JOINT COMMISSION ON HEALTH CARE

FINANCIAL CONDITION OF VIRGINIA'S RURAL HOSPITALS

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

FINAL REPORT

COMMONWEALTH OF VIRGINIA
RICHMOND
2026

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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This Final Report on the *Financial Condition of Rural Hospitals in Virginia* has been revised to make clear that the Center for Healthcare Quality and Payment Reform (CHQPR) does not identify individual hospitals "at risk of closure" and that individual rural hospitals in Virginia designated as "at risk of closure" in Table 2 on page 13 were identified by JCHC staff applying factors described by CHQPR to Virginia hospital data. The methodology applied by the JCHC differs from that applied by CHQPR. The list of rural hospitals identified as "at risk of closure" in Table 2 on page 13 of the Final Report on the *Financial Condition of Rural Hospitals in Virginia* has not changed.

The Final Report on the *Financial Condition of Rural Hospitals in Virginia* is also revised to make clear that the number of rural hospitals estimated by CHQPR as "at risk of closure" nationwide is drawn from the January 2026 edition of CHQPR's report on *Rural Hospitals at Risk of Closing* rather than the May 2026 edition, which was published after the date on which research for the Commission Draft Report on the *Financial Condition of Rural Hospitals in Virginia* was completed, and to correct the designation of Buchanan General Hospital in Table 5 on page 20 of the report. Buchanan General Hospital was incorrectly designated as "at risk" of closure. In the final report, Buchanan General Hospital is correctly designated as having "no risk factors" pursuant to the JCHC staff analysis.

Financial condition of Virginia's rural hospitals

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Financial condition of Virginia's rural hospitals

Executive Summary

Rural hospitals in the Commonwealth face growing risk of financial distress, service reduction, and potential closure as they face challenges with low patient volumes, unfavorable payer mix, inadequate reimbursement, rising costs, and persistent workforce shortages. Federal payment adjustments and special rural designations help support some hospitals, but they do not fully solve the structural gap between costs and reimbursement. These pressures are steadily weakening the financial stability of hospitals that serve as critical access points for emergency, inpatient, and outpatient care in geographically isolated and medically underserved communities. Since 2005, 108 rural hospitals have closed throughout the nation, and 139 rural hospitals have eliminated inpatient services.

Rural hospitals' risk of financial distress or closure can be identified through analysis of financial performance indicators. The Center for Healthcare Quality and Payment Reform (CHQPR) framework focuses on operating margins and financial reserves to assess risk of closure, while the University of North Carolina Sheps Center Financial Distress Index (FDI) combines financial, operational, and market-level factors to predict longer-term risk of experiencing financial distress. Using factors described by the CHQPR and distress risk determined by the FDI model, JCHC staff identified seven rural hospitals in the Commonwealth as being at highest risk of either immediate closure or experiencing financial distress. These hospitals share a common pattern of system affiliation, thin operating margins, limited reserves, heavy public-payer dependence, structural difficulty sustaining broad inpatient services including obstetrical services, and a shift towards outpatient revenue dominance.

Financial and operating pressures are forcing many hospitals to concentrate on emergency and outpatient care, reduce or eliminate inpatient services, and restructure in ways that preserve access but narrow what the hospital can provide to its community. When this happens, communities face longer travel times, delayed access to care, and the loss of an important economic anchor. These trends extend to the larger rural hospital system in Virginia. Facility and system-level efforts seek to address these broad challenges through collaboration and innovative models. However, federal policy changes under H.R. 1 further compound risk factors faced by rural hospitals in the Commonwealth.

Financial condition of Virginia's rural hospitals

Rural hospitals in the Commonwealth of Virginia are experiencing financial and operational pressures that may place them at risk of financial distress or closure. Challenges faced by Virginia's rural hospitals, including declining patient volumes, low reimbursement rates, increasing expenses, and workforce shortages, are reflective of national trends. Rural hospitals serve as critical access points for emergency, inpatient, and specialty care – particularly in geographically isolated and medically underserved communities. Maintaining the financial sustainability of these institutions is vital to ensuring continued access to essential health care services in Virginia.

At its October 2025 meeting, the Joint Commission on Health Care (JCHC) directed staff to conduct a study of the financial and operational conditions of rural hospitals in Virginia. The study examines rural hospital conditions by: (i) describing the financial and operational trends of rural hospitals nationwide and in the Commonwealth, (ii) describing the frameworks through which risk of rural hospital insolvency can be analyzed, (iii) assessing the risk of rural hospital insolvency in the Commonwealth, and (iv) providing an overview of unique characteristics and priorities of rural hospitals in Virginia at the greatest risk of insolvency or closure.

JCHC staff used both qualitative and quantitative research methods to collect the evidence used to inform this study, including literature review, document review, and stakeholder interviews. See APPENDIX 1 for detailed methodology.

Rural hospitals are at risk of financial distress and closure nationwide

Rural hospitals are an important access point for essential health services in the communities they serve. Like hospitals across the United States, rural hospitals are facing growing financial pressure. Operating costs including labor, medical supplies, and facility maintenance have increased significantly in recent years, while payments from Medicare, Medicaid, and private insurers have not kept pace. Rural hospitals, however, often encounter additional obstacles related to their size, location, and the populations they serve. These factors make rural hospitals particularly vulnerable to financial distress and closures, despite ongoing federal support efforts.

Rural hospitals provide an array of health care services in the communities they serve

Hospitals are licensed healthcare facilities that provide a range of medical services. These services, referred to as service lines, generally include emergency services for urgent and life-threatening conditions, planned and emergency surgical services, and obstetrical services for pregnant patients, among others. Services can be delivered on either an inpatient or outpatient basis. Inpatient services require admission to the hospital and at least one overnight stay, such as for surgeries, serious illnesses, or recovery from major medical events. Outpatient services are provided to patients who seek treatment from the hospital but do not stay overnight, such as for diagnostic tests, minor procedures, and follow-up appointments. While some hospital services may be provided by other health care providers in a community, many hospital services cannot be provided by other providers, making hospitals a vital component of the Commonwealth's health care system.

Rural hospitals — hospitals located outside of a metropolitan area — often serve as the primary source of hospital-based care for residents of the communities they serve. While communities in metropolitan areas may have access to an array of health care providers and multiple hospitals within a reasonable driving distance, rural communities are often served by a single hospital, with long travel times to other hospitals. Of the 6,100 hospitals operating in the United States, 1,797 are rural hospitals. In Virginia, 36 of the state's 109 licensed inpatient hospitals are classified as rural.

Rural hospitals face unique challenges that increase risk of financial distress and closure compared to non-rural counterparts

Rural communities tend to have smaller populations than suburban or urban communities, which can result in lower patient volumes at rural hospitals. As a result, rural hospitals are often smaller than other hospitals, with fewer licensed beds and fewer specialized services and service lines. Low patient volumes, smaller capacity, and more limited service lines mean that fewer patients receive services for which reimbursement may be paid, leading to lower revenues for rural hospitals.

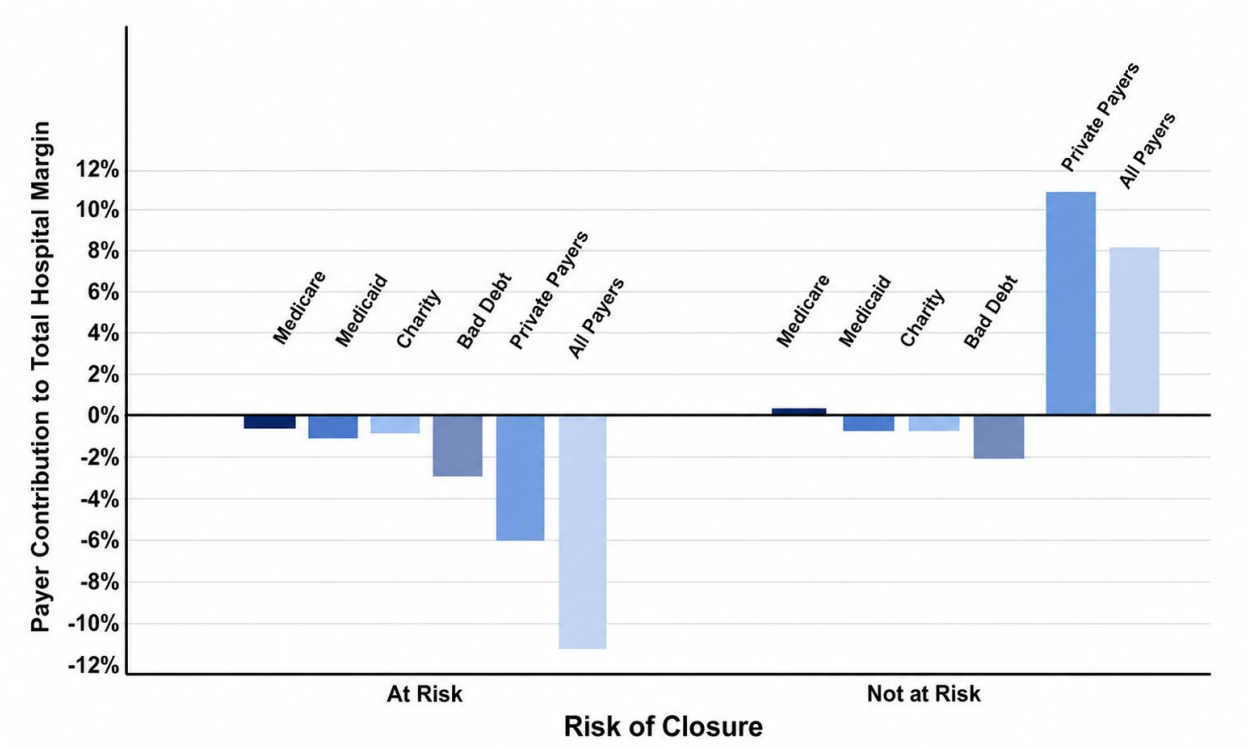
Payer mix creates additional challenges for rural hospitals. Rural hospitals treat a higher proportion of Medicare and Medicaid patients than their non-rural counterparts. Medicaid and Medicare base reimbursement rates may not fully cover the cost of services provided to patients at rural hospitals. As the proportion of hospital patients covered by Medicaid and Medicare increases, the gap between the cost of providing health care services and income from reimbursement grows. When public payers account for over 60 percent of revenue, rural hospitals consistently spend more on care than they recoup in payments.

Private insurance reimbursements do not uniformly stabilize rural hospitals. Individual hospitals negotiate reimbursement rates with health insurance providers. Although private payers generally reimburse at higher rates than Medicare or Medicaid, many rural hospitals

still operate at a loss because they lack the bargaining power and patient volume needed to negotiate favorable contracts. Rural hospitals with greater negotiating power — those with higher patient volumes that translate into greater market share — are often able to negotiate higher reimbursement rates than hospitals with less negotiating power. Hospitals with low market share such as small rural hospitals with low patient volumes are often at a disadvantage in reimbursement rate negotiations and often receive private insurance payments that are insufficient to fully cover the cost of care.

Analyses of hospital cost reports reveal that rural hospitals identified as at-risk of closure experience negative margins across nearly every payer category, including private insurance (FIGURE 1). For these hospitals, losses associated with Medicare, Medicaid, charity care, and bad debt are substantial, and private insurance payments are often not high enough to offset those deficits. As a result, these hospitals continue to operate with overall negative margins. In contrast, hospitals that are not considered at-risk of closure receive more favorable reimbursements from private payers that are able to offset the losses incurred in providing services to patients enrolled in Medicare and Medicaid.

FIGURE 1. Payer-specific profits and losses at rural hospitals (2024-25 cost report years)



The bars show the median profit or loss on services delivered to patients with each type of insurance in each group of rural hospitals.

SOURCE: Center for Healthcare Quality & Payment Reform, CMS Cost Report Data, 2024-25

For rural hospitals, low patient volume combined with low reimbursement from public and private health insurance translates into low revenue, which limits the resources available to support operations, maintain infrastructure, and recruit staff. Despite these challenges, rural hospitals must still maintain essential equipment, facilities, and staff to provide health care services, keeping certain expenses fixed and high. Inflation in the cost of medical supplies, pharmaceuticals, and contracted services further increases operating expenses across the health care sector. Because the cost of providing health care services does not fall when a hospital's census drops, even modest declines in patient volume can quickly turn into operating losses.

Staffing is a major challenge and expense for Virginia's rural hospitals. In Virginia, many rural communities fall within federally designated Health Professional Shortage Areas and Medically Underserved Areas, where recruiting and retaining physicians, nurses, and technicians is especially difficult. Rural communities may not offer lifestyle and salaries available in cities, making recruiting and retention challenging. In recent years, many hospitals have faced increasing labor costs associated with workforce shortages. Broader competition for health care providers willing to provide services in rural areas increases recruitment and retention costs and has forced rural hospitals to increase reliance on expensive contract staffing to fill workforce gaps. Labor expenses alone typically account for more than half of hospital operating costs, making workforce pressures particularly consequential for small hospitals with limited financial flexibility. For hospitals already operating with thin margins and limited reserves, these pressures can quickly transform modest deficits into sustained operational losses.

Finally, rural hospitals can't easily diversify services to offset low revenues resulting from low patient volume, low reimbursements, and high expenses. Large urban systems, with higher patient volumes and financial resources to support more specialized service lines, can operate profitable lines like elective orthopedics or cardiology to deliver positive revenue and provide financial cushions to cover the cost of service lines that lose money such as emergency care. The small size, limited capacity, and low patient volume of most rural hospitals prevents these hospitals from offering more extensive service lines and higher revenue services. As a result, rural hospitals often provide a more limited array of basic health care services contributing to thin or negative margins.

Federal payment models seek to reduce financial challenges faced by rural hospitals

Hospitals receive reimbursement for health care services consistent with frameworks administered by the Centers for Medicare & Medicaid Services (CMS) which implements prospective payment methodologies for the Medicare and Medicaid programs. Under the Medicare Inpatient and Outpatient Prospective Payment Systems (IPPS and OPPS), hospitals are reimbursed at rates set by CMS that reflect the expected cost of health care services rather than on the basis of actual cost. Prospective reimbursement rate amounts

are determined using national or regional formulas rather than analysis of each hospital's actual cost of providing care. As a result, Medicaid and Medicare reimbursement rates may not be adequate to cover hospitals' actual cost of providing care.

Federal payment models are intended to mitigate financial pressures on rural hospitals and preserve access to health care by providing additional federal funds to support rural hospital operations. Critical Access Hospital (CAH), Sole Community Hospital (SCH), Medicare Dependent Hospital (MDH), and Rural Referral Center (RRC) payment models provide adjustments to public payer reimbursements by modifying or supplementing prospective payments to account for geographic isolation, patient mix, or reliance on Medicare revenue. Hospitals may use multiple payment models if they meet program criteria, and several rural hospitals in Virginia operate under at least one of these payment models (TABLE 1).

