5th annual RURAL HOSPITAL REPLACEMENT FACILITY STUDY

2009

How Replacement Facilities Impact Operations and the Bottom Line: Findings from the Field

5th ANNIVERSARY 5 2004~2009

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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.

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design by annie|catherine, Westbrook, Maine
printed by JSMcCarthy Printers, Augusta Maine.
printed on recycled paper in a facility whose electricity is generated entirely by wind power

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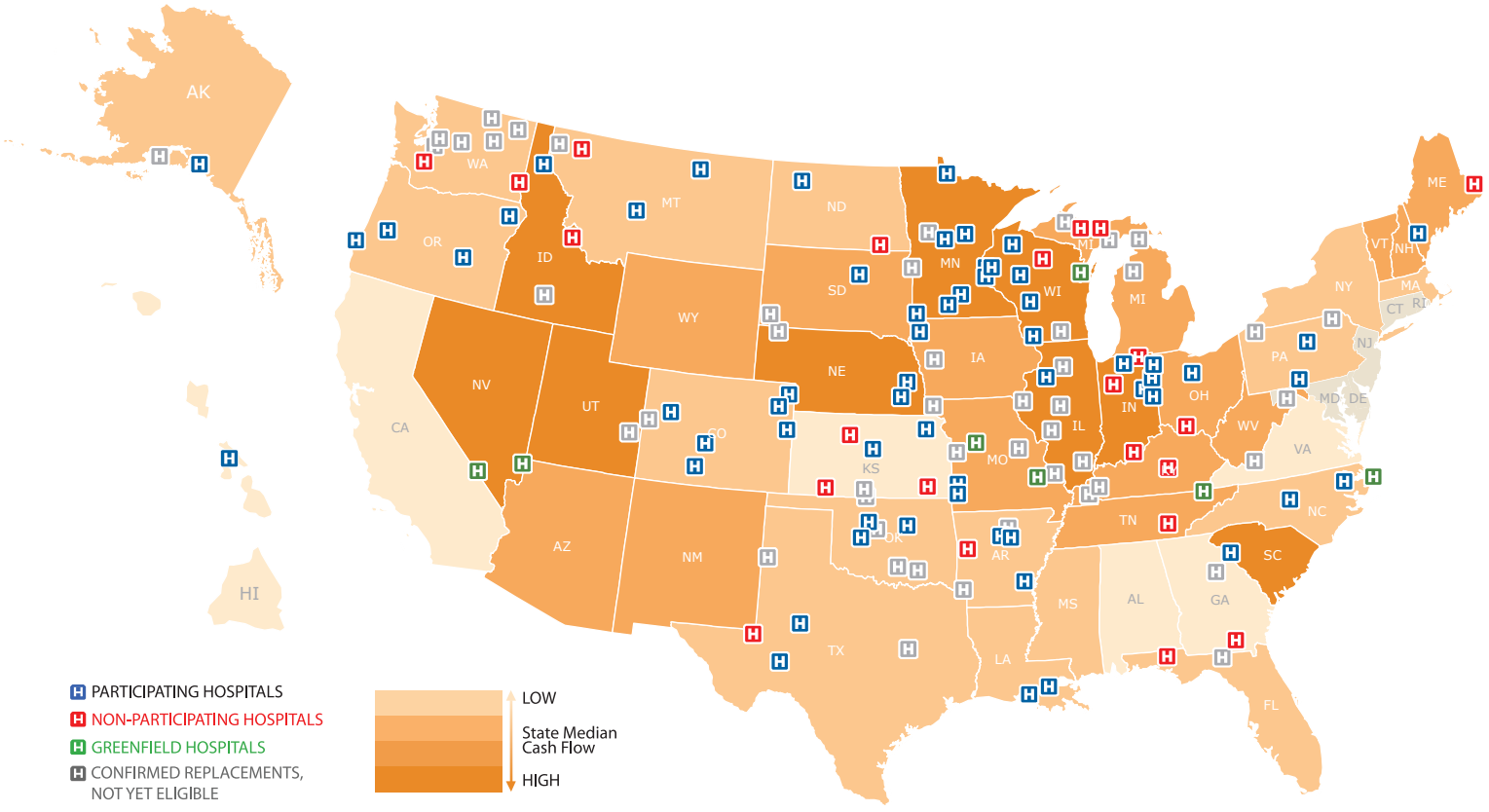
COVER PHOTOS: LEFT, BUCYRUS COMMUNITY HOSPITAL, OHIO; RIGHT, KIT CARSON COUNTY MEMORIAL HOSPITAL, COLORADO

GROWTH IN THE STUDY FROM 2005~PRESENT

	ELIGIBLE CAHs	PARTICIPATING #	PARTICIPATING %	PARTICIPANTS BY YEARS IN NEW FACILITY 1+ #	1+ %	2+ #	2+ %	3+ #	3+ %
2005	27	20	74%	20	100%	11	55%	8	40%
2006	30	24	80%	24	100%	19	79%	13	54%
2007	39	33	85%	33	100%	27	82%	25	76%
2008	56	45	80%	45	100%	37	82%	30	67%
2009	82	62	76%	62	100%	53	85%	38	61%



Source for median cash flows: Flex Monitoring Team Data Summary Report No.6, CAH Financial Indicators Report: Summary of Indicator Medians by State, October 2009 (corrected).

The goal of the CAH replacement study is simple, yet compelling: understanding the benefits and pitfalls of facility investments from the communities that have direct experience. In each of the past five years, the study has shed new light on important challenges, problems, and successes. This year is no different as replacement facilities faced the same economic challenges – deferred elective services and increases to uncompensated care, for example – as the rest of the country. Yet unlike most CAHs operating in older facilities, the replacement hospital CEOs had large debt payments to make. The consensus: they wouldn't have changed a thing.

Over the years, the evidence supporting increased volumes in a replacement facility has grown. With 62 hospitals participating in this year's study, there is ample evidence that the replacement facilities have made positive impacts to the organizations' abilities to meet local healthcare needs. The total volume analysis, as shown on the chart below, shows consistent growth following construction of the new facility — reflecting increased utilization of existing services, and for many hospitals, the development of new services.

The study documents the driving factors of replacement success stories—most importantly an increased ability to recruit and retain physicians and staff. CEOs reported that in spite of general rural challenges, physicians contacted them proactively to inquire about openings, and waiting lists of nurses interested in working at the replacement CAHs were being compiled.

