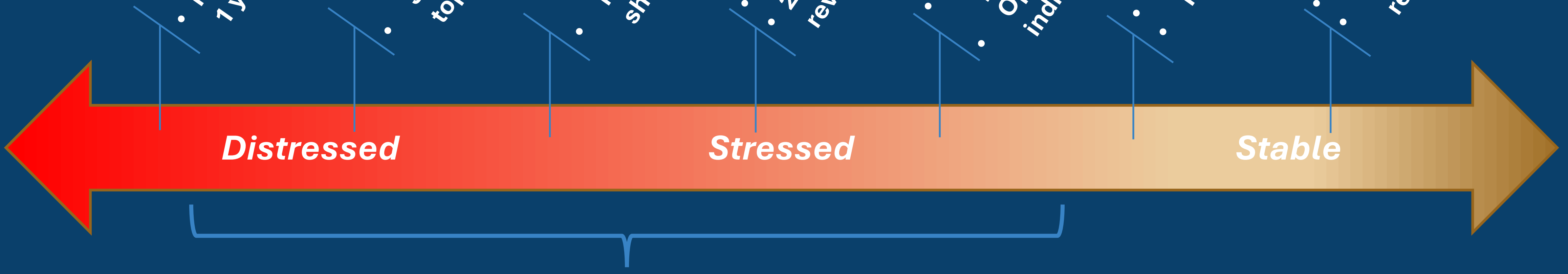
- Accelerated deterioration in market position
- Material weakening of balance sheet ratios

- 2+ years of declining margins
- 2+ years of flat top-line revenue

- Modest deterioration in market position
- Operating, financial & strategic indicators trending negative

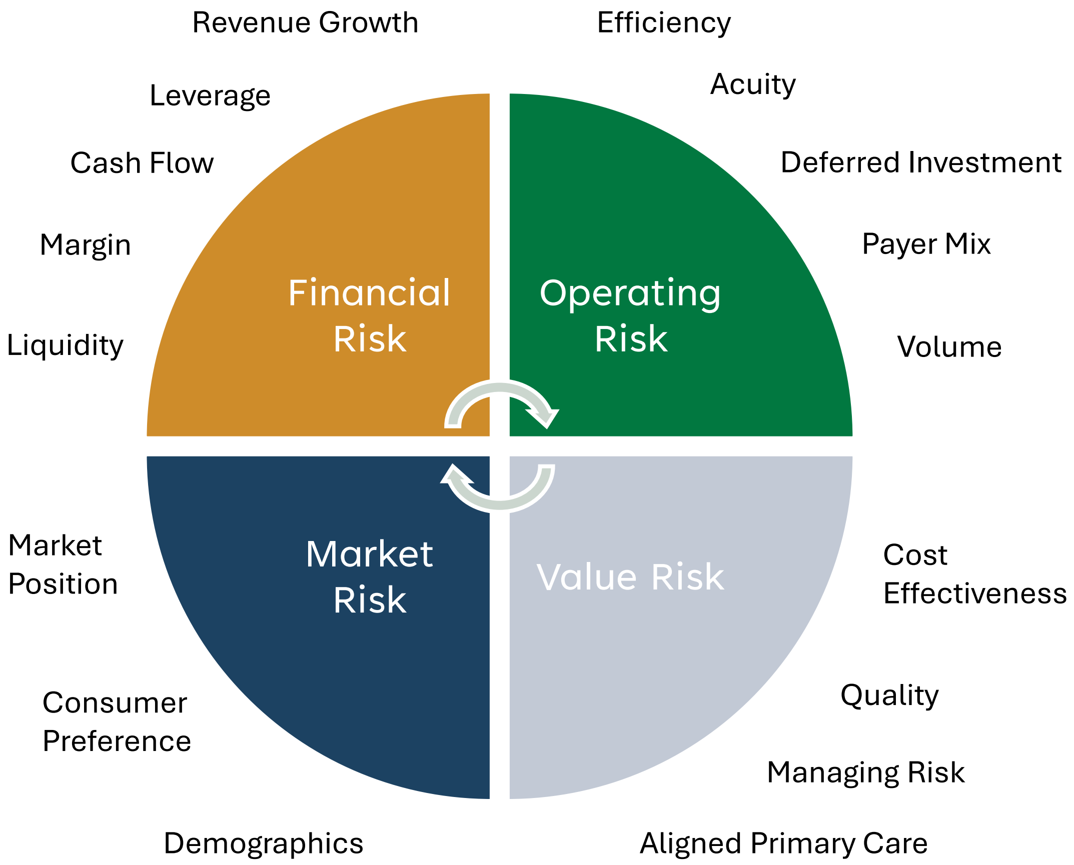
- Adequate reinvestment in the asset base
- Increasing positive market share