TABLE 1. Rural hospitals in Virginia are reimbursed under diverse payment models

Payment Models	Number of Rural Hospitals
Critical Access Hospital (CAH)	8
Sole Community Hospital (SCH)	13
Medicare Dependent Hospital (MDH)	6
Rural Referral Center (RRC)	7

SOURCE: JCHC staff analysis of Virginia Health Information Annual Licensure Survey Data, 2024 and UNC Sheps Center FDI Data, 2025-2026 (Malone TL, Pink GH, Holmes GM. An Updated Model of Rural Hospital Financial Distress. Journal of Rural Health, 2024. doi: 10.1111/jrh.12882). (Note: some hospitals have multiple payment models and are counted for each payment model)

Among the earliest and most enduring of these payment adjustments is CAH designation, established under the Medicare Rural Hospital Flexibility Program by the Balanced Budget Act of 1997. CAH status is available to small rural hospitals meeting criteria including rural location and a maximum of 25 acute care beds. Under this model, hospitals receive cost-based reimbursement from Medicare that covers approximately 99 percent of their actual documented allowable costs for inpatient, outpatient, laboratory, therapy, and swing-bed (beds that switch between acute care and skilled nursing for post-hospital recovery) services. This helps low-volume hospitals align payments closer to actual expenses, easing the financial strain of rural operations. As of early 2026, there are over 1,350 CAHs throughout the nation operating in 45 states; eight of these are in Virginia.

Other rural-specific payment models operate within the prospective payment system but provide targeted adjustments. SCHs receive enhanced reimbursement to reflect their status as the sole source of inpatient care within a defined geographic area, allowing payment

rates to incorporate historical costs rather than relying exclusively on national averages. MDHs, which serve a high proportion of Medicare patients, benefit from payment protections that account for their reliance on Medicare revenue, including blended rates tied to both current and historical costs. RRCs, often larger rural hospitals that function as regional hubs, receive adjustments such as more favorable wage index calculations and referral-based recognition that supports their broader service capacity. Hospitals may identify as an RRC in addition to other rural hospital reimbursement payment models. While these payment models do not fully offset low prospective payment amounts, they represent incremental efforts to better align reimbursement with the realities of rural care delivery.

Rural hospitals that serve a high volume of low-income, uninsured, or Medicaid patients may also be eligible for supplemental Disproportionate Share Hospital (DSH) payments. DSH payments are state-administered and federally matched through the Medicaid and Medicare programs, providing funds to offset the cost of uncompensated or under-reimbursed care. These payments are especially critical for rural hospitals operating in economically vulnerable communities where payer mix compromises financial stability.

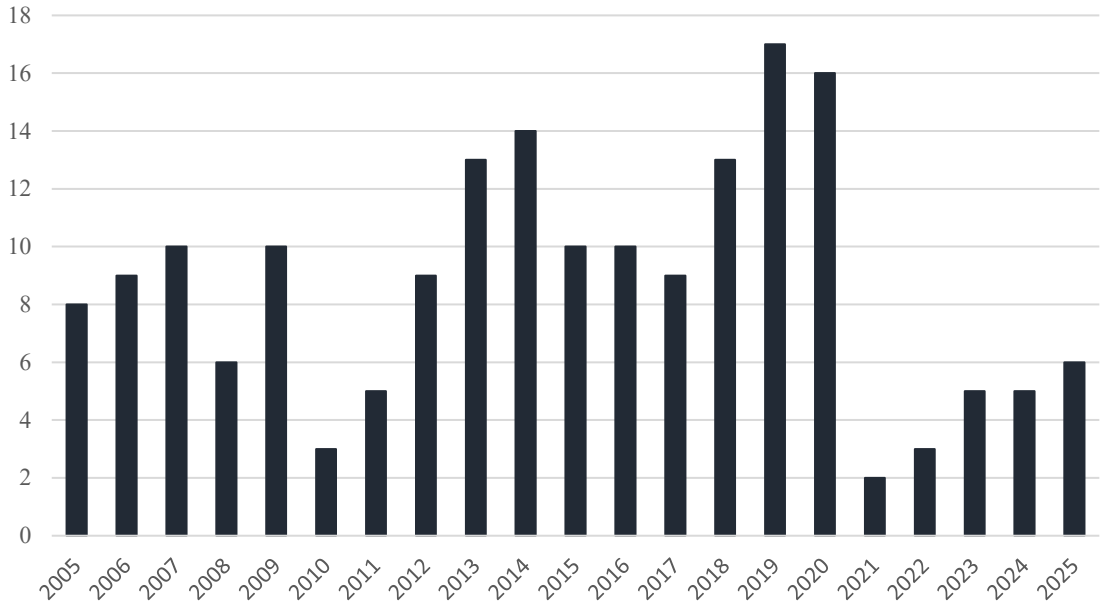
Despite federal interventions, 247 rural hospitals closed or ceased providing inpatient services since 2005

Despite federal programs intended to mitigate financial distress experienced by rural hospitals, many rural hospitals have closed or restructured to provide outpatient services only over the last two decades.

Since 2005, 108 rural hospitals have closed in the United States

Rural hospitals that operate under a prolonged state of financial distress caused by low revenues and high expenses are at risk of closing. In the United States, 108 rural hospitals have closed since 2005 (FIGURE 2). The pace of closures temporarily slowed between 2021 and 2022, as financial challenges faced by rural hospitals were buffered by federal funding available during the COVID-19 public health emergency. However, with the elimination of supplemental federal funding, the rate of closures accelerated in 2023 and continue to persist. Local subsidies and nonoperating income may provide some relief to rural hospitals that are able to obtain funds, but almost one-third of rural hospitals recorded overall losses in 2024–2025 despite the availability of local funding, indicating that additional hospitals may be at risk of closing in the future.

FIGURE 2. Rural hospital closures have increased since 2005



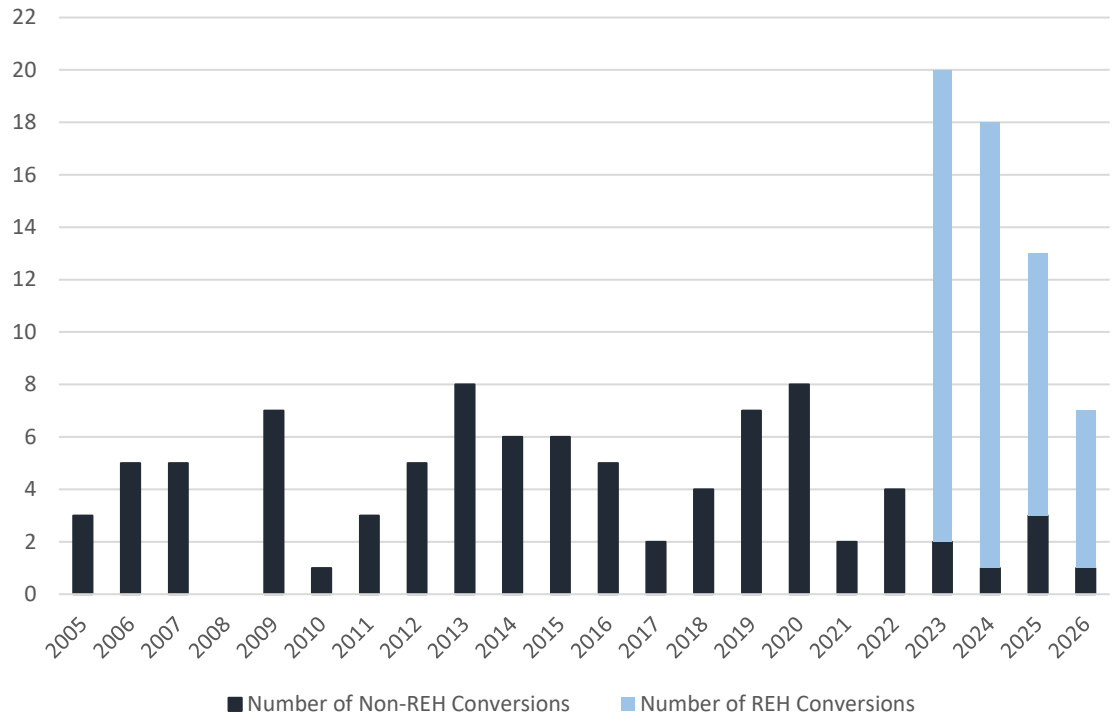
SOURCE: Center for Healthcare Quality & Payment Reform, Cecil G. Sheps Center for Health Services Research, CMS Data 2005-2025 (Note: No closures have been recorded in 2026 YTD as of 5/26/26)

In Virginia, two rural hospitals have closed since 2005 – Pioneer Health Services of Patrick County and Wellmont Mountain View Regional in the City of Norton. Additionally, Lee County Community Hospital closed in 2013 and later reopened in 2021 under a limited-service model, restoring emergency and outpatient care but not full inpatient capacity.

Since 2005, 139 rural hospitals have reduced services, eliminating inpatient service lines and focusing on outpatient and emergency services

Between 2005 and 2022, 81 rural hospitals restructured operations to eliminate inpatient services (FIGURE 3). In practice, this approach stabilizes financial conditions by narrowing the scope of services to those for which demand is more predictable and that are less capital-intensive. While these hospitals no longer provide inpatient services for their communities, they retain a local footprint by maintaining outpatient services such as primary care, specialty services, skilled nursing care, or long-term care.

FIGURE 3. 139 rural hospitals have eliminated inpatient service lines since 2005



SOURCE: Center for Healthcare Quality & Payment Reform, Cecil G. Sheps Center for Health Services Research, CMS Data 2005-2026 YTD as of 5/26/26 (Note: REH Conversion = CMS designated hospitals that eliminated inpatient services to provide emergency and outpatient offerings)

Beginning January 1, 2023, the Rural Emergency Hospital (REH) payment models, authorized in the Consolidated Appropriations Act of 2021, provided incentives to eligible CAHs and small rural hospitals to eliminate inpatient capacity entirely and focus on 24-hour emergency care, observation services, and outpatient care. Participating hospitals receive enhanced reimbursement through outpatient prospective payment rates plus a five percent add-on and a fixed monthly facility payment. Nationally, since 2023, 51 hospitals have received participated in REH payment models, though no rural hospitals in Virginia participate in this payment models. This emerging model signals a structural shift in rural hospital service delivery where remaining outpatient and emergency infrastructure can continue to meet routine and stabilization needs, allowing communities to retain a baseline level of access that might otherwise be lost entirely.

While a number of rural hospitals have utilized the REH payment model to mitigate financial risk and preserve access to certain essential health care services in rural communities by eliminating inpatient services and focus on emergency and outpatient services, not all rural hospitals are eligible for this payment model. Some continue to

operate under existing models, navigating financial challenges. Others have chosen to restructure without the benefit of the REH payment model. Between 2023 and 2025, an additional seven rural hospitals in the United States restructured to eliminate inpatient services and focus on emergency and outpatient services, bringing the total number of rural hospitals that have eliminated inpatient services in the United States to 139 – 51 through the REH program and an additional 88 outside of the REH program.

Rural hospital closures and elimination of service lines reduce access to care and negatively impact individuals and communities

Closure of or elimination of service lines by rural hospitals reduces access to essential health care services for individuals residing in communities served by the facility. Patients who previously received services at rural hospitals that close or reduce services must travel to other locations to receive care, often travelling longer distances that require more time and greater financial costs. Rural hospitals that close are disproportionately more likely to be located in communities that already face social and economic disadvantages. Hospitals that close are about twice as likely to be located in high-poverty, high-social vulnerability counties compared to those that remain open — indicating that individuals affected by rural hospital closures or reductions in services are likely to be those with the fewest resources available to overcome barriers to accessing health care services. For patients with transportation-related barriers to care, limited transportation options may further reduce access to health care services. For patients with time-sensitive or clinically complex conditions, additional travel distance to the nearest facility increases clinical risk. Increased travel time is associated with higher mortality particularly for acute conditions such as myocardial infarction or heart attack, stroke, and major trauma. For pregnant patients, increased travel distance for health care services can elevate the risk of inadequate prenatal care and likely contribute to higher maternal and neonatal morbidity and mortality in affected regions. Long distances and travel times thus pose an access challenge for patients, who may not receive timely care or opt to forgo care altogether.

Rural hospital closure or elimination of services offered by rural hospitals also reshapes surrounding health systems. Studies of "bystander" hospitals show that within two years of the closure of a rural hospital, neighboring hospitals experience more than a 10 percent increase in emergency department visits and higher admission volumes as they absorb displaced patients. Nonprofit bystander hospitals incur millions in additional annual costs, much of it for lower-acuity patients whose care does not generate proportional reimbursement. What begins as a single institution's failure thus becomes a regional access and sustainability problem.

Rural hospital closures and elimination of services offered by rural hospitals also carries significant economic consequences for the communities they serve. In many areas, the local hospital is one of the largest employers and a central economic anchor, supporting not only

clinical staff but a broader network of service, administrative, and ancillary jobs. When hospitals close or scale back services, the effects are immediate, resulting in job losses, reduced local spending, diminished ability to attract and retain professionals, and overall weakening of the economic base. These impacts extend beyond the health sector, affecting small businesses, housing markets, and local tax revenues that support public services. At the same time, reduced access to care can affect workforce stability more broadly, as residents face greater barriers to maintaining their health and productivity. In this way, rural hospital instability is not solely a health care issue; it is closely tied to the economic resilience and long-term viability of rural communities.

Rural hospitals' risk of financial distress or closure can be identified through analysis of financial performance indicators

Analysis of financial performance over time can identify rural hospitals at risk of financial distress or closure. Established frameworks and analytic models that assess financial performance, operational trends, and market-level conditions identify factors that place rural hospitals at financial risk and can provide a practical basis for distinguishing between short-term financial strain and more persistent structural instability.

Analysis of financial performance over time can identify rural hospitals at greatest risk of financial distress and closure

Rural hospital closures rarely occur suddenly or without prior indication of financial distress. In most cases, closure represents the culmination of a multi-year period of financial deterioration that becomes visible through consistent patterns across several core indicators of hospital financial performance. Hospital revenues, expenses, and operating margins indicate whether a hospital is able to cover the cost of doing business. Liquidity measures such as working capital, days cash on hand, and net assets capture the hospital's ability to meet short-term financial obligations. Positive operating margins can indicate that a hospital is able to meet ongoing operational expenses while building liquidity to protect against future expenses or support future growth and improvements. Hospitals with flat or negative operating margins may be unable to meet expenses from current revenue and may be forced to utilize other resources to sustain operations. When flat or negative operating margins result in losses that persist across multiple fiscal years, the erosion of financial reserves may impact the hospital's ability to maintain routine operations or absorb unexpected costs, eventually leading to facility closure.

