



STROUDWATER

**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+ 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



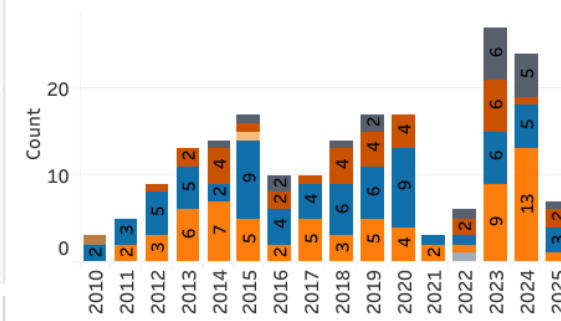
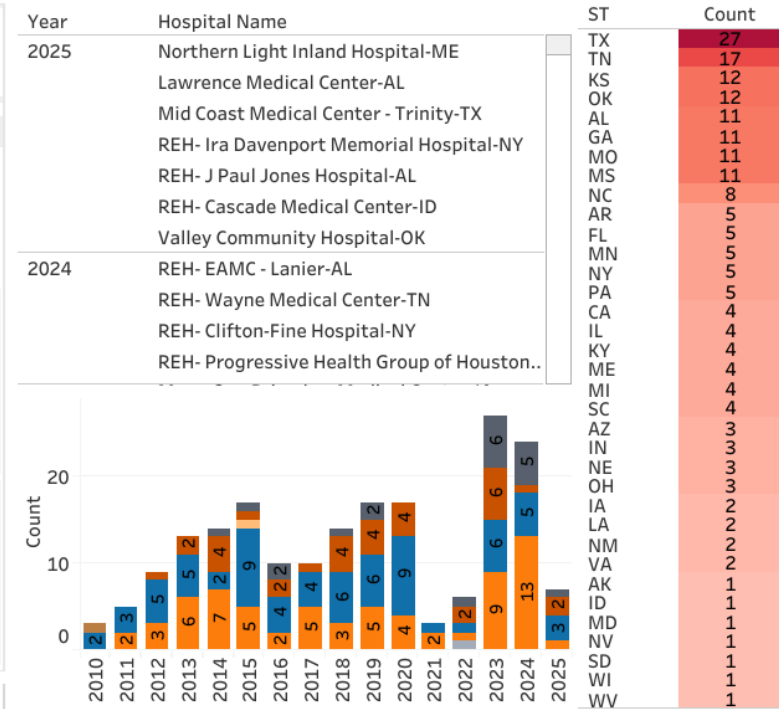
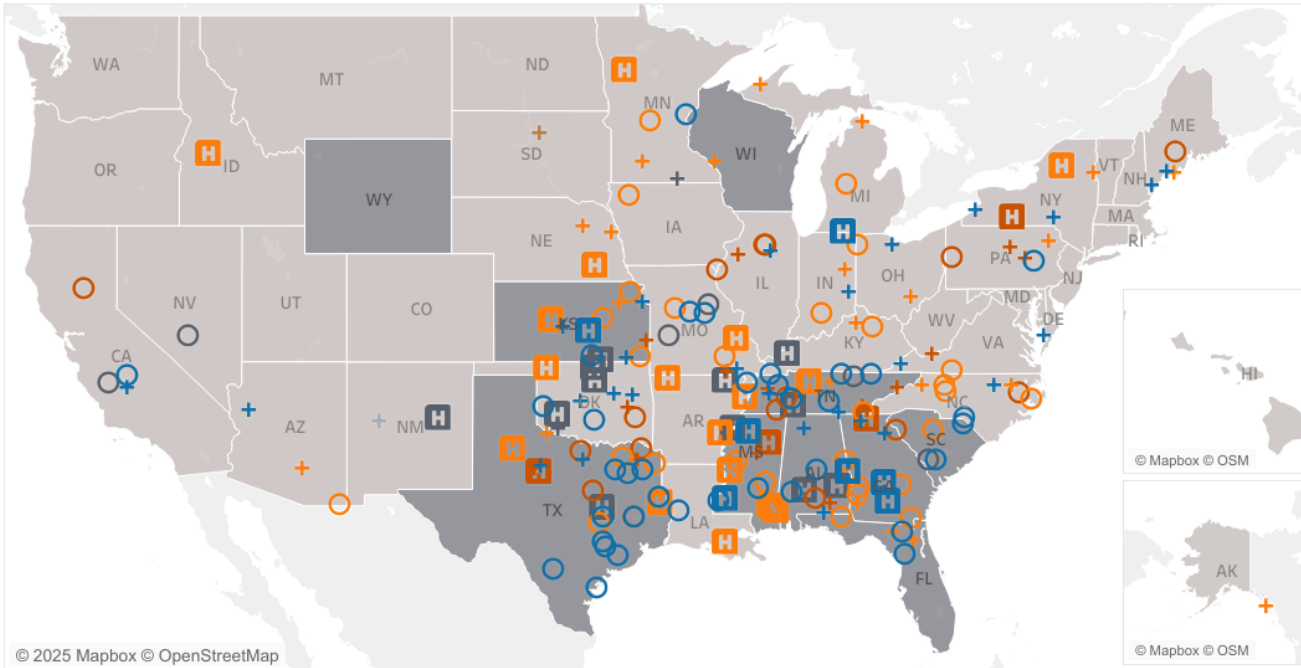
80%+/- of hospitals are within these three options



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	1	1	1					3
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
Total	71	68	34	20	1	1	1	196

Medicare Payment Type

- Prospective Payment System (Blue)
- Critical Access Hospital (Orange)
- Medicare Dependent Hospital (Red)
- Sole Community Hospital (Grey)
- Re-based Sole Community Hospital (Light Blue)
- Rural Referral Center (Yellow)
- IHS (Dark Blue)

Current Status

- REH (Blue Square)
- Complete Closure (Orange Circle)
- Convert to Other (Blue Plus)

Current Status of Medicaid Expansion Decision

- Adopted the Medicaid Expansion (Light Grey)
- Not Adopting the Medicaid Expansion at this Time (Dark Grey)