- Consistent margins
- Growing top-line revenue



Examine/re-examine the benefits of performance improvement and/or partnership

Factors That Affect Risk



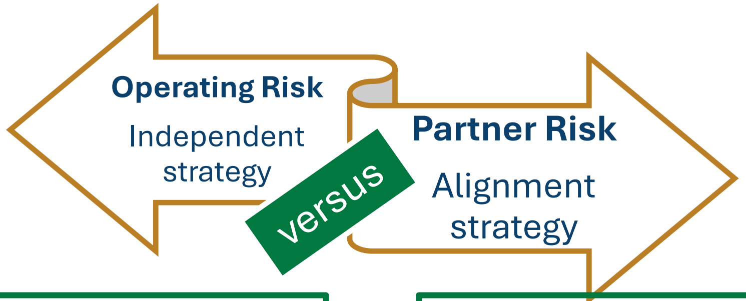
- The four risk domains depicted to the left describe the major sources of strategic risk in today's environment
- Poor performance in one domain will have collateral or "spillover" effects on one or more of the other domains
- Key trends within each risk category should be monitored annually and long-term 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.

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**

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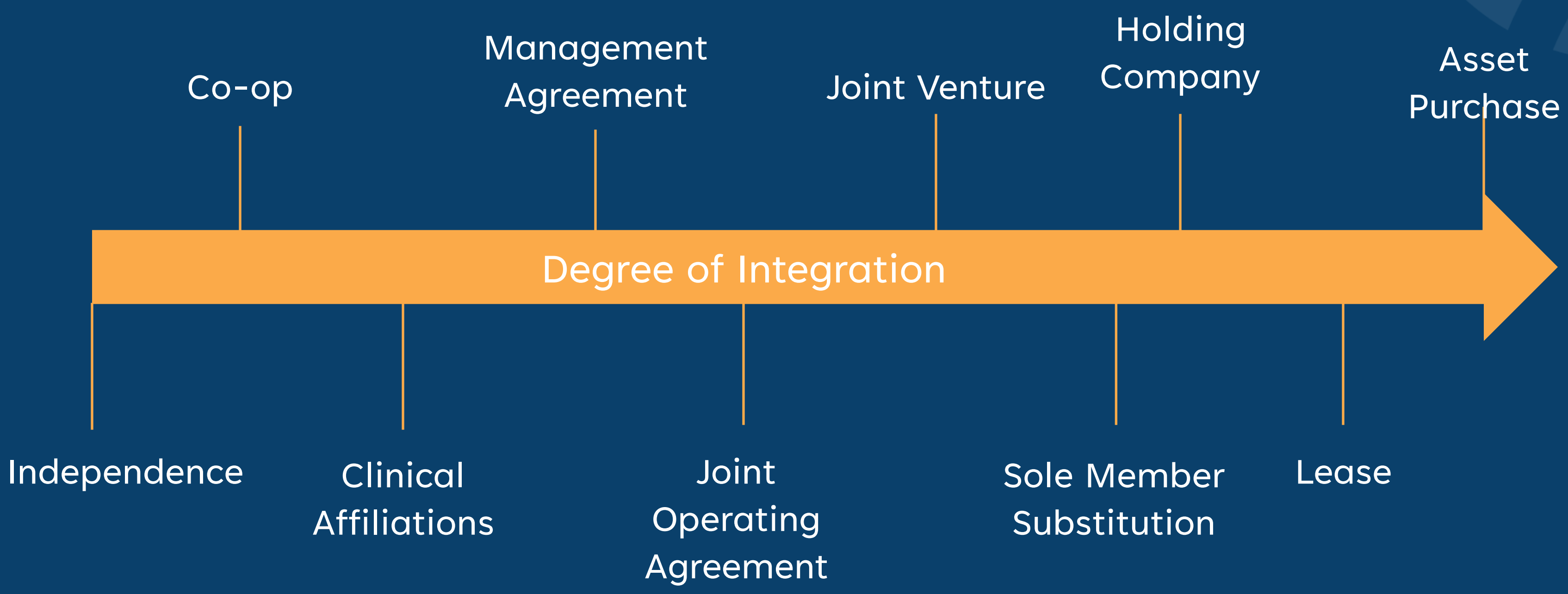
