Special Industry Report

4th Annual Rural Hospital Replacement Facility Study

2008 Findings

Prepared by:

Stroudwater Associates

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Questions from the Field

- “What will the impact be in terms of volumes, profitability, and liquidity…..and are these results sustainable?”
- “How does our community afford the millions of dollars needed for updating or replacing our facility?”
- “Where do we access capital?”
- “How does a replacement facility affect our ability to recruit providers and staff?”
- “How have other CAHs dealt with the CMS relocation issues?”
- “Are there lessons learned from other rural facilities that have been replaced?”
- “Do replaced CAHs have a positive economic impact on their communities?”
• Purpose: Determine the impact associated with a new facility using the experiences of small, rural hospitals that have been replaced
  – Quantitative
    • Volumes: Discharges, patient days, outpatient visits, adjusted patient days
    • Operating efficiency: Gross FTEs, and FTEs and operating expense per adjusted patient day
    • Financial: Operating margin, EBIDTA, Days cash and investments on hand
  – Qualitative
    • 41 Interviews with CEOs/CFOs
• New for 2008 Study
  – **12 new** CAHs participating – 36% increase
    • 27 new CAHs opening in 2008 for next year’s study

<table>
<thead>
<tr>
<th>Year</th>
<th>Eligible CAHs</th>
<th>Participating #</th>
<th>Participating %</th>
<th>Participants by Years in New Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>27</td>
<td>20</td>
<td>74%</td>
<td>20</td>
</tr>
<tr>
<td>2006</td>
<td>30</td>
<td>24</td>
<td>80%</td>
<td>24</td>
</tr>
<tr>
<td>2007</td>
<td>39</td>
<td>33</td>
<td>85%</td>
<td>33</td>
</tr>
<tr>
<td>2008</td>
<td>56</td>
<td>45</td>
<td>80%</td>
<td>45</td>
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– Updated interview findings with emphasis on:
  • Did the hospital relocate? Any impact of the 75% rule?
  • Is the hospital pursuing additional capital projects?
• Sponsorship provided by Dougherty Company, LLC and The Neenan Company

• Original study: Advisory group consulted for input to process
  – Jerry Coopey, Federal Office Rural Health Policy
  – Terry Hill, Rural Health Resource Center
  – Ira Moscovice, University of Minnesota
  – Larry VanHorn, Vanderbilt University
  – Charles Ervin, Dougherty Mortgage, LLC

• Hospital participation
  – Reviewed historical financial and utilization data
  – Provided most recent operating information
  – Participated in 30 minute follow-up interview
Hospital Candidates and Selection

- Database from 2005, 2006, 2007 studies, supplemented by Federal Office of Rural Health Policy (FORHP)
  - Eligible hospitals
    - Replacement of clinical space between 01/01/98 and 01/01/08
    - Historical basis of operations for comparison
  - Candidates identified by State Office of Rural Health and State Hospital Association representatives
  - Stroudwater validated candidate list for eligibility with study criteria

- **45 of 56 eligible CAHs participated (80%)**
  - 2005 Study: 20 of 27 eligible CAHs participated (74%)
  - 2006 Study: 24 of 32 eligible CAHs participated (75%)
  - 2007 Study: 33 of 39 eligible CAHs participated (85%)
2008 Study: Eligible Facilities (n=56) and Greenfields (n=8)
All Replacements, Including Construction in Progress (n=104)
Study Limitations

- CAHs replacing their facility are not randomly selected and may not be the typical CAH
  - Study did not control for differences in:
    - Historical financial performance
    - Access to capital and/or fundraising
    - Management team experience

- Variation in quantitative and qualitative data suggests no selection bias in participation
  - Data reflects positive and negative performance
  - Interviewees shared both good and bad experiences
Prior Year Findings
• Nearly all CAHs reported growth in both inpatient and outpatient services
  - Annualized growth (does not account for compounding)
    • Acute and Swing Bed Discharges: Median 3.8%
    • Acute and Swing Bed Days: Median 4.4%
    • Outpatient Visits: Median 7.4%
    • Adjusted Discharges: Median 11%
  - Exceptions to growth related to:
    • Physician losses
    • Out-migration for primary care
    • Reached market potential
    • Competition
    • Facility constraints

