7th annual RURAL HOSPITAL REPLACEMENT FACILITY STUDY

2011

How Replacement Facilities Impact Operations

prepared and sponsored by STROUDWATER ASSOCIATES

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RURAL COMMUNITIES THAT HAVE BUILT A CRITICAL ACCESS HOSPITAL HAVE PIONEERED A NEW ERA. FIND OUT HOW A REPLACEMENT FACILITY IMPACTED THEIR OPERATIONS AND BOTTOM LINES.

THE 2011 RURAL HOSPITAL REPLACEMENT FACILITY STUDY IS PREPARED AND SPONSORED BY

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COVER PHOTOS: LEFT, TRI-VALLEY HEALTH CAMBRIDGE HOSPITAL, CAMBRIDGE, NE; RIGHT, MELISSA MEMORIAL HOSPITAL, HOLYOKE, CO.

The 2005, 2006, 2007, 2008, 2009 and 2010 studies are available at www.stroudwater.com

Design by annie|catherine, Portland, Maine.

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DELTA MEMORIAL HOSPITAL, DUMAS, AR

EXECUTIVE SUMMARY

In each of the past six years, the rural hospital replacement study has consistently shown that Critical Access Hospitals (CAHs) enjoy enhanced financial performance after replacement, in addition to other benefits such as higher employee retention and ease of recruitment. But the combination of a severe economic downturn and landmark healthcare reform legislation presents hospitals with a unique and perhaps unprecedented set of challenges. In 2010, the study began to examine the impact of the recent economic downturn on the performance of replacement facilities. This study looks further at the impact of the slumping economy and makes a first attempt to measure the performance of replacement CAHs against a standard which is becoming an increasingly important factor in healthcare reimbursement: quality.

The National Bureau of Economic Research declared the "Great Recession," which began in December of 2007, officially ended in June of 2009, making it the longest recession of the post World War II era. Even now, more than two years later, the effects of the recession linger and the outlook calls for a long, slow recovery to pre recession economic vitality. From 2004 through 2010, the Centers for Medicare & Medicaid Services (CMS) reported average annual growth in hospital discharges of only 1.6 percent and growth in patient days of only 0.3 percent annually. Many hospitals reported declining patient volumes in multiple lines of service.

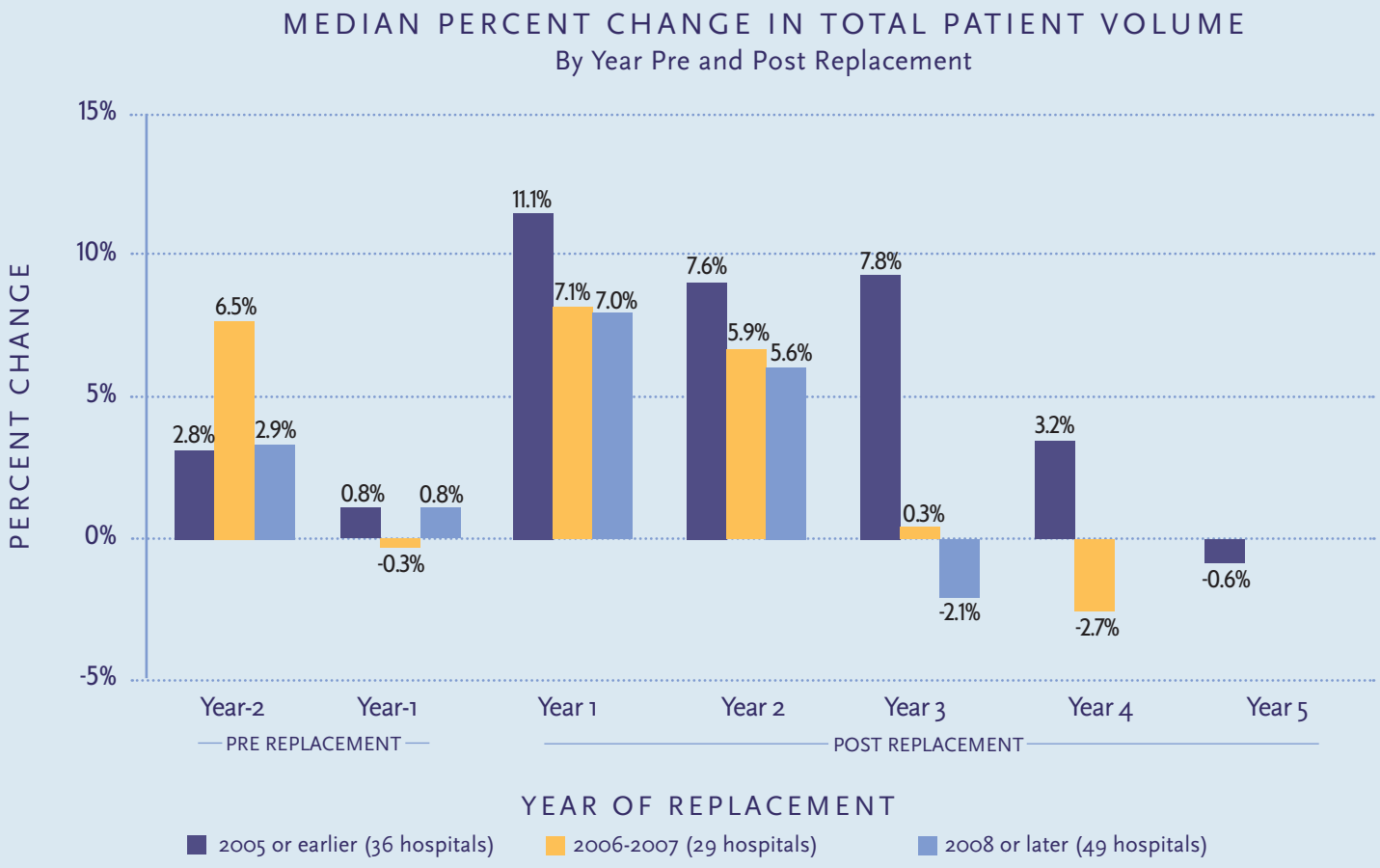
The experiences of those facilities replaced during and immediately following the recession are most instructive to those considering replacement in the near future. In 2010, additional focus was added to examine the performance of hospitals replaced during 2006 and 2007, immediately before the recession, compared to those facilities replaced in earlier years. But performance data from those newest replacements was limited. In the 2011 study, the impact of the recession is further examined by adding more hospitals to the study, gathering an additional year of performance data for those hospitals replaced in 2006 and 2007, and taking a first look at the performance of those hospitals that opened during and even after the official end of the recession. With data from 114 rural hospital replacement facilities, Stroudwater focused additional analysis on those facilities which experienced their first years of operation during this difficult economic period. The results show that these facilities fared well. Rural facilities replaced during the period between 2006 and 2010 experienced solid growth in patient volumes as measured by patient days, outpatient visits, and adjusted patient days.

NEW FOR THE 2011 STUDY

- 23 new CAHs participating; a 25 percent increase over the number of 2010 participants
- New segmentation of hospitals based on year of replacement
  - 2005 and earlier (pre recession)
  - 2006-2007 (recession)
  - 2008 or later (post recession)
- Reporting on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores

Looking more closely at the data, hospitals' experiences differed based on when the facilities were replaced. Hospitals were separated into three time-based cohorts: facilities replaced in 2005 or earlier (pre recession), facilities replaced in 2006 and 2007 (recession), and facilities replaced in 2008 and 2009 (post recession). As shown in the chart on the next page, hospitals in all three groups experienced strong volume growth in the first and second years of operation following replacement. The pre recession replacement hospitals were able to sustain substantial volume growth even beyond the first

two years of operation. Those replaced during the recession had no volume growth in the third year and lost volume in the fourth year following replacement. The post recession replacements lost volume in the third year of operations. Because many of the measures in this study are based on patient volume or are driven by patient volume, this pattern of results was repeated in performance with regards to staffing, operating costs, and profitability.



"The results of the study suggest that a replacement facility can be a platform for a financially viable hospital delivering a high quality patient experience."

While higher quality of care and a better patient experience are expectations of a new hospital facility, they are not assured. In 2011, CMS released data to be used for the Medicare Value Based Payment Program (VBPP) which included quality-related measures reported by all hospitals, including CAHs. Replacement CAHs scored higher than CAHs in general on every measure of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Additionally, replacement CAHs reported HCAHPS scores that would qualify for incremental payments under VBPP. While this program is currently not applicable to CAHs, research is underway to develop a similar program which would adjust CAH reimbursement based on quality measures.

While the challenges of a slow economy and healthcare reform will remain as important considerations for several years to come, the results of the study suggest that a replacement facility can be a platform for a financially viable hospital delivering a high quality patient experience.