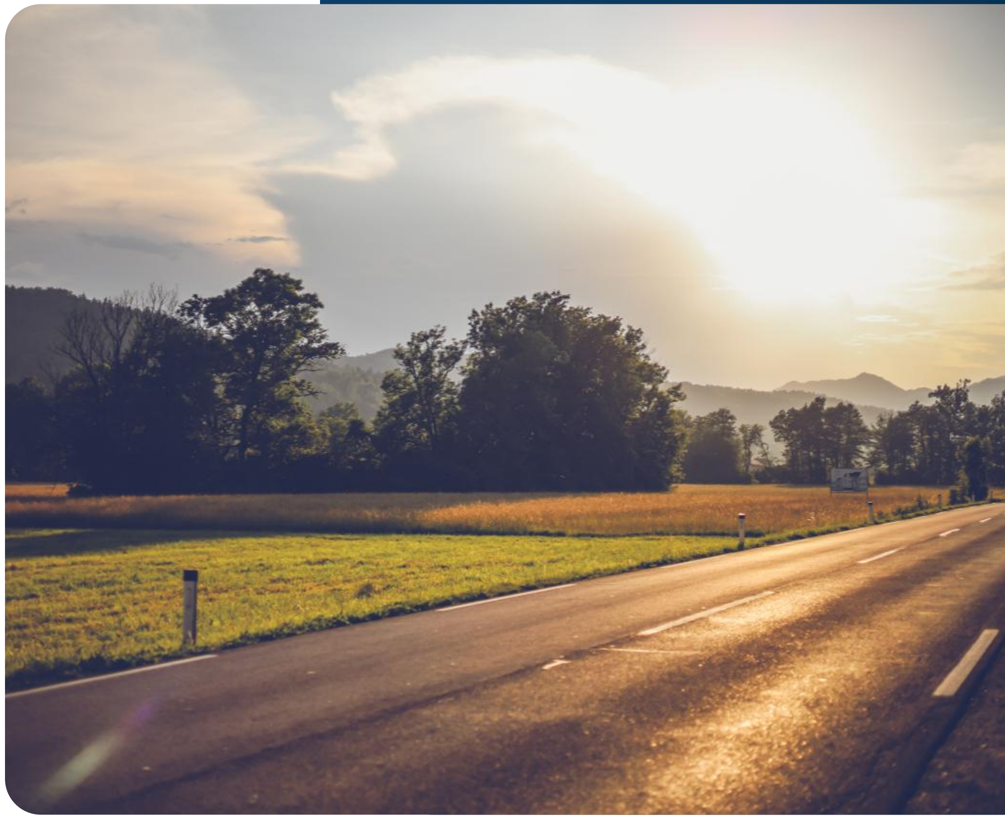
How to Ensure Your Partnership Creates Value

Continuum of Partnership Structures



Value Levers for Rural Health Systems

- The following value levers are often misunderstood or undervalued by existing and potential partners:
    - Cost-based payment
    - Cost report optimization opportunities
    - Home office cost allocation
    - 340B eligibility and post Genesis ruling opportunities
    - Swing beds
    - Rural health clinics (RHCs)
    - Decanting volume and utilizing Critical Access Hospitals (CAHs) as specialized components of the continuum of care
    - The value of attributed lives and a primary care base that is cash flow positive
    - The “true” value of incremental referrals