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



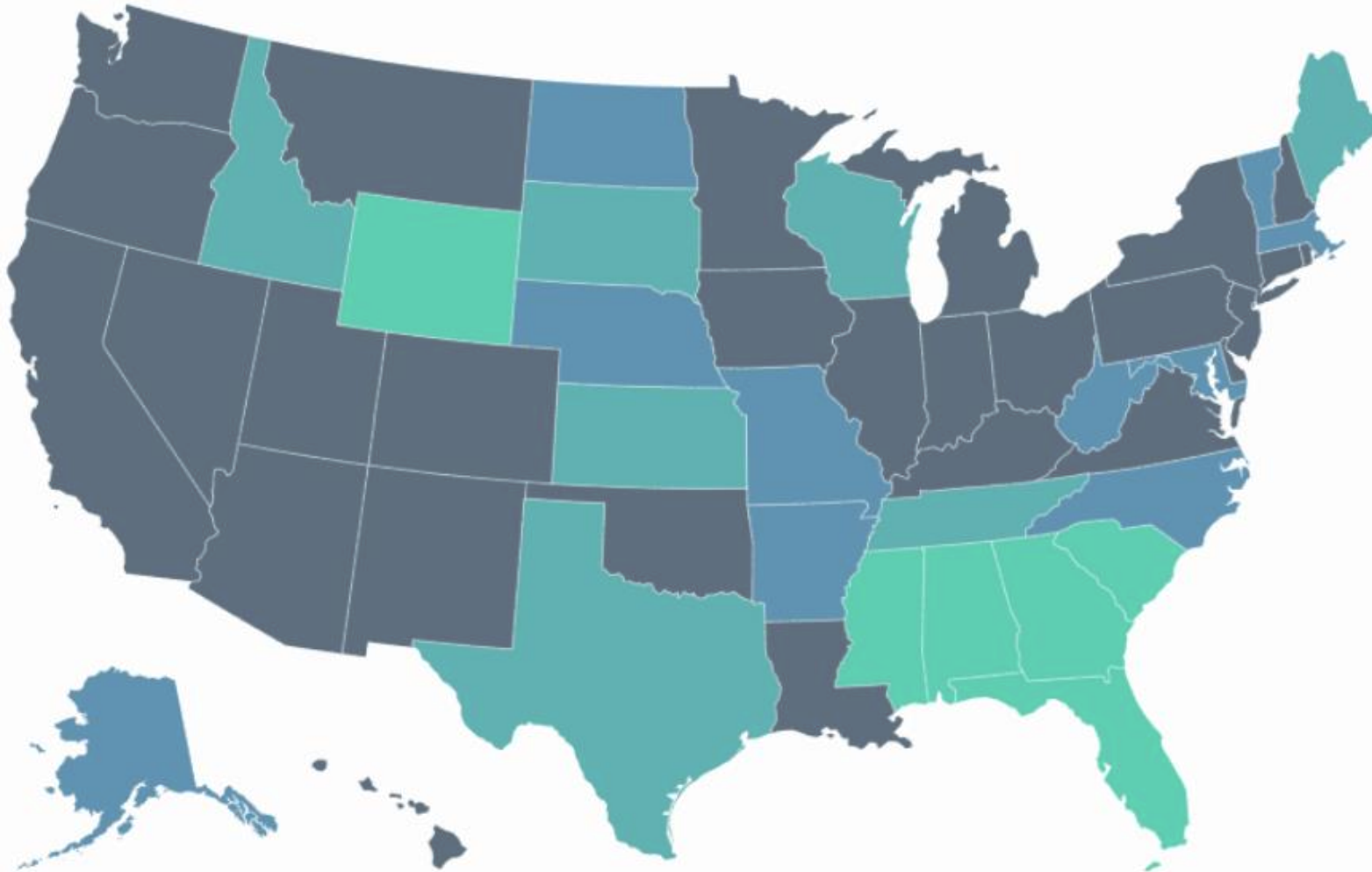
PENDING MEDICAID CUTS BY STATE

Federal Medicaid Cuts in the Enacted Reconciliation Package, By State



As a % of 10-year baseline federal spending (2025-2034)

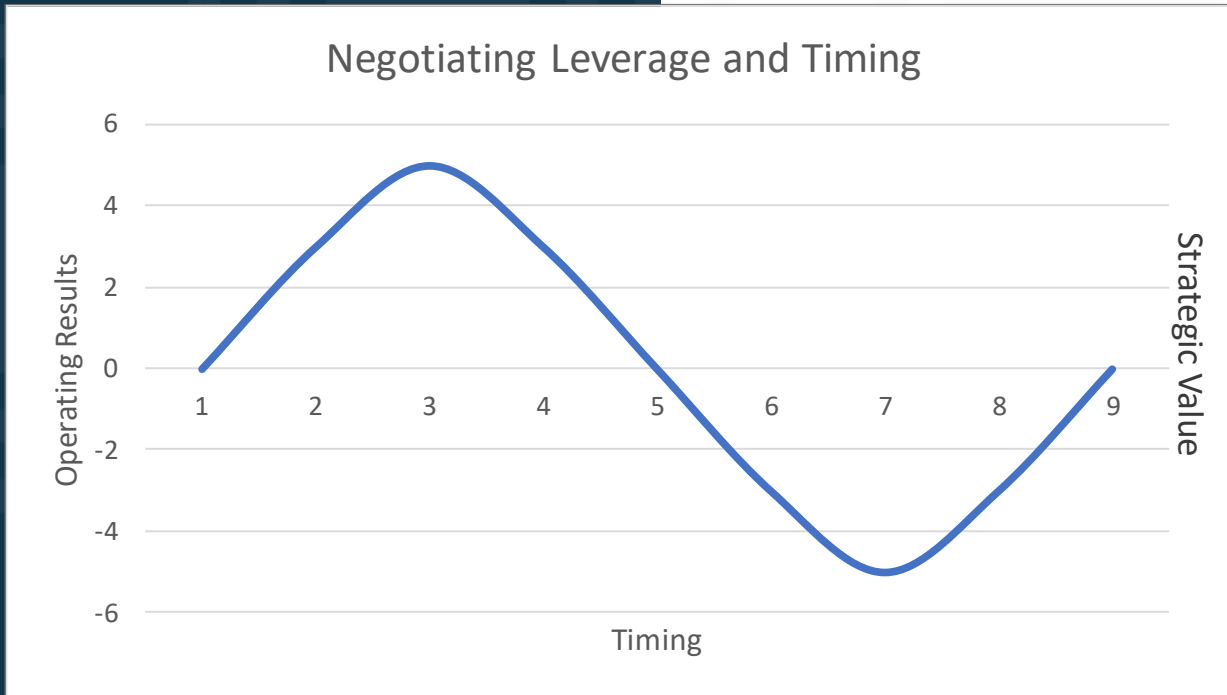
< 7% 7%–10% 10%–13% ≥ 13%



Source: <https://www.kff.org/medicaid/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-and-enrollment-loss-across-the-states/>