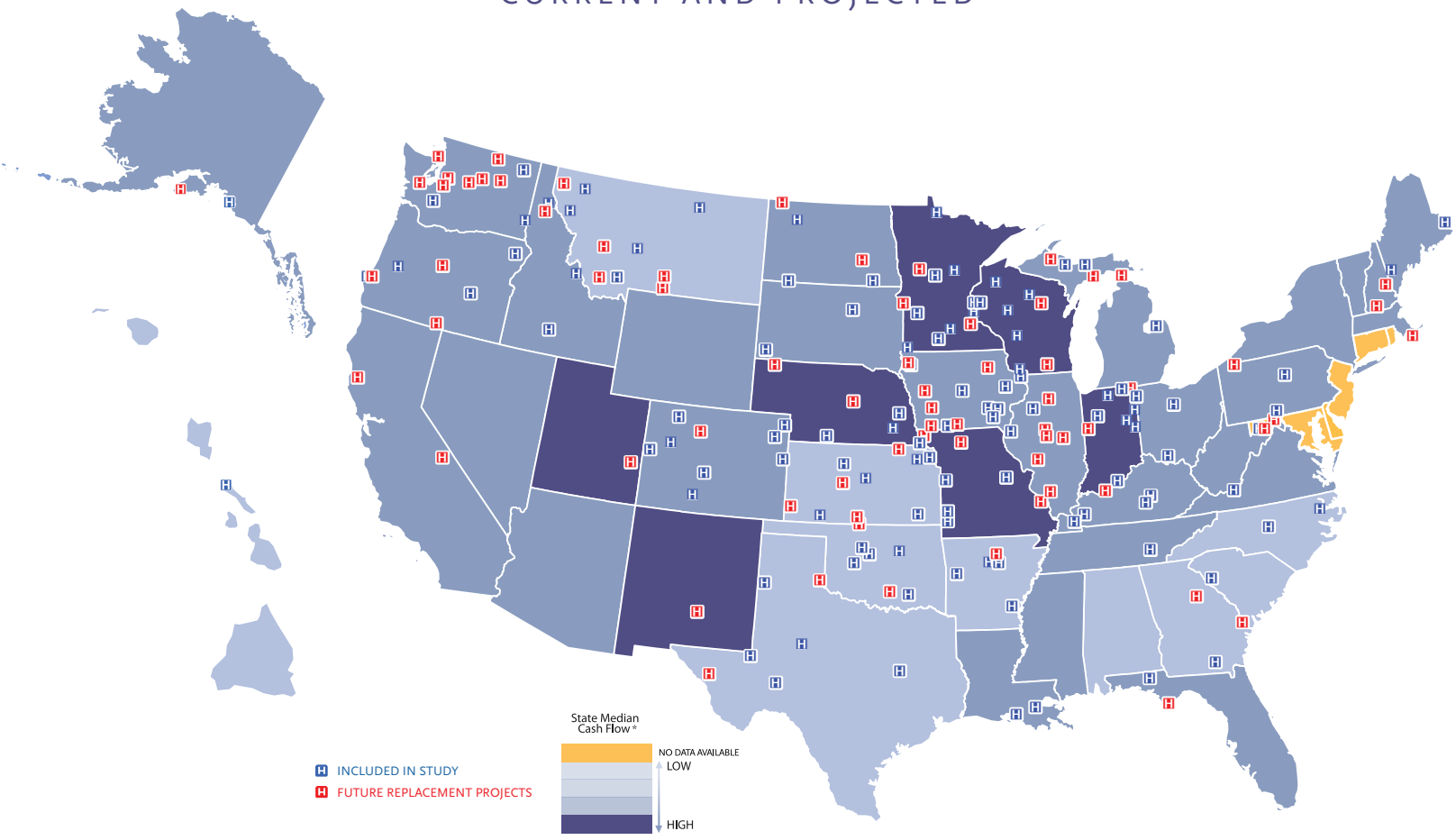
MCCUNE-BROOKS REGIONAL HOSPITAL, CARTHAGE, MO

Purpose

When the study began in 2005, few resources existed for rural hospital leadership, boards, and community leaders to assist them in understanding what a new replacement facility hospital would do to or for their bottom line. The study's purpose is to gather and present quantitative and qualitative data from communities that have replaced their Critical Access Hospital (CAH) to educate those considering, embarking on, or in the midst of a replacement facility project.

The study typically generates discussion around a replacement in three pivotal areas: Driving Factors (why would we replace?); Access to Capital (what can we afford?); and the Role of Leadership (how do we do this?).

ELIGIBLE CAH REPLACEMENT FACILITIES: CURRENT AND PROJECTED



*Median cash flow margins for all CAHs within each state, as reported by the Flex Monitoring Team, August 2011

Eligibility

With the assistance of State Office of Rural Health and State Hospital Association representatives, a list of candidates is established. Stroudwater then validates the candidate list and ensures the eligibility criteria are met:

- Hospitals had Critical Access Hospital designation prior to replacement
- Opened clinical areas between January 1, 1998 and January 1, 2010
- Operations in the community for at least three years prior to replacement

Validated hospitals are included in the study. From 2005 to 2011 the number of hospitals included in the study has increased from 20 to 114. As shown on the map above, there are many other replacement projects underway or in the planning process.

Process

The methodology established in 2005 and followed in each subsequent year of the study was developed and vetted by an advisory panel which included governmental, academic, and financial experts as well as a national non-profit entity whose mission is to build capacity in rural hospitals. Quantitative and qualitative data contribute to the methodology.

The 2011 study uses publicly available cost report data, input from hospital CEOs and CFOs, the American Hospital Association Guide and the American Hospital Directory. The quantitative data analyzed for the purposes of the study include: volumes (patient days, outpatient visits, adjusted patient days), operating efficiency (gross Full Time Equivalents or FTEs, FTEs per adjusted patient day, operating expense per adjusted patient day) and financial results (operating margin, EBIDA, days cash and investments on hand).

Interviews with a sample of hospital CEOs and CFOs were conducted in prior years' studies to complement and further examine the quantitative data. The interviews focused on any impact, whether positive or negative, the replacement facility had on quality, staff recruitment and retention, and the economy of the local community. While no interviews were conducted with the facilities added to this year's study, the body of data gathered from historical interviews still forms an important component of the total findings in the study.

"In the first year following replacement, all groups experienced growth in total patient volume,..."

Design

A CAH's market potential, level of competition, physician support, management experience, historical financial performance, access to capital, and more are unique to the community served. To begin to control for these differences, the study compares data from before the replacement project to data after, with Year 1 for each hospital being the first year in which the hospital operated in its new facility for at least 6 months.