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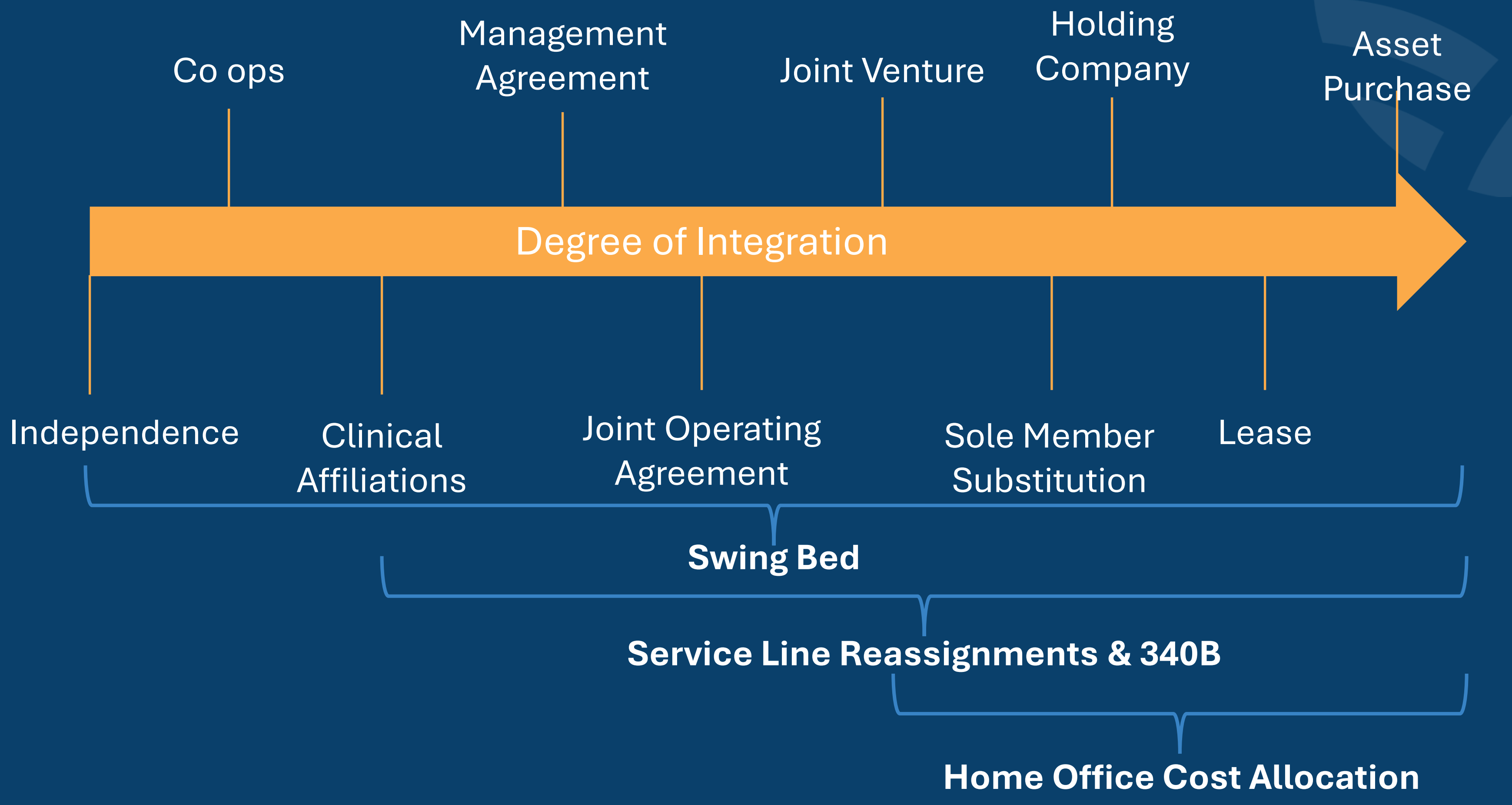
Continuum of Partnership Structures



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Partnering Is Not a Risk-free Endeavor