TIME IS NEVER A NEUTRAL FACTOR



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

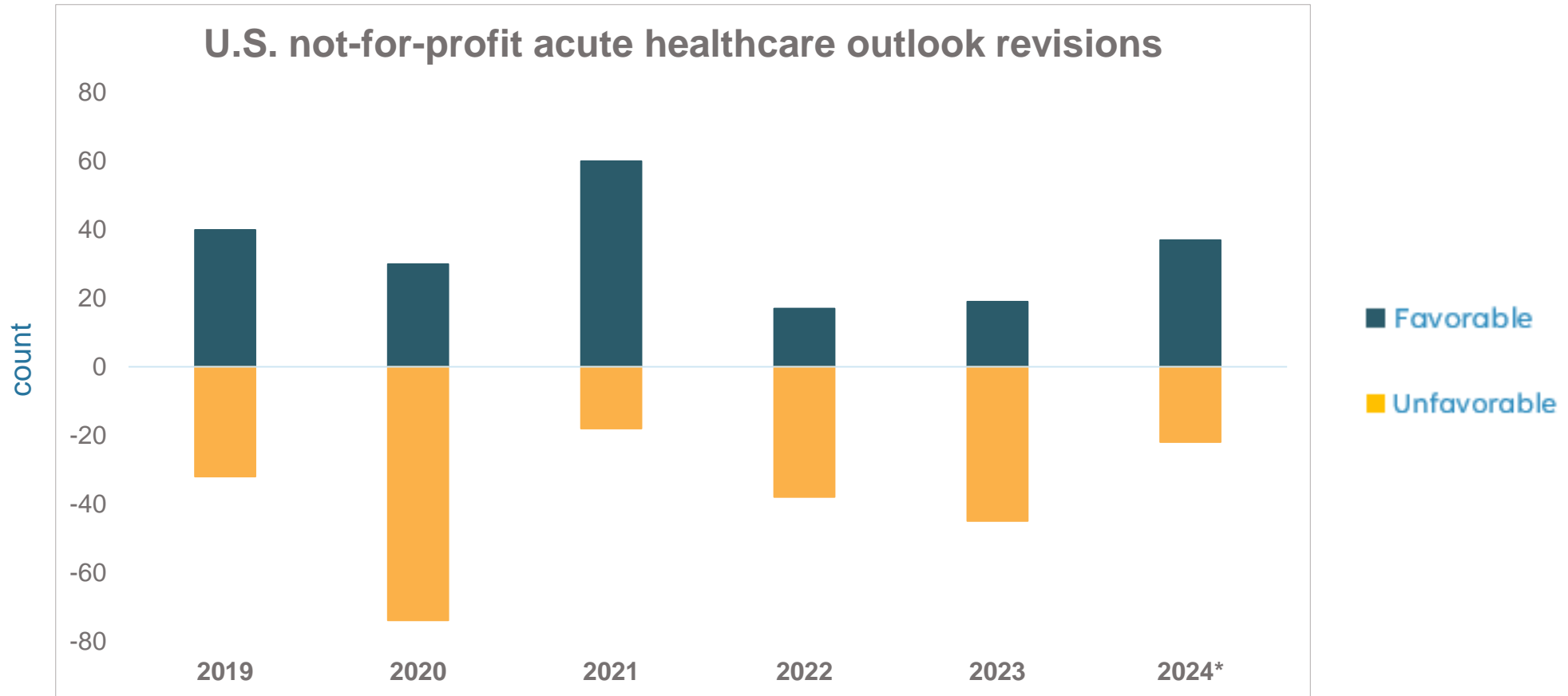
Time to demonstrate results from a performance improvement plan

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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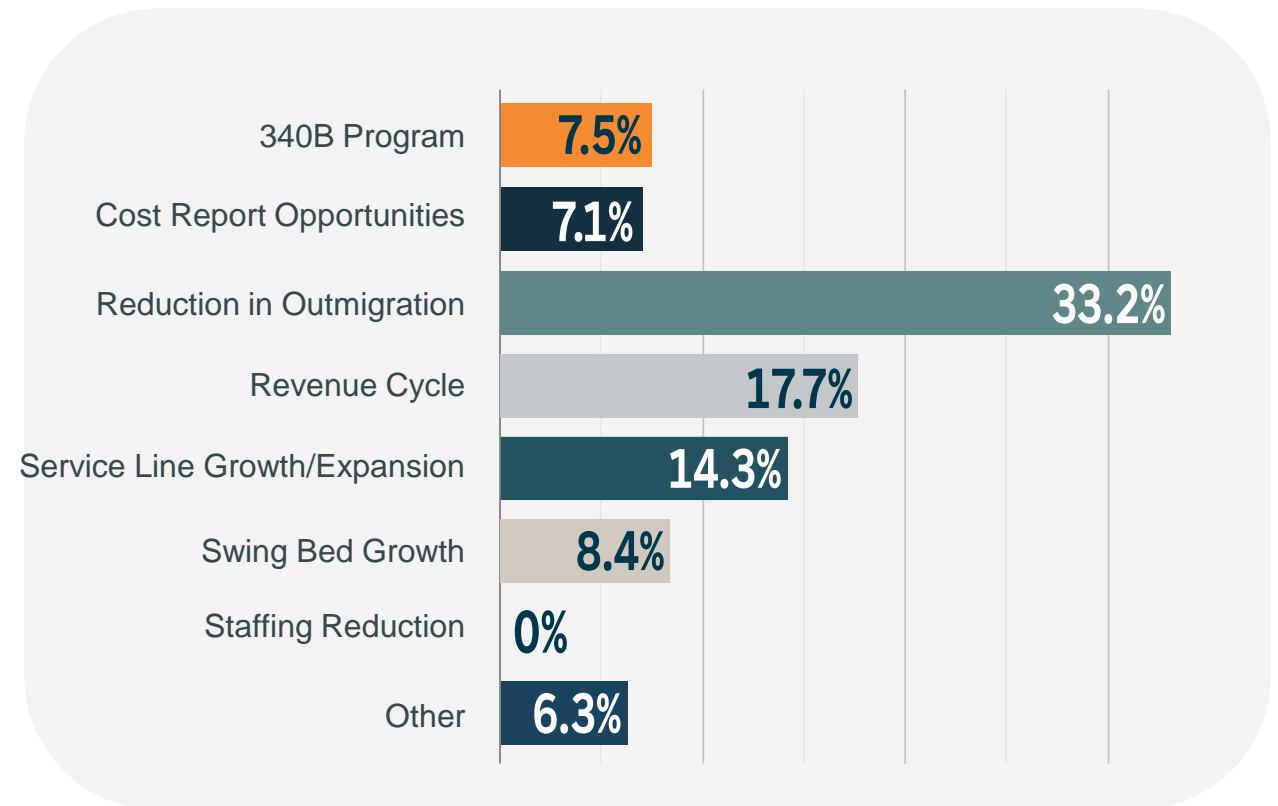
RISK MITIGATION VIA IMPROVED PERFORMANCE

- 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



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





STRATEGIC RISKS INHERENT WITH STRATEGIC OPTIONS

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**

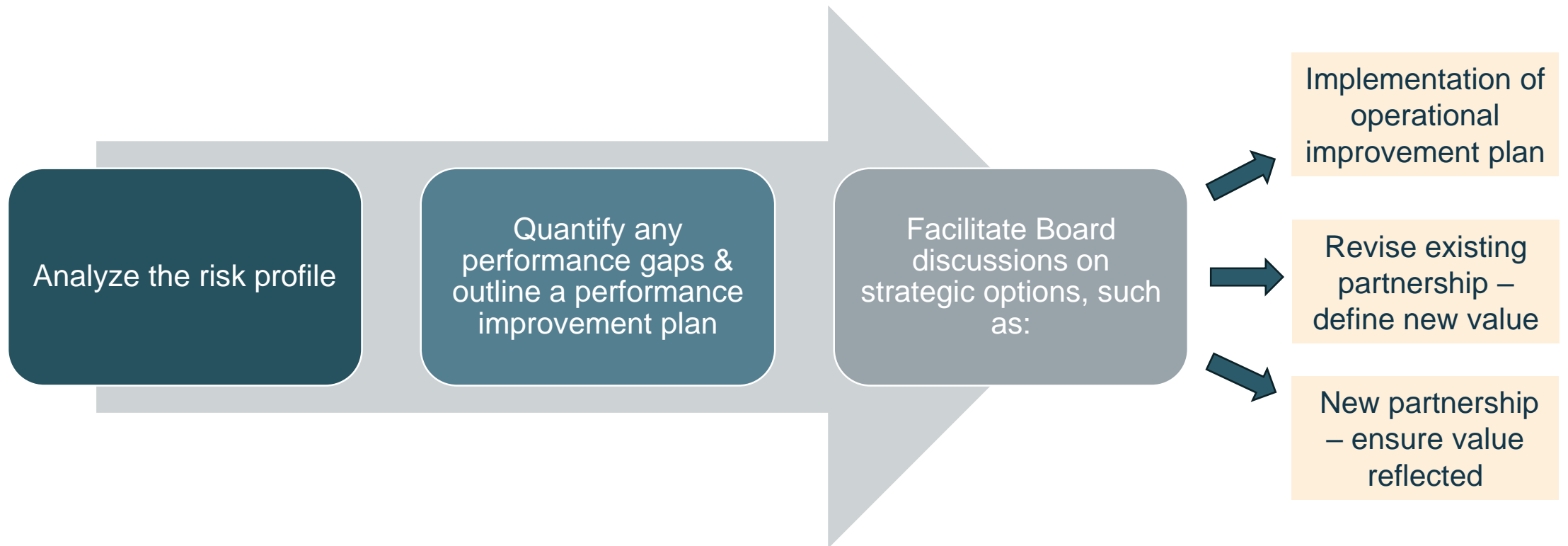
How do you minimize Partner Risk?