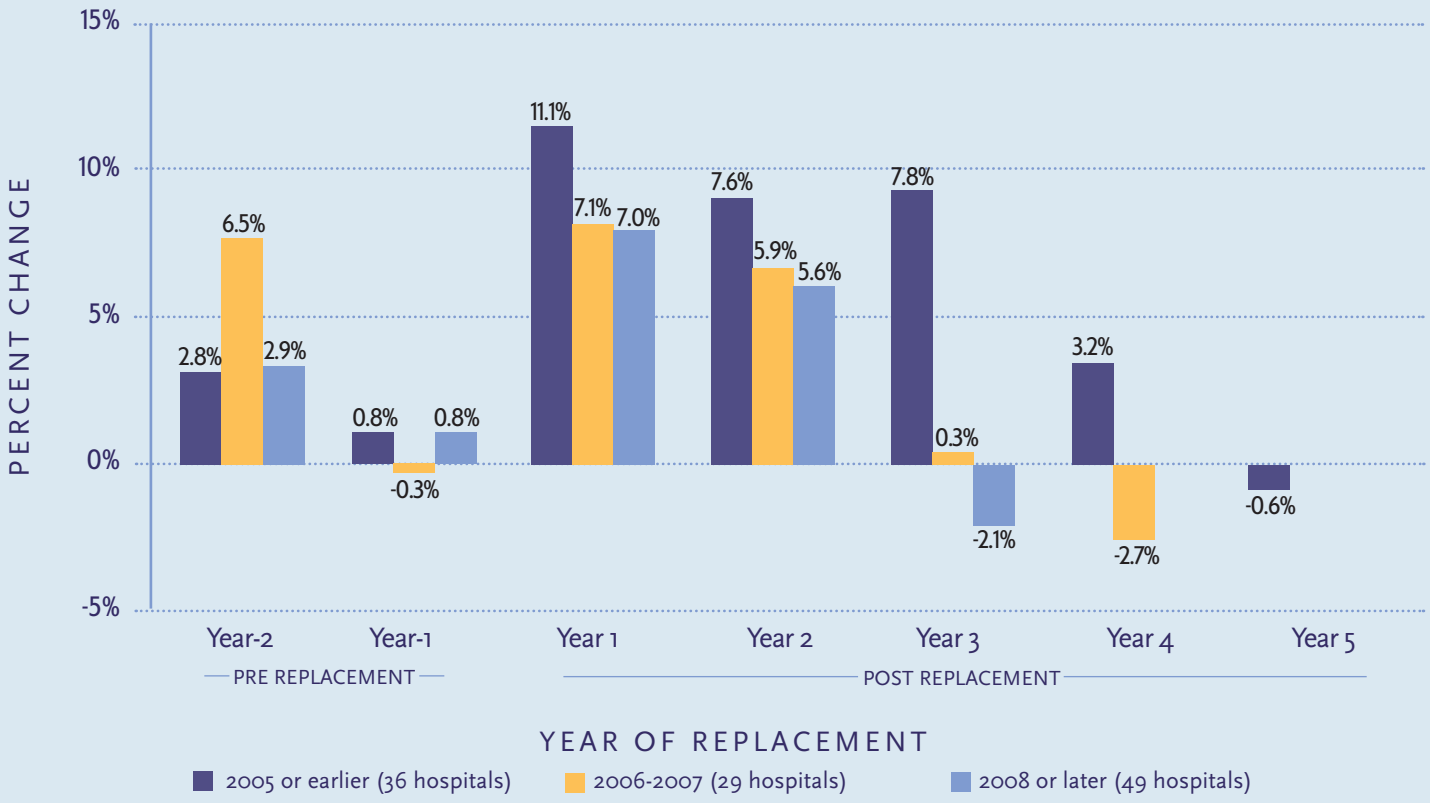
Volume Experiences

To label the new facilities included in this study as "replacements" may be a bit of a misnomer. Although each is different in overall scope, complexity, and volume levels, CAHs provide more outpatient than inpatient services. And these new facilities are designed to reflect the increased emphasis on ambulatory service. As such, to evaluate total volumes across such a varied spectrum, the study uses the industry standard approach of creating an overall measure of volume that takes both inpatient and outpatient volume into account. "Adjusted patient days" reflects in a common measure the total activity for different hospitals with different mixes of services provided.

Median volumes for all three cohorts of replacement CAHs were flat in the year prior to replacement. In the first year following replacement, all groups experienced growth in total patient volume, with those replaced in 2005 or earlier experiencing the largest post replacement increase of 11 percent, compared to 7 percent and 6 percent growth for the 2006-2007 cohort and the 2008 or later cohort, respectively. Additionally, the volume growth for the 2005 or earlier cohort continued longer and at greater levels than for the other two cohorts of replacement CAHs. Of the 114 participating hospitals, 27 (24 percent) reported accumulated volume losses post replacement, and 18 of those 27 were facilities replaced in 2008 or later.

MEDIAN PERCENT CHANGE IN TOTAL PATIENT VOLUME

By Year Pre and Post Replacement

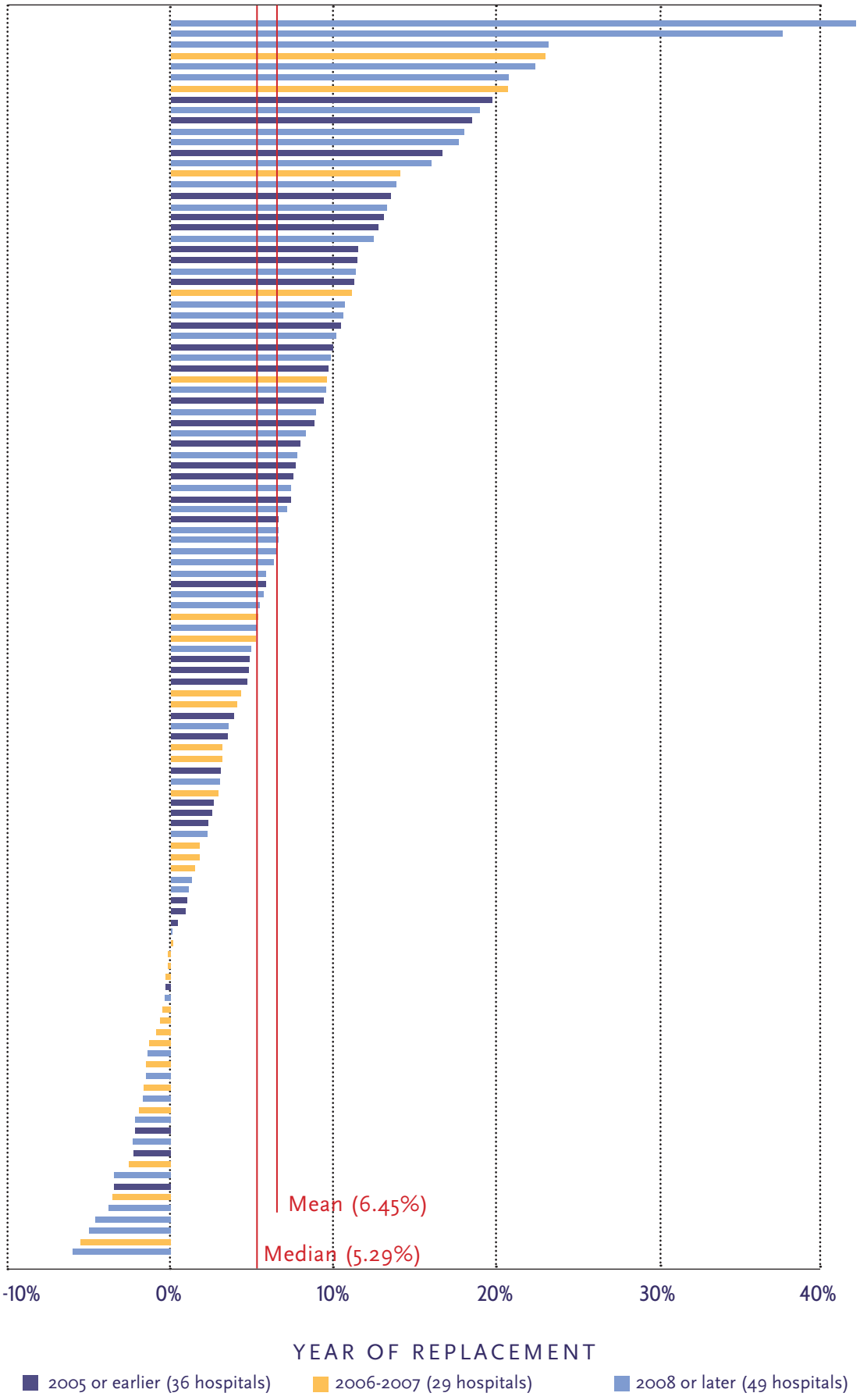


RIO GRANDE HOSPITAL, DEL NORTE, CO

PHILLIPS COUNTY MEDICAL CENTER, MALTA, MT

PERCENT CHANGE IN TOTAL VOLUME

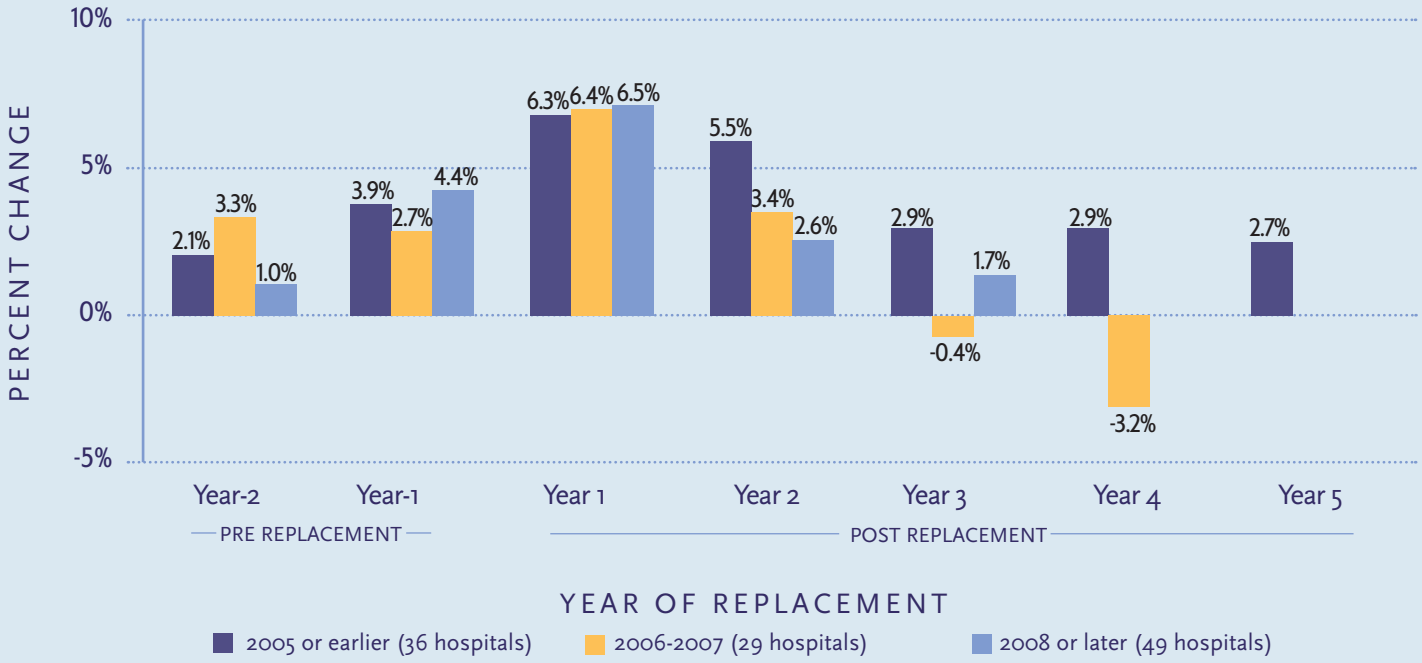
Average annual change for all years post replacement



While median values provide us with guidance regarding the general experience of the group, the results for individual facilities vary greatly from those medians.