EXISTING PARTNERS

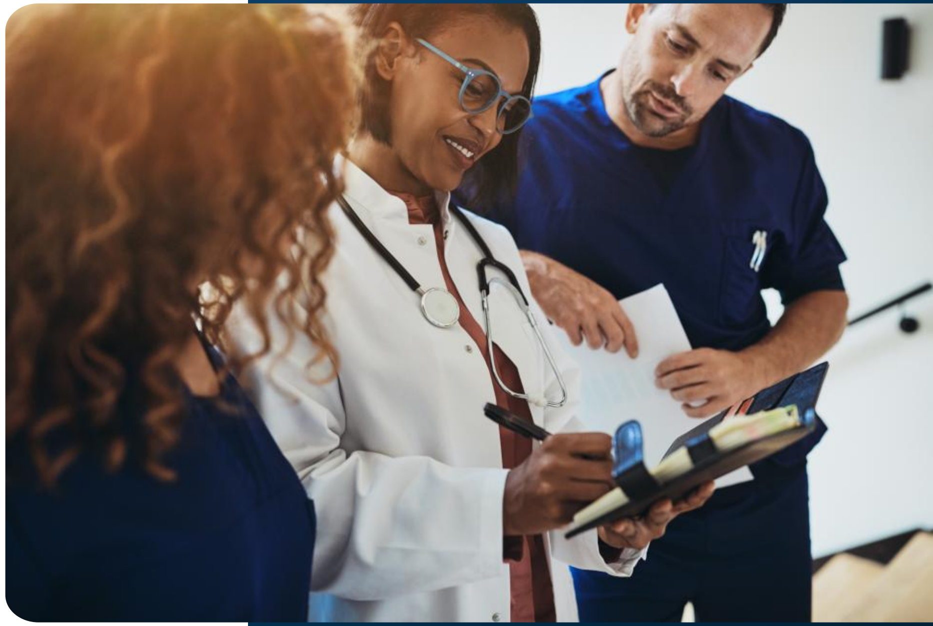
- Ensure that your partner understands your value proposition
- Ensure your affiliation structure enhances the value provided by the partnership for both parties
- Identify and quantify any missed/potential opportunities
- Quantify the ROI of investments to reflect the unique rural value proposition

PROSPECTIVE PARTNERS

- Vet and select a strategically aligned partner
- Assess their track record
- Select an affiliation structure that fits your strategic objectives and constraints
- Craft contractually enforceable terms that reflect the rural value proposition

Process for Enhancing Existing Partnerships

- Unleashing previously untapped value should benefit both the rural affiliate and the parent
- Quantify opportunities with a pragmatic and realistic mindset—do not overpromise and under-deliver
- Get some early wins on the board to build confidence and buy-in
- Prioritize opportunities based on:
    - Low cost to implement
    - Quick ROI/time for payback
    - Ability to execute
    - Value to partner, affiliate, and system
    - Strategic fit of the opportunity
- Focus on educating colleagues about recurring benefits and including benefits in future capital allocation decisions



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A Costly Strategic Error Avoided

- A health system with four Critical Access Hospitals totaling $55M in operating revenue believed these rural affiliates were a significant drag on operating results
  - The system engaged Stroudwater to perform an in-depth financial and operational analysis of its rural affiliates
- The operational and financial evaluation found a total of $6M in annual missed operating cash flow improvement opportunities
- We also found an additional $9M in errors in the System’s evaluation of the contribution margin of these rural affiliates.
- Combined, the $15M in missed opportunities and performance evaluation mistakes painted a misleading picture of the rural affiliate’s contribution margin to the system and revealed previously hidden opportunities
- The evaluation provided the system with an actionable roadmap to realize the true accretive value of its rural affiliates

An Investment with Far-Reaching Effects

- Rural affiliates contribute value in the following, frequently unmeasured, ways, often described as “network effects”:
  - **Growth:** Enhancing system market share locally and growing the number of patients joining the network
  - **User Retention:** Providing access points and increasing patient use of the network
  - **User Engagement:** Share of patient healthcare spend
  - **Network Density:** Increase the number of connections or interactions per patient
  - **Referral Rate:** Track how many system users are referred by the affiliate
  - **Complementary Products/Services:** For indirect network effects, measure the benefits of improved access, more timely prevention, and improved quality and outcomes