• Annualized 4% increase in gross FTEs to accommodate higher patient volume and/or expanded services
• Annualized decrease in FTEs per adjusted discharge
  – Median -3.3%
  – Primarily the result of increased patient volumes which reduce standby capacity

• Annualized increase in operating expense per adjusted discharge
  – Median 4.1%
  – Primarily the result of additional interest and depreciation expense
  – Trend indicates declining costs as volumes accumulate

• Total Margin varies significantly among CAHs both pre- and post replacement
  – Year One: Median 0.3%
  – Year Two: Median -0.2%
  – Year Three: Median 1.3%
• EBIDTA varies much less than total margin
  – Year One: Median 14%
  – Year Two: Median 12%
  – Year Three: Median 12%

• Days of cash and investments on hand
  – Year One: Median 71 days
  – Year Two: Median 62 days
  – Year Three: Median 63 days

• Qualitative research offered “lessons learned” that can’t be put into numbers
  – Positive examples of new PI initiatives
  – Use of affiliated partner to access capital
  – Improved provider and staff recruitment
  – Direct and indirect positive economic impact to community
  – Balancing community needs and “what you can afford”
• Increased CAH activity in facility projects continues
  – Mix of renovation and replacement projects

• Historically high levels of credit now becoming more restrictive
  – HUD/USDA programs are likely to see increased activity

• Economy is a roller coaster

• Presidential election introduced uncertainty
  – Candidates had very different healthcare plans

• Quality is moving to the forefront and is directly tied to your balance sheet:
  – Pay for performance
  – Value Based Purchasing
  – Competition for quality and patient safety
Volume Indicators: Percentage Change in Discharges by Year

Annual Percent Change in Discharges

37 Hospitals with at Least Two Years Pre- and Post-Replacement Data

<table>
<thead>
<tr>
<th>% Change</th>
<th>Pre-Replacement -2 Years</th>
<th>Post-Replacement +2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>Mean</td>
</tr>
<tr>
<td>1.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3%</td>
<td></td>
<td></td>
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<tr>
<td>7.2%</td>
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<td></td>
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<tr>
<td>6.0%</td>
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</tbody>
</table>
Volume Indicators: Annualized Percentage Change in Discharges

Median = 2.7%

35 of 45 (78%) Increased
10 of 45 (22%) Decreased
2008 Findings

Volume Indicators: Percentage Change in Patient Days

Annual Percent Change in Patient Days
37 Hospitals with at Least Two Years Pre- and Post-Replacement Data

Pre-Replacement -2 Years % Change Per Year
-1.2%

Post-Replacement +2 Years % Change Per Year

Median
-1.2%
3.0%
5.3%

Mean
9.8%
Volume Indicators: Annualized Percentage Change in Patient Days

Median = 3.6%

35 of 45 (78%) Increased
10 of 45 (22%) Decreased
Volume Indicators: Percentage Change in Outpatient Visits

Annual Percent Change in Outpatient Visits

37 Hospitals with at Least Two Years Pre- and Post-Replacement Data

<table>
<thead>
<tr>
<th>% Change</th>
<th>Pre-Replacement -2 Years</th>
<th>Post-Replacement +2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>3.8%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Mean</td>
<td>4.7%</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

Median: 3.8%, 4.7%
Mean: 8.5%, 11.5%
**Volume Indicators: Annualized Percentage Change in Outpatient Visits**

**2008 Findings**

*Median = 7.5%*

45 of 45 (100%) Increased
Annual Percent Change in Total Volume

37 Hospitals with at Least Two Years Pre- and Post-Replacement Data

<table>
<thead>
<tr>
<th>% Change Per Year</th>
<th>Pre-Replacement -2 Years</th>
<th>Post-Replacement +2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median</td>
<td>2.7%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Mean</td>
<td>4.6%</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

-5%  0%  5%  10%  15%
2008 Findings

Volume Indicators: Annualized Percentage Change in Adjusted Patient Days

Median = 6.7%

40 of 45 (89%) Increased
5 of 45 (11%) Decreased
Hitting Targets?