- 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**

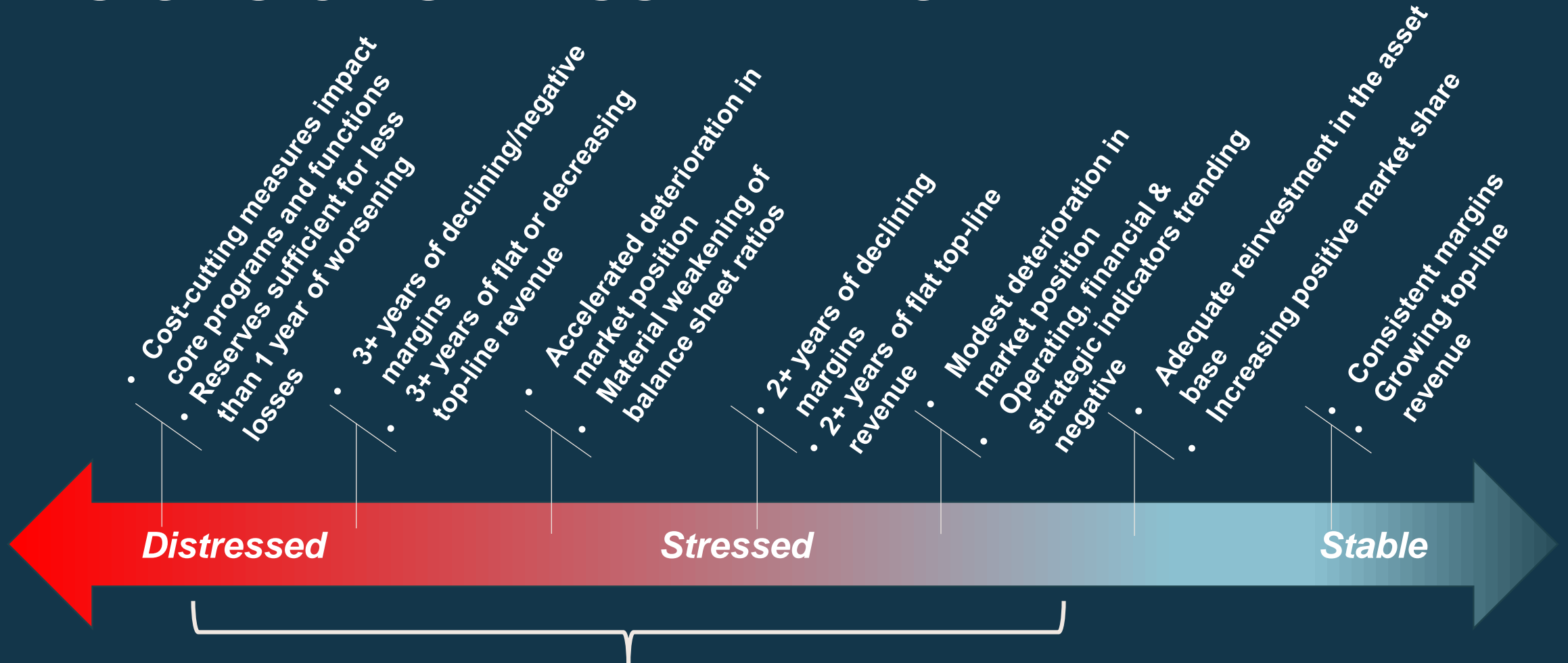


KEY POINT: OPERATING RESULTS AND STRATEGIC RISK

- 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.



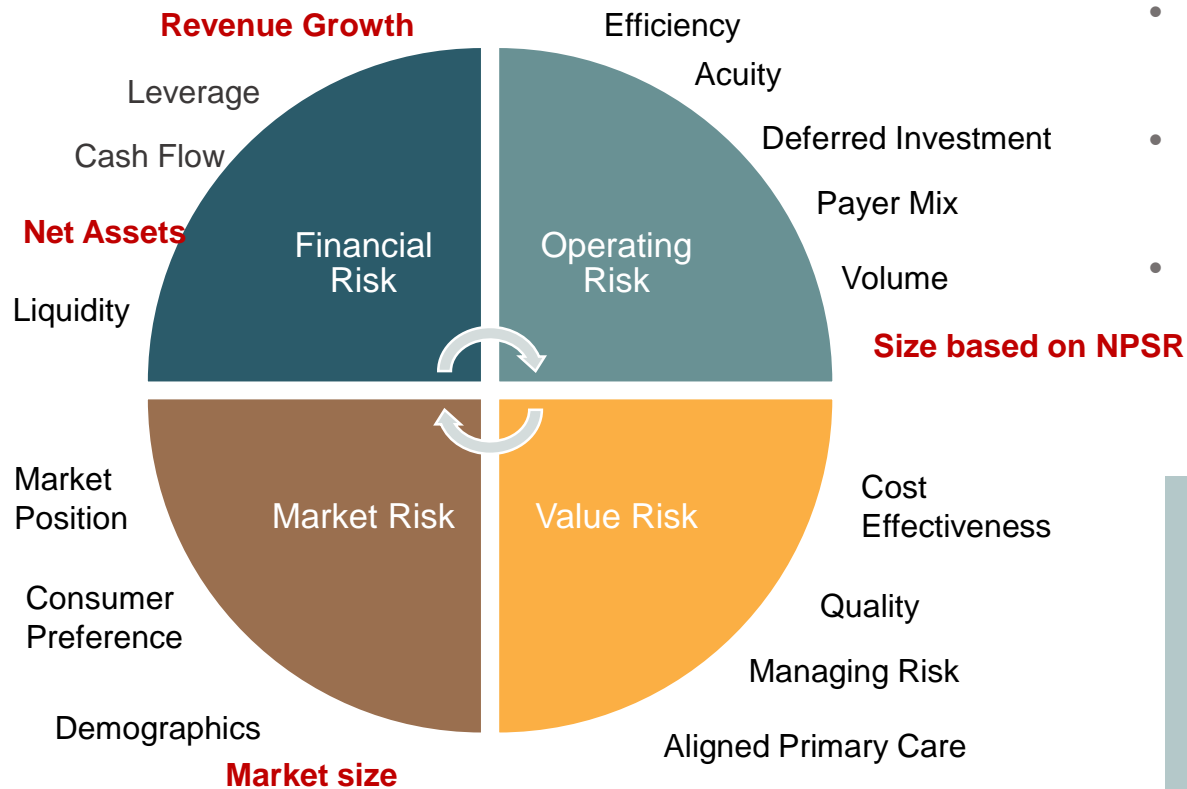
SIGNS OF STRESS: ABRIDGED



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.