Existing frameworks provide insight into rural hospital risk of financial distress or closure

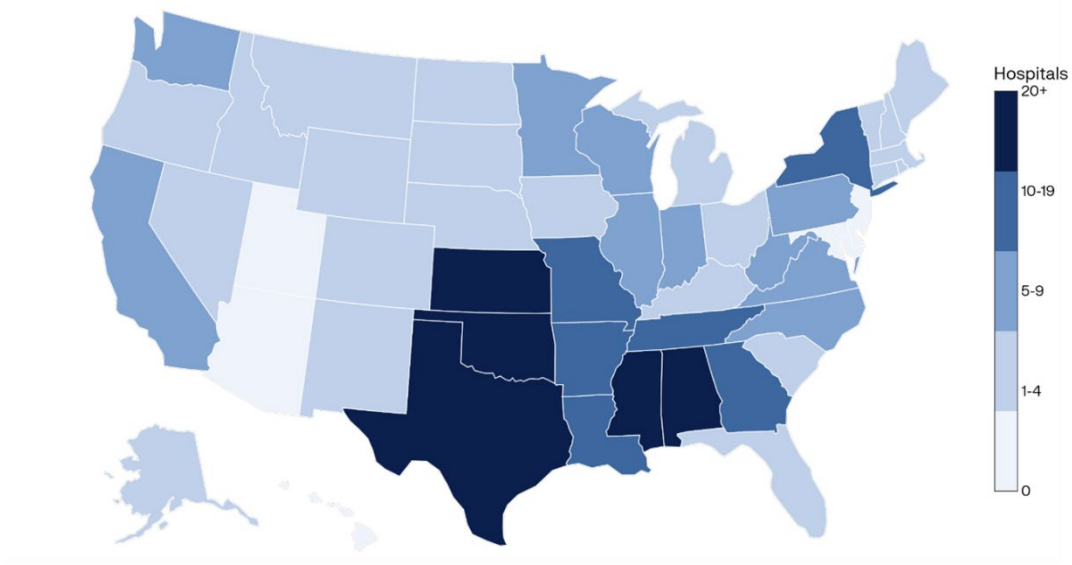
The Center for Healthcare Quality and Payment Reform (CHQPR) analyzes indicators of rural hospital financial performance to specify the number of rural hospitals in each state that are at high risk of closure due to financial conditions. The Financial Distress Index (FDI), developed by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, combines analysis of financial performance with evaluation of operational and market-level factors that may influence financial performance to identify rural hospitals at high risk of financial distress and instability. These models can be used to understand the scope of rural hospitals' risk of financial distress or closure in Virginia.

Factors described by the CHQPR can be used to identify rural hospitals at risk of closure

The CHQPR estimates the number of rural hospitals by state experiencing current financial strain based on observable financial conditions. The CHQPR framework focuses on two primary indicators of hospital financial health: (i) patient service operating margins, which measure whether revenue from patient care services is sufficient to cover the direct and indirect costs of delivering care and (ii) net assets – the hospital's accumulated financial reserves. Hospitals with negative patient service operating margins and low or negative net assets are categorized as being at risk or at immediate risk of closure depending upon how long they may be able to offset their losses. Data on hospital financial performance are derived directly from financial information reported by each facility.

CHQPR's findings indicate that a significant proportion of rural hospitals in the United States are operating with negative patient service margins, and many also have limited or declining reserves. In January 2026, the CHQPR analysis estimates that 734 rural hospitals nationwide fall into the at risk of closure category, with 309 of those at immediate risk of closure (see APPENDIX 2 for full CHQPR risk categories by state). Nationally, the highest number of hospital closures are concentrated in southern regions across Kansas, Mississippi, Texas, Alabama, and Oklahoma (FIGURE 4). These states have between 20 and 30 hospitals at immediate risk of closure – accounting for almost half of the rural hospitals in some of these states. In Virginia, the CHQPR estimates that eight hospitals are at risk of closure, with five of those at immediate risk of closure.

FIGURE 4. Rural hospitals classified at immediate risk of closure by CHQPR



SOURCE: CHQPR Rural Hospitals at Risk of Closing, 2026;
Center for Healthcare Quality & Payment Reform, CMS Data

The CHQPR does not publish the list of hospitals in each state that fall within at risk and immediate risk categories. JCHC staff used factors described by the CHQPR as associated with the risk of closure to analyze financial data, last updated in January 2026, to identify 13 rural hospitals in Virginia at risk of closure (TABLE 2). Based on JCHC analysis, hospitals identified as "at risk" experienced either negative patient margins or negative net assets. Hospitals identified as "at immediate risk" have negative patient margins and negative net assets, reflecting more immediate financial strain.

TABLE 2. JCHC analysis identified 13 Virginia rural hospitals at risk of closure

Hospital	Closure Risk
Ballad Health Dickenson Community Hospital	At Risk
Ballad Health Smyth County Community Hospital	At Risk
Bath Community Hospital	At Risk
Bon Secours Rappahannock General Hospital	At Risk
Bon Secours Southampton Memorial Hospital	At Immediate Risk
Bon Secours Southern Virginia Medical Center	At Risk
Carilion Giles Community Hospital	At Immediate Risk
Carilion Tazewell Community Hospital	At Immediate Risk
Duke Lifepoint Twin County Regional Hospital	At Risk
HCA LewisGale Hospital Pulaski	At Risk
Sentara Halifax Regional Hospital	At Immediate Risk
VCU Health Community Memorial Hospital	At Risk
VCU Health Tappahannock Hospital	At Immediate Risk

SOURCE: JCHC staff analysis of CHQPR Data on Rural Hospitals website and Rural Hospitals at Risk of Closing Report, updated January 2026.

The Sheps Center's FDI model uses financial, operational, and market-level data to identify rural hospitals at risk of financial instability

The FDI model incorporates several categories of inputs to determine rural hospital financial condition and identify rural hospitals that may be at risk of financial instability. Financial performance measures, such as operating margin, liquidity, and net assets, indicate whether a hospital's core patient care activities generate sufficient revenue to cover expenses and the hospital's ability to meet short-term financial obligations and continue operating without disruption. Analysis of organizational characteristics, such as hospital size and ownership type, provide insight into hospitals' access to capital, administrative capacity, and sources of financial support. Market-level factors, including local income levels, payer mix, and population characteristics, reflect the external environment in which the hospital operates and influence both demand for services and reimbursement levels that drive revenue. These variables are combined into a single composite score that assigns hospitals to one of four categories: lowest risk of experiencing distress, mid-lowest risk of experiencing distress, mid-highest risk of experiencing distress, and highest risk of experiencing distress. The categorization is calibrated using historical data on hospital closures and financial deterioration, such that hospitals in higher-risk categories exhibit characteristics similar to those observed in hospitals prior to closure.

The 2025 FDI prediction, the most current available, identifies 86 hospitals as meeting the criteria for highest risk of experiencing distress and 329 hospitals as meeting the criteria for mid-highest risk of experiencing distress (see APPENDIX 3 for full FDI risk categories by state). In Virginia, four hospitals meet FDI's criteria for highest risk of experiencing distress and eight meet the criteria for mid-highest risk of experiencing distress (TABLE 3).

TABLE 3. Twelve Virginia rural hospitals are at either highest risk or mid-highest risk of experiencing financial distress

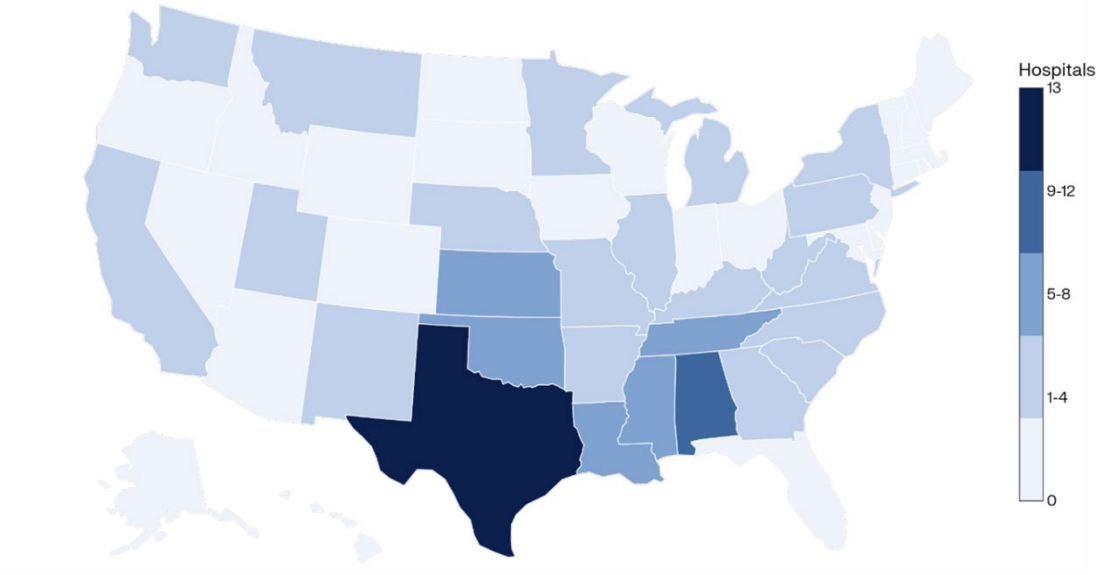
Hospital	FDI Distress Risk[i]
Ballad Health Dickenson Community Hospital	Mid-Highest Risk of Distress
Bon Secours Rappahannock General Hospital	Mid-Highest Risk of Distress
Bon Secours Southampton Memorial Hospital	Highest Risk of Distress
Bon Secours Southern Virginia Medical Center	Highest Risk of Distress
Southside Community Hospital	Mid-Highest Risk of Distress
Buchanan General Hospital	Mid-Highest Risk of Distress
Carilion Giles Community Hospital	Mid-Highest Risk of Distress
Carilion Tazewell Community Hospital	Highest Risk of Distress
Duke Lifepoint Twin County Regional Hospital	Mid-Highest Risk of Distress
Sentara Halifax Regional Hospital	Mid-Highest Risk of Distress
VCU Health Community Memorial Hospital	Highest Risk of Distress
VCU Health Tappahannock Hospital	Mid-Highest Risk of Distress

SOURCE: JCHC staff analysis of Malone TL, Pink GH, Holmes GM. An Updated Model of Rural Hospital Financial Distress. Journal of Rural Health, 2024. doi: 10.1111/jrh.12882. *(Note: FDI Highest Risk Category = Highest Risk of Distress)*

Nationally, similar to the CHQPR, the FDI identifies the highest number of rural hospitals at highest risk of experiencing financial distress in the southern regions across Texas, Alabama, Oklahoma, and Tennessee where between eight and 13 hospitals are identified at highest risk (FIGURE 5). Virginia, with four hospitals designated as being at highest risk of experiencing distress, is amongst the 15 states that have multiple hospitals at highest risk.

[i] The most current FDI index utilizes fiscal data through FY 2023 to render risk category predictions for FY 2025.

FIGURE 5. Number of rural hospitals at "highest risk" of experiencing distress by the FDI



SOURCE: UNC Sheps Center FDI Data, 2025-2026 (Malone TL, Pink GH, Holmes GM. An Updated Model of Rural Hospital Financial Distress. Journal of Rural Health, 2024. doi: 10.1111/jrh.12882).

Seven rural hospitals in Virginia are classified as being at the highest level of risk

Taken together, the JCHC analysis and the UNC Sheps Center FDI model identify a subset of rural hospitals in Virginia that are at the highest risk of financial distress or closure. Of Virginia's 36 rural hospitals, two are identified in the highest risk categories of both models – as at immediate risk of closure by the JCHC analysis and as at highest risk of experiencing distress by the FDI model. An additional three are identified as at immediate risk of closure by the JCHC analysis while meeting criteria for being at mid-highest risk of experiencing distress by the FDI model. The final two are identified as at risk of closure by the JCHC analysis and as meeting criteria for highest risk of distress by the FDI model (TABLE 4). Altogether, seven rural hospitals meet criteria for the highest risk category as measured by at least one of these models.

TABLE 4. Seven Virginia rural hospitals are at either immediate risk of closure or at highest risk of experiencing financial distress

Hospital	Closure Risk	FDI Distress Risk
Bon Secours Southampton Memorial Hospital	At Immediate Risk	Highest Risk of Distress
Bon Secours Southern Virginia Medical Center	At Risk	Highest Risk of Distress
Carilion Giles Community Hospital	At Immediate Risk	Mid-Highest Risk of Distress
Carilion Tazewell Community Hospital	At Immediate Risk	Highest Risk of Distress
Sentara Halifax Regional Hospital	At Immediate Risk	Mid-Highest Risk of Distress
VCU Health Community Memorial Hospital	At Risk	Highest Risk of Distress
VCU Health Tappahannock Hospital	At Immediate Risk	Mid-Highest Risk of Distress

SOURCE: JCHC staff analysis of CHQPR Data on Rural Hospitals website, updated January 2026, and Malone TL, Pink GH, Holmes GM. An Updated Model of Rural Hospital Financial Distress. Journal of Rural Health, 2024. doi: 10.1111/jrh.12882.

Patterns evidenced by highest risk hospitals are consistent with statewide trends in Virginia's rural hospitals

Financial and operational data reported by the seven rural hospitals in Virginia identified as being at the greatest risk of financial distress by the FDI model or closure by the JCHC analysis reveal similarities and trends, which are evident in the experience of rural hospitals in Virginia more broadly. These trends indicate risk of financial distress or closure, but also provide insight into rural hospitals' response to financial pressures and their efforts to preserve access to essential health care services in rural communities (see APPENDIX 4 for detailed facility profiles and APPENDIX 5 for ten-year trend data on each facility).

Analysis of financial and operational measures reveals similar trends across the seven rural hospitals at greatest risk of financial distress or closure

The seven hospitals at highest risk of financial distress or closure share a common operating context: each serves a predominantly rural population with limited commercial insurance coverage, obtains the substantial majority of its revenue from Medicare and Medicaid, and operates within health systems that can absorb losses that would otherwise threaten facility viability. These structural conditions produce predictable patterns in

financial performance, inpatient capacity and utilization, and service availability – patterns that are evident across ten years of data and that underscore the systemic rather than facility-specific nature of rural hospital financial risk in Virginia.

All seven rural hospitals at highest risk reporting operating losses in 2024

Across all seven hospitals, total gross revenue grew substantially between 2015 and 2024, driven primarily by expansion of outpatient services. Despite this revenue growth, every facility reported a negative operating margin in 2024, meaning revenues and gains did not cover expenses and losses. Combined operating losses across the seven hospitals totaled approximately $54.9 million in 2024, with individual facility deficits ranging from $1.3 million at Bon Secours Southern Virginia Medical Center to $19.1 million at Sentara Halifax Regional Hospital. Three of the seven hospitals were already reporting operating losses in 2015. By 2024, all seven experienced losses as expenses exceeded revenue. Operating margins – measured as the ratio of net operating income to total net revenue – ranged from approximately negative 2 percent at Carilion Giles Community Hospital to negative 29 percent at Bon Secours Southampton Memorial Hospital.

A payer mix dominated by Medicare and Medicaid — comprising 70 to 85 percent of volume across all of these hospitals — creates a structural gap between the cost of delivering care and the reimbursement received for it. This gap grew wider at most hospitals between 2015 and 2024 even as gross revenues increased. Several hospitals report worsening payer mix trends: Bon Secours Southampton saw commercial coverage decline by nearly four percentage points and self-pay nearly double between 2022 and 2025, while Sentara Halifax reported a shift away from commercial and Medicaid coverage toward Medicare and self-pay.