The graph to the left exhibits, for each facility, the average annual change in total volume for all years post replacement, ranging from a single year for the newest replacements up to five years for older replacements. The median annual growth rate for all hospitals for all years is 5.29 percent, but the volume changes range from a decrease of 6 percent to an increase of nearly 43 percent. Twenty-six of the 114 participating hospitals experienced declines in total volume. Half of those facilities which lost volume were replaced in 2005 or earlier, but the larger volume declines generally occurred in the most recent replacements. Similar variability was experienced in the other measures presented in this study.

MEDIAN PERCENT CHANGE IN STAFFING
By Year Pre and Post Replacement



Staffing

Rural hospitals are often challenged with staff shortages, particularly with physician and other clinical professionals. The ability to both recruit and retain highly qualified professionals is integral to the health of an organization.

An enhanced ability to recruit higher quality personnel following replacement was cited by several of the CEOs interviewed. In particular, CEOs indicated that the promise of a new facility played a key role in the recruitment of physicians, who ultimately contribute to the volume growth discussed above. A number of facilities reported discontinued use of agency staffing and reduced turnover rates. Many organizations reported having no nursing vacancies and several indicated they have waiting lists.

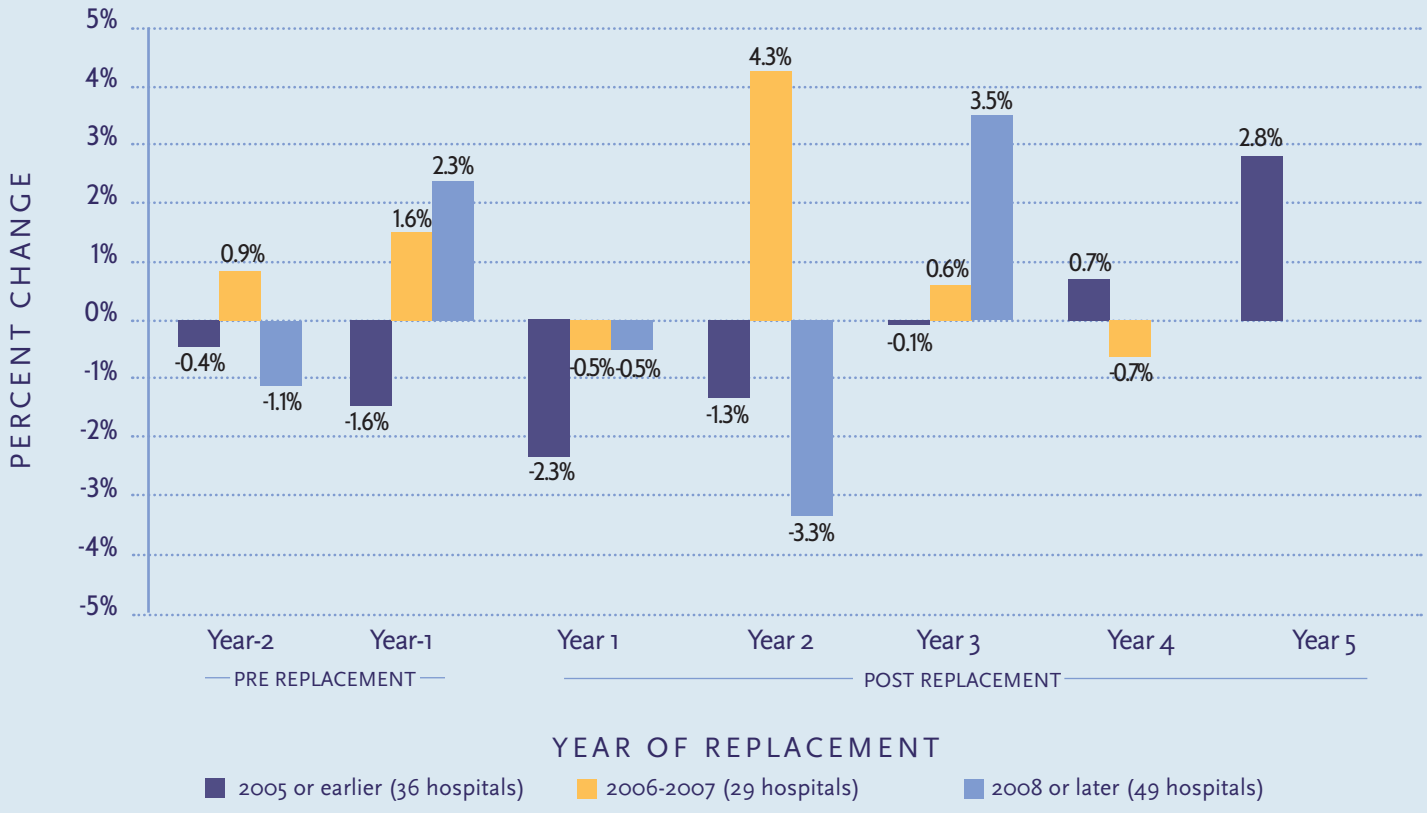
All facilities increased staffing at higher rates in their first post replacement year to support new volume being served by the facility. Hospitals replaced in 2005 or earlier continued to increase staff at a faster pace for the second year after replacement and by the third year had returned to growth rates similar to their pre replacement period. Hospitals replaced during 2006 and 2007, and 2008 or later slowed staffing increases back to pre replacement pace in Year 2, and by Year 3 were hiring at a slower pace than before replacement. This may be a result of the difficult economy as well as the less robust volume growth experienced by these facilities.

Even with higher staffing overall, the number of staff per unit of service (defined as Adjusted Patient Days) decreased on average for all replacement groups in the first year post replacement. This measure reflects improved efficiencies in the operations. However, facilities replaced in 2006-2007, and 2008 or later, saw declines in efficiency in the second and third years post replacement, as increased staffing was not matched by continued increases in volume. Approximately half of all participating hospitals experienced improved post replacement efficiency, with those hospitals replaced in 2005 or earlier being more likely to have improved efficiency.

"Approximately half of all participating hospitals experienced improved post replacement efficiency."

MEDIAN PERCENT CHANGE IN STAFFING EFFICIENCY

By Year Pre and Post Replacement



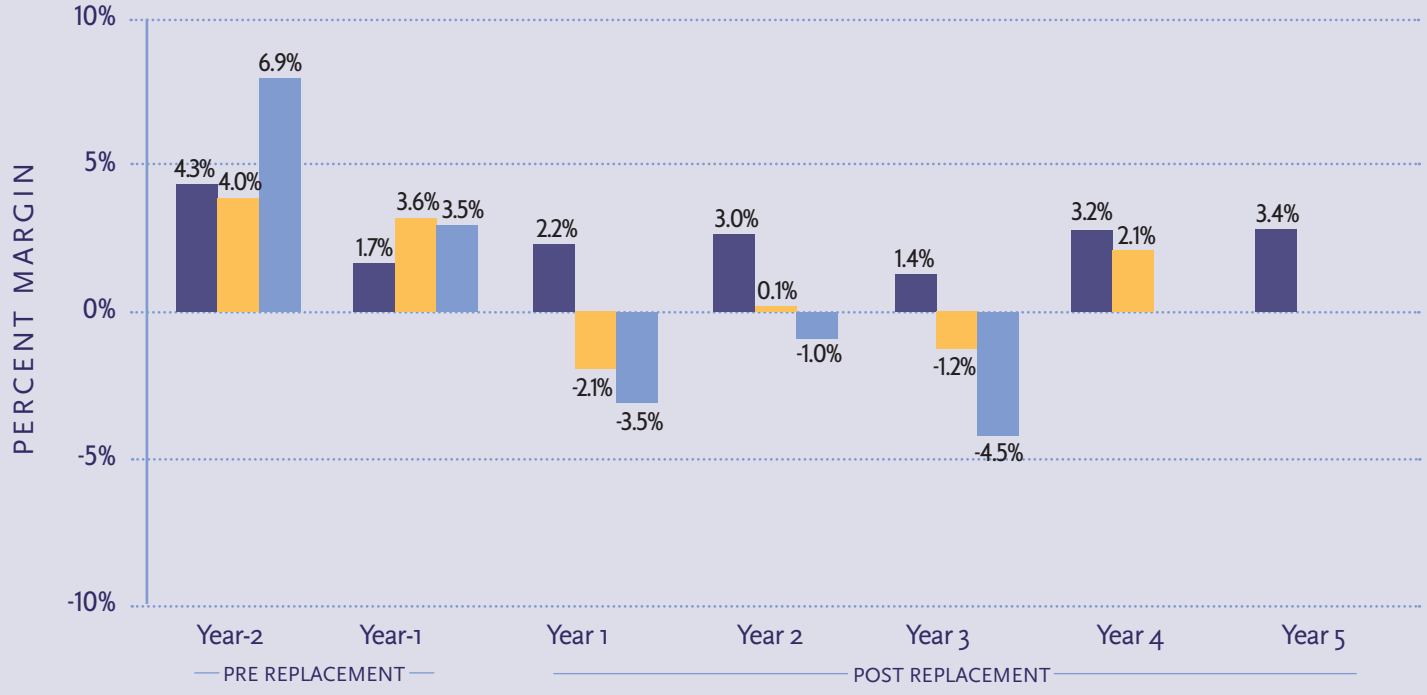
COMMUNITY MEMORIAL HOSPITAL, HICKSVILLE, OH

FINANCIAL PERFORMANCE

Total Margin

Facilities replaced in 2005 or earlier maintained total margins post replacement, as increased volume offset increases in facility costs, specifically interest and depreciation, and the cost of additional staffing. Those hospitals replaced in 2006-2007, and 2008 or later, saw margins decline as the volume increases post replacement were not enough to offset the higher costs. Facilities need to closely manage budgets in the first years following a facility investment in order to realize the benefits from any increases in patient volume.