As in prior years, the study also documents other reported benefits of CAH replacement facilities, including perceived enhancements to quality and an improved economic impact in the community.

While the data shows the average experience is positive, a number of replacement CAHs have reported troubles: volumes are not meeting targets, the facility was not sized appropriately, increased competition from physicians, and poor overall financial results, for example.

Many pieces must fall into place to execute a facility project successfully, and CAH leaders understand there is little margin for error in their businesses. The CEOs who lived through the process understand it is an enormous challenge, and have been generous in not only contributing to this study, but also in spending time with peer inquiries from across the country.

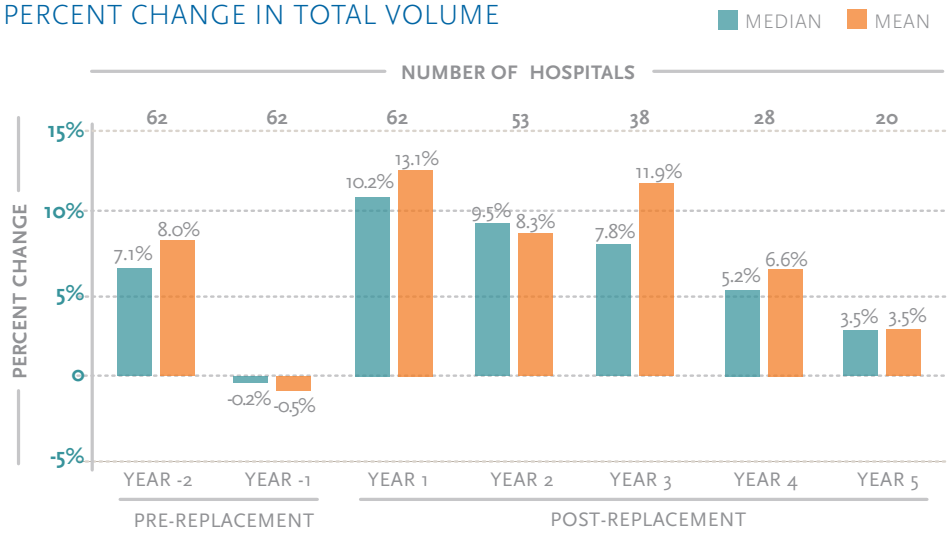
"If it were a ship, it would have sunk."

We are all grateful for their contributions to the field.

NEW FOR 2009 STUDY

- Seventeen new CAHs participating: a 38% increase over the number of 2008 participants.
- 200% increase in the number of participants since the study's first year
- Updated interview findings: 34 interviews were conducted
- New question: How has the recent economic downturn affected patient volumes and hospital operations?

PERCENT CHANGE IN TOTAL VOLUME



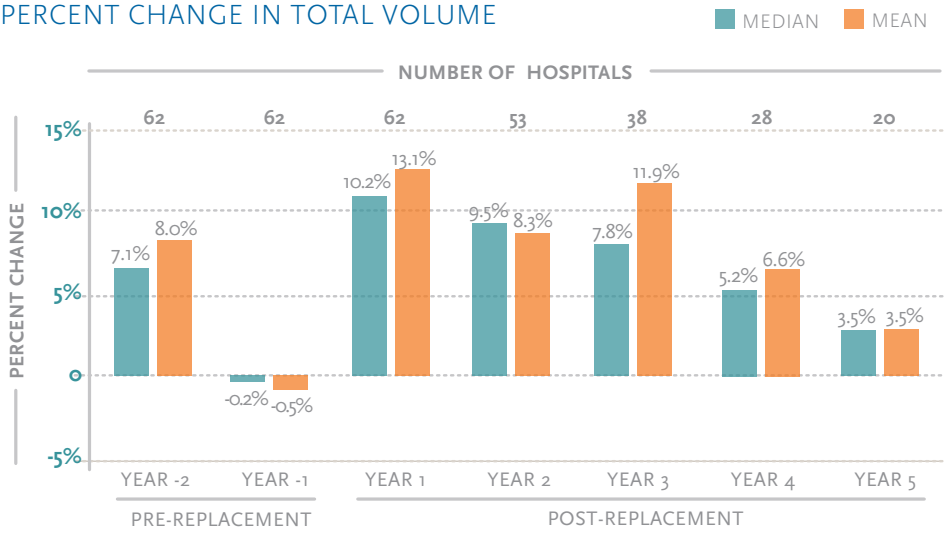
" We assumed a 10% increase in volumes. Our inpatient volume increased 13%, outpatient volume increased 15%, and CT volume is up 30%."

" Outpatient is 7% more than forecasted. Inpatient is 5% more than forecasted."

" In July we budgeted 9.5 patients; we are currently at 15."

" A group of three orthopedists recently approached us. They want to do cases here. We'll be opening a third OR shortly."

PERCENT CHANGE IN TOTAL VOLUME

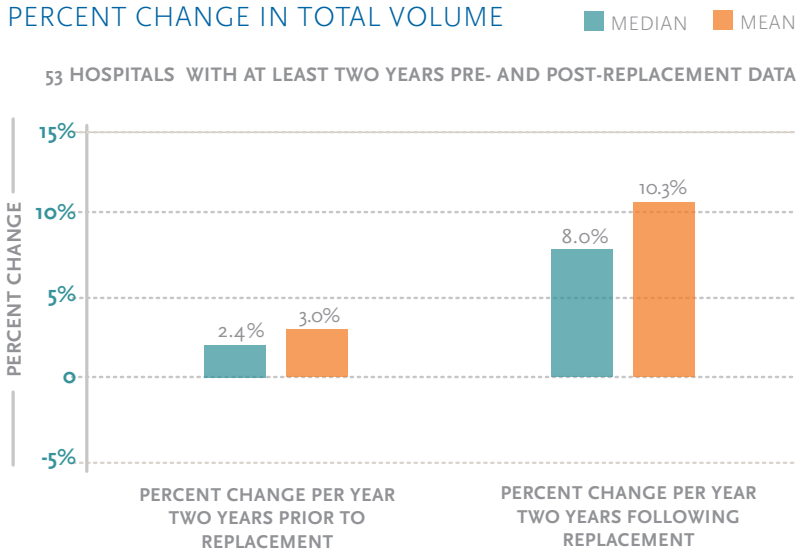


CAHs provide more outpatient than inpatient services, although each is different in the overall scope, complexity, and volume levels. To evaluate total volumes across such a varied spectrum, the study uses the industry standard approach of creating an overall measure of volume that takes the differences between hospitals into account. "Adjusted patient days" reflects the total activity for different hospitals in a common measure. Appendix 2 offers the detailed study data on inpatient and outpatient volumes separately.