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

<table>
<thead>
<tr>
<th></th>
<th>INPATIENT</th>
<th>OUTPATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXCEEDING</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>AT</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>BELOW</td>
<td>9</td>
<td>3</td>
</tr>
</tbody>
</table>
• “Volumes continue to increase, OP in particular.”
• “Just purchased new 32 slice CT to replace single slice. Oncology is booming.”
• “Way ahead of initial projections.”
• “ER visits were up to 1,755, highest number in history. Waking docs up at night!”
• “Original feasibility study projected $1M loss in Year 1 and breakeven Year 3. We are already at breakeven in Year 1 and will be profitable next year.”
• “Instituted orthopedics program. Surgery program increased 94%.”
• “Before the new facility we didn’t know if we could support one PT, we now have five.”
• “We were able to create margin in second year due to increased volume.”
“We are seeing patients now that would have never used our hospital.”

“Our volumes leveled off this year.”

“Lower than expected.”

“Recently losing IP market share but OP is keeping up.”

“IP lower than expected but OP is exceeding targets. Largest increase in volumes is in the ER.”

“IP has not met expectations but OP is $1M over projection.”

“After four years we have leveled mostly because we did not build large enough. Only built 15 beds.”
• CAHs generally reported growth in both inpatient and outpatient services

<table>
<thead>
<tr>
<th>Measure (Medians)</th>
<th>2 Yrs Pre-</th>
<th>2 Yrs Post-</th>
<th>All Years Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges</td>
<td>1.5%</td>
<td>7.2%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Days</td>
<td>-1.2%</td>
<td>5.3%</td>
<td>3.6%</td>
</tr>
<tr>
<td>OP Visits</td>
<td>3.8%</td>
<td>8.5%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Adjusted Patient Days</td>
<td>2.7%</td>
<td>9.9%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

• Exceptions to growth related to:
  – Lack of 2007-2008 flu season
  – Physician losses
  – Reached market potential
  – Competition
  – Facility constraints
Operating Efficiency: Percentage Change in FTEs

Annual Percent Change in Staffing
37 Hospitals with at Least Two Years Pre- and Post-Replacement Data

<table>
<thead>
<tr>
<th>% Change Per Year</th>
<th>Median</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Replacement -2 Years</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>Post-Replacement +2 Years</td>
<td>5.0%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>
Operating Efficiency: Percentage Change in FTEs

Annualized Change in Staffing
All Years Since Replacement

- Median = 3.8%

41 of 45 (89%) Increased
5 of 45 (11%) Decreased
Operating Efficiency: Percentage Change in FTEs per Adjusted Patient Day

2008 Findings

Annual Percent Change in Staffing Efficiency
36 Hospitals with at Least Two Years Pre- and Post-Replacement Data

Pre-Replacement -2 Years
% Change Per Year

-1.9%
-0.1%

Post-Replacement +2 Years
% Change Per Year

-6.2%
-4.0%

*Measured by FTEs per Adjusted Patient Day
Operating Efficiency: Percentage Change in FTEs per Adjusted Patient Day

Overall declines in FTEs per unit of service reflect improved efficiency.
Operating Efficiency: % Change in Operating Expense per Adjusted Patient Day

Annual Percent Change in Operating Expense per Unit of Service

37 Hospitals with at Least Two Years Pre- and Post-Replacement Data

<table>
<thead>
<tr>
<th>% Change Per Year</th>
<th>Median</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Replacement -2 Years</td>
<td>7.7%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Post-Replacement +2 Years</td>
<td>4.7%</td>
<td>7.1%</td>
</tr>
</tbody>
</table>
Operating Efficiency: % Change in Operating Expense per Adjusted Patient Day

2008 Findings

Median = 4.9%

35 of 45 (80%) Increased
9 of 45 (20%) Decreased
Comparison of Replacement Expenses to National Average

Variance from National Operating Expense per Unit of Service
# Hospitals Pre- and Post-Replacement

Overall expenses per unit of service were higher than national averages leading into the new facility, due to higher standby costs.