Process Recommendations for New Partnerships

Have prospective partners compete for the privilege of being your partner

- Use the process to gather information about your options
- Use the process to educate prospective partners as to your value
- Assess whether a partner is willing to adjust terms and commitments to reflect the quantification of your value
- Leverage the analyses of your value, the competitive process, and the asymmetry of information to negotiate improved terms
- Evaluate prospective partners' track records with their rural affiliates
- Do not sign an exclusive Letter of Intent (LOI) until you have an acceptable term sheet in hand

Case Study: Quantifying Your Value

CAH was projected to have a negative cash balance within two years and needed to partner

Using the value levers, Stroudwater determined our client would be able to fund investments and increase operating performance by about $670K annually through a partnership – net of debt service on $3.6M of needed investments

By quantifying the value levers, our client received robust proposals with strong commitments for the community

As of April 2024, our client has signed an LOI with a preferred partner and is set to close on the definitive agreement on June 1, 2024

Case Study: Quantifying Your Value, Cont.

Performance Improvement Initiatives	Client
Swing Bed Estimate	$ 120,000
340b Opportunity	$ 250,000
Cost Report Opportunity	$ 170,610
Home Office Cost Allocation Low Estimate	$ 470,000
Home Office Cost Allocation High Estimate	$ 780,000
Total Savings Low Estimate	$ 1,010,610
Total Savings High Estimate	$ 1,320,610

Required Investment Over 5 Years	
Required Investment	3,587,639
Percentage Debt Financing	100%
Cost Based Reimbursement	40%

- The table to the left demonstrates the savings incurred by different value levers for our client
- The table below demonstrates the effect of the performance improvement initiatives on operating performance inclusive of required investments

Projection Estimate

	Year 1	Year 5	Year 10	Year 15	Year 20	Year 25	Year 30	Year 35
Principal Balance Outstanding	$ 3,587,639	$ 3,114,290	$ 2,491,503	$ 1,684,434	$ 777,344	$ 350,054	$ (0)	
Annual Depreciation Expense	$ (160,148)	$ (160,148)	$ (160,148)	$ (158,498)	$ (140,165)	$ (59,315)	$ (39,254)	$ -
Annual Interest Expense	$ (195,209)	$ (174,450)	$ (141,196)	$ (98,039)	$ (48,818)	$ (22,109)	$ (2,340)	$ -
Total Annual Depreciation Plus Interest	$ (355,357)	$ (334,598)	$ (301,344)	$ (256,537)	$ (188,983)	$ (81,424)	$ (41,594)	$ -
Incremental Cost-Based Payments	$ 141,041	$ 132,802	$ 119,603	$ 101,820	$ 75,007	$ 32,317	$ 16,509	$ -
Net Interest and Depreciation Cost	$ (214,316)	$ (201,796)	$ (181,741)	$ (154,718)	$ (113,975)	$ (49,107)	$ (25,086)	$ -
Annual Principal Payment	$ (84,575)	$ (105,334)	$ (138,588)	$ (179,596)	$ (201,854)	$ (95,084)	$ (77,897)	$ -
Total Annual Cost (after Cost Based Payment)	$ (298,891)	$ (307,130)	$ (320,329)	$ (334,314)	$ (315,829)	$ (144,191)	$ (102,983)	$ -
Projection Low Estimate								
Total Annual Operating Improvements	$ 1,010,610	$ 1,010,610	$ 1,010,610	$ 1,010,610	$ 1,010,610	$ 1,010,610	$ 1,010,610	$ 1,010,610
Net Change In Operating Performance - Low Estimate	$ 711,719	$ 703,480	$ 690,281	$ 676,296	$ 694,781	$ 866,419	$ 907,627	$ 1,010,610
Projection High Estimate								
Total Savings High Estimate	$ 1,320,610	$ 1,320,610	$ 1,320,610	$ 1,320,610	$ 1,320,610	$ 1,320,610	$ 1,320,610	$ 1,320,610
Net Change In Operating Performance - High Estimate	$ 1,021,719	$ 1,013,480	$ 1,000,281	$ 986,296	$ 1,004,781	$ 1,176,419	$ 1,217,627	$ 1,320,610