Shifting capacity and utilization at the highest risk hospitals reflects increasing financial pressures

Operational data across the seven hospitals reflect a consistent pattern of contraction in capacity and utilization of inpatient services generally and obstetrical services specifically, variability in surgical service utilization, and sustained utilization of emergency department services, though individual trajectories diverge considerably based on each hospital's service configuration, local demographic trends, and health system investment strategy. Importantly, service line reductions are not the result of passive decline — they largely reflect deliberate decisions made under financial pressure: choices to discontinue services that volumes can no longer safely sustain, or to concentrate limited resources on the care that can be reliably delivered. For the communities these hospitals serve, access to care is progressively narrowing even where the hospital itself remains open.

Inpatient Services. Between 2015 and 2024, inpatient utilization and capacity declined at nearly every facility, with patient days (the cumulative number of days patients spend in the hospital) falling between 34 percent and more than 60 percent and staffed bed counts

(the number of beds actually supported by available staff) contracting sharply — in several cases to a fraction of licensed capacity (the number of beds a hospital is approved to operate). For example, as of 2024, Carilion Tazewell operated 15 staffed beds against 56 licensed beds, while internal data from 2025 and 2026 year-to-date provided by Bon Secours Southampton Memorial Hospital indicate that the facility now staffs just 20 acute care inpatient beds of its 90 licensed, with an actual occupancy rate of just eight percent. Similarly, current internal data indicates that Sentara Halifax now staffs 49 of its 85 licensed beds.

Obstetrical Services. Obstetric services have emerged as one of the most visible and consequential markers of service erosion, with most of the highest risk rural hospitals in Virginia experiencing a decline in obstetrical service capacity and utilization. Bon Secours Southampton Memorial closed its labor and delivery unit, which provides obstetrical services, in 2017 after deliveries fell below sustainable thresholds. Sentara Halifax experienced a more gradual decline in obstetrical service utilization, with deliveries falling from 446 in 2015 to zero by 2024 as the hospital opted to discontinue obstetrical services in 2023 when it reached a point where safe, staffed 24/7 coverage could no longer be reliably sustained. VCU Community Memorial represents the sole counterexample among the seven, having introduced obstetric services in 2017 and grown its delivery volume to 272 births in 2025, with the number of inpatient beds dedicated labor and delivery beds expanded to six. The broader pattern is consistent with national research showing that rural obstetric service closures typically follow prolonged volume declines rather than single decision points. The loss of local obstetric service access carries direct consequences for maternal and infant health outcomes. Sentara Halifax has established transfer agreements with VCU Community Memorial in South Hill and Lifepoint Sovah Health in Danville to manage obstetric needs, but these arrangements, while critical, do not replace the routine prenatal and delivery care that was previously available locally.

Surgical Services. Surgical services illustrate different responses to financial distress, with variations in surgical service utilization across the highest risk rural hospitals. Carilion Tazewell eliminated all surgical capacity by 2017 and has operated without them since, while Carilion Giles — within the same system — rebuilt its surgical volume to over 1,000 procedures by 2024, surpassing its earlier baseline. VCU Community Memorial has maintained services between 2015 and 2024, exceeding 4,500 annual procedures in 2024. Between these endpoints, other hospitals have experienced volatile trajectories: Bon Secours Southern Virginia Medical Center expanded outpatient surgical volume from 719 procedures to over 1,600 across two fiscal years, only to see it collapse to just seven procedures in 2025 as staffing and financial pressures shifted. Bon Secours Southampton, Sentara Halifax, and VCU Tappahannock have each experienced sustained surgical contraction, though Sentara Halifax and VCU Tappahannock both showed signs of recovery in their most recent internally provided data. This volatility itself is a form of distress, signaling that service line sustainability in these settings can be fragile even when short-term trends suggest improvement.

Emergency Services. While inpatient utilization has declined, emergency department utilization remained stable or increased at all seven hospitals, underscoring the continued and, in some communities, growing reliance on these hospitals as the primary point of access to acute and unscheduled care. At Bon Secours Southampton Memorial Hospital, emergency department visits held essentially flat at approximately 15,000 annually between 2015 and 2024 — even as patient days fell by more than 60 percent. At Bon Secours Southern Virginia Medical Center, emergency department visits increased from 14,358 in 2015 to 15,267 in 2024, during a period when patient days declined by 55 percent. VCU Health Community Memorial Hospital recorded a 15 percent increase in emergency department visits — from 22,680 to 26,183 — over the same period. This pattern, evident across all seven hospitals, confirms that even as the inpatient footprint of these hospitals has contracted, their role as the community's frontline access point for unscheduled and emergent care remains constant or grows.

Recruitment and retention challenges have accelerated service line reductions across highest risk rural hospitals

Recruitment challenges have driven the closure of specialty services at hospitals like Sentara Halifax Regional Hospital, which has eliminated neurology, urology, ear, nose, and throat (ENT), and obstetric services since the beginning of the study period and can no longer maintain around-the-clock orthopedic coverage. Bon Secours Southern Virginia Medical Center has similarly eliminated surgery across multiple specialties, chemotherapy infusion, and other services since its acquisition. The inability to recruit and retain specialists remains one of the most persistent barriers to maintaining service breadth in rural settings. In response, these hospitals have pursued a range of adaptive strategies: telehealth programs covering specialties such as neurology, psychiatry, and critical care; creative scheduling models to extend the reach of limited physician capacity; and transfer agreements to connect patients with services no longer available locally. VCU Health Community Memorial has taken a longer-term approach through its Accreditation Council for Graduate Medical Education (ACGME)-accredited Rural Family Medicine Residency Track, designed to build a sustainable physician pipeline in underserved communities. These adaptations represent meaningful institutional investment but do not restore the specialty services that have been lost or fully replicate the breadth of care previously available locally.

All seven highest risk hospitals experienced a decisive shift toward outpatient revenue as inpatient services contract or consolidate

Elimination of inpatient service lines or reductions in capacity can reduce expenses and an emphasis on outpatient services can allow rural hospitals to increase revenues. All seven rural hospitals identified as at highest risk for financial distress or closure have experienced a decisive shift toward outpatient revenue as the primary driver of financial performance. Outpatient revenue grew steadily over the decade, while inpatient revenue

stagnated or fell. For example, VCU Community Memorial grew outpatient revenue from $144 million in 2015 to $373 million in 2025, while Bon Secours Southampton's inpatient revenue decreased from $58 million to $34 million in 2025. Outpatient services continue to generate revenue, but the hospitals that remain open are fundamentally different institutions than they were a decade ago — smaller, less comprehensive, and increasingly reliant on system-level referral networks and telehealth infrastructure to provide health care services. This structural reorientation toward outpatient revenue has sustained gross revenue in the near term but has not resolved the underlying financial challenge: all seven hospitals reported operating losses in 2024, indicating that outpatient growth alone has not been sufficient to offset the structural reimbursement gaps and cost pressures these hospitals face.

Highest risk rural hospitals are affiliated with larger health systems, which may constitute a protective factor for hospitals facing financial distress

All seven rural hospitals in Virginia identified at greatest risk of financial distress are affiliated with larger health systems — Bon Secours Mercy Health, Carilion Clinic, VCU Health, and Sentara Health. No independent rural hospitals appear in the highest-risk category of either the FDI or the JCHC analysis. However, two independent Virginia rural hospitals fall into the next tier of risk across at least one of the models (TABLE 5). These include Buchanan General Hospital, a small standalone facility in far Southwest Virginia, and Bath Community Hospital, a critical access hospital serving one of the least densely populated areas in the Commonwealth.

TABLE 5. Two independent rural Virginia hospitals are either at risk of closure or at mid-highest risk of experiencing financial distress

Hospital	Closure Risk	FDI Distress Risk[ii]
Buchanan General Hospital	No Risk Factors[iii]	Mid-Highest Risk of Distress
Bath Community Hospital	At Risk Factors	Lowest Risk of Distress

SOURCE: JCHC staff analysis of CHQPR Data on Rural Hospitals website, updated January 2026, and Malone TL, Pink GH, Holmes GM. An Updated Model of Rural Hospital Financial Distress. Journal of Rural Health, 2024. doi: 10.1111/jrh.12882.

[ii] The most current FDI index utilizes fiscal data through FY 2023 to render risk category predictions for FY 2025.

[iii] In the draft report, Buchanan General Hospital was mis-identified as at risk of closure. Upon further review, Buchanan General Hospital did not meet at risk criteria pursuant to the methods applied by JCHC analysts to identify hospitals at risk. Its status has been updated to "no risk factors" in the final report.

The FDI model and JCHC analysis may not fully capture differences in financial risk between independent and system-affiliated hospitals, as standardized thresholds and model inputs do not account for availability of system-level capital, cross-subsidization, or internal financial support that can materially alter a hospital's risk profile. Indeed, the patterns across risk categorizations suggest that system affiliation functions as a primary protective factor standing between these hospitals and outright closure: parent systems absorb operating losses, provide capital investment, and maintain staffing infrastructure that independent hospitals must sustain on their own. The implication is significant - independent rural hospitals that lack this cross-subsidization may face a materially greater risk of closure than their current risk classification suggests.

The experiences across the seven rural hospitals at greatest risk are consistent with the trends across Virginia's rural hospitals

The experiences across the seven rural hospitals identified as at greatest risk of closure or financial distress closely mirror broader trends in Virginia's 36 rural hospitals. These hospitals exhibit similar patterns of declining inpatient utilization, sustained financial pressure reflected in weak or negative operating performance, and increasing reliance on outpatient and emergency services as inpatient activity contracts. In several cases, reductions in service lines and staffing adjustments have occurred alongside or prior to financial deterioration. Across these hospitals, the same underlying conditions are present: low patient volume, constrained revenue, and limited ability to absorb ongoing operating pressures, all of which align with the statewide pattern of weakening inpatient service viability in rural hospitals.

Virginia's rural hospitals have experienced a decline in capacity

Virginia's rural hospitals have experienced contraction in inpatient capacity from 2015 to 2024 (TABLE 6; see APPENDIX 6 and 7 for data points across all 36 Virginia rural hospitals). Total licensed beds declined by approximately 7.4 percent and total staffed beds declined by 6.3 percent. Licensed labor and delivery beds, which are a subset of inpatient beds, declined by 22.1 percent while staffed labor and delivery beds declined even more sharply by 42.1 percent, indicating that obstetric service capacity contracted at roughly three times the rate of overall inpatient bed capacity. Occupancy of staffed beds fell from 50.2 percent to 46.0 percent over the period. These trends indicate that the system is not simply contracting in proportion to demand, but is experiencing a sustained reduction in inpatient utilization even where physical capacity remains: hospitals are maintaining beds and infrastructure, but fewer patients are being admitted for inpatient care over time, leaving more unused capacity within existing hospitals.

TABLE 6. Since 2015, Virginia's rural hospitals have experienced significant contraction in inpatient capacity

Category	2015	2024	Percent Change
Total Licensed Beds	3,671	3,399	-7.4%
Total Staffed Beds	2,362	2,214	-6.3%
Total Patient Days	432,471	374,706	-13.4%
Staffed Bed Occupancy	50.2%	46.0%	-4.2 pp
Total L&D Licensed Beds	204	159	-22.1%
Total L&D Staffed Beds	152	88	-42.1%

pp = percentage points SOURCE: JCHC staff analysis of Virginia Health Information Annual Licensure Survey Data 2015 and 2024

Inpatient, obstetrical, and surgical utilization have decreased

Virginia's rural hospitals experienced substantial declines in inpatient, obstetrical, and surgical service utilization, reflecting continued contraction in higher-acuity and resource-intensive lines of care (TABLE 7; see APPENDIX 7 for data points across all 36 Virginia rural hospitals). Between 2015 and 2024, total inpatient service patient days fell by 13.4 percent, a sharper decline than capacity itself. Over the same period, obstetrical service utilization also fell, with total deliveries decreasing by 39.9 percent. Total surgical procedures declined by 15.8 percent between 2015 and 2024. The decline was especially pronounced for inpatient surgical procedures, which fell by 32.1 percent, while outpatient surgical procedures declined by 12.3 percent. The combined trends suggest an overall reduction in procedural capacity rather than a simple shift from inpatient to outpatient settings.

TABLE 7. Surgical and obstetrical service utilization at rural hospitals have decreased since 2015

Category	2015	2024	Percent Change
Total Surgical Procedures	133,635	112,562	-15.8%
Total Inpatient Surgical Procedures	23,301	15,830	-32.1%
Total Outpatient Surgical Procedures	110,334	96,732	-12.3%
Total Deliveries	9,313	5,593	-39.9%

SOURCE: JCHC staff analysis of Virginia Health Information Annual Licensure Survey Data 2015 and 2024 *(Note: Total surgical procedures include total inpatient and total outpatient surgical procedures)*

Emergency department utilization has remained steady

Emergency department utilization has remained comparatively stable over time, declining by approximately 3.2 percent between 2015 and 2024 (TABLE 8; see APPENDIX 7 for data points across all 36 Virginia rural hospitals). The relatively modest decline in emergency department visits indicates that rural residents continue to rely heavily on emergency departments for immediate and unscheduled care, even as other hospital-based services contract. This stability may also reflect broader access challenges in rural communities, including shortages of primary care providers, limited specialty care availability, and increased dependence on hospital emergency departments for routine or urgent healthcare needs.

TABLE 8. Emergency department visits at rural hospitals remained relatively steady between 2015 and 2024

Category	2015	2024	Percent Change
Total Emergency Department Visits	810,156	783,980	-3.2%

SOURCE: JCHC staff analysis of Virginia Health Information Annual Licensure Survey Data 2015 and 2024

Revenue growth has shifted towards outpatient services while inpatient services make up a smaller share of total revenue

The revenue data reflects a significant shift in how rural hospitals in Virginia generated operating income between 2015 and 2024 (TABLE 9; see APPENDIX 8 for data points across all 36 Virginia rural hospitals). Twelve rural hospitals in the Commonwealth operated at negative margins in both 2015 and 2024. Total gross revenue, representing the

total amount charged for hospital services before contractual adjustments and discounts, increased by 96.1 percent during this period, indicating that rural hospital systems as a whole did not contract financially. However, the distribution of that growth became increasingly concentrated in outpatient services rather than inpatient care.

TABLE 9. Outpatient revenue at rural hospitals constitutes a greater portion of total revenue in 2024

Category	2015	2024	Percent Change
Total Gross Inpatient Revenue	$2,682,355,379	$3,986,330,939	48.6%
Total Gross Outpatient Revenue	$5,269,094,832	$11,606,279,943	120.3%
Total Revenue	$7,951,450,211	$15,592,610,882	96.1%

SOURCE: JCHC staff analysis of Virginia Health Information Hospital Detail reports 2015 and 2024

Outpatient revenue increased by 120.3 percent between 2015 and 2024, while inpatient revenue increased by 48.6 percent. As a result, outpatient services accounted for approximately 74.4 percent of total gross revenue in 2024, compared to 66.3 percent in 2015. This shift reflects a clear reorientation of the rural hospital revenue base toward outpatient reimbursement streams over time. Inpatient revenue continues to grow, but at a substantially slower rate than outpatient revenue. This divergence suggests outpatient services play an increasingly important role in sustaining hospital finances, while inpatient services account for a shrinking share of total revenue generation.