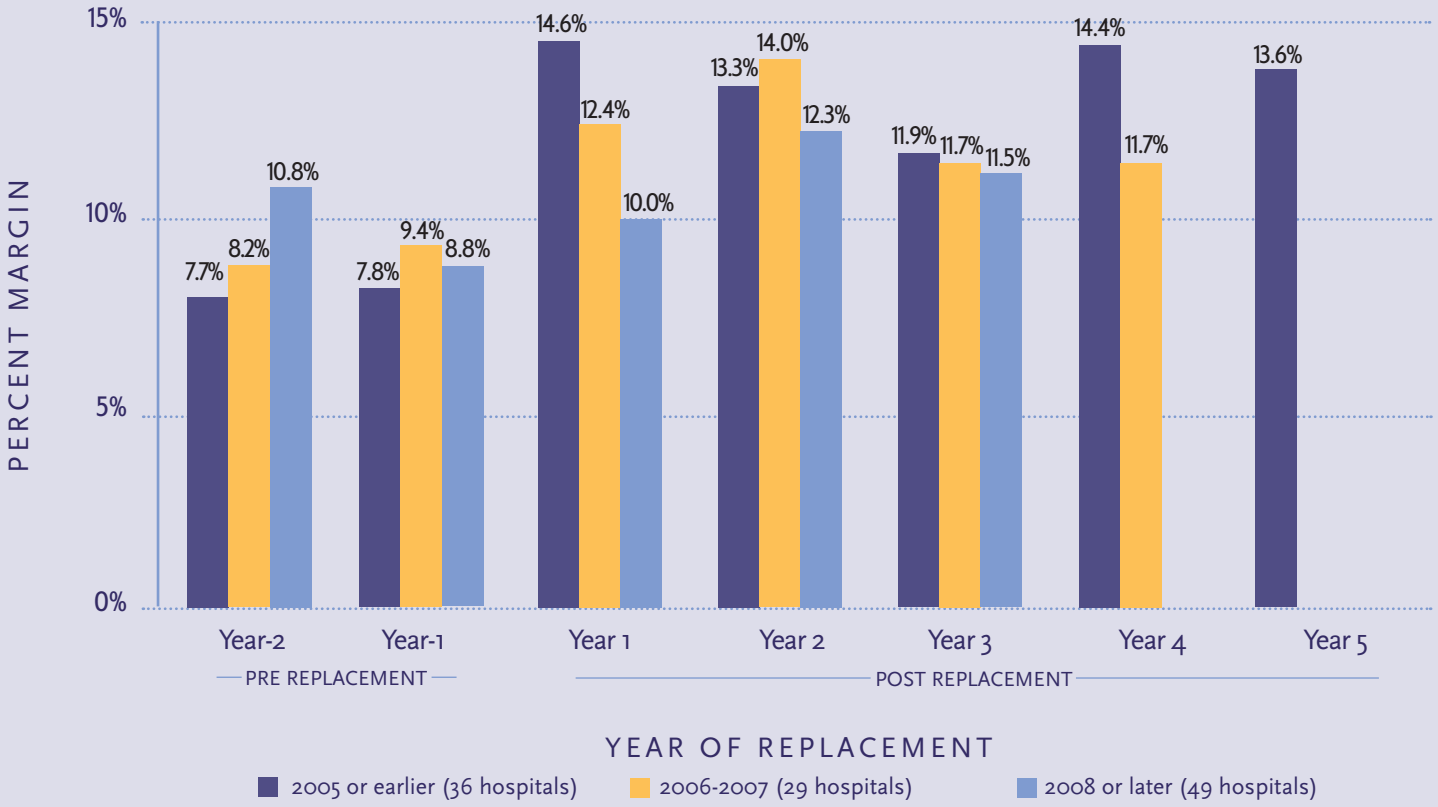
MEDIAN TOTAL MARGIN
By Year Pre and Post Replacement



YEAR OF REPLACEMENT

2005 or earlier (36 hospitals) | 2006-2007 (29 hospitals) | 2008 or later (49 hospitals)

MEDIAN EBIDA MARGIN
By Year Pre and Post Replacement



EBIDA Margin

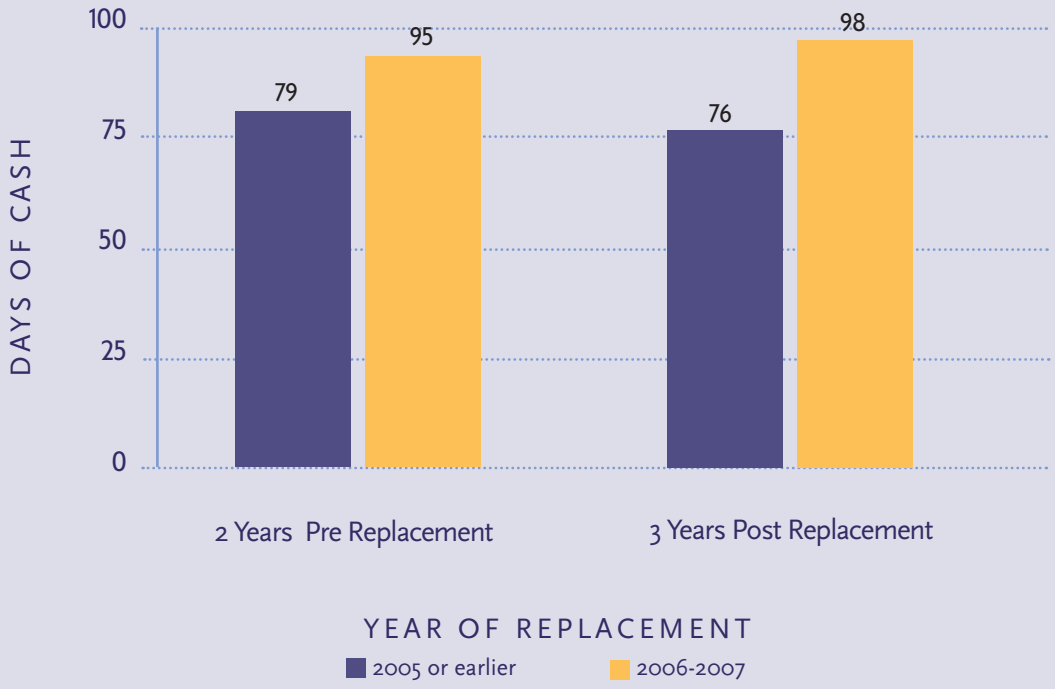
Earnings Before Interest Depreciation and Amortization (EBIDA) is a measure that approximates cash flow. It displays less variation than total margin, and replacement CAHs in all three categories showed improvement in EBIDA post replacement. This suggests that the lower margins experienced by more recent replacements are driven by higher capital costs, specifically depreciation and interest, rather than operating costs, such as salaries. Boards generally target an EBIDA margin that reflects enough cash flow to sustain operations through the startup of the new facility.


KEWANEE HOSPITAL, KEWANEE, IL

"All three cohorts of hospitals maintained cash levels on hand after replacement."

AVERAGE DAYS CASH AND INVESTMENTS ON HAND

65 Hospitals with at Least Three Years Post Replacement Data



Average Days Cash on Hand

Post replacement days cash on hand varies with overall financial performance, the facility's initial reserves, and the amount of borrowing required to fund the replacement facility. Lenders evaluate cash on hand both prior to and following replacement to ensure working capital is sufficient.