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Rural Partnership Key Takeaways

Key Takeaways for Rural Partnerships

- The accretive value of existing and prospective rural affiliates is almost always misunderstood or absent from negotiations or management decision making
- The value of a rural referral "network" is often excluded when evaluating performance and accretive value
- Result #1: Key deal terms that would reinforce long-term value creation for the rural affiliate and system are absent
- Result #2: Systems that operate rural affiliates often miss value-added opportunities or fail to account for rural accretive contribution margin when allocating resources
- Result #3: Chronic underinvestment in rural affiliates
- Result #4: System and rural affiliate long-term performance is diluted and suboptimized

Thank You

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Appendix

Additional Case Studies

Case Study: Cost of Delay

- The hospital was a strong rural PPS health system facing major capital investment needs
- Previously, the rural system had affiliated its multi-specialty group with a regional health system with a strong track record of operating multi-specialty groups
- The rural system Board elected to defer a proposed affiliation that met substantially all their requirements and included a $25M capital infusion toward investment needs
- 12 months later, the regional system had entered into other commitments and had to pull back their capital commitment
- Six months later, the rural system elected to affiliate on the same terms negotiated previously, less the $25M investment commitment
- **Time is never a neutral factor**

Case Study: Did Not Understand Rural Value

- Our CAH client entered discussions with a large multi-state health system regarding a potential affiliation
- The large health system misunderstood the value of the home office cost allocation, placing only $100K incremental value on this allocation vs. an estimated $3M+ annual value calculated by Stroudwater
    - A greater than 50% share of cost-based payment
- The benefit of a modest change in referrals (+2.5% market share gain)
- Result: The prospective partner revised their offer from minimal capital commitment and virtually no local role in governance to an offer that included major investment commitments, major service commitments, and a significant continuing affiliate role in governance

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Case Study: Non-Competitive Process

A CAH retained Stroudwater to assist with a partnership process where the preferred partner had already been identified

The client had not run a competitive process. The preferred partner at the time was the third organization they had approached sequentially.

Due to the client's one-at-a-time approach, our client's leverage with negotiations was affected

Result: Without a competitive process, our client lost leverage, did not receive strong proposals, and missed out on capital and service continuation commitments

Case Study: The Wrong Preferred Partner

- A distressed Critical Access Hospital (CAH) had a preferred affiliation candidate identified and a signed letter of intent when they approached Stroudwater for assistance because the affiliation process was stalled
- Their preferred partner—a large regional referral center—did not understand the value proposition of having a CAH as part of their health system
- Stroudwater recommended that the client conduct a process to evaluate a broader selection of affiliation options alongside their preferred partner
- Stroudwater educated all interested parties about the unique value proposition of having a CAH affiliate (home office cost allocation, rural health clinics, 340B eligibility, swing beds, cost-based payment, etc.)
- Despite these education efforts, their prior exclusive prospective partner could not incorporate these value drivers into their proposal
- Thankfully, an alternative preferred partner emerged with previous experience with distressed rural hospitals, a track record of successful turnarounds, and expertise in operating rural affiliates
- Our client vetted its options and selected the newly identified partner based on its expertise, track record, and the quality of the terms of its proposal

Case Study: The Wrong Partner/Structure

- Two financially stressed rural health systems combined into a single health system using a joint operating agreement (JOA)
- The JOA agreement called for the members to share profits and losses, while member boards and assets remained separate
- The practical effect was that the member who lost more was owed a check by the member who lost less
- Resentment, distrust, and hostility became the common language at the combined system and on each member board
- Stroudwater was called in to ”fix” this situation
  - ➢ **Goal 1: Avoiding bankruptcy of one member and forestalling litigation among the parties**
  - ➢ **Goal 2: Find a partner(s) that could recapitalize each member and enter into separate affiliation agreements with each member given the complete breakdown in trust**
- 18 months later, these goals were realized. Both communities maintained their health systems despite this multi-year misadventure.