This change in revenue composition occurs alongside documented declines in inpatient capacity, surgical volume, and obstetric services. In that context, outpatient revenue growth is not necessarily indicative of expanded service offerings or increased system capacity. Instead, it is more consistent with a structure in which billable activity is increasingly concentrated in outpatient settings as inpatient and procedural services contract or consolidate. Total revenue growth therefore reflects redistribution of financial activity rather than expansion across service lines.

Virginia's rural hospitals' shift towards outpatient care prevents closures but still results in loss of access to key services

Consistent with national trends and across Virginia's rural hospitals, the central pattern in rural health care has not been widespread hospital closure, but a gradual and ongoing contraction of services within rural hospitals that continue to operate. Many rural hospitals in Virginia continue to provide health care services but have shifted toward outpatient-

focused models or emergency-centered configurations, reducing access to inpatient services.

These hospitals may continue to operate, but the range of services available to the community is becoming progressively narrower. Emergency departments are often preserved as essential access points, and outpatient services remain the most financially stable component of care delivery, while inpatient capacity is reduced or eliminated. The result in Virginia is a system where access is increasingly defined by presence rather than scope. Rural hospitals remain physically embedded in their communities, but the ability to receive inpatient admission, deliver babies, or undergo routine surgical procedures locally has diminished in many areas. The key issue is therefore not only whether hospitals stay open, but how the composition of services changes within them, and how those cumulative reductions reshape what "local access to care" actually means across rural regions of the Commonwealth.

Federal policy changes further compound risk factors faced by rural hospitals in the Commonwealth

Proposed Medicaid reductions under H.R. 1 (2025; Public Law 119-21) would significantly decrease the flow of federal dollars into Virginia's health care system, disproportionately affecting rural hospitals that rely more heavily on Medicaid revenue and have limited commercial payer mix to offset losses.

A central concern is the tightening of rules regarding supplemental payments. Supplemental payments such as DSH and Upper Payment Limit (UPL) payments provide additional funding for services to patients enrolled in Medicaid while other supplemental payments, such as Graduate Medical Education (GME), support other aspects of health care delivery. In Virginia, supplemental payments are a core component of hospital income. Reductions in these payments effectively lower total hospital revenue, directly impacting hospitals already operating on thin margins.

Additional federal policy shifts further compound this outlook. Restrictions on state-directed payment programs (SDPs) — state arrangements that allow Virginia to direct Medicaid funds to specific providers or services — and limits on provider taxes reduce Virginia's ability to generate the state dollars needed to draw down federal matching funds, which in turn shrinks the total Medicaid dollars the state can target to support hospitals and health care providers. At the same time, proposed eligibility and coverage changes are expected to increase insurance churn where more people cycling on and off Medicaid or moving between plans raise overall uninsurance rates. That volatility increases uncompensated care because hospitals face more patients who are uninsured or whose coverage lags (for example, a patient treated in the ED while awaiting re-enrollment or after losing coverage), which directly raises bad-debt and charity care costs documented in several at-risk hospital profiles. Medicare reimbursement trends, particularly reductions in

outpatient payment rates, threaten a critical revenue stream that many rural hospitals depend on to subsidize emergency and inpatient services.

The Rural Health Transformation Fund (RHTF), initially positioned as a stabilizing investment, is unlikely to fully offset these losses. Virginia's anticipated allocation — originally estimated at roughly $1 billion over five years or $200 million per year — has been scaled down to closer to $189.5 million for FY 2026, the first year of the program. The limited duration of the funding available through the RHTF and the wide range of purposes for which the funding may be used limit the effectiveness of the program as a vehicle for broad financial stabilization for rural hospitals. As a result, while hospitals facing persistent operating deficits may receive support for discrete transformation efforts, rural hospitals may not be able to use RHTF grant funds to address underlying structural challenges.

The dynamics of the changing federal policy landscape combined with recent trends in rural hospital financial and operational conditions point toward a likely next phase in Virginia's rural healthcare landscape: a gradual shift away from full-service hospital models in the most financially vulnerable communities. Some hospitals may pursue service line reductions, including through conversion to REH models where feasible. Others may increasingly rely on partnerships with larger systems or regional networks to maintain access to care. The combined effect of reduced federal support and changes to supplemental and state-directed payment programs will likely continue to shape how individual rural hospitals configure services — with implications for both the financial sustainability of individual hospitals and the scope of care available to rural communities across Virginia.

Appendix 1: Methods and data sources

JCHC staff used multiple data sources and analytic methods to inform this study of financial distress among rural hospitals in Virginia. Methods included a structured literature review, document review, operational and financial data analysis, structured interviews, and review of relevant state and national policy strategies. Detailed methods for each source are documented below.

Literature Review

JCHC staff conducted a structured review of the peer-reviewed literature to identify (1) commonly used measures of hospital financial condition/analytic frameworks for assessing hospital financial stability or distress, and (2) national and regional trends affecting rural and independent hospitals.

The literature review was conducted in two databases: PubMed and EconLit. PubMed indexes biomedical and health services research literature, while EconLit indexes peer-reviewed literature in economics, including health economics and hospital finance research. These databases were selected to ensure coverage of both clinical/health systems research and financial or economic analyses relevant to hospital performance.

Searches were conducted using Boolean operators and field restrictions. Core search strings included the following structure:

> *hospital OR "critical access hospital" OR "rural hospital"*
>
> *AND*
>
> *financial OR finance OR "financial distress" OR "financial condition" OR solvency OR margin OR liquidity OR bankruptcy*
>
> *AND*
>
> *measure* OR indicator* OR framework OR model OR index OR predict* OR risk*
>
> Additional searches focused on national and regional trends affecting rural hospital stability:
>
> *hospital OR "rural hospital" OR "independent hospital"*
>
> *AND*
>
> *closure* OR consolidation OR acquisition OR merger OR distress OR vulnerability OR trend* OR risk*

Searches were limited to publication years 2010 through 2026 and to articles written in English with full text available. Given the large amount of literature available on this topic, JCHC staff further limited the inclusion criteria to systematic literature reviews or meta-analyses, resulting in 92 total studies specific to rural hospitals (54 from PubMed and 38

from EconLit). Following title and abstract review, staff retained 21 studies for full-text review.

To ensure inclusion of foundational and commonly cited financial distress models not captured in systematic reviews, targeted searches were conducted for specific frameworks (e.g., Altman Z-Score adaptations for hospitals, composite financial indices, and predictive bankruptcy models). Articles were retained if they described measurable financial indicators, composite indices, or predictive models applicable to nonprofit or rural hospitals.

Findings from this review informed selection of financial indicators and analytic approaches appropriate for evaluating distress risk among Virginia hospitals.

Document Review

JCHC staff conducted a structured review of publicly available reports, policy analyses, and technical documents addressing rural hospital finance, hospital closures, and financial vulnerability. Sources included federal agency reports (e.g., Centers for Medicare & Medicaid Services; Health Resources and Services Administration), national research organizations (e.g., Medicare Payment Advisory Commission; American Hospital Association), and relevant Virginia state agency publications.

Searches were conducted using structured keyword combinations similar to the Boolean framework above, adapted for grey literature searches (e.g., "rural hospital financial distress report," "hospital closure risk model," "Virginia rural hospital finance").

Documents were included if they:

- Described measurable indicators of hospital financial health;
- Presented or evaluated analytic frameworks for distress prediction; or
- Provided contextual data on rural hospital trends nationally or in Virginia.

Documents were excluded if they lacked empirical analysis or did not address hospital-level financial metrics.

Data Analysis

Literature and document review identified two models categorizing rural hospitals into risk of closure and risk of distress categories:

1. University of North Carolina Cecil G. Sheps Center for Health Services Research's Financial Distress Index (FDI)
2. Center for Healthcare Quality and Payment Reform's (CHQPR's) rural hospital risk of closure framework

JCHC staff obtained the most recent FDI dataset by request from the Virginia State Office of Rural Health at the Virginia Department of Health. The FDI is a validated predictive model,

published in the Journal of Rural Health, that estimates the probability that a rural hospital will experience financial distress within two years. JCHC staff did not modify the FDI model specification, predictor variables, or risk thresholds. Instead, staff conducted secondary analysis of the published FDI risk categorizations and available operational and financial data to compare risk classifications and identify hospitals appearing in the highest-risk categories.

The CHQPR is a national policy center that analyzes rural hospital risk of closure through analysis of patient operating margins and net assets; however, CHQPR does not publish the names of hospitals in each category of closure risk. JCHC staff conducted an analysis of factors described by the CHQPR framework to identify hospitals in the Commonwealth at risk or at immediate risk of closure. The FDI model and the JCHC analysis together identify rural hospitals in Virginia that are both at greatest risk of closure and rural hospitals that are at greatest risk of experiencing distress due to strains over the years, offering a more multifactor long-term predictive view.

Staff identified seven Virginia hospitals that were classified in the highest-risk category by both the FDI model and the JCHC analysis. For the seven highest-risk hospitals, staff conducted direct interviews with facility leadership identifying the following:

- Facility strengths in sustaining operations
- Operational and financial challenges faced by the facility
- Changes in payor mix over the study period (FY 2015 – FY 2024)
- Facility's response to strains in terms of service line decisions or staffing efforts

Additionally, staff examined 10-year trends across operational and financial data sourced from Virginia Health Information's (VHI's) Annual Licensure Survey Data and Hospital Detail Reports between FY 2015 and FY 2024. Data spanned licensed versus staffed beds, patient days, emergency department visits, outpatient surgical procedures, inpatient surgical procedures, labor and delivery licensed versus staffed beds, and deliveries. Financial analysis focused on revenue composition, including inpatient and outpatient revenue streams, net revenue, expenses, and overall bottom-line performance.

Interview responses and VHI data across the 10 years were developed into a series of case studies narrating the operational and financial history and current state of all seven rural hospitals categorized as being at highest risk. Staff also requested FY 2025 and FY 2026 year-to-date data from all facilities which was included as available.

In addition, staff identified 36 rural hospitals across both analytic perspectives, using the primary rural definition established by the Federal Office of Rural Health Policy (FORHP) and incorporating any additional hospitals classified as rural under either model. For this broader set of hospitals, staff compared FY 2015 and FY 2024 data, using the most recent VHI data available, to assess point-in-time changes in operational and financial indicators.

Appendix 2: National CHQPR Table

RURAL HOSPITALS AT RISK OF CLOSING

State	Hospital Closures Since 2015	Inpatient Service Closures (REH)[2]	Open Rural Inpatient Hospitals	Hospitals With Losses on Services[1]		Hospitals at Risk of Closing		Hospitals at Immediate Risk	
				Number	Percent	Number	Percent	Number	Percent
Kansas	8	3	100	82	82%	68	68%	30	30%
Mississippi	3	7	67	38	57%	35	52%	24	36%
Texas	14	4	154	105	68%	84	55%	23	15%
Alabama	3	3	48	32	67%	28	58%	22	46%
Oklahoma	7	5	74	45	61%	48	65%	20	27%
New York	3	3	51	24	47%	23	45%	15	29%
Tennessee	10	2	52	20	38%	17	33%	13	25%
Arkansas	0	5	47	38	81%	31	66%	12	26%
Georgia	3	1	73	34	47%	25	34%	11	15%
Louisiana	1	1	56	34	61%	25	45%	11	20%
Missouri	9	2	57	28	49%	28	49%	10	18%
Pennsylvania	3	0	52	17	33%	17	33%	9	17%
Illinois	3	0	79	23	29%	16	20%	8	10%
Indiana	3	0	55	16	29%	9	16%	8	15%
Washington	0	0	45	29	64%	19	42%	7	16%
Minnesota	3	1	97	33	34%	19	20%	6	6%
West Virginia	1	0	34	16	47%	13	38%	6	18%
North Carolina	6	0	56	13	23%	9	16%	6	11%
California	2	0	59	23	39%	16	27%	5	8%
Wisconsin	0	0	81	19	23%	12	15%	5	6%
Virginia	2	0	31	6	19%	8	26%	5	16%
Maine	3	0	24	10	42%	10	42%	4	17%
South Carolina	3	0	22	7	32%	7	32%	4	18%
Montana	0	0	53	26	49%	16	30%	3	6%
North Dakota	0	0	38	27	71%	14	37%	3	8%
Michigan	2	1	66	15	23%	9	14%	3	5%
Florida	5	0	22	7	32%	8	36%	3	14%
Ohio	1	0	74	13	18%	7	9%	3	4%
Oregon	0	0	34	12	35%	7	21%	3	9%
Nebraska	1	1	71	19	27%	6	8%	3	4%
Wyoming	0	0	27	10	37%	6	22%	3	11%
South Dakota	0	1	48	9	19%	6	12%	3	6%
Kentucky	2	2	69	21	30%	15	22%	2	3%
Colorado	0	0	43	16	37%	10	23%	2	5%
Iowa	2	0	94	19	20%	9	10%	2	2%
New Mexico	1	1	27	8	30%	8	30%	2	7%
New Hampshire	0	0	18	7	39%	4	22%	2	11%
Connecticut	0	0	4	3	75%	3	75%	2	50%
Idaho	0	1	27	13	48%	10	37%	1	4%
Vermont	0	0	13	8	62%	8	62%	1	8%
Nevada	1	0	14	6	43%	4	29%	1	7%
Massachusetts	0	0	7	4	57%	2	29%	1	14%
Alaska	1	0	16	3	19%	2	12%	1	6%
Rhode Island	0	0	1	1	100%	1	100%	1	100%
Hawaii	0	0	13	10	77%	8	62%	0	0%
Arizona	1	0	27	5	19%	4	15%	0	0%
Utah	0	0	22	5	23%	0	0%	0	0%
Delaware	0	0	3	1	33%	0	0%	0	0%
Maryland	1	0	9	0	0%	0	0%	0	0%
New Jersey	0	0	2	0	0%	0	0%	0	0%
U.S. Total	108	44	2,256	960	43%	734	33%	309	14%

[1] Rural hospitals that had a negative margin (loss) on patient services in the most recent year available (2024-25).
[2] Conversion to Rural Emergency Hospital (REH) which requires closure of inpatient services.