Variance continues for first two years of the facility investment and by year three, replacement hospitals are below national expenses per unit of service.
“We have added over 100 employees in the last year and a half.”

“Added another ambulance crew.”

“Continue to add staff, went from 200 to 240 FTEs.”

“Redesigned nursing to be more efficient – a centralized nurses’ station.”

“Sharing one entrance with privately owned physician practice – mall concept.”

“Put radiology and lab together because they share staffing.”

“Only CAH in the state to receive Energy Star Award.”

“Clean rooms 20% faster to help with infection control.”

“Nursing is more efficient which results in a reduced wait time.”

“Replaced ER company with 3 employed ER trained PAs - $20K savings.”
Operating Efficiency: Takeaways

- Operating efficiency improved in replacement facilities overall:

<table>
<thead>
<tr>
<th>Measure (Medians)</th>
<th>2 Yrs Pre-</th>
<th>2 Yrs Post-</th>
<th>All Years Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td>FTEs</td>
<td>3.7%</td>
<td>5.0%</td>
<td>3.8%</td>
</tr>
<tr>
<td>FTEs per Adj. ADC</td>
<td>-1.9%</td>
<td>-6.2%</td>
<td>-3.2%</td>
</tr>
<tr>
<td>Operating Expense per Adj. ADC</td>
<td>7.7%</td>
<td>4.7%</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

- Primarily the result of:
  - Increased FTEs to accommodate higher volumes
  - Increased patient volumes reduce standby capacity
  - Trend indicates declining costs as volumes accumulate
Profitability: Total Margin

37 Hospitals with at Least Two Years Pre- and Post-Replacement Data

Pre-Replacement -2 Years
Average %

- Median: 2.3%
- Mean: 1.9%

Post-Replacement +2 Years
Average %

- Median: 0.6%
- Mean: 0.0%
Profitability: EBIDTA

EBIDA Margin

37 Hospitals with at Least Two Years Pre- and Post-Replacement Data

% Change

-5% 0% 5% 10% 15%

Pre-Replacement -2 Years
Average %

Post-Replacement +2 Years
Average %

0.2 0.4 0.6 0.8 1 1.2 1.4

Median
Mean

7.8% 7.2%
13.3% 12.7%
Profitability: Days of Cash and Investments on Hand

Days Cash on Hand

37 Hospitals with at Least Two Years Pre- and Post-Replacement Data

- Pre-Replacement -2 Years Average %: 83.5 (Median) vs. 103.2 (Mean)
- Post-Replacement +2 Years Average %: 71.0 (Median) vs. 91.2 (Mean)
• **Financial results in summary:**

<table>
<thead>
<tr>
<th>Measure (Medians)</th>
<th>Year One</th>
<th>Year Two</th>
<th>Year Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Margin</td>
<td>0.3%</td>
<td>2.8%</td>
<td>1.4%</td>
</tr>
<tr>
<td>EBIDA</td>
<td>12.6%</td>
<td>14.0%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>68</td>
<td>62</td>
<td>83</td>
</tr>
</tbody>
</table>

- Total margin varies significantly among CAHs both pre- and post-replacement
- Much less variation in EBIDA with nearly all CAHs reporting positive results
  - Positively impacted by interest and depreciation included in Medicare cost base
- Replaced CAHs are at front end of capital cycle which generally depresses liquidity (aka, cash)
- Initial reduction is core rationale for minimizing equity investment
• The size and makeup of the service area is comparable between replacement communities and all other CAHs