Median volumes in the replacement CAHs were flat in the year prior to replacement, then increased 10% post-replacement. On average, volumes continued to grow in subsequent years. Combining the two years pre-replacement, volumes grew 2.4% per year, while in the two years post-replacement, volumes increased 8% per year. Of all 62 participating hospitals, five (8%) reported accumulated volume losses post-replacement, and three of the five were in the first two years post-replacement.

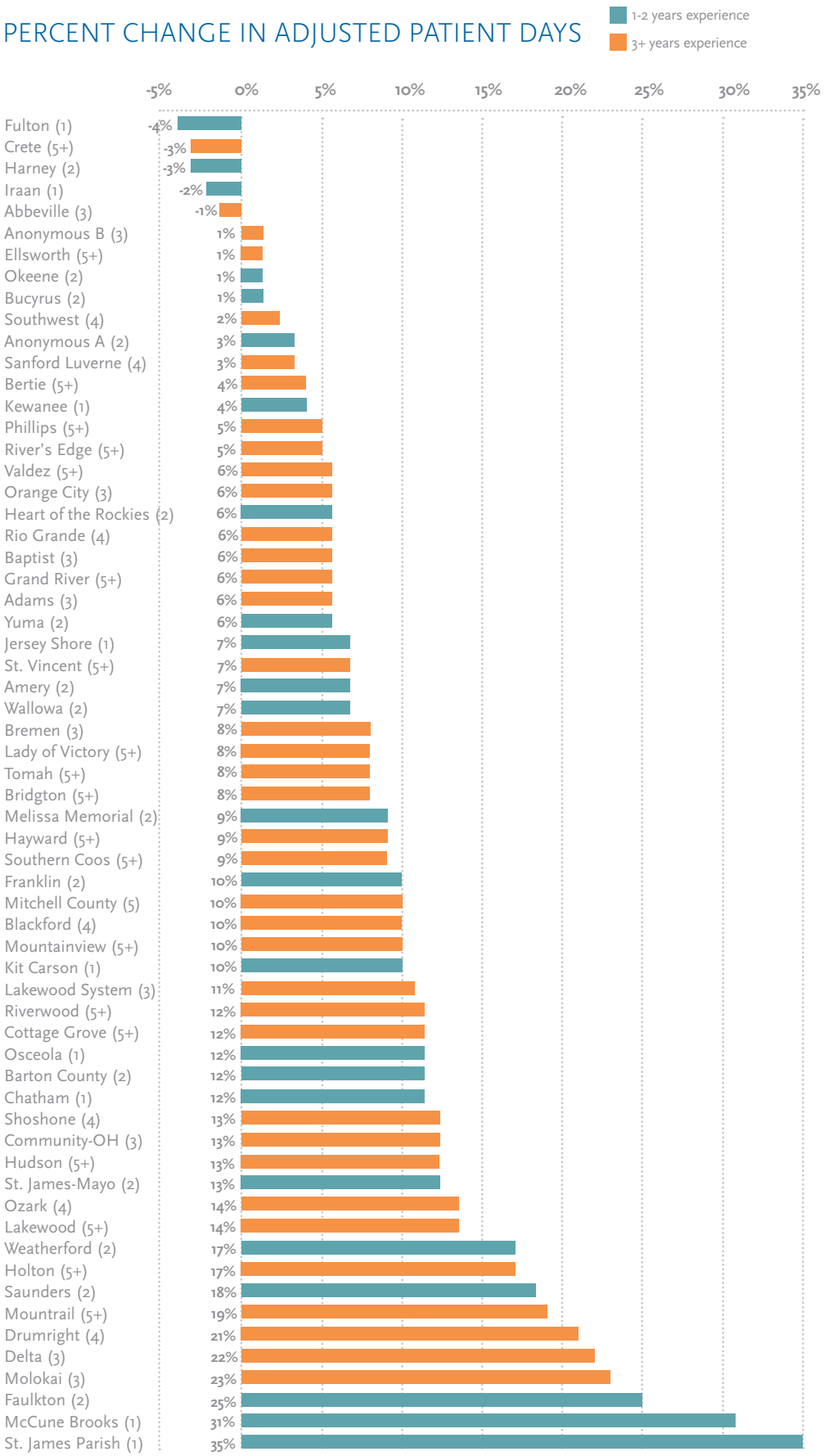
JERSEY SHORE HOSPITAL, PENNSYLVANIA

PERCENT CHANGE IN TOTAL VOLUME



Total volume is defined as adjusted patient days.

PERCENT CHANGE IN ADJUSTED PATIENT DAYS




AMERY MEDICAL CENTER, WISCONSIN

" Double-digit increases in all departments... different than other area hospitals."

" Outpatient volumes are down this year due to competition from a local surgi-center, but still above initial projections."

" Volumes are flat, but our market share is up. There are fewer elective surgeries."

" First 18 months were below expectations, but the last seven months have been significantly ahead of projections. Our cash position is well ahead of forecast."

" Large plant has been closed. We felt this in outpatient volume. However, change in perception has offset/tempered the degree of pain. We would be much worse off in our old facility."

Compound Annual Growth (Decline) in Post Replacement Volumes

The shortage of providers in rural areas is a fact. This shortage has a demonstrated impact on the ability to meet the community's healthcare needs and ultimately, upon the financial health of the hospital. In short, when patients leave the community for primary care or selected specialty services, they are unlikely to return.

Most CEOs reported that their replacement hospital had a positive impact on their ability to recruit. The few CEOs that did not see a positive impact reported other problems that overshadowed the facility, such as remote location or local economic problems.

The majority of hospitals continue to report that, as in prior years, volumes are ahead of expectations. The most common reason attributed to higher than expected volume growth was the success of the physician recruitment strategy. Good doctors attract patients who may have been leaving the community, resulting in increased volumes and better financial viability. Based on the CEO interviews, outpatient volumes are more likely than inpatient volumes to be reported above expectations.

" Big 'wow' factor; moved us up the food chain."