HOSPITAL CLOSURE OVERVIEW

GOALS OF THE RURAL HOSPITAL CLOSURE STUDY

Define & describe	Define & describe the glide path to rural hospital closure during the five years prior to closure
Strive	Strive to make the exposures of closure more understandable and actionable for rural hospital leadership
Provide	Provide early warning framework for hospital leaders and boards of organizations
Develop	Develop a framework for hospital boards to drive adoption of proactive steps to reduce hospital's overall strategic risk
Educate	Educate rural health systems regarding their organization's specific risk profile



THANK YOU, NORTH CAROLINA RURAL HEALTH RESEARCH PROGRAM

Stroudwater would like to thank the **North Carolina Rural Health Research Program, especially George Pink, PhD, and Tyler Malone, PhD, for their** collaboration surrounding their research and concepts predicting financial distress and relative risk among rural hospitals.

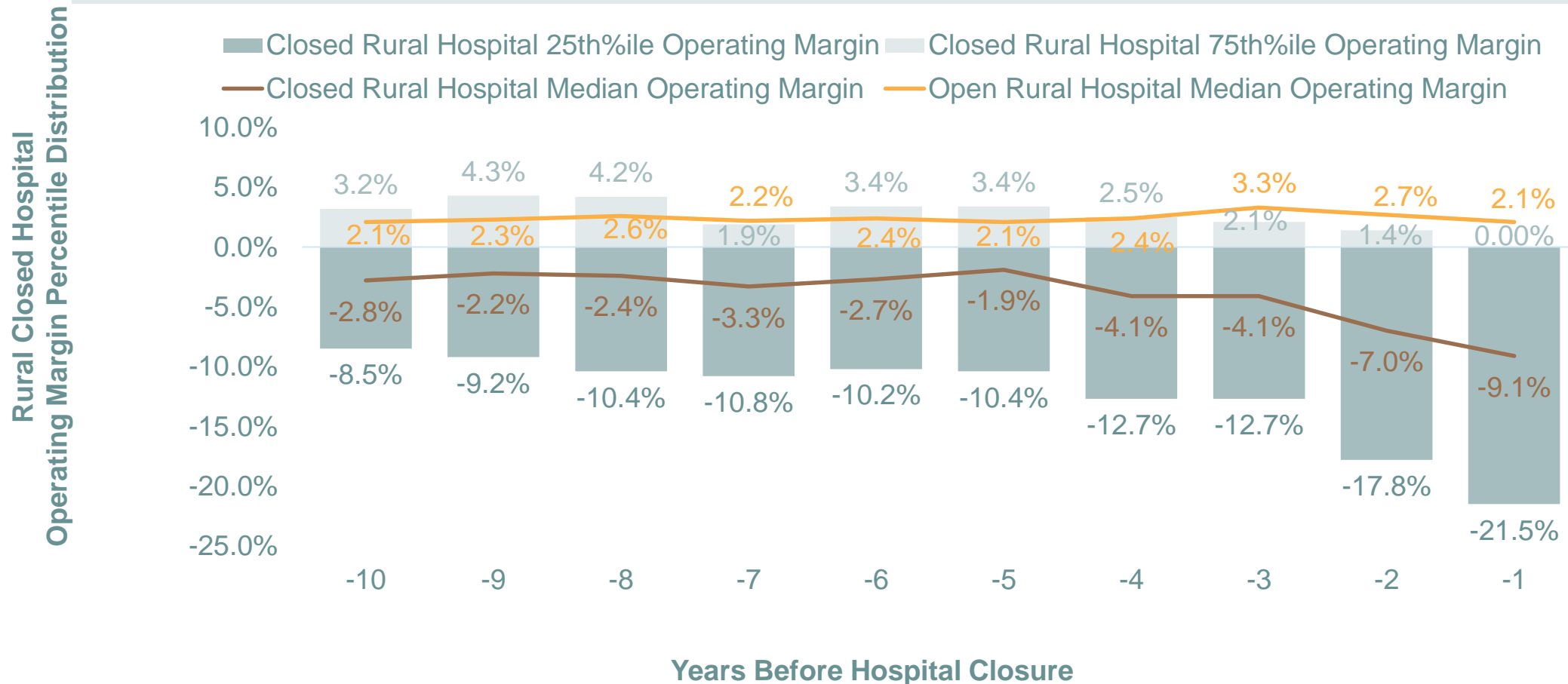
Details of the UNC rural hospital research can be found in the following publications at www.shepscenter.unc.edu/programs-projects/rural-health:

- *Thomas SR, Pink GH, Reiter KL. Trends in Risk of Financial Distress among Rural Hospitals from 2015 to 2019 (April 2019). FB 153*
- *Thomas SR, Pink GH, Reiter KL. Geographic Variation in the 2019 Risk of Financial Distress among Rural Hospitals (April 2019). FB 152*
- *Richman ED, Pink GH. Characteristics of Communities Served by Hospitals at High Risk of Financial Distress (December 2017). FB 141*
- *GM Holmes, BG Kaufman, GH Pink. Predicting Financial Distress in Rural Hospitals. Journal of Rural Health, Summer 2017;33(3):239-249*
- *Kaufman BG, Randolph R, Pink G, Holmes M. Trends in Risk of Financial Distress among Rural Hospitals (October 2016). FB 133*
- *Kaufman B, Pink G, Holmes M. Prediction of Financial Distress among Rural Hospitals (January 2016). FB 126*