Data current as of January 2026
Data on individual hospitals are available at www.RuralHospitals.org

Source: CHQPR, 2026

Appendix 3: National FDI Table

NCI RHRP	State	Highest	Mid-highest	Mid-lowest	Lowest	Number of Hospitals
States with Multiple Hospitals at Highest Risk	TX	13	21	47	47	128
	AL	9	15	15	7	46
	OK	8	23	23	11	65
	TN	8	11	20	9	48
	KS	6	34	43	16	99
	LA	5	7	16	18	46
	MS	5	22	19	10	56
	VA	4	8	7	12	31
	GA	3	17	17	29	66
	KY	3	12	20	35	70
	MN	3	4	23	60	90
	AR	2	9	25	9	45
	NY	2	8	16	13	39
	NC	2	14	16	19	51
	WV	2	5	8	9	24
States with 1 Hospital at Highest Risk	CA	1	7	19	26	53
	IL	1	3	13	51	68
	MI	1	8	19	26	54
	MO	1	10	21	27	59
	MT	1	9	13	21	44
	NE	1	2	16	48	67
	NM	1	3	6	11	21
	PA	1	4	11	23	39
	SC	1	5	7	8	21
	UT	1	1	3	17	22
	WA	1	8	19	15	43
States with 0 Hospitals at Highest Risk	AK	0	0	1	7	8
	AZ	0	0	6	11	17
	CO	0	3	16	23	42
	CT	0	0	0	0	0
	DE	0	0	0	2	2
	FL	0	3	11	9	23
	HI	0	1	2	3	6
	ID	0	1	11	17	29
	IN	0	7	13	33	53
	IA	0	5	25	62	92
	ME	0	1	9	11	21
	MD	0	0	0	0	0
	MA	0	1	1	0	2
	NV	0	2	5	5	12
	NH	0	0	3	11	14
	NJ	0	0	1	1	2
	ND	0	4	14	17	35
	OH	0	7	14	51	72
	OR	0	5	7	17	29
	RI	0	0	0	0	0
	SD	0	6	10	29	45
	VT	0	0	6	7	13
	WI	0	8	14	50	72
	WY	0	5	6	10	21
Totals for All States	ALL	86	329	637	953	2,005

Source: Malone TL, Pink GH, Holmes GM. An updated model of rural hospital financial distress. *J Rural Health.* 2024. doi:10.1111/jrh.12882.

APPENDIX 4: Highest Risk Rural Hospital Case Studies

The following case studies provide profiles of each of these hospitals to situate the JCHC staff analysis of hospital closure risk and Sheps Center Financial Distress Index (FDI) risk designations within their operational and geographic context. Each profile outlines the hospital's health system affiliation, primary service area (including key counties served), and its role within the local care network. Where relevant, the analysis also incorporates facility-specific history and prior service configurations to establish how current risk status relates to longer-term patterns of service evolution. Across the cases, the focus is on linking financial and operational indicators to observable changes in service capacity (see APPENDIX 5 for data trends for all seven facilities from 2015 to 2024) and access within the communities these hospitals serve, particularly in areas where inpatient services function as a core component of the local health infrastructure.

Case Study 1: Bon Secours Southampton Memorial Hospital and Bon Secours Southern Virginia Medical Center

Bon Secours Mercy Health is a Cincinnati-based, non-profit, faith-based healthcare organization formed through the 2018 merger of Bon Secours Health System and Mercy Health. The combined system operates approximately 50 hospitals across seven states and Ireland, making it one of the largest Catholic health systems in the United States. In Virginia, Bon Secours maintains a significant footprint concentrated in the Richmond and Hampton Roads regions, encompassing a mix of tertiary, community, and rural facilities.

Southampton Memorial Hospital and Southern Virginia Medical Center were not originally part of this system. Both were previously owned by Community Health Systems (CHS), a for-profit hospital operator that, by the late 2010s, had begun divesting financially underperforming rural hospitals. In October 2019, CHS announced a definitive agreement to sell three Virginia hospitals—Southside Regional Medical Center in Petersburg, Southampton Memorial Hospital in Franklin, and Southern Virginia Regional Medical Center in Emporia—to Bon Secours Mercy Health, with the transaction closing on January 1, 2020.

Southampton Memorial Hospital

Southampton Memorial Hospital (SMH) was identified by JCHC staff analysis as at immediate risk of closure and the FDI as at highest risk of experiencing financial distress. SMH is reimbursed by the Centers for Medicare & Medicaid Services (CMS) as a Sole Community Hospital that serves the City of Franklin and the surrounding rural service area including Southampton, Isle of Wight, Sussex, and portions of Suffolk. Prior to the 2020 transaction, the hospital had already experienced a prolonged period of service line contraction under CHS ownership. The most significant change occurred in April 2017, when the hospital eliminated routine obstetric services and closed its labor and delivery (L&D) unit. Deliveries declined from 144 in fiscal year (FY) 2015 to effectively zero by FY 2018, with the hospital retaining only the capacity to respond to obstetric emergencies.

Inpatient utilization and surgical volumes experienced a sharp decline at SMH over the study period while emergency visits remained relatively stable. Patient days fell from 6,606 in FY 2015 to 2,445 by FY 2024, representing a reduction of more than 60 percent, while staffed beds decreased from over 100 to approximately 80 between the 2015 and 2024 study period. Internally provided data indicates that just 20 of the 90 licensed acute care beds are currently staffed with a staffed occupancy rate of 28.0 percent in 2025 rising slightly to 36.0 percent year-to-date. This shift demonstrates a significant change in service need for the patient population. In contrast, emergency department (ED) utilization remained relatively stable, fluctuating between approximately 12,000 and 15,000 visits annually and returning to 15,026 visits in FY 2024. In 2025, the facility maintained similar volumes with a total of 14,350 emergency visits. Surgical volume followed a similar downward trajectory as inpatient care, with total procedures declining from a peak of 2,794 in FY 2019 to 1,107 by FY 2024, and inpatient surgeries decreasing from 589 to 67 over the same period. The decreasing trend continued into 2025 with total surgical procedures falling to 948 and inpatient surgical volume falling to 48.

Total gross revenue has remained comparatively stable, supported by outpatient services (see FIGURE 5-A in APPENDIX 5), despite declines in inpatient and surgical activity as well as a consistently negative bottom line (revenue and gains in excess of expenses and losses) trending down since acquisition (see FIGURE 5-B in APPENDIX 5). Outpatient revenue increased from $121.1 million in FY 2015 to approximately $188.7 million in FY 2024 and continued increasing to over $200.2 million in 2025, while inpatient revenue declined from $58.5 million to $41.5 million between FY 2015 and FY 2024 before decreasing to $33.6 million in 2025. The trends reflect a clear shift in the hospital's revenue composition toward outpatient care.

SMH's current greatest challenge centers around the physical state of the facility. SMH has suffered from decades of deferred maintenance from previous ownership. Bon Secours has invested over $10 million since the acquisition to address critical issues like moisture damage, rain leaks, and heating, ventilation, and air conditioning (HVAC) failures in the emergency department, but administrators estimate this deferred necessary major renovations or replacement for a couple of years.

As SMH continues to serve a primarily Medicare or Medicaid population (comprising over 70 percent of payer mix) where Medicare Advantage plans have proliferated, the facility faces challenges in denied coverage of longer hospital stays even when patients cannot be safely discharged due to lack of home health services or transportation. Data provided by the hospital further details the extent of financial and operational pressure at Southampton Memorial Hospital. The facility's payer mix has continued to worsen, shifting away from commercial insurance toward Medicaid and self-pay. Between 2022 and 2025, commercial mix declined from 24.5 percent to 20.6 percent, a drop of 3.9 percentage points, while Medicare also fell from 52.4 percent to 49.5 percent. In the same period, Medicaid mix increased from 18.1 percent to 20.6 percent, and self-pay and other coverage nearly doubled from 5.1 percent to 9.3 percent. This shift toward lower-reimbursement and no-

reimbursement payers compounds the financial challenges already present from declining inpatient volumes.

Operationally, the hospital's acute care footprint has become remarkably small relative to its licensed capacity. The hospital has identified surgical, procedural, and critical care services as the service lines at greatest risk and most challenging to maintain. Additionally, the facility currently offers long-term care (LTC) services, staffing 92 of its 129 licensed LTC beds. Thirty-four LTC beds are scheduled to transition to another long-term care provider as excess capacity, and the remaining 95 LTC beds and operations are slated for divestiture in June 2026, further reshaping the facility's operational scope. Outpatient services include imaging, therapy, laboratory, surgery, and cardiovascular services, though volumes have shifted due to population decline in the surrounding rural areas. To strengthen care coordination and continue offering access to services for SMH's service area, the hospital collaborates with all Bon Secours Mercy Health Virginia facilities and has implemented telemedicine services for psychiatry, neurology, and stroke care.

Southern Virginia Medical Center

Southern Virginia Medical Center (SVMC) was identified by JCHC staff as at risk of closure and by the FDI as at highest risk of experiencing financial distress. SVMC is reimbursed by CMS as a Medicare Dependent Hospital located in Emporia that serves Greensville County and the surrounding region. SVMC reflects a similar trajectory as SMH, though with more pronounced financial instability at baseline. Unlike Southampton, the facility did not offer obstetric services during the study period, with no reported obstetrical capacity or deliveries. At the time of acquisition, its negative 47 percent operating margin placed it among the most financially distressed rural hospitals in the Commonwealth.

Utilization trends following acquisition continue to show sustained pressure on inpatient services. Patient days declined from 7,180 in FY 2015 to 3,216 by FY 2024 during the study period before declining further to 2,313 patient days per 2025 internal data. Staffed beds dropped to 73 of 80 licensed beds by FY 2024. However, most recent internal data indicates that just 12 acute care inpatient beds were staffed in 2025 with a 52.8 percent staffed occupancy rate – reflecting a significant contraction in inpatient demand as observed at SMH. Like SMH, emergency department visits remained stable and slightly increased over time, reaching 15,267 visits in FY 2024 and remaining stable in 2025 with 14,568 visits. Surgical volume data reflects a more nuanced trajectory. While inpatient procedures declined to just 29 by FY 2024, total surgical activity has shown notable growth in recent years, rising from 719 procedures in FY 2022 to 1,193 in FY 2023 and 1,615 in FY 2024, driven almost entirely by outpatient procedures. This recent expansion in outpatient surgical volume suggests a deliberate operational pivot, with the facility increasingly serving as a site for ambulatory procedures even as inpatient surgical capacity has contracted. The most current internally provided surgical volumes indicate that 736 outpatient surgical procedures and 17 inpatient procedures were performed in 2025 and a total of 1,615 total surgical procedures have already been completed at the facility year-to-date as of April 2026.

Financially, the hospital demonstrates overall revenue growth despite declining inpatient utilization (see FIGURE 5-C in APPENDIX 5). Total gross revenue increased from $188 million in FY 2015 to $269 million in FY 2024, driven primarily by outpatient revenue, which rose from $119.1 million to $225.2 million during the same period. Internal financial data maintains this trend with total gross revenue rising to $292.3 million dollars and outpatient revenue continuing to increase to $248.9 million dollars in FY 2025. In contrast to SMH, SVMC's bottom line improved over the course of the study period – although remaining in negative margins - from a low of negative $11.9 million in FY2019 to negative $1.2 million in FY 2024 (see FIGURE 5-D in APPENDIX 5). These margins further improved based on internal data reporting a negative margin of negative $449 thousand in FY 2025. Additionally, the payer mix has seen an approximate three percent increase in Medicaid since 2023, while Medicare has remained relatively consistent and commercial payer percentages have fluctuated between 10.5 percent and 12.5 percent.

In further contrast to the SMH facility, SVMC operates in a new building with available space to offer additional hospital-based services or co-locate services with another provider. Current facility challenges include infrastructure needs around broadband connectivity to support telehealth providers and increase service line access.

The hospital reported that since assuming ownership around 2020, Bon Secours has observed a broader shift toward greater demand for outpatient services and reduced demand for inpatient care. The facility has experienced notable service line losses, including the discontinuation of active outpatient and inpatient surgery across multiple specialties such as cataract, podiatry, orthopedic, general, urology, oncology, ear, nose, throat (ENT), pain management, and vascular surgery. Additional services lost include transesophageal echocardiography procedures, chemotherapy infusion, and an active sleep lab that previously performed over 300 procedures annually. Current outpatient offerings include endoscopy, imaging, ultrasound, cardiovascular studies, laboratory, emergency services, physical therapy, cardiac rehabilitation, a minimal-volume sleep lab, infusion services, and mental health intensive outpatient services. The hospital identified surgical and procedural areas, maternal care, oncology, infusion, specialty and consult services, and critical care as the service lines at greatest risk.

To address access challenges, the facility has implemented several telehealth initiatives including teleneurology for acute stroke, a telenocturnist program for inpatient care, and a telepsychiatry program for acute treatment and evaluation in the emergency department. Southern Virginia also partners with the Greater Reach Community Services Board to collaborate on care for psychiatric patients presenting to the emergency department.

Across both facilities, inpatient utilization has contracted significantly over time, while emergency department volumes have remained stable and, in some cases, increased. At Southampton, the elimination of obstetric services prior to acquisition and the subsequent decline in inpatient and surgical volumes illustrate a sustained reduction in service scope. At Southern Virginia Medical Center, the absence of obstetric services and surgical volume loss combined with persistent financial instability and declining patient days, reflects

similar structural pressures. In both cases, total revenue has been maintained or increased primarily through outpatient services, even as inpatient care has diminished. However, bottom line trends vary between the two facilities – though both facilities remain at negative margins. The result is a shift in the functional role of these hospitals, where inpatient capacity has been reduced while emergency and outpatient services continue to serve as the primary drivers of utilization and revenue.

Case Study 2: Carilion Tazewell Community Hospital and Carilion Giles Community Hospital

Carilion Clinic is a Roanoke-based, non-profit integrated health system that operates seven hospitals serving patients across central / western Virginia and southern West Virginia. The system is anchored by Carilion Medical Center (CMC) in Roanoke. CMC is a 703-bed academic medical center providing access to tertiary and quaternary services, the largest Neonatal Intensive Care Unit (NICU) in western Virginia and the only level 1 trauma access for adult and pediatric west of Charlottesville. Carilion is a physician-led organization that emphasizes regional integration across 250 care access sites, including smaller community hospitals that are part of a broader referral and care coordination network supported by centralized command and transfer logistics. Carilion also provides the teaching faculty of the medical school in partnership with Virginia Tech as part of a broader array of strategic investments to improve access to care across the region served by Carilion and the Commonwealth as a whole. These investments to sustain access across rural communities also include three air-ambulances (Lifeguard) and emergent /non-emergent ground transportation services with a fleet of ambulances and transport assets. Additional strategic investments include funding access to primary care and specialty physicians in smaller communities and developing telehealth infrastructure to extend greater physician access into rural areas.

Carilion Tazewell Community Hospital and Carilion Giles Community Hospital represent two rural facilities within this system, each serving geographically distinct but similarly rural and medically underserved regions in Southwest Virginia. Both hospitals operate with limited bed capacity and reflect different approaches to sustaining rural hospital operations within an integrated system.

Tazewell Community Hospital

Carilion Tazewell Community Hospital (CTCH) was identified by JCHC staff analysis as at immediate risk of closure and the FDI as at highest risk of experiencing financial distress. CTCH is designated by the Centers for Medicare & Medicaid Services (CMS) as a Medicare Dependent Hospital located in Tazewell County that operates under a licensed bed capacity of 56 beds but has functionally maintained a substantially lower staffed bed count throughout the study period, ranging from just 4 to 15 staffed beds between FY 2015 and FY 2024. This staffed capacity reflects responsive operational scaling aligned with demand/utilization levels and clinical resource capacity. Patient days declined from 2,462 in FY 2015 to a low of 1,800 in FY 2018 before increasing to 3,080 by FY 2024, indicating

some variability but ultimately a relatively low-volume inpatient environment. Emergency department visits remained stable over time, beginning at 10,728 visits in FY 2015, declining during the COVID-19 period, and recovering to 10,482 visits by FY 2024. The most notable structural shift at Tazewell is the discontinuance of surgical services due to lack of surgeon presence in the community. While the hospital reported 167 outpatient surgical procedures in FY 2015 and 76 in FY 2016, surgical volume dropped to zero beginning in FY 2017 and has remained absent through FY 2024, with no inpatient surgical procedures reported at any point during the study period. This indicates a full transition away from surgical capacity as part of the fundamental changes in healthcare, specifically the shortage of physicians and economic landscape in rural settings.