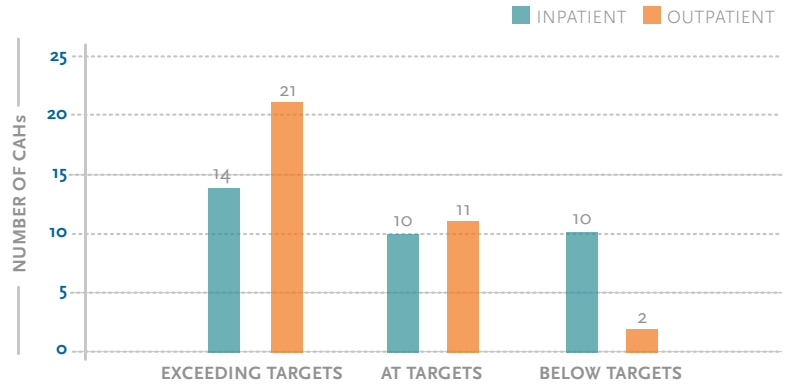
" Recruited five physicians and one PA– all young, well-educated—only paid recruiting fee on one of them."

" With the plans for the new facility, we were able to recruit a new surgeon."

" Privilege to recruit to a facility like this."

" Received unsolicited letters from physicians wanting to join the staff."

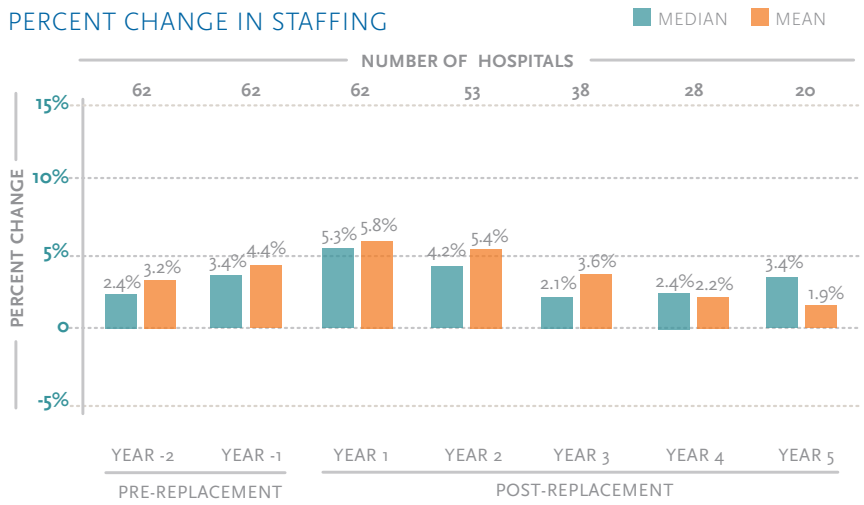
NUMBER OF CAHs EXCEEDING, AT, OR BELOW VOLUME TARGETS
(AS REPORTED)



COMMUNITY MEMORIAL HOSPITAL, OHIO

"We interviewed many physicians and often got comments like, 'This is everything we ever wanted.'"

PERCENT CHANGE IN STAFFING



"Higher quality infrastructure supports higher quality staff."

"Now have nurses driving 30 miles to work for us, never happened before."

"Better workflow increases staff satisfaction."

"Employees' pride in new facility is immeasurable."

"Able to recruit a talented OR manager because of the facility."

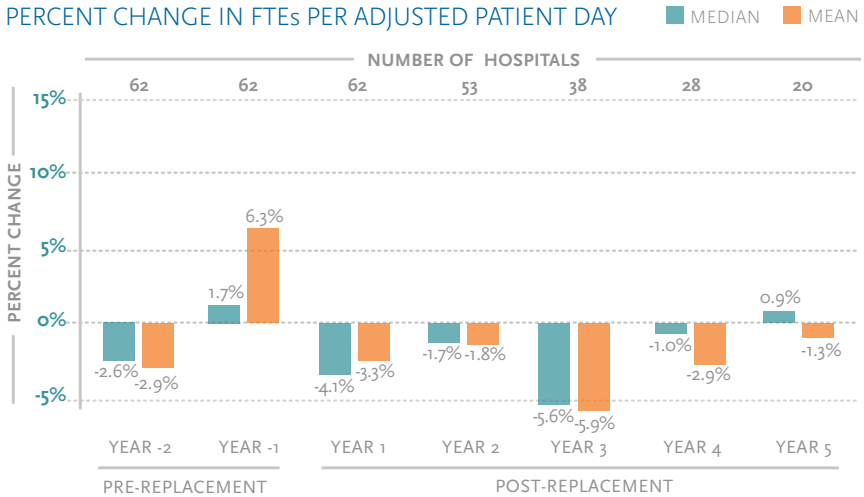
Rural hospitals are often challenged with staff shortages, particularly nursing and other professionals. The ability to both recruit and retain highly qualified professionals is integral to the health of an organization. And in most communities, these are often some of the best jobs available.

Median pre-replacement versus post-replacement growth in staffing was 3.4% to 5.3%, as shown above. This reflects that staffing is being added in anticipation of the new facility, and continues at a slightly higher rate following the opening.

Even with higher staffing overall, the number of staff per unit of service (as defined by adjusted patient days) goes down on average. This measure reflects improved efficiencies in the operations, as shown below.

An enhanced ability to recruit higher quality personnel was specifically cited by seven of the CEOs interviewed. A number of facilities reported they discontinued use of agency staffing and indicated that turnover rates are down. More than half of those interviewed said they have no nursing vacancies and several indicated they have waiting lists.