  – Median replacement Service Area = 12,200
  – Service area definitions from Dartmouth Atlas
  – Replacement community 10 year growth rates are modest at 3.1% median
  – 14.2% median growth of 65+ population
Demographics and Service Area: Comparison

- The size and makeup of the economics is also comparable between replacement communities and all other CAHs
  - Household income median for service area is $41,000
  - Replacement household income medians are 84.1% of the state and 76.4% of the US
1. How did the organization access capital?
2. Goals of the replacement?
3. Barriers to initiating the project?
4. How far did the new facility relocate?
5. Is the facility meeting the expected volumes?
6. Are you currently involved in any new capital projects?
7. Has the new facility supported PI initiatives?
8. Effect on provider or staff recruiting/retention?
9. What would you change if you could?
10. What would you recommend to other organizations considering replacement?
11. Have you noticed community economic development occurring as a result of your new facility?
How did the organization access capital?

- CAHs acquired capital through:
  - Guarantee from System: 9
  - Guarantee from County/City: 6
  - HUD 242/USDA:
    - HUD 242 Loan Guarantee: 4
    - USDA Community Facilities – Direct and guarantee: 11
  - Private Placement: 8
- Nearly all CAHs held major fundraising/capital campaigns to supplement external capital
  - The few that did not wished they would have
How did the organization access capital?

- “Feasibility study done to evaluate fund-raising, study indicated no support from community, elected not to do major capital campaign.”
- “Raised cash and pledges of $1.6 million through development dollars.”
- “Local physician chaired the capital campaign … Raised $3.2 million in a community of 11,000.”
- “Started planning early and made financial preparations.”
- “Conventional loan, fixed revenue, bonds, city sales tax.”
Replacement Goals: Old facility not meeting needs

- Old facility was landlocked/out of capacity
  - “Old hospital from 1949, well-maintained but inefficient. No toilets in rooms.”
  - “Increase square footage to support services, improve quality, recruit and retain medical and professional staff.”
  - “Original hospital was built in 1951 and there was no space.”

- Continue to serve actual community needs
  - “We were failing as a hospital. The longer we put it off, the more at risk we were of becoming irrelevant.”
  - “Back in 1950, it was a perfect location, but as the community grew access became a problem.”
  - “Address patient amenities and experience entirely.”

- Financially responsible and viable
  - “Linked existing doctors’ building with the new hospital.”

- Goals to convert semi-private to private beds
- Goals to increase outpatient space
Replacement Goals: Thoughtful, Innovative Design

- “Heated sidewalks for safety in outside access.”
- “First to use wood pellet system for heating. Recover the cost in 18 months. All automated, boiler came from Austria.”
- “Design ‘green’ functionality into the new facility: boiler regulators, types of lighting. Considering thermo-energy.”
- “Working to put boiler regulators in: cost savings, reduces emissions, and extends the life of the boiler.”
- “Design quality and safety into rooms: round corners, strategically placed grab bars, and infection control.”
- “More efficient lay-out of space.”
“First architect designed plans we could not afford.”

“One year educational process.”

“Getting it going, financial constraints from prior year losses.”

“Barrier was financial constraint imposed by prior year losses.”

“Cost to capital issues. We started in 1996 to build balance sheet to support capital needs.”
Barriers to Initiating Project: Community Stakeholders

• “Identified key leaders in each age bracket, developed a Powerpoint for them to present at community meetings.”

• “The community got behind it and from that point forward it’s pretty smooth sailing.”

• “We kept staying on message like a political campaign.”

• “President of the capital campaign was initially one of the skeptics.”
Barriers to Initiating Project: Relocation as a barrier?