Despite the absence of surgical services and constrained inpatient capacity, CTCH demonstrates steady financial growth over time, driven primarily by outpatient services (see FIGURE 5-E in APPENDIX 5). The bottom line (revenue and gains in excess of expenses and losses) remained negative between FY 2015 and FY 2024 but showed a more positive change between FY 2023 and FY 2024 (see FIGURE 5-F in APPENDIX 5). Total gross revenue increased from $46.7 million in FY 2015 to $97.1 million in FY 2024, more than doubling over the study period. Outpatient revenue rose consistently, from approximately $34.8 million to $75.0 million, while inpatient revenue also increased modestly, from $11.9 million to $22.1 million. This pattern reflects a facility that has stabilized and expanded its financial base without reliance on surgical services or significant inpatient growth, maintaining a limited inpatient footprint while supporting increasing outpatient activity.

Importantly, this absence of inpatient surgery does not reflect a withdrawal from community care so much as a reconfiguration of the hospital's role within a changing healthcare landscape. Carilion Tazewell functions as a critical access point for Tazewell County and surrounding Appalachian communities—providing 24/7 emergency care, inpatient stabilization for low-acuity conditions, diagnostic and imaging services, outpatient treatment, and swing-bed/rehabilitation care that allows patients to recover closer to home. In this sense, CTCH increasingly operates as a rural access, stabilization, and continuity-of-care hub. Patients requiring higher-acuity intervention are coordinated through Carilion's transfer network to facilities such as Carilion Medical Center (CMC) and Carilion New River Valley Medical Center (CNRV).

The Carilion Clinic health system seeks to preserve as much care as possible within the community while leveraging the strength of a larger integrated system. Even when patients must initially travel for procedures or higher-acuity care, follow-up visits, chronic disease management, rehabilitation, and ongoing specialty access can increasingly occur closer to home. That strategy is reflected in the expansion of telemedicine services, virtual specialty access, and regional outpatient outreach efforts. CTCH has expanded virtual care capabilities across multiple service lines, including cardiology outpatient services and specialty follow-up care. The development of outpatient and virtual infrastructure in Bluefield reflects an effort to reduce travel burden for rural patients while keeping them connected to specialty care and system resources.

Many of these initiatives are ultimately driven by physician recruitment realities. Physician recruitment to rural communities remains one of the greatest challenges facing healthcare systems nationally, and nearly every rural access strategy ultimately ties back to physician recruitment and retention. Virtual services, shared specialists, telemedicine, and integrated staffing models have become creative mechanisms to sustain access in communities where traditional physician staffing models are increasingly difficult to support independently.

CTCH has also spent years rebuilding primary care access within the region through partnerships with the Carilion Foundation and broader system resources. Maintaining primary care access is viewed as essential not only to community health, but also to sustaining the hospital itself and preserving long-term healthcare access within the region.

Giles Community Hospital

Carilion Giles Community Hospital (CGCH) was identified by JCHC staff analysis as at immediate risk of closure and the FDI as at mid-highest risk of experiencing financial distress. CGCH is designated by CMS as a Critical Access Hospital (CAH) located in Pearisburg and serving Giles County and surrounding areas, operates on a smaller licensed bed base of 25 beds but maintains a comparatively higher level of staffed capacity relative to its size. Staffed beds declined from 17 in FY 2015 to a low of 9 in FY 2018 before increasing steadily to full capacity at 25 staffed beds by FY 2024. In contrast to Tazewell, Giles has maintained a more consistent inpatient presence, with patient days declining from 6,037 in FY 2015 to 4,182 in FY 2020 before rebounding to 6,165 by FY 2024, ultimately exceeding its initial baseline. Emergency department utilization remained stable throughout the period, with visits fluctuating between approximately 9,800 and 12,400 annually and reaching 12,440 visits in FY 2024.

Surgical services at CGCH declined through the middle of the study period due to surgeon vacancies in the community but have recovered in recent years. Total surgical procedures decreased from 1,037 in FY 2015 to a low of 611 in FY 2020 before rebounding steadily to 1,099 by FY 2024, surpassing the initial baseline. This recovery has been driven primarily by outpatient procedures, which rose from 538 in FY 2020 to 1,048 in FY 2024, while inpatient surgical procedures declined from 168 in FY 2015 to 51 in FY 2024. Unlike Tazewell, Giles retained and rebuilt portions of its procedural capacity, reflecting a different operational response within the same integrated system. Shared-provider arrangements have become essential to sustaining these services, with physicians from CNRV and Roanoke-based facilities supporting surgical and procedural care locally. These collaborative staffing models allow rural facilities to maintain services that would otherwise be difficult to sustain independently.

Financially, CGCH demonstrates substantial revenue growth, particularly in outpatient services (see FIGURE 5-G in APPENDIX 5). CGCH's bottom line fluctuated widely between FY 2015 and FY 2024 (see FIGURE 5-H in APPENDIX 5). However, total gross revenue increased from $90.0 million in FY 2015 to $167.7 million in FY 2024. Outpatient revenue more than tripled over the same period, rising from $59.6 million to $129.1 million, while

inpatient revenue also increased from $30.4 million to $38.7 million. This growth occurred alongside fluctuations in inpatient utilization and a recovery in surgical volume, indicating that revenue expansion has been driven primarily through outpatient care, renewed procedural activity, and broader system integration. As with CTCH, these trends reflect the growing importance of outpatient services, coordinated specialty access, and integrated care delivery models in sustaining rural hospitals.

CGCH has also expanded telemedicine-supported services and implemented operational models designed to maximize limited physician resources. One example is the use of virtual observation management within the emergency department, where system-based physicians help manage observation patients remotely. This approach reflects the creativity increasingly required to preserve services in rural communities by leveraging centralized physician support, technology-enabled care, and broader system integration.

Like Tazewell, Giles functions as both a local access point and an entryway into the broader Carilion network. The hospital stabilizes acute medical needs locally while coordinating transfers and specialty referrals when higher-acuity care is required. At the same time, the hospital has retained a broader procedural footprint that allows more outpatient surgery and procedural care to remain within the community.

The Tazewell and Giles facilities reflect two distinct but complementary operational models within the same health system. There is a shared reliance on outpatient care as the primary driver of financial performance, though the two facilities have arrived at different service configurations: Tazewell as a non-surgical stabilization and access hub, and Giles as a facility that has retained its procedural capacity within a broader integrated system structure. Both hospitals benefit from Carilion's centralized transfer and communications center, which coordinates patient transfers to higher levels of care at the flagship CMC facility or other specialized centers within the network. Integrated health systems now play a critical role in sustaining rural healthcare access. Ongoing support for rural hospitals increasingly depends on system-level coordination, physician sharing, graduate medical education, transfer infrastructure, telehealth capabilities, and broader operational support.

The most consistent drivers of financial strain across both rural hospitals and their broader supporting rural health system include payer mix imbalance, workforce shortages, inflationary pressure, and demographic decline. More than 70 percent of services within these communities are provided to Medicare and Medicaid patients, with an additional uninsured population requiring access to financial assistance programs. Rural hospitals rely heavily on commercial insurance reimbursement to cross-subsidize underfunded government payers, but unlike more densely populated and growing regions, the level of cross-subsidization required in rural communities has become increasingly difficult to sustain.

Physician capacity remains one of the single greatest limiting factors affecting rural healthcare investment decisions. As industries and businesses declined throughout portions of Southwest Virginia, younger working populations decreased and the economic

realities supporting those services changed significantly. The shortage of physicians willing to practice in rural communities increasingly shapes decisions about service expansion, sustainability, and operational design. Carilion Clinic has also invested in telehealth infrastructure to provide rural patients with access to specialists through virtual consultations, seeking to address the shortage of primary care and specialist physicians in these communities. However, technological advances in physician access do not replace the need for long-term physician commitment in rural health settings. Carilion's medical education programs at CMC are viewed as particularly important in exposing future physicians to rural healthcare environments and strengthening long-term recruitment opportunities.

The experiences of Carilion Tazewell Community Hospital and Carilion Giles Community Hospital demonstrate that rural hospital sustainability increasingly depends not on preserving historical operating models, but on adapting creatively through integration, workforce innovation, telehealth, and mission-driven system support.

Case Study 3: VCU Health Community Memorial Hospital and VCU Health Tappahannock Hospital

Virginia Commonwealth University (VCU) Health System is a Richmond-based academic health system anchored by Virginia Commonwealth University Medical Center and supported by a growing network of community hospitals across the Commonwealth. VCU Health operates several hospitals and has built a distinctive model that combines academic medicine with rural healthcare delivery—uniquely infusing research, clinical trials, and graduate medical education into facilities serving medically underserved communities. Over the past decade, VCU Health has expanded its regional footprint through affiliations and acquisitions, incorporating community-based facilities into a broader academic and referral network. VCU Health Community Memorial Hospital in South Hill and VCU Health Tappahannock Hospital, acquired from Riverside Health System in 2021, represent two distinct community hospital settings within this broader system, each serving rural and semi-rural populations with differing utilization patterns and service line configurations.

Community Memorial Hospital

VCU Health Community Memorial Hospital (CMH) was identified by JCHC staff analysis as at risk of closure and the FDI as at highest risk of experiencing financial distress. CMH is reimbursed through the Centers for Medicare & Medicaid Services (CMS) as a Sole Community Hospital located in South Hill that serves Mecklenburg County and surrounding areas along the Virginia–North Carolina border, reflecting a comparatively stable and high-utilization rural hospital profile. The facility operates as both a safety net hospital and an academic training site—recently launching a graduate medical education (GME) program where medical residents spend their second-year practicing in the rural community after completing their first year in at the VCU Medical Center in Richmond. The hospital just increased its residency program from three to four slots, based on the facility's experience

that most residents practice within about 100 miles of where they train, and matched all four positions.

Over the study period, the hospital reduced its licensed bed capacity from 99 beds in FY 2015 to 70 beds by FY 2019, where it has remained through FY 2025 per internally reported data. Between FY 2015 and FY 2025, staffed beds increased from 68 to 70 and percent occupancy rate increased from 60.2 to 70.1 percent. This shift reflects a recalibration of licensed capacity in response to patient demand alongside a sustained operational commitment to inpatient services. Patient days remained consistently high throughout the study period, increasing from 13,589 in FY 2015 to 15,372 in FY 2024, with a peak of over 17,000 in FY 2022. In 2025, patient days remained stable at 15,379. Emergency department utilization also remained strong and steadily increased, rising from 22,680 visits in FY 2015 to 26,183 visits by FY 2024, indicating sustained demand for acute and unscheduled care. The hospital reports 26,549 total ED visits in 2025 continuing the steadily increasing trend.

Unlike many rural hospitals experiencing service contraction, Community Memorial has maintained a broad surgical platform, with total surgical procedures remaining relatively stable over time. Surgical volume fluctuated but ultimately remained above 5,000 procedures annually in most years, with 5,182 procedures reported in FY 2024. Both inpatient and outpatient surgical services have been sustained, with inpatient procedures ranging from 512 to 982 over the study period. Internally reported data indicated that surgical volumes of 4,609 in FY 2025 with inpatient surgical procedures accounting for 583 of them.

In addition, the hospital demonstrates the reintroduction and expansion of obstetric services. No deliveries were reported in FY 2015 or FY 2016, and only 17 occurred in FY 2017 as the program was being established. By FY 2018, however, the hospital had operationalized a dedicated L&D unit, reporting 180 deliveries that year and sustaining volumes of approximately 190 annually through FY 2020. Beginning in FY 2021, the program expanded further, with 231 deliveries reported that year and volumes reaching 235 deliveries by FY 2024. This growth corresponds with the establishment of a small but consistent obstetrical service capacity of four beds operating under a Labor, Delivery, Recovery, & Postpartum (LDRP) model where patients remain in the same room throughout the entire birthing process. Since the study period, the hospital reports that the obstetrical service capacity has grown to six LDRP beds with 272 deliveries in FY 2025.

Financially, VCU Health Community Memorial Hospital shows sustained growth across both inpatient and outpatient revenue streams (see FIGURE 5-I in APPENDIX 5). The hospital's inpatient payer mix is approximately 85 percent Medicare and Medicaid, 11 percent commercial, 3 percent self-pay, and 1 percent other, with a slight ongoing shift from traditional Medicare to Medicare Advantage plans. The outpatient payer mix is somewhat more favorable, attracting greater commercial coverage for outpatient surgeries, imaging, radiation therapy, and infusions. Total gross revenue increased from $222.1 million in FY 2015 to $448.3 million in FY 2024. Outpatient revenue rose from $144.4 million to $321.6

million, while inpatient revenue increased from $77.7 million to $126.7 million, with a particularly notable increase in FY 2022. In FY 2025, the hospital reports total gross outpatient revenue growing to $372 million, total gross inpatient revenue growing to $159 million, and total gross revenue increasing to $532 million. While the hospital's bottom line (revenue and gains in excess of expenses and losses) has fluctuated immensely over the years, it has demonstrated an upward trajectory since FY 2022 (see FIGURE 5-J in APPENDIX 5). The hospital's financial trajectory reflects growth across service lines rather than reliance on a single category, aligning with its relatively stable inpatient utilization, maintained surgical capacity, and expanded obstetric services. The hospital recently opened a helicopter base and is on a journey to become a Level 3 trauma center, which would allow more patients to stay in Virginia rather than being transferred out of state.

The facility offers a broad array of outpatient services for a rural hospital, including radiation oncology, infusion therapy for both cancer and non-cancer conditions, advanced imaging, mammography, bone density scanning, dental care, rehabilitation services for adults and pediatric patients, pulmonary function testing, robotic surgery, cardiac rehabilitation, pulmonary rehabilitation, and occupational health and wellness programs. Community-based clinics affiliated with Medical College of Virginia (MCV) Physicians provide access across specialties including orthopedics, general surgery, urology, ENT, audiology, pain management, pulmonary medicine, gastroenterology, cardiology, family medicine at three locations, pediatrics, medical and radiation oncology, and behavioral health. Despite this breadth, the hospital identifies obstetrics/gynecology and gastroenterology as the service lines most difficult to sustain due to ongoing physician recruitment challenges. The Rural Family Medicine Residency Track, which welcomed its inaugural class of residents on July 1, 2024, is fully ACGME-accredited, and the hospital is exploring additional graduate medical education tracks to further strengthen the physician pipeline at CMH. As part of VCU Health, the hospital collaborates with fellow health systems and federally qualified health centers on workforce planning and shared learning and is exploring opportunities to align mobile health initiatives and other service lines to better serve rural communities.