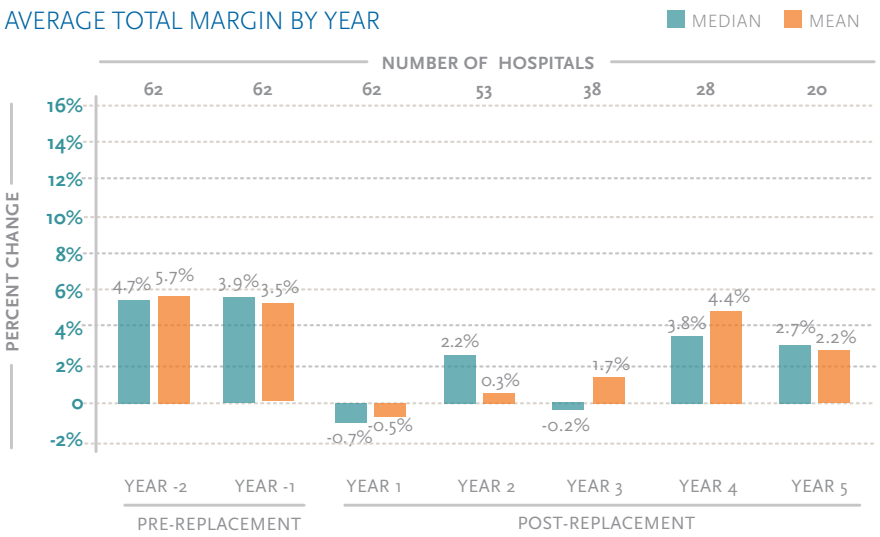
PERCENT CHANGE IN FTEs PER ADJUSTED PATIENT DAY



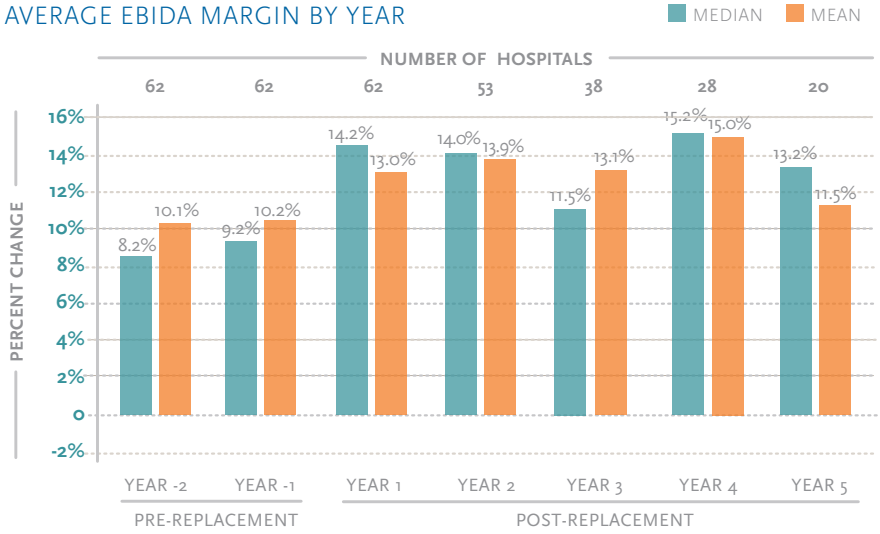
OSCEOLA MEDICAL CENTER, WISCONSIN


BARTON COUNTY MEMORIAL HOSPITAL, MISSOURI

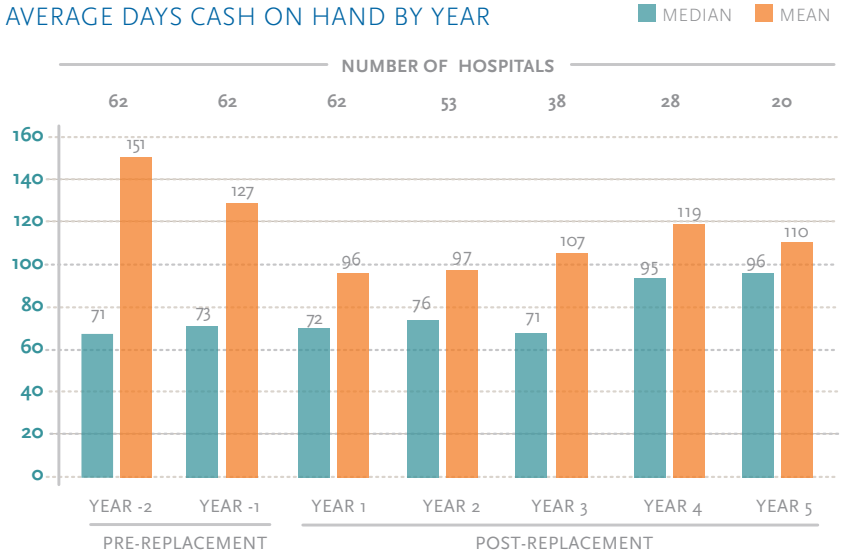
AVERAGE TOTAL MARGIN BY YEAR



AVERAGE EBIDA MARGIN BY YEAR



AVERAGE DAYS CASH ON HAND BY YEAR



Total Margin

The median average total margin declines post-replacement resulting from the increases in facility costs; specifically interest, depreciation, and in many cases additional staffing. Boards of directors can expect budgets reflecting decreased financial performance in the first years following a facility investment.

EBIDA Margin

Earnings Before Interest Depreciation and Amortization (EBIDA) is a measure that approximates cash flow. It displays less variation than total margin, with the median replacement CAH showing positive results. Boards should target an EBIDA margin that reflects enough cash flow to sustain operations through the startup of the new facility.

Average Days Cash on Hand

The average days cash on hand reflects the cash "cushion." Post-replacement cash on hand varies with overall financial performance and the facility's initial reserves. Lenders evaluate cash on hand both pre- and post-replacement to ensure working capital is sufficient.

The availability of capital is in constant flux. At the time the CAHs in the study were funding their projects, capital markets were flush. This is reflected in the number of new participants that utilized "unenhanced revenue bonds" which means that the bonds were sold to investors based on the hospital's ability to repay from its own revenues.

HUD and USDA have both reported significantly more utilization of their programs in today's environment, providing lenders more protection against default. Other CAHs are seeking affiliations with systems in order to access capital.

Most replacement CAHs reported successful fundraising campaigns that helped offset borrowing needs. It is uncertain how the economy will affect fundraising for projects currently in planning. Some CEOs are reporting a downturn in giving, while others indicated no change.

SOURCES OF FUNDING	# OF FACILITIES ACCESSING THIS SOURCE
Guarantee from system	10
Guarantee from county/city	8
HUD 242 mortgage insurance	7
USDA Community Facilities direct and guarantee	14
Unenhanced revenue bonds	18

"Capital campaign surpassed goal twice. We raised $3 million."

"$750,000 raised in a community of 2,400 and a total county of 5,000 people. I'm still blown away."

"We raised $450,000 on a goal of $1 million. We hired a professional fundraiser who angered the whole town."

"We were lucky on our timing...unenhanced 25 year revenue bonds at a low rate."

"Part of obligated bond group in the system."