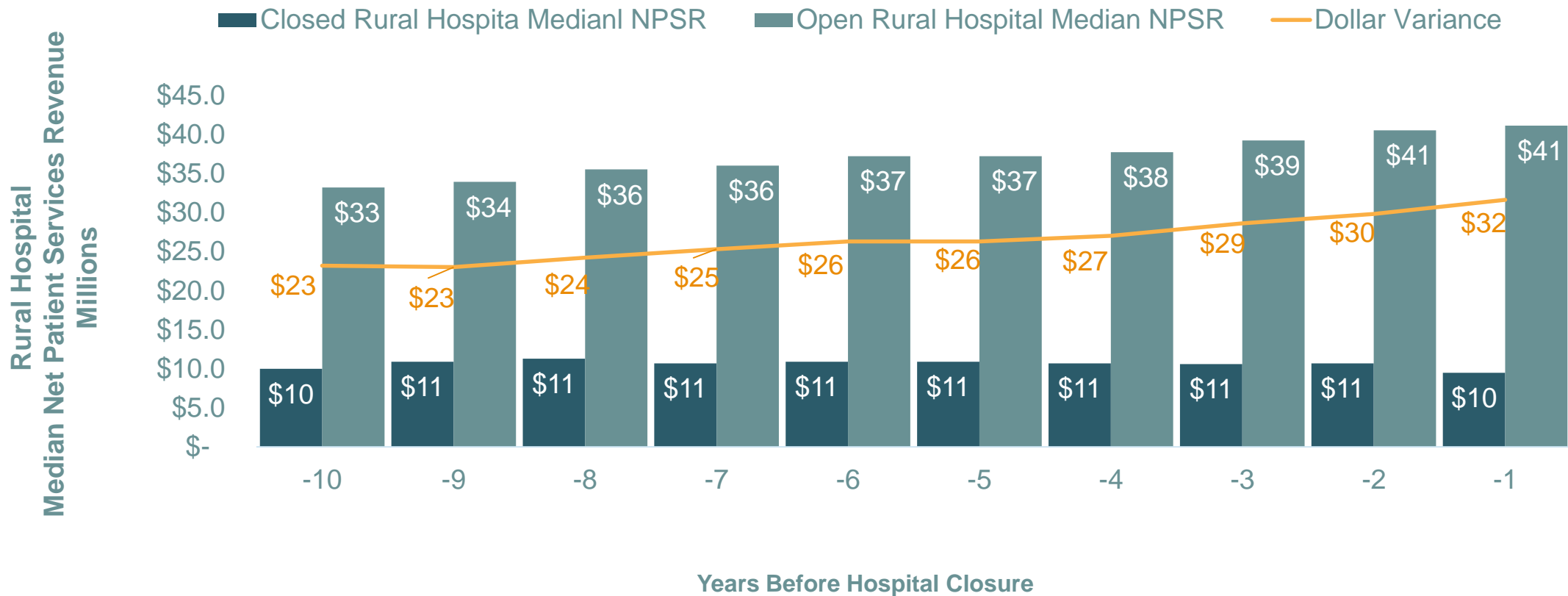
CLOSED RURAL HOSPITAL OPERATING MARGIN DISTRIBUTION

- Lower quartile closed hospitals had significant operating losses 10 years before closure
 - Rural closed hospital median operating margins for the 25th percentile of all closed hospitals demonstrate significant and declining operating losses 10 years before closure, ranging from -8.5% to -21.5%
 - Rural closed hospital median operating margins for higher performing hospitals (in the 75thile) remained at risk of closure, with median operating margins exceeding those of open hospital operating margins until 3 years before closure



RURAL HOSPITAL NET PATIENT SERVICE REVENUE CLOSED VS. OPEN

- Rural open hospitals demonstrate 2% median Net Patient Service Revenue (NPSR) compound annual growth trend
 - Rural open hospital median NPSR had a compound annual growth rate (CAGR) of 2%
 - Rural closed hospital median NPSR's CAGR declined by 1% annually

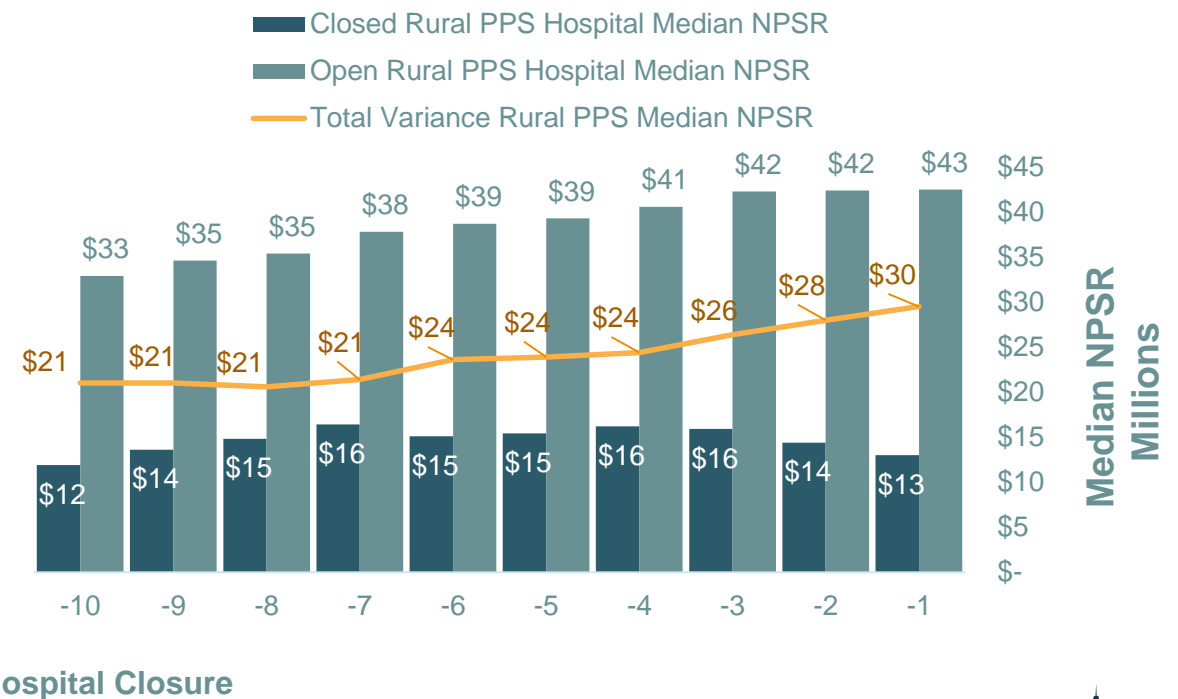
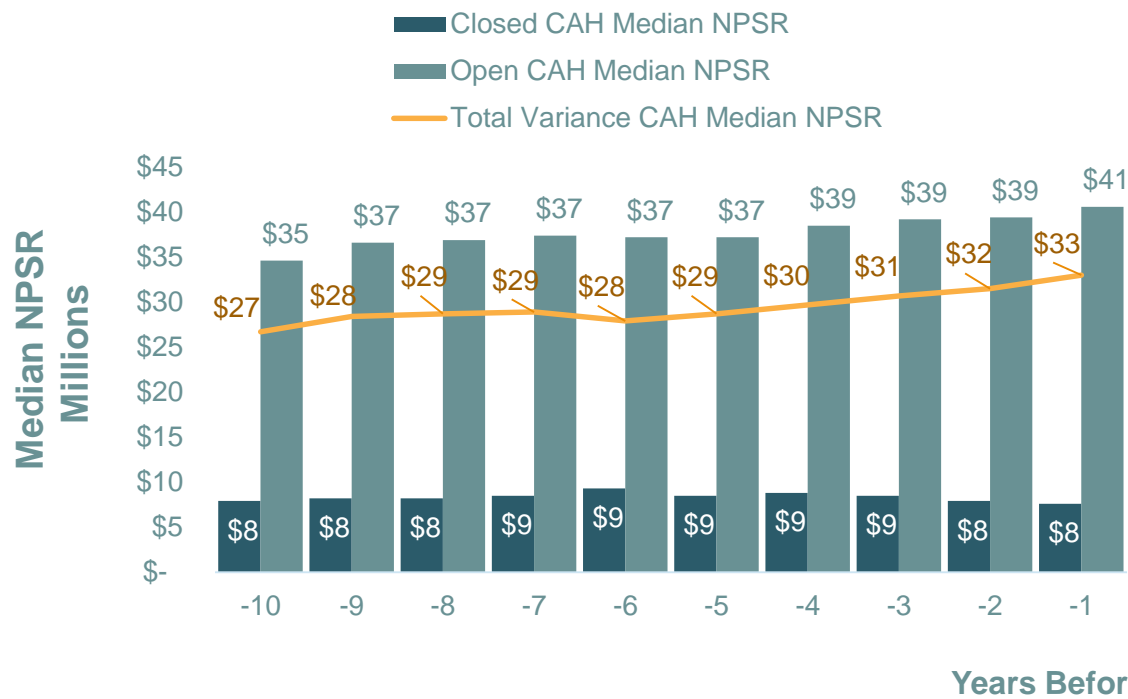