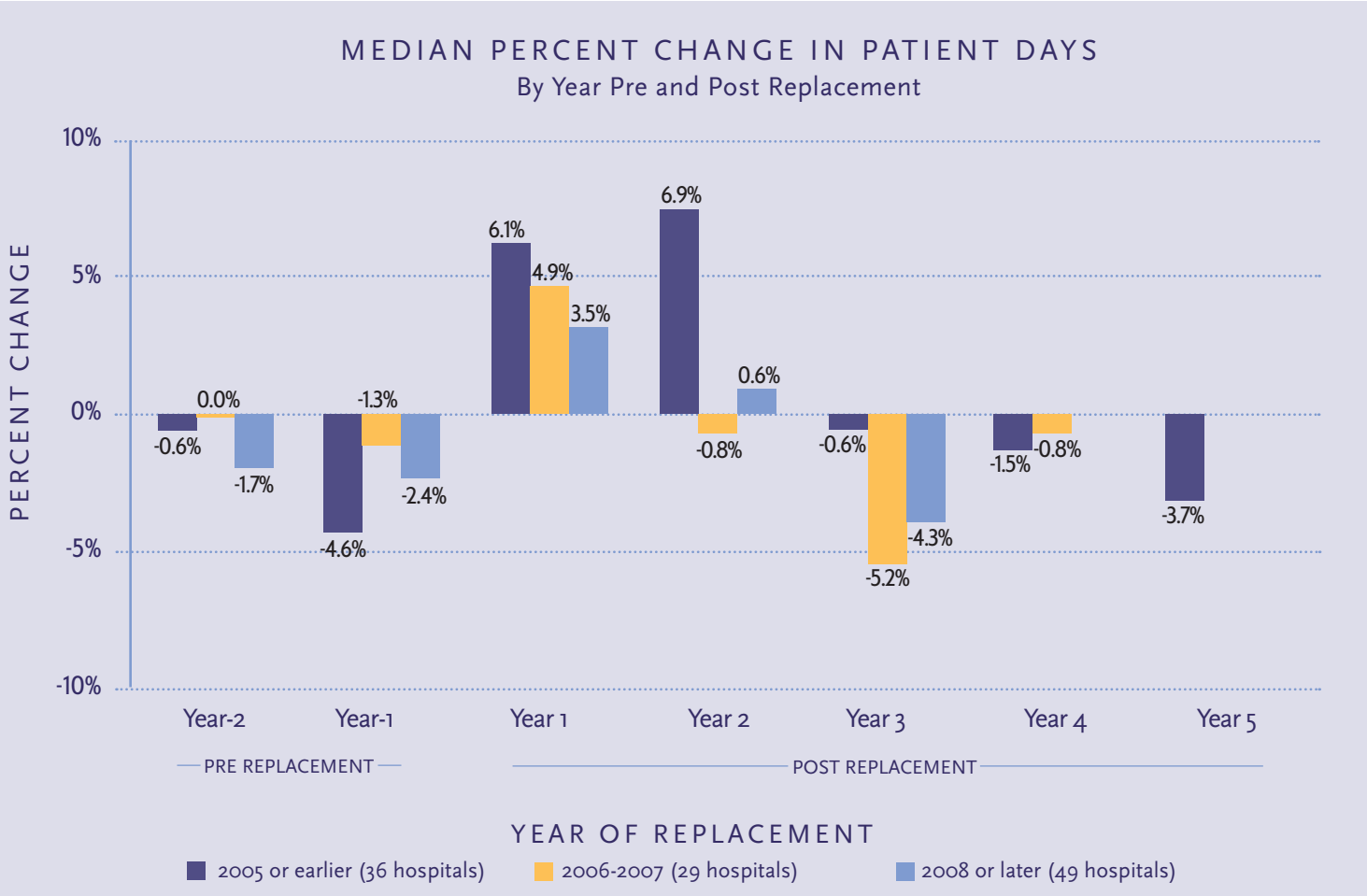
All three cohorts of hospitals maintained cash levels following replacement. Cash on hand in the years immediately preceding replacement can fluctuate greatly due to the influx of cash borrowed for construction. Looking at the average of several years before and after replacement, those hospitals replaced during 2006 - 2007 had more cash on hand before replacement than facilities replaced in 2005 or earlier, but both groups maintained cash levels after replacement that were similar to their cash levels before replacement.

BUCYRUS COMMUNITY HOSPITAL, BUCYRUS, OH

The study uses adjusted patient days as the measure for total patient volume, reflecting the combined impact of changes for both inpatient and outpatient services. The data on this page are presented to show the replacement hospital experiences for inpatient and outpatient volumes separately. Data reflect year-to-year changes: growth shown from one year to the next is incremental to any change in volume reported in the previous year.

Inpatient Volumes

Pre-replacement inpatient volumes were flat or decreasing, with median volume changes falling for all three replacement groups in the year just before replacement. The post replacement data show that all three groups experienced increases in patient days in the first year following replacement. Those hospitals replaced in 2005 or earlier showed the largest increase, with median growth of 6.1 percent, compared to a 4.9 percent increase for hospitals replaced in 2006-2006 and a 3.5 percent increase for hospitals replaced in 2008 or later. The 2005 or earlier hospitals also recorded a large increase in inpatient volume during the second year after replacement, while both groups of later replacements saw inpatient activity level off in Year 2. Inpatient volume levels fell for all three cohorts in Years 3, 4 and 5, though the losses were less in those hospitals replaced in 2005 or earlier.

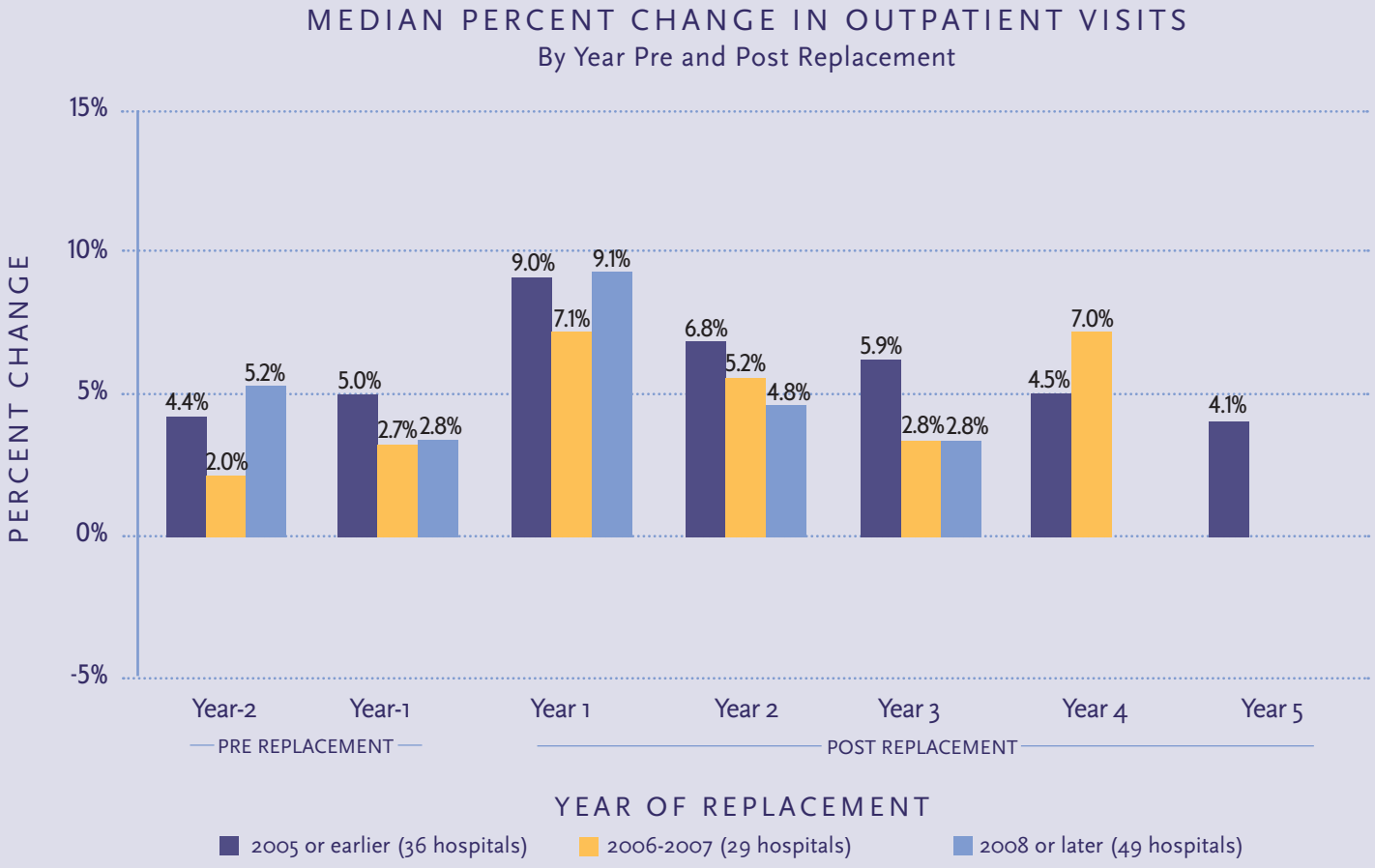


Outpatient Volume

Outpatient service volumes were growing approximately 3-5 percent per year prior to replacement. In the first year following replacement, outpatient volumes grew from 7-9 percent, with each replacement group experiencing at least 4 percent higher growth than pre replacement. The higher growth levels continued through the second post replacement year. By Year 3, growth in all three groups had returned to pre replacement levels.