IMPACT OF THE ECONOMY

"No impact on patient volumes. While others in the big city are cutting staff, our volumes have remained constant."

"We are maintaining modest growth, while colleagues in the area are seeing a big dip."

"We had a dip in outpatient volumes from November to January, but volumes have picked up again."

"A lot of hospitals are hurting. The new facility plays into our ability to attract patients."

"Volumes have been steady, but we've seen an increase in bad debt."

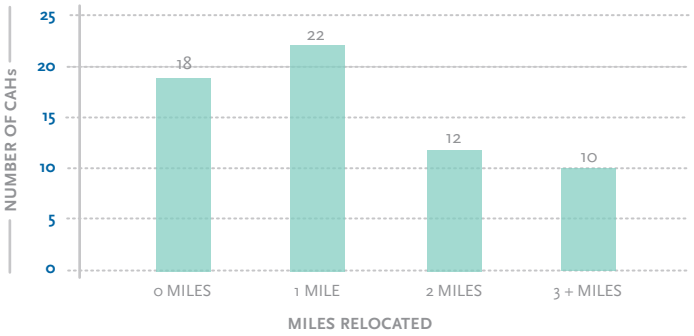
"We have seen lower staff turnover because of the economic uncertainty."

Hospital inpatient and outpatient volumes are reported as being above expectations, on average, in spite of the economy. A number of CEOs indicated their facilities helped them be more competitive in attracting patients. Other CEOs said that the replacement facility did not differentiate their experience from others in their region and that volume losses were consistent with other community hospitals.

Several CEOs indicated the final quarter of 2008 and the first quarter of 2009 displayed flat volumes, or even a decrease, but other hospitals in the area were reported to be faring worse. Unemployment rates, concern about job security if on medical leave, and the decision not to have elective surgeries were all cited as factors contributing to lower volumes. Nearly all of those interviewed reported an increase in charity care and bad debt.

KIT CARSON COUNTY MEMORIAL HOSPITAL, COLORADO

DISTANCE CAH RELOCATED FROM FORMER CAMPUS



DID THE NEW FACILITY RELOCATE?

"CMS required us to get a letter stating the replacement facility met all original necessary provider criteria."

"Didn't think we'd have a problem, but it was an additional uncertainty."

GOALS OF THE REPLACEMENT

"Part of the hospital was over 100 years old."

"Do you want to walk down the 'suicide staircase' to rehab?"

"...inadequate privacy. The ER was two beds separated by a curtain."

"Could not do anything with the existing space. The hospital was built in 1929 in landlocked space."

"Integrated new facility with old---tied it all together by staining old bricks to match new; from road it looks all the same."

"The old facility was abominable. We could not attract a new surgeon."


ORANGE CITY MUNICIPAL HOSPITAL, IOWA

BARRIERS TO INITIATING THE PROJECT?

"If it was good enough for my grandparents, it's good enough for me."

"A big issue was what to do with the old facility."

"The biggest barrier was financing. Traditional routes were impossible."


DELTA MEMORIAL HOSPITAL, ARKANSAS

HAS THE NEW FACILITY SUPPORTED PATIENT SAFETY AND QUALITY?

"Very low infection rates relative to other facilities. Physicians have actually commented on it."

"QIO awarded us the Platinum Award for CMS core measurement."

"Intangibles, such as pride, translate into better patient care."

"New facility gives us the opportunity to focus on quality rather than just keeping the lights on."

"Now in the top 1% of HCAPS scores in the country."

"Prior to the new facility, patient satisfaction scores were below the 10th percentile in the ER and 80th percentile in inpatient...reached 99th percentile in new facility."

"Having the facility helped facilitate getting an EMR ...the 'desire' has definitely increased."

WHAT WOULD YOU CHANGE IF YOU COULD?

"Would not tuck administration away in a corner, creates divided culture and email ties CEOs to their desks."

"Would keep administration visible and interactive with physician group."

"Add privacy to business office to support financial counseling."

"Site selection was influenced by politics, leaving us with limitations."

"You can never have enough space...plan for flexibility and growth."

"Would have invested in EMR as part of new facility."

"Would have added more specialty clinic space. We are running full and having to double up physicians."

WALLOWA MEMORIAL HOSPITAL, OREGON

WHAT WOULD YOU RECOMMEND TO OTHER ORGANIZATIONS CONSIDERING REPLACEMENT?

"Can't just look at the status quo."

"If you can figure out the financing, go out and do it."

"Used 'defining statements' to allocate resources."

"Look out more than three years. We ran out of space after three years."

"During construction period we did 26 FAQs to keep the community current."

"Working with the board: you'll never have enough information to make a decision, at some point you've got to decide."

HAVE YOU NOTICED COMMUNITY ECONOMIC DEVELOPMENT OCCURRING AS A RESULT OF YOUR NEW FACILITY?

"When you take $19 million and put it into a construction project a good part comes back to the community."

"Company made it clear when they moved here that healthcare was important."

"New MOB built by physicians is completed and fully occupied, built three extra suites which are already filled."