NPSR CAH AND RURAL PPS HOSPITALS CLOSED VS. OPEN

- Rural open hospital median Net Patient Service Revenue (NPSR) grew between 2% and 3% annually
- Rural closed hospital median NPSR declined by 1% for CAHs and increased by 1% for PPS hospitals annually
 - Rural open CAH hospital median NPSR had a compound annual growth rate (CAGR) of 2% annually
 - Rural open PPS hospital median NPSR had a CAGR of 3% annually
 - Rural closed CAH hospital median NPSR's CAGR declined by 1% annually
 - Rural closed PPS hospital median NPSR CAGR increased by 1% annually

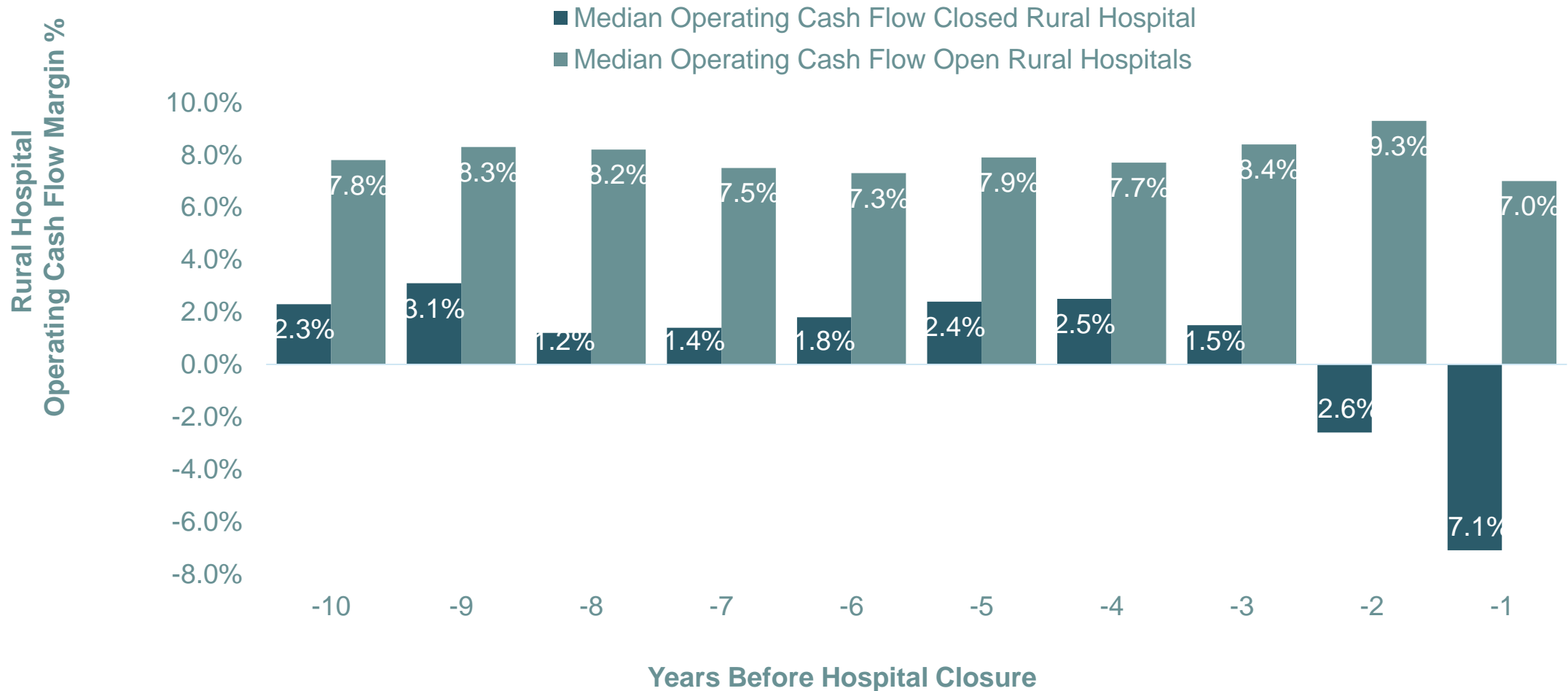
Critical Access Hospitals Median NPSR

Rural PPS Hospitals Median NPSR



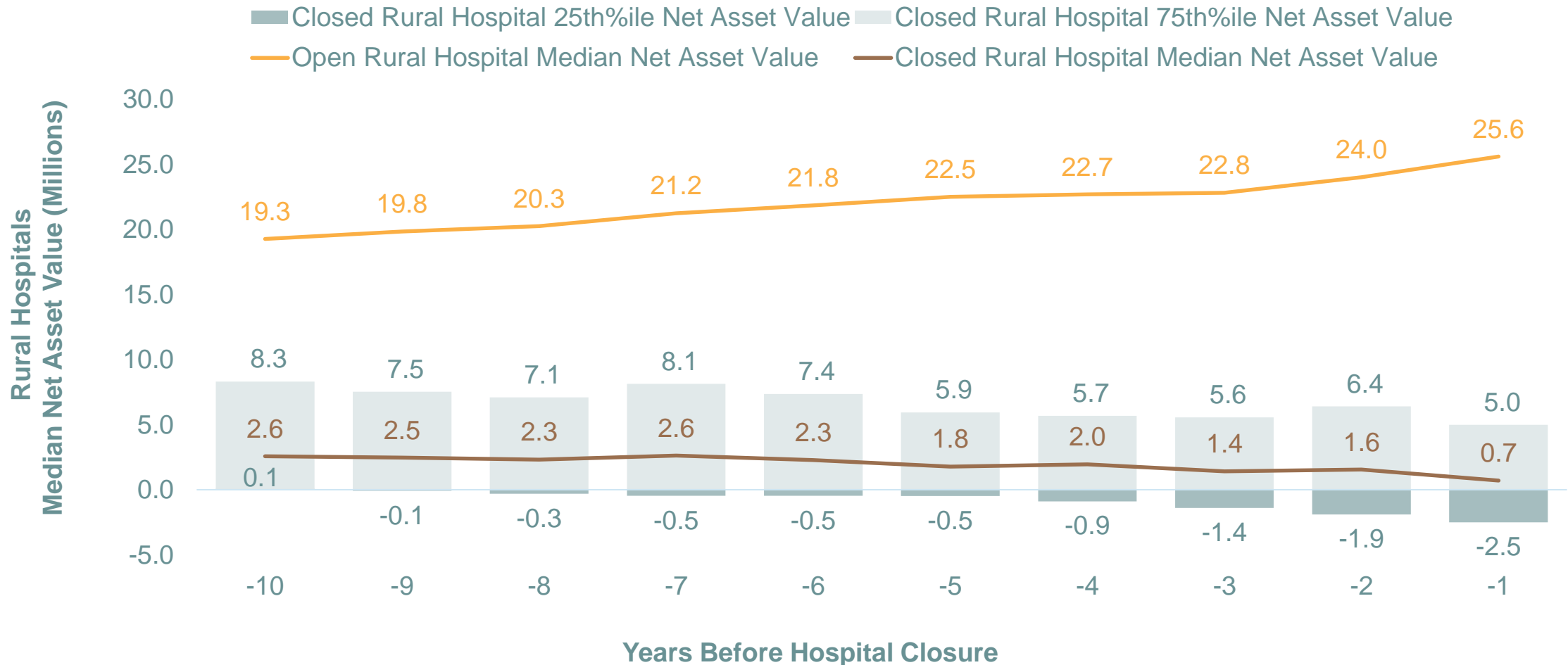
OPERATING CASH FLOW RURAL CLOSED VS. RURAL OPEN HOSPITALS

- Median operating cash flow for closed rural hospitals may become unsustainable
- The path of median operating cash flow for closed rural hospitals changes 3 to 4 years prior to hospital closure



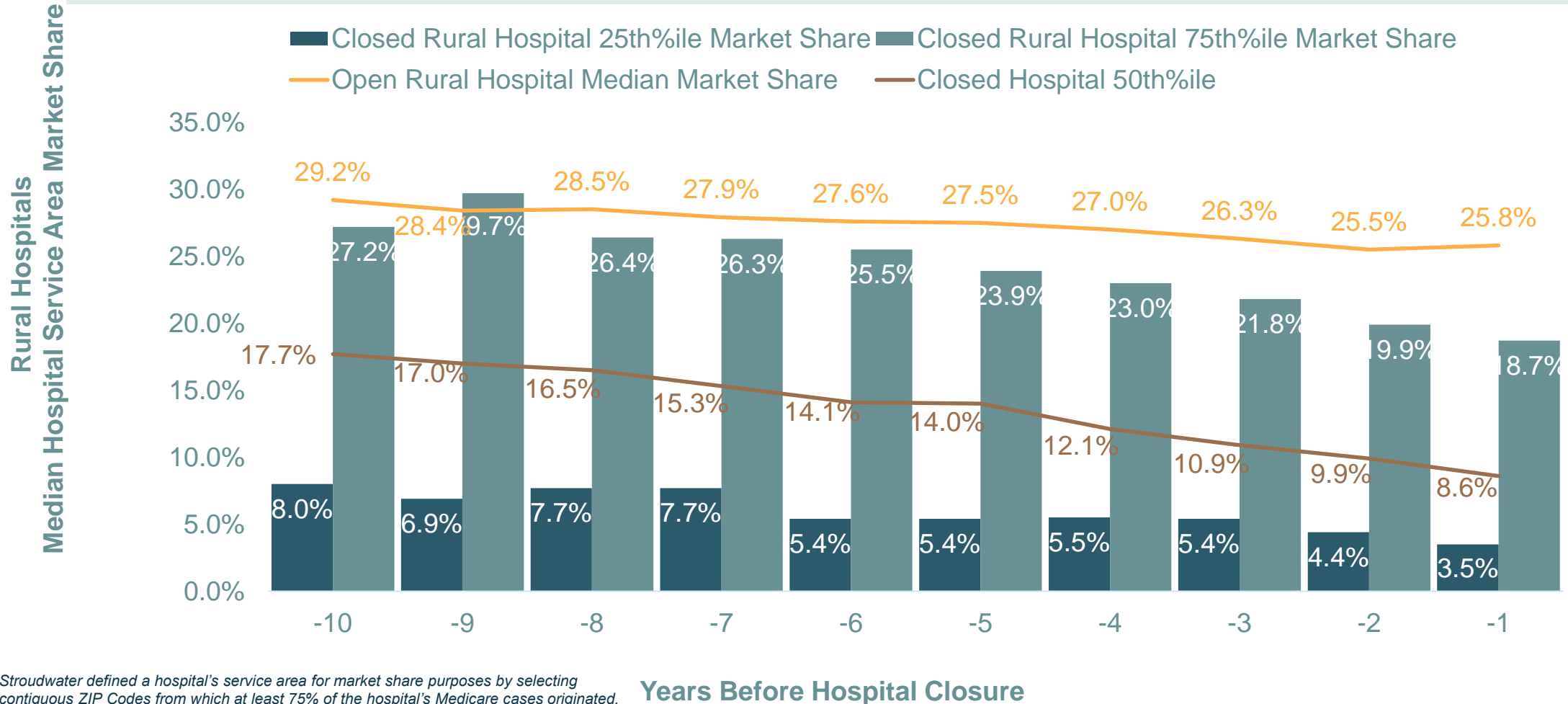
CLOSED RURAL HOSPITAL NET ASSET VALUE DISTRIBUTION

- Net asset value trends substantially lower for closed hospitals and declines consistently over time
- Closed rural hospitals median net asset value is significantly less and trends negatively compared to the median net asset value for open rural hospitals