DISTANCE CAH RELOCATED FROM FORMER CAMPUS

<table>
<thead>
<tr>
<th>Distance</th>
<th>Number of CAHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 MILES</td>
<td>13</td>
</tr>
<tr>
<td>1 MILE</td>
<td>17</td>
</tr>
<tr>
<td>2 MILES</td>
<td>9</td>
</tr>
<tr>
<td>3 or more miles</td>
<td>3</td>
</tr>
</tbody>
</table>
Barriers to Initiating Project: Relocation as a barrier?

- 9 CAHs were affected by CMS relocation rules
  - All reported that 75% rule would have been met
- “Our CFO did a great job submitting data demonstrating we met the 75% rule.”
- “Letter was written during construction. Got a 3-sentence letter back from CMS saying we maintained CAH status.”
- “No problem. We felt we could give them the data they needed.”
• “Broke ground on a 7,500 square foot Rural Health Clinic that will open in October.”

• “Planning MOB to be built on hospital campus.”

• “Had shell for third OR, currently in process of equipping it to support anticipated volumes.”

• “Planning an $8M expansion project – doubling PT, adding permanent MRI, building 2 new ORs…”

• “Adding ten more spaces for parking.”

• “Looking to expand by adding procedure room, cardiac rehab, and pharmacy.”

• “Starting to look at more space for visiting specialists.”

• “Current master facility plan includes pushing out ER, OB and adding 2 floors to MOB.”

• “Will be developing medical campus breaking ground next year. Adding assisted living, rehab, office space, etc.”
Has the new facility supported Patient Safety Initiatives?

- “Surgery recovery rooms are separate and all IP rooms are private which has contributed to reduced infections.”
- “Continue to maintain close to zero surgical infection rates.”
- “This year very, very, very low post surgical infection rates.”
- “Surgeon from a for-profit surgery center told patient he would prefer to do surgery at our hospital because infection rate so low.”
- “Design of new unit is much safer; OB is a locked unit.”
- “Private bathrooms and rooms to prevent patient falls and isolate patients with infections.”
- “Proximity of clinic and physicians helps with quality scores, communication barrier eliminated.”
- “Design quality and safety into rooms: rounded corners, grab bar strategically placed.”
- “Without new facility, same old same old.”
- “Staff enthusiastically began 5 Million Lives campaign.”
Any effect on provider recruiting and retention?

- “Additions for 2007 including urologist full time and orthopedist 1.5 days per week.”
- “Facility has no more space for new providers.”
- “We have 5 internists, that was our goal. Added one FP during the year.”
- “Doctors are seeking us out – we’re not advertising.”
- “Got cold letters from out of state physicians seeing if there are openings.”
- “We were able to recruit a physician to our clinic because of the new facility.”
- “Did not even have to recruit, FPs contacting us to ask about vacancies.”
- “Locum clinic doctor signed on full time two days after new facility opened.”
Any effect on provider recruiting and retention?

- “The last two doctors we signed did a walk-through and they basically asked, “Where do I sign up?”
- “Retained both physicians from last year and recruited two more.”
- “Physicians had been on several interviews and said this was the best facility they had seen.”
- “Have built this facility so that we could recruit new MDs when current MD retires.”
- “Current medical staff are being recruited but won’t leave because of the new facility.”
- “Visiting subspecialties has been a ‘gold mine’. Say dedicated space is first rate, better than their own practices.”
- “Had two PCPs in private clinic forever – just recruited third and fourth MDs!”

River’s Edge Hospital and Clinic
(formerly St. Peter’s)
Minnesota
Any effect on staff recruiting/retention?

• “Hired CEO because of new facility, “I wanted to be a part of this.”

• “Prior to new facility, DON was pulling her hair out trying to recruit and keep nurses. Nurse staff has stabilized, able to recruit a lab tech.”

• “Haven’t had a nurse shortage for multiple years.”

• “Firmly believe that with the new facility, local kids will want to get nursing degree and work at home.”

• “Have been very successful in recruiting staff. Nursing staff is full. Have not had locums in years.”
Any direct/indirect impact on community economic development?