Quality

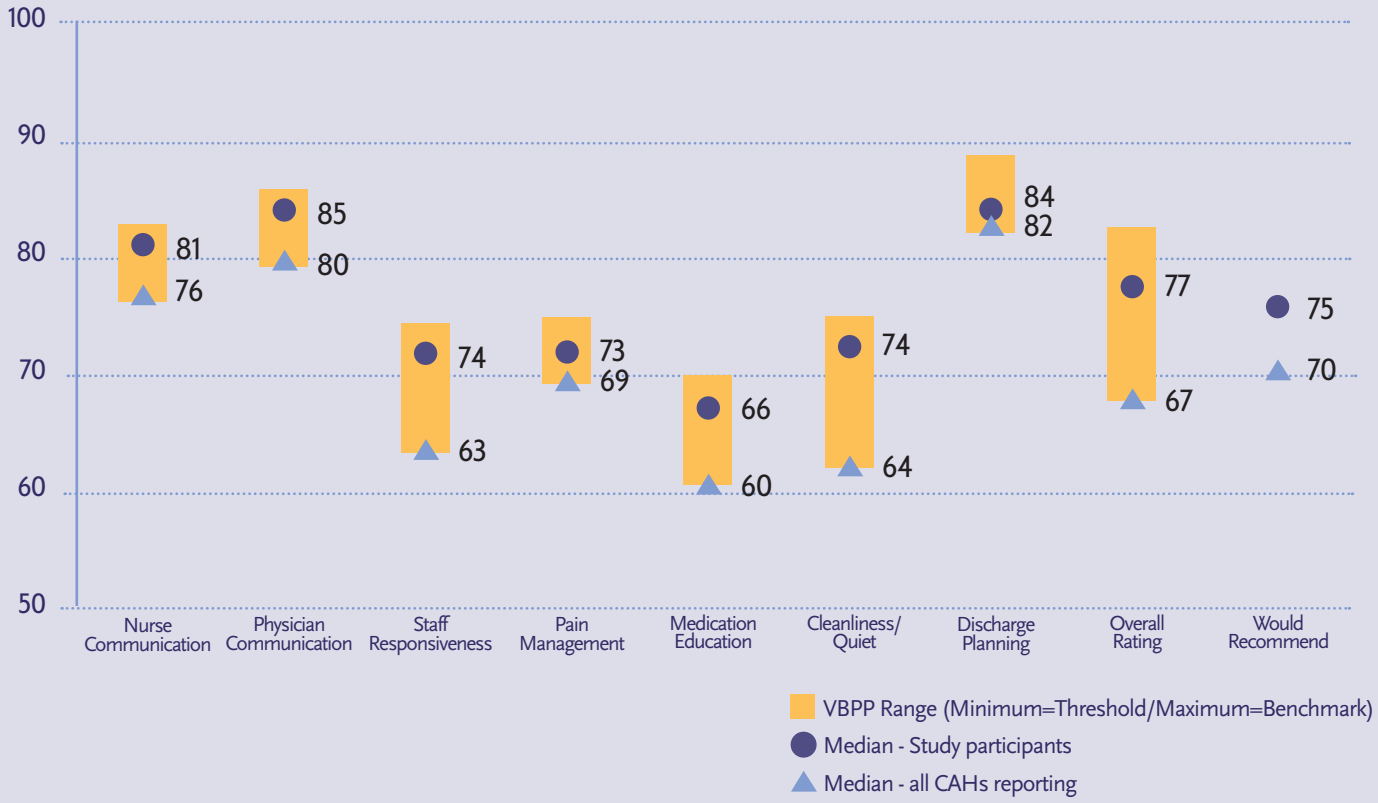
While higher quality of care and a better patient experience are expectations of a new hospital facility, they are not assured. As both public and private payers place increased emphasis on quality as a determinant in hospital reimbursement, organizations contemplating a replacement facility need to understand how these future reimbursement methods will affect them. Because CAHs are not required to report quality data, there are not large amounts of data available. However, in 2011 CMS released data to be used for the Medicare Value Based Payment Program (VBPP) which included quality-related measures reported by all hospitals, including CAHs. Only about 20 percent of CAHs reported core quality measures on patient care processes and outcomes. But approximately half of all CAHs reported scores for the Hospital Consumer Assessment of Healthcare Providers



HCAHPS PERFORMANCE: REPLACEMENT CAHS VS. ALL CAHS

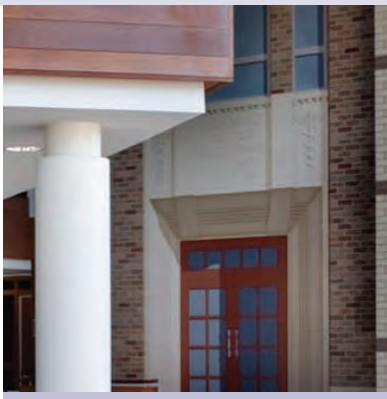
July 1, 2009 through March 31, 2010

(Baseline period for Medicare Value Based Purchasing Program)



and Systems (HCAHPS) survey, which measures patients' perceptions of their hospital experience. A review of the data indicated that replacement CAHs reported HCAHPS scores at approximately the same rate as CAHs in general, allowing for comparison of the performance of replacement CAHs to the universe of CAHs.

As indicated on the graph above, replacement CAHs scored higher than CAHs in general on every HCAHPS measure. Additionally, replacement CAHs reported HCAHPS scores that would qualify for incremental payments under VBPP. While this program is currently not applicable to CAHs, research is underway to develop a similar program which would adjust CAH reimbursement based on quality measures.



"...replacement CAHs scored higher than CAHs in general on every HCAHPS measure."

CONCLUSIONS

Critical Access Hospitals, like all hospitals, face challenging times. Hospitals are still reimbursed based on the volumes of services provided, but a down economy has dampened demand for services. And patients are being given more responsibility for paying for those services, increasing hospitals' levels of bad debt and charity care. Healthcare reform is placing more emphasis on value, requiring hospitals to either lower costs or provide higher quality for the same price. This combination of factors might suggest to some that now is not the time for CAHs to replace their facilities. But the combination of increased outpatient volume, increased efficiency, improved EBIDA margin and higher HCAHPS scores might suggest that for some CAHs a replacement facility is a necessary element for future success.

JERSEY SHORE HOSPITAL, JERSEY SHORE, PA

HARNEY DISTRICT HOSPITAL, BURNS, OR

STROUDWATER ASSOCIATES

Stroudwater Associates is a prominent healthcare advisory firm with a dedicated team that is passionate about the health of rural people and places. With offices in Portland, Maine and Atlanta, Georgia Stroudwater provides strategic, financial, facility planning, and operational consulting services to a national clientele — from academic medical centers to small, rural hospitals, and from integrated health systems to stand-alone community hospitals.

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Andleeb Dawood, Vice President, 406.586.5131 ADawood@doughertymarkets.com

THE NEENAN COMPANY

The Neenan Company has provided integrated design and construction services in the healthcare industry for more than 20 years. In the past 10 years, Neenan has completed over 200 healthcare projects totaling over 2,000,000 square feet of healthcare projects across the United States. The Neenan Company collaborates with our clients in transforming their built environment, facilitating improved patient access and a heightened quality of care. At Neenan, we bring together professionals of many disciplines to work concurrently, under one roof – entwining planning, design, functionality, performance and cost – to create sustainable facility solutions for our clients. We serve physician groups, hospitals, and healthcare providers across the nation to transform their organizations through their facilities.

Michael Curtis, Vice President Business Development, 303.710.1873 michael.curtis@neenan.com