CLOSED RURAL HOSPITALS MARKET SHARE DISTRIBUTION COMPARED TO OPEN RURAL HOSPITAL MEDIAN MARKET SHARE

- High-performing closed rural hospital median market share declines over time and typically remains below that of open rural hospitals
- The 25th percentile closed hospital market share is consistently lower than open rural and closed rural hospitals



Stroudwater defined a hospital's service area for market share purposes by selecting contiguous ZIP Codes from which at least 75% of the hospital's Medicare cases originated, three years prior to closure for closed hospitals and during calendar year 2024 for currently open hospitals.

Years Before Hospital Closure



KEY IDENTIFIED RISK FACTORS



TOP LINE
REVENUE &
GROWTH



OPERATING
PERFORMANCE
-
MARGIN & CASH
FLOW



LIQUIDITY



FUND BALANCE



MARKET
POSITION &
MARKET SHARE



MARKET
POPULATION,
MHHI, POVERTY
RATE



HOSPITAL
CHARACTERISTICS
-
CAH VS. PPS





STRATEGIC RISK ANALYSIS

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 MITIGATING
STRATEGIC
RISK**



**TIME IS
NEVER A
NEUTRAL
FACTOR**



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



**THERE ARE
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FREE
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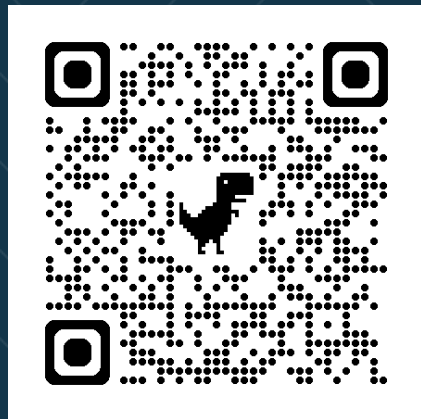
**EARLY
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THANK YOU



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