- “Opening new K-12 school. New hospital contributed to voters to pass new school. Combined these attract new families.”
- “Town council keenly realizes that hospital will attract industry.”
- “Continue to add staff to promote program growth – increased from 200 to 400 FTEs.”
- “New high school construction is underway.”
- “The community has a better sense of pride in itself and comfort that healthcare services can be delivered locally.”
- “20 acres, three blocks north of the hospital, just acquired to develop a community center.”
- “Large parcel across the street has been cleared by private developed for medical space.”
Any direct/indirect impact on community economic development?

- “Talking to private developer about developing medical space on our campus.
- “City Council wanted to keep the land for ‘industry’, healthcare is an industry.
- “New MOB being built by physicians. New retail and housing are growing.”
- “When we are selling a company on our community, the hospital is a key place.”
What would you change if you could?

- “Design facility to be more flexible for expansion or built in additional unused space. We built to fit for operation that existed at the time of expansion.”
- “Important that private rooms are big enough.”
- “Engage pre-construction manager one year before the architects.”
- “We did not involve clinical departments in design … have had to spend dollars and do workarounds.”
- “Would have shelled in space.”
- “3 partners you must find first: 1) financial partner 2) reputable pre-construction firm 3) financing partner”
What would you recommend to other organizations?

• Planning

  – “Give much more attention to replacement over renovating. Sacrifice so much when just renovating.”

  – “Could not imagine renovating an old site and getting same outcomes for efficiency, patient experience, etc.”

  – Engage community – transparency: what are we doing and why are we doing it?”

  – “Involve clinicians in upfront design to improve patient flow, efficiency, and communication.

  – “If any way to make it happen financially, do it. Level of care and quality of service is not comparable to old Hill Burton hospital.”

  – “If you’re a community hospital don’t ignore the community – get involved early.”

  – “We can’t afford a new facility? We can’t afford not to have a new facility.”
What would you recommend to other organizations?

• Advisors
  
  – “Spend money where you need it. Pre-construction services reduces risks, improves quality of facility, and drives down financing costs.”
  
  – “Hire a financial consultant first to determine what you can afford BEFORE going to architects.”
  
  – “Hire a financial advisor who is neutral.”
  
  – “Make sure covenants aren’t too restrictive … don’t want to overly hinder future operations.”
  
  – “Be leery of CAH consultants – there are a lot of CAH consultants running around out there.”
What would you recommend to other organizations?

• Flexibility for Growth
  – “Build in growth plans to original design.”
  – “Expect influx in patient volumes so plan and staff accordingly.”
  – “Use shell space for growth.”
  – “Use shelled space if you can afford any at all.”
  – “Architects designed for averages, not peaks, imaging and lab get jammed up.”
  – “Invest in new technologies to improve services to the community.”
  – “Look out more than three years. We ran out of space after three years.”
• Continued increase in CAHs pursuing replacement projects
• Patient volumes generally increased beyond expectations
• Staffing increased for higher volumes and/or new services
• Increasing evidence of reductions to unit costs
• Facility as physician recruitment strategy
• Improved ability to recruit and retain staff in an increasingly competitive environment
• Direct and indirect economic development consistently reported
• Findings from the analysis of replacement CAHs are compelling; however, experiences vary, which indicates there are no guarantees for success
  – The 45 CAHs that participated in the study are likely unique in many ways
  – Factors, other than a new facility, influencing success:
    • Environmental and general healthcare trends
    • Service area: health status, competition, and market share
    • Pre- vs. post-replacement service offerings
    • Changes in physician supply and/or capabilities
    • Capabilities of the management team & community support
• We would like to thank all of the participating hospitals for their contributions to this study. Their willingness to share both their data and their stories enriched the final product.

• We would also like to acknowledge the sponsors and Advisory Group for their on-going contributions and support.

• Copies of the full report include a narrative appropriate for CEOs, CFOs, Trustees, and other interested stakeholders. Printed copies are available free, upon request, or by downloading them from www.stroudwaterassociates.com.

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Thank you.