2011 DIRECTORY

FACILITY NAME	STATE	ADMIN/CEO	TEL	POP
Abbeville Area Medical Center	SC	Rich Osmus	864-366-5011	17,869
Adams County Regional Medical Center	OH	Saundra Stevens	937-386-3400	31,306
Adams Memorial Hospital	IN	Marvin Baird	260-724-2145	42,402
Amery Regional Medical Center	WI	Michael Karuschak	715-268-8000	26,823
Atchison Hospital	KS	John Jacobson	913-367-2131	17,889
Atoka County Medical Center	OK	Paul Reano	580-889-3333	13,321
Baptist Health Medical Center - Heber Springs	AR	Edward Lacy	501-887-3000	23,322
Barton County Memorial Hospital	MO	Rudy Snedigar	417-681-5100	19,688
Bell Memorial Hospital	MI	Richard Ament	906-486-4431	24,722
Bertie Memorial Hospital	NC	Jeff Sackrison	252-794-6600	12,456
Booneville Community Hospital	AR	Dzaidi Daud	479-675-2800	11,243
Bridgton Hospital	ME	David Frum	207-647-6000	33,665
Bucyrus Community Hospital	OH	Scott Landrum	419-562-4677	21,796
Caldwell Medical Center	KY	Charles Lovell	270-365-0300	19,183
Carilion Giles Community Hospital	VA	James Tyler	540-266-6000	26,700
Casey County Hospital	KY	Rex Tungate	606-787-6275	13,423
Cass Regional Medical Center	MO	Chris Lang	816-380-3474	28,112
Chatham Hospital	NC	Carol Straight	919-799-4000	25,570
Chippewa County-Montevideo Hospital & Medical Clinic	MN	Mark Paulson	320-269-8877	12,409
Clark Fork Valley Hospital	MT	Gregory Hanson	406-826-4800	10,238
Clinch Memorial Hospital	GA	Phillip Cook	912-487-5211	7,712
Community Hospital of Bremen	IN	Scott Graybill	574-546-2211	10,663
Community Medical Center	NE	Ryan Larsen	402-245-2428	8,271
Community Memorial Hospital	OH	Mel Fahs	419-542-6692	13,131
Cottage Grove Community Hospital	OR	Mary Anne McMurren	541-942-0511	18,988
Crete Area Medical Center	NE	Carol Friesen	402-826-2102	11,294
Delta Memorial Hospital	AR	Cris Bolin	870-382-4303	11,146
Doctor's Memorial Hospital	FL	Jo Ann Baker	850-547-8000	19,582
Drumright Regional Hospital	OK	Darrel Morris	918-382-2300	5,958
Ellsworth County Medical Center	KS	Roger Masse	785-472-3111	11,201
Fall River Health Service	SD	Tricia Uhlir	605-745-3159	8,008
Family Health West	CO	Errol Snider	970-858-9871	12,236
Faulkton Area Medical Hospital	SD	Jay Jahnig	605-598-6262	2,407
Fort Logan Hospital	KY	Mike Jackson	606-365-4600	27,537
Franklin Foundation Hospital	LA	Parker Templeton	337-828-0760	17,424
Fulton County Medical Center	PA	Jason Hawkins	717-485-3155	21,439
Grand River Hospital and Medical Center	CO	Jim Coombs	970-625-1510	25,576
Harney District Hospital	OR	Jim Bishop	541-573-7281	6,888
Harrison County Hospital	IN	Steve Taylor	812-738-4251	40,895
Hayward Area Memorial Hospital	WI	Tim Gullingsrud	715-934-4321	18,955
Heart of the Rockies RMC	CO	Ken Leisher	719-530-2210	22,501
Hermann Area District Hospital	MO	Dan McKinney	573-486-2191	7,832
Holton Community Hospital	KS	Ron Marshall	785-364-2116	10,302
Hospital "A", U.S.A.	-	-	-	36,861
Hospital "B", U.S.A. calais	-	-	-	13,532
Hudson Hospital & Clinics	WI	Marian Furlong	715-531-6000	35,763
Indiana University Health Blackford Hospital	IN	Steven West	765-348-0300	19,050
Indiana University White County Memorial Hospital	IN	Stephanie Long	574-583-7111	19,891
Iraan General Hospital	TX	Teresa Callahan	432-639-2575	1,799
Jefferson County Health Center	IA	Deb Cardin	641-472-4111	20,781
Jersey Shore Hospital	PA	Carey Plummer	570-398-0100	34,508
Jones Regional Medical Center	IA	Eric Briesemeister	319-462-6131	19,688
Keokuk County Health Center	IA	Ray Brownsworth	641-622-2720	3,564
Kewanee Hospital	IL	Margaret Gustafson	309-852-7500	25,010
Kingfisher Regional Hospital	OK	Nancy Schmid	405-375-3141	11,250
Kit Carson County Memorial Hospital	CO	Joe Stratton	719-346-5311	9,034
LakeWood Health Center	MN	Jason Breuer	218-634-2120	4,490

FACILITY NAME	STATE	ADMIN/CEO	TEL	POP
Lakewood Health System Hospital	MN	Tim Rice	218-894-1515	20,106
Limestone Medical Center	TX	Penny Gray	254-729-3281	9,339
Madison Valley Medical Center	MT	Loren Jacobson	406-682-6862	6,064
Marshall County Hospital	KY	Kathy Long	270-527-4800	27,417
McCune-Brooks Regional Hospital	MO	Bob Copeland	417-358-8121	32,978
Meade District Hospital	KS	Mickey Thomas	620-873-2141	8,005
Melissa Memorial Hospital	CO	John Ayoub	970-854-2241	3,037
Memorial Hospital	IL	Ada Bair	217-357-8500	14,797
Midwest Medical Center	IL	Tracy Bauer	815-777-1340	7,845
Mitchell County Hospital	TX	Robbie Dewberry	325-728-3431	10,700
Moloka`i General Hospital	HI	Janice Kalanihuia	808-553-5331	5,680
Morton General Hospital	WA	Ron DeArth	360-496-3537	11,451
Mountainview Medical Center	MT	Aaron Rogers	406-547-3321	1,923
Mountrail County Medical Center	ND	Rick Wittmeier	701-628-2424	2,224
Munising Memorial Hospital	MI	Kevin Calhoun	906-387-4110	6,489
North Canyon Medical Center	ID	David Butler	208-934-4433	20,618
North Valley Hospital	MT	Jason Spring	406-863-3500	34,258
Oakes Community Hospital	ND	Lee Boyles	701-742-3291	11,632
Okeene Municipal Hospital	OK	Shelly Dunham	580-822-4417	5,671
Orange City Municipal Hospital	IA	Martin Guthmiller	712-737-4984	12,843
Osceola Medical Center	WI	Jeffrey Meyer	715-294-2111	11,836
Our Lady of Victory Hospital	WI	Cynthia Eichman	715-644-6144	13,508
Ozark Health Medical Center	AR	Kirk Reamey	501-745-7000	22,142
Parkview LaGrange Hospital	IN	Rob Myers	260-463-9000	35,826
Parmer Medical Center	TX	Lance Gatlin	806-250-2754	7,381
Phillips County Hospital & Family Health Clinic	MT	Ward Van Wichen	406-654-1100	3,825
Potomoc Valley Hospital	WV	Linda Shroyer	304-597-3500	20,815
Providence Mount Carmel Hospital	WA	Bob Campbell	509-685-5100	25,461
Providence Valdez Medical Center	AK	Sean McAllister	907-835-2249	4,121
Pullman Regional Hospital	WA	Scott Adams	509-332-2541	36,739
Ringgold County Hospital	IA	Gordon Winkler	641-464-3226	6,346
Rio Grande Hospital	CO	Arlene Harms	719-657-2510	18,002
River's Edge Hospital & Clinic	MN	Colleen Spike	507-931-2200	15,372
Riverwood Healthcare Center	MN	Michael Hagen	218-927-2121	14,494
Rooks County Health Center	KS	Michael Sinclair	785-434-4553	5,314
Sacred Heart Hospital	WI	Monica Hilt	715-453-7700	12,679
Sanford Luverne Medical Center	MN	Tammy Loosbrock	207-283-2321	11,700
Saunders Medical Center	NE	Ken Archer	402-443-4191	7,580
Scheurer Hospital	MI	Dwight Gascho	989-453-3223	12,781
Shoshone Medical Center	ID	Gary Moore	208-784-1221	12,113
Southern Coos Hospital & Health Center	OR	James Wathen	541-329-1031	10,148
Southwest Health Center	WI	Don Rohrbach	608-348-2331	27,731
St. James Medical Center - Mayo Health System	MN	Scott Thoreson	507-375-3391	9,108
St. James Parish Hospital	LA	Mary Ellen Pratt	225-746-2990	15,217
St. Vincent Randolph Hospital	IN	Cheech Albarano	765-584-0004	18,383
Steele Memorial Medical Center	ID	Jeff Hill	208-756-5600	10,492
Story County Medical Center	IA	Todd Willert	515-382-2111	10,910
The Memorial Hospital	CO	George Rohrich	970-824-9411	17,349
Tomah Memorial Hospital	WI	Philip Stuart	608-372-2181	22,840
Tri-Valley Health / Cambridge Memorial Hospital	NE	Roger Steinkruger	308-697-1124	5,150
Wallowa Memorial Hospital	OR	David Harman	541-426-3111	6,962
Washington County Hospital and Clinics	IA	Dennis Hunger	319-653-5481	20,587
Weatherford Regional Hospital	OK	Debbie Howe	580-772-5551	22,897
West River Health Services	ND	Jim Long	701-567-4561	14,562
Wilson Medical Center	KS	Dennis Shelby	620-325-2611	4,385
Winkler County Memorial Hospital	TX	Bill Ernst	432-586-8299	6,947
Yuma District Hospital and Clinics	CO	John Gardner	970-848-5405	9,302

Population is defined as the sum total of populations in all ZIP codes in which the hospital had at least 10% market share of 2010 Medicare admissions.

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PHOTOS: TOP: CARILLON GILES COMMUNITY HOSPITAL, PEARISBURG, VA; BOTTOM LEFT: KIT CARSON COUNTY MEMORIAL HOSPITAL, BURLINGTON, CO; BOTTOM RIGHT: PROVIDENCE VALDEZ MEDICAL CENTER, VALDEZ, AK

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