HEART OF THE ROCKIES REGIONAL MEDICAL CENTER, COLORADO

FACILITY NAME	CITY	STATE	ADMINISTRATOR/CEO	TELEPHONE	POPULATION
Abbeville Area Medical Center	Abbeville	SC	Richard Osmus	864-366-5011	22,700
Adams Memorial Hospital	Decatur	IN	Marvin Baird	260-724-2145	33,700
Amery Regional Medical Center	Amery	WI	Michael Karuschak	715-268-8000	15,600
Baptist Health Medical Center - Heber Springs	Heber Springs	AR	Edward Lacey	501-887-3000	13,300
Barton County Memorial Hospital	Lamar	MO	Rudy Snedigar	417-681-5100	13,700
Bertie Memorial Hospital	Windsor	NC	Jeff Sackrison	252-482-6268	10,300
Blackford Community Hospital	Hartford City	IN	Steven West	765-348-0300	14,800
Bridgton Hospital	Bridgton	ME	John Carlson	207-647-6000	17,900
Bucyrus Community Hospital	Bucyrus	OH	Jerry Klein	419-563-9376	20,400
Chatham Hospital	Siler City	NC	Carol Straight	919-799-4001	22,300
Community Hospital of Bremen	Bremen	IN	Scott Graybill	574-546-2211	11,100
Community Memorial Hospital	Hicksville	OH	Mel Fahs	419-542-5560	6,600
Cottage Grove Community Hospital	Cottage Grove	OR	Mary Anne McMurren	541-942-0511	19,100
Crete Area Medical Center	Crete	NE	Carol Friesien	402-826-2102	8,500
Delta Memorial Hospital	Dumas	AR	Cris Bolin	870-382-8126	8,200
Drumright Regional Hospital	Drumright	OK	Darrell Morris	918-382-2300	6,900
Ellsworth County Medical Center	Ellsworth	KS	Roger Masse	785-472-3111	7,200
Faulkton Area Medical Hospital	Faulkton	SD	Jay Jahnig	605-598-6262	1,800
Franklin Foundation Hospital	Franklin	LA	Parker Templeton	337-355-1283	18,800
Fulton County Medical Center	McConnellsburg	PA	Jason Hawkins	717-485-6109	17,700
Grand River Hospital and Medical Center	Rifle	CO	Martie Wisdom	970-625-1510	12,800
Harney District Hospital	Burns	OR	Jim Bishop	541-573-8329	6,900
Hayward Area Memorial Hospital	Hayward	WI	Barbara Peickert	715-934-4244	13,300
Heart of the Rockies RMC	Salida	CO	Ken Leisher	719-530-2210	21,700
Holton Community Hospital	Holton	KS	Ron Marshall	785-364-2116	5,500
Hudson Hospital & Clinics	Hudson	WI	Marian Furlong	715-531-6000	32,600
Iraan General Hospital	Iraan	TX	Teresa Callahan	432-639-2871	1,700
Jersey Shore Hospital	Jersey Shore	PA	Carey Plummer	570-398-0100	14,700
Kewanee Hospital	Kewanee	IL	Margaret Gustafson	309-852-7500	17,000
Kit Carson County Memorial Hospital	Burlington	CO	Joe Stratton	719-346-5311	6,800
LakeWood Health Center	Baudette	MN	SharRay Palm	218-634-2120	6,400
Lakewood Health System Hospital	Staples	MN	Tim Rice	218-894-8610	10,900
McCune-Brooks Regional Hospital	Carthage	MO	Bob Copeland	417-358-8121	25,500
Melissa Memorial Hospital	Holyoke	CO	John Ayoub	970-854-2241	3,100
Mitchell County Hospital	Colorado City	TX	Karl Stinson	325-728-3431	9,300
Moloka` i General Hospital	Kaunakakai	HI	Janice Kalanihuia	808-553-5331	4,700
Mountainview Medical Center	White Sulphur Springs	MT	Aaron Rogers	406-547-3321	1,900
Mountrail County Medical Center	Stanley	ND	Mitch Leupp	701-628-2424	2,400
Okeene Municipal Hospital	Okeene	OK	Shelly Dunham	580-822-4417	4,000
Orange City Municipal Hospital	Orange City	IA	Martin Guthmiller	712-737-4984	10,400
Osceola Medical Center	Osceola	WI	Jeffrey Meyer	715-294-2111	6,800
Our Lady of Victory Hospital	Stanley	WI	Cynthia Eichman	715-644-5571	8,700
Ozark Health Medical Center	Clinton	AR	Kirk Reamey	501-745-9502	5,100
Phillips County Hospital & Family Health Center	Malta	MT	Ward Van Wichen	406-654-1100	3,600
Providence Valdez Medical Center	Valdez	AK	Sean McAllister	907-835-2249	4,100
Rio Grande Hospital	Del Norte	CO	Arlene Harms	719-657-2510	3,300
River's Edge Hospital & Clinic	St. Peter	MN	Colleen Spike	507-931-2200	12,300
Riverwood Healthcare Center	Aitkin	MN	Michael Hagen	218-927-5501	12,700
Sanford Hospital - Luverne	Luverne	MN	Mark Henke	207-283-2321	7,000
Saunders Medical Center	Wahoo	NE	Earl Sheehy	402-443-1417	5,000
Shoshone Medical Center	Kellogg	ID	Mike Pruitt	208-784-1221	4,300
Southern Coos Hospital and Health Center	Brandon	OR	James Wathen	541-347-2426	6,900
Southwest Health Center	Platteville	WI	Anne Klawiter	608-348-2331	14,900
St. James Medical Center - Mayo Health System	St. James	MN	Matt Grimshaw	507-375-3391	6,400
St. James Parish Hospital	Lutcher	LA	Mary Ellen Pratt	225-746-2990	10,200
St. Vincent Randolph Hospital	Winchester	IN	Cheech Albarano	765-584-0004	11,300
Tomah Memorial Hospital	Tomah	WI	Philip Stuart	608-372-2181	17,400
Wallowa Memorial Hospital	Enterprise	OR	David Harman	541-426-5300	6,900
Weatherford Regional Hospital	Weatherford	OK	Debbie Howe	580-774-2314	13,800
Yuma Hospital District	Yuma	CO	John Gardner	970-848-5405	4,500
Hospital "A", U.S.A.	-	-	-	-	19,700
Hospital "B", U.S.A.	-	-	-	-	12,900

2007 population data provided by Applied Geographic Solutions for service area as defined by the Dartmouth Atlas Hospital Service Area, or immediate ZIP Code if Dartmouth HSA is not available.

PURPOSE

The study is an educational resource for hospital leadership, board members, rural physicians, and community decision makers. Its purpose is to gather quantitative and qualitative data from communities who have replaced their critical access hospital to educate those considering, embarking on, or in the midst of a replacement facility project.

ELIGIBILITY CRITERIA

- Critical Access Hospital designation
- Replaced clinical areas between January 1, 1998 and January 1, 2009
- Operations in the community for at least three years prior to the replacement

The study typically generates discussion around a replacement. Initial areas for self-evaluation are:

Driving Factors: why would we replace?
Access to Capital: what can we afford?
Role of Leadership: how do we do this?

PARTICIPANTS

The Federal Office of Rural Health, State Offices of Rural Health and State Hospital Associations review and provide input on candidate hospitals for the study. Stroudwater Associates independently contacted each of the nominated facilities to confirm that the project was a replacement facility and to invite them to participate in the study.

PROCESS

The methodology established in 2005 and followed in each subsequent year of the study was developed and vetted by an advisory panel which includes government, academic, and financial expertise as well as a national non-profit entity whose mission is to build capacity in rural hospitals. Two data sets contribute to the methodology:

1. Quantitative Data

Stroudwater Associates uses publicly available cost report data, and participating hospitals verify the accuracy of the data and supplement the request with year-to-date experience. The quantitative data requested include:

Volumes: discharges, patient days, outpatient visits

Operating Efficiency: gross FTEs, FTEs per adjusted discharge, operating expense per adjusted discharge

Financial: operating margin, EBIDA, days cash and investments on hand

2. Qualitative Data:

Interviews with hospital CEOs are conducted both to complement and further examine the quantitative data. The interviews focus on any impact, whether positive or negative, the replacement facility has on quality, recruitment and retention, and the community. In addition, interviewees are asked what they would do differently.

DESIGN

Though the same factors play into a hospital's operational outcomes, the range within each factor is as varied as the number of critical access hospitals nationwide. The study compares data from before the replacement project to data after the replacement project. This comparison begins to control for differences within the community.

KEWANEE HOSPITAL, ILLINOIS


LAKEWOOD HEALTH SYSTEM HOSPITAL, MINNESOTA

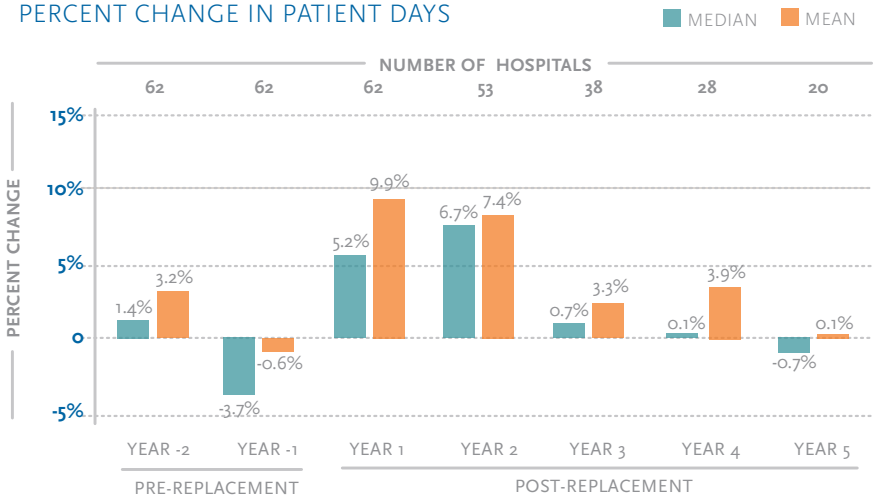
APPENDIX 2
Inpatient and Outpatient Volumes


RIO GRANDE HOSPITAL, COLORADO


FRANKLIN FOUNDATION HOSPITAL, LOUISIANA


CHATHAM HOSPITAL, NORTH CAROLINA

PERCENT CHANGE IN PATIENT DAYS



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.

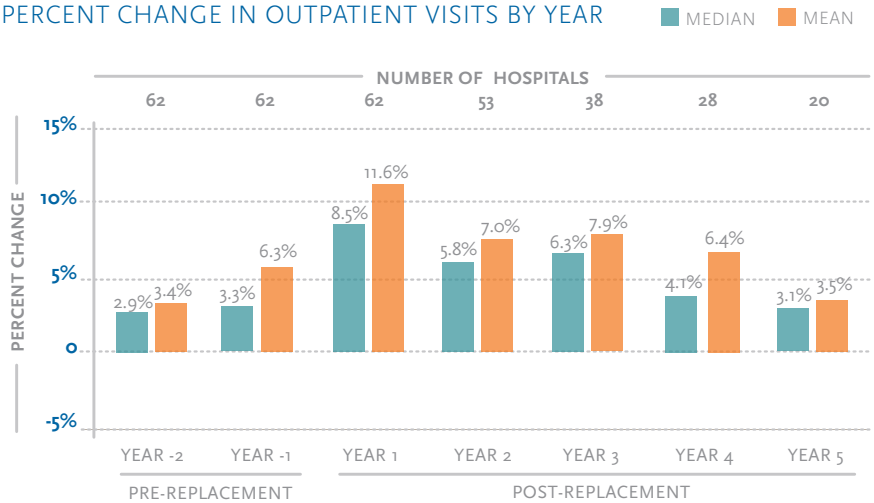
Inpatient Volumes

Pre-replacement inpatient volumes were flat or decreasing, with median volume changes of 1.4% two years before the new facility, and -3.7% one year prior. The post-replacement data show growth in patient days totaling 5.2% in the first year and 6.7% in the following year. Volumes held level in years three through five.

Outpatient Volumes

For outpatient services, volumes were increasing at approximately 3% per year for the two years prior to the new facility. In the first year of the replacement, outpatient visits increased 8.5%, followed by an additional 5.8% and 6.3% growth per year in years two and three, and 3% to 4% growth in years four and five.

PERCENT CHANGE IN OUTPATIENT VISITS BY YEAR



The sponsors wish to thank the participating hospitals for their commitment to this project and dedication in providing helpful advice to others at the beginning stages. The study reflects the hard work of great teams and their contributions make this a better study each year.

Stroudwater Associates

Stroudwater Associates is a prominent healthcare advisory firm committed to thought leadership grounded in experience. With offices in Portland, Maine; Atlanta, Georgia; Nashville, Tennessee; and Scottsdale, Arizona, Stroudwater provides strategic, financial, facility planning, and operational consulting services to a national clientele—from small, rural hospitals to academic medical centers, and from integrated health systems to stand-alone community hospitals.

Since 2005, Eric Shell and Brian Haapala have authored the Rural Hospital Replacement Study and presented the findings at national and regional conferences. This year, Jim Puiia joined Stroudwater and helped author the study.

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As an integrated design-build firm, The Neenan Company specializes in the design and construction of Rural and Critical Access Hospitals. By appropriately sizing a facility based on needed services, projected revenues, and financing capacity, Neenan creates cost-effective, sustainable facility investments that enable our clients to expand and enhance healthcare in their communities.

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GRAND RIVER HOSPITAL AND MEDICAL CENTER, COLORADO

5th ANNIVERSARY

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TOP LEFT: LAKEWOOD HEALTH SYSTEM HOSPITAL, MINNESOTA; BOTTOM LEFT: MELISSA MEMORIAL HOSPITAL, COLORADO; RIGHT: MCCUNE-BROOKS REGIONAL HOSPITAL, MISSOURI.