Tappahannock Hospital

VCU Health Tappahannock Hospital was identified by JCHC staff analysis as at immediate risk of closure and the FDI as at mid-highest risk of experiencing financial distress. VCU Tappahannock is reimbursed by CMS as a Sole Community Hospital, located in Tappahannock that serves the Northern Neck and Middle Peninsula regions. The Tappahannock facility reflects a more variable utilization pattern compared to CMH over the FY 2015 to FY 2024 period. The hospital maintained a constant licensed bed capacity of 67 beds but operated with significantly lower staffed bed levels, ranging from 15 to 37 staffed beds between FY 2015 and FY 2024. Patient days fluctuated considerably, increasing from 5,154 in FY 2015 to 6,327 in FY 2017, declining through FY 2022 to a low of 1,530, and then rebounding sharply to 7,071 in FY 2023 before stabilizing at 6,505 in FY 2024. Internally reported data indicates that the facility now staffs 31 of its 67 licensed beds

operating at 61 percent capacity in FY 2025. Emergency department visits followed a similar pattern of disruption and recovery, declining significantly to 8,254 visits in FY 2021 before returning to nearly 20,000 visits by FY 2024. The hospital reported total ED visits stabilizing at 18,686 in FY 2025.

The disruption in services is attributed to deficits in medical staff during the transition from Riverside Health System to VCU Health, which led to declines in inpatient volumes. However, those volumes have since recovered. The facility's inpatient market share, or portion of total hospital admissions or patient days the facility captured with its geographic region, has rebounded from those deficits and is now growing. VCU has brought on new staff, including additional physician positions, which has allowed them to increase capacity and inpatient services, with plans to add more positions in the coming year.

Surgical services at Tappahannock Hospital have been maintained throughout the study period but show a gradual decline in overall volume. Total surgical procedures decreased from 3,887 in FY 2015 to 1,094 in FY 2024, with both inpatient and outpatient procedures declining over time. Surgical volumes appear to have stabilized with the facility completing a total of 1,414 surgical procedures per internally reported FY 2025 data. Unlike CMH, the hospital has not maintained or introduced obstetric services, with no L&D beds or reported deliveries during the study period. The hospital does not provide obstetric services, thoracic surgery, or certain other specialized procedures. However, Tappahannock has actively collaborated with regional partners to ensure maternal health and other necessary specialized services remain available in the community.

Since acquisition, the inpatient payer mix at Tappahannock is approximately 85 percent Medicare and Medicaid, 11 percent commercial, 3 percent self-pay, and 1 percent other coverage, with an increase in Medicare patients as the local population ages and a recent increase in self-pay patients. Despite growing reimbursement challenges and reductions in surgical activity and variability in inpatient utilization, the hospital demonstrates significant financial recovery and growth in recent years (see FIGURE 5-K in APPENDIX 5). The total gross revenue rebounded from $92.9 million in FY 2021 to $235 million by FY 2024. Outpatient revenue increased from $108.3 million in FY 2015 to $181.5 million in FY 2024, while inpatient revenue rose from $35.2 million to $53.5 million, reflecting recovery across both service categories following the disruption observed in FY 2021. Hospital data confirms this positive trajectory into FY 2025 with total gross revenue increasing to $311.5 million. While the facility's bottom line has remained negative with an overall downward trend through FY 2024 (see FIGURE 5-L in APPENDIX 5), positive trends in financial metrics suggest that the facility's bottom line may face a more positive trajectory in upcoming years.

The facility maintains a comprehensive outpatient platform that includes advanced imaging, nuclear stress testing, ultrasound, and breast imaging, as well as bone density screening, echocardiograms, pulmonary function testing, outpatient surgery, endoscopy, endoscopic retrograde cholangiopancreatography (ERCP), rehabilitation services including physical therapy, occupational therapy, and speech-language pathology, and chemotherapy

infusion. Since 2015, the hospital has removed sleep studies and added positron emission tomography (PET) imaging capabilities. Through MCV Physicians-affiliated clinics, the hospital provides community access to family medicine, cardiology, gastroenterology, pulmonology, orthopedic surgery, general surgery, vascular surgery, urology, nephrology, infectious disease, and pediatrics. While the hospital is not contemplating closure of any current services, it identified chemotherapy infusion, intensive care unit (ICU)-level care, and speech therapy as the service lines placing the most strain on the organization. To continue providing patients with access to specialty care, the hospital has expanded its telehealth capabilities through VCU Health, currently offering tele-stroke services, inpatient telemedicine consultations for infectious disease, cardiology, critical care, and nephrology, and remote cardiac monitoring support, with a teleneurohospitalist program near completion.

The VCU CMH and Tappahannock facilities illustrate two different operational profiles within the same health system that are supported by systemic affiliation and a flagship hospital that provides a broad array of services and educational infrastructure. At CMH, inpatient utilization, surgical capacity, and service line breadth have been sustained and, in some cases, expanded, including the addition of obstetric services and continued growth in both inpatient and outpatient revenue. At Tappahannock, utilization and service lines have been more variable, with a notable disruption in FY 2021 followed by recovery in patient volume and revenue, alongside a gradual reduction in surgical procedures and no expansion into obstetric services. In both cases, emergency department utilization remains a consistent component of hospital activity, while outpatient revenue growth contributes significantly to overall financial performance. A cornerstone of VCU's rural strategy is the scaling of virtual care to provide access to subspecialists. Patients come in for appointments where the only virtual element is the physician—the infrastructure, support staff, and allied health professionals are all physically present, making subspecialty care accessible without requiring patients to travel hours to Richmond. The populations in these service areas aren't growing, but both VCU rural hospitals are growing market share by meeting previously unmet healthcare needs.

Case Study 4: Sentara Halifax Regional Hospital

Sentara Health (formerly Sentara Healthcare) is a Norfolk-based, non-profit integrated health system with a broad footprint across Virginia and North Carolina, encompassing acute care hospitals, physician networks, and a large health plan. Sentara Halifax Regional Hospital was identified by JCHC staff analysis as at immediate risk of closure and the FDI as at mid-highest risk of experiencing financial distress. Sentara Halifax is reimbursed by the Centers for Medicare & Medicaid Services (CMS) as a Sole Community Hospital as well as a Rural Referral Center located in South Boston. The hospital serves Halifax County and the surrounding Southside region, an area characterized by persistent economic challenges, high chronic disease burden, and limited access to alternative hospital services. The hospital is approximately an hour away from the closest competing facility and three hours away from the nearest Sentara facility, making it geographically isolated within its own

system. Historically, the hospital operated as a full-service regional facility with a substantially larger inpatient footprint. Over the past decade, however, the facility has undergone a marked contraction in both capacity and service line scope, reflected clearly in its utilization and operational data.

The facility's licensed bed capacity increased modestly from 173 in FY 2015 to 192 beginning in FY 2016, where it has remained through FY 2024. However, the number of staffed beds tells a different story: operational capacity declined steadily from 85 staffed beds in FY 2015 to just 44 by FY 2024, a reduction of nearly half. This widening gap between licensed and staffed capacity reflects a sustained contraction in the hospital's operational footprint. Patient days declined from 13,589 in FY 2015 to 9,005 by FY 2024, a reduction of approximately 34 percent. Internally reported data provides that the hospital staffed 49 of its 192 licensed beds in 2025 operating at 25.2 percent staffed occupancy. The pace of this decline indicates a significant downsizing of the hospital's inpatient role within the region. Emergency department utilization, while more stable, also reflects variability and an overall downward shift relative to earlier years, declining from 27,758 visits in FY 2015 to 21,563 by FY 2024, with intermittent recovery periods in between. The hospital reported continued stabilization with 20,943 total ED visits in FY 2025.

Surgical services at Sentara Halifax Regional Hospital demonstrate both volatility and long-term contraction with the hospital attributing technological/medical advances and workforce challenges as primary drivers. Medical advances have allowed historically complex procedures requiring inpatient care to now be performed on an outpatient basis, reducing the inpatient demand across many surgical procedures. Specialty services face challenges in consistent staffing. Total surgical procedures remained relatively stable between FY 2015 and FY 2018 before an anomalous spike in FY 2019, where total procedures exceeded 9,000, driven largely by outpatient activity. However, surgical volumes returned to prior levels in FY 2020 and subsequently declined sharply. By FY 2024, total surgical procedures had fallen to 934, with inpatient surgical procedures declining to just 185. Internal FY 2025 surgical volumes demonstrate growth as total surgical procedures increased to 2,412. While the initial downward trend aligns with the broader contraction of inpatient services and suggests a narrowing of procedural capacity over time, the growth in FY 2025 indicates a potential redirection as the facility responds to community needs.

The hospital's obstetrical services reflect one of the most visible and consequential changes in service availability. In FY 2015, the hospital reported 446 deliveries supported by 15 licensed L&D beds and 6 staffed L&D beds, indicating an active obstetric program serving the surrounding region. Over the following decade, deliveries declined gradually but persistently: from 446 in FY 2015 to 419 in FY 2016, 392 in FY 2017, and continuing downward through 364, 356, and 323 deliveries in FY 2018 through FY 2020. The decline accelerated in the final years of the study period, with deliveries falling from 286 in FY 2021 to 241 in FY 2022, then sharply to 126 in FY 2023, and ultimately to zero in FY 2024. Staffed L&D beds followed a parallel trajectory, declining from 6 in FY 2015 to 3 by FY 2023 and reaching zero in FY 2024, even as 15 licensed beds were maintained throughout the

period. The hospital reports maintaining 5 licensed L&D beds in FY 2025 but reports no deliveries. This gradual erosion—rather than abrupt closure—reflects the compounding effects of declining birth rates in the service area, staffing challenges inherent to maintaining 24/7 obstetric coverage, and the economic reality that low-volume delivery programs carry disproportionate fixed costs.

The facility's current payor mix is comprised of approximately 75 percent Medicare or Medicaid patient population and contributes to facility challenges where reimbursement rates do not cover costs. The aging, shrinking population means younger, healthier individuals are leaving while those remaining are older, sicker, and more likely to have government insurance. Despite these substantial changes in service scope, inpatient utilization, and payor mix, the hospital's financial profile shows relative stability with moderate growth over time (see FIGURE 5-M in APPENDIX 5). Although the hospital's bottom line (revenue and gains in excess of expenses and losses) generally remained negative throughout the study period (see FIGURE 5-N in APPENDIX 5), the facility's total gross revenue increased from $269.0 million in FY 2015 to $327.3 million in FY 2024. Outpatient revenue grew from $180.5 million to $242.8 million, while inpatient revenue declined modestly from $88.5 million to $84.5 million. By FY 2025, the facility reports a total gross inpatient revenue of $88.4 million, total gross outpatient revenue of $265.6 million, and total gross revenue increasing to $354 million. The stability of overall revenue, even as inpatient utilization declined significantly, reflects a shift in the hospital's revenue composition toward outpatient services in response to evolving community needs.

To maintain services amid declining volumes, Sentara Halifax has pursued opportunities for innovation. Virtual care has become essential, with the hospital working directly with Halifax County to upgrade broadband infrastructure for telehealth. The approach to service decisions has become regionally collaborative rather than competitive—building transfer agreements and partnerships with other hospitals, Federally Qualified Health Centers (FQHCs), clinics, and physicians throughout the region. The hospital has explored creative scheduling models, asking whether certain specialty services could be offered fewer days per week rather than maintaining expensive 24/7 coverage that volumes no longer justify. While the hospital doesn't experience high turnover as geographic isolation limits local competition, recruitment still remains difficult.

Current outpatient services span urgent care, family medicine, pediatrics, gynecology, hematology and oncology, infusion therapy, cardiology, laboratory, radiology, behavioral health, general surgery, and orthopedics. However, physician recruitment challenges since 2015 have resulted in the closure of neurology; obstetric; ear, nose, and throat (ENT); and urology services. Staffing challenges extend to maintaining around-the-clock orthopedic coverage as well. The hospital identified surgery and surgical specialties—specifically urology, ENT, orthopedics, and obstetrics—as the service lines at greatest risk.

The operational role of Sentara Halifax Regional Hospital has transformed substantially over the study period. The hospital transitioned from a higher-capacity, full-service inpatient facility to a significantly smaller operation with reduced inpatient volume,

diminished surgical activity, and the gradual loss of its obstetric program. While emergency department utilization remains a core component of activity and outpatient revenue continues to support overall financial performance, the scale of reduction in staffed beds, patient days, and procedural volume indicates a sustained contraction in the hospital's inpatient and service delivery capacity. To address gaps in coverage, the facility has established obstetric transfer agreements with VCU Health Community Memorial Hospital in South Hill and SOVAH Health in Danville and receives tele-neurology support through Sentara Martha Jefferson Hospital – reinforcing the need for collaborative approaches across many rural hospitals throughout the Commonwealth.

Appendix 5: Highest Risk Rural Hospitals – 10 Year Trends

Table 5-A. Bon Secours Southampton Memorial Hospital

Table 5-B. Bon Secours Southern Virginia Medical Center

Table 5-C. Carilion Tazewell Community Hospital

Table 5-D. Carilion Giles Community Hospital

Table 5-E. VCU Health Community Memorial Hospital

Table 5-F. Riverside Tappahannock Hospital

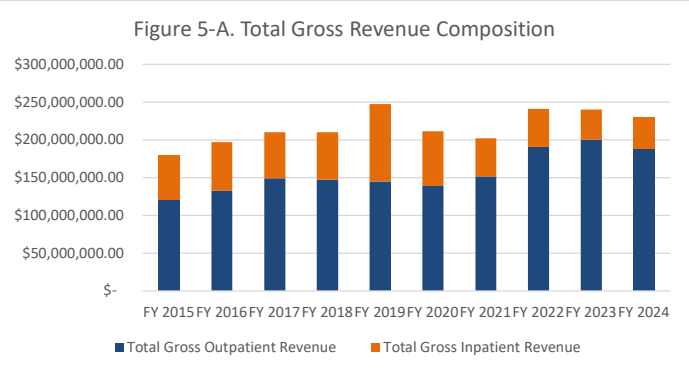
Table 5-G. Sentara Halifax Regional Hospital

Table 5-A. Bon Secours Southampton Memorial Hospital

Source: Virginia Health Information (VHI) Annual Licensure Survey Data and Hospital Detail Reports, FY 2015-2024

Metric	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Licensed Beds	90	90	90	90	90	105	90	90	90	90
Staffed Beds	102	102	102	90	90	105	90	80	80	80
Patient Days	6,606	5,934	6,508	7,191	5,762	4,857	5,458	4,300	2,954	2,445
ED Visits	15,000	14,030	13,742	13,236	14,394	12,353	12,756	14,293	14,231	15,026
Total Surgical Procedures	2,210	2,191	2,310	2,312	2,794	1,480	1,411	1,532	1,341	1,107
Outpatient Surgical Procedures	1,769	1,810	2,083	2,053	2,205	1,175	1,317	1,444	1,255	1,040
Inpatient Surgical Procedures	441	381	227	259	589	305	94	88	86	67
L&D Licensed Beds	10	10	10	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
L&D Staffed Beds	10									
L&D Deliveries	144	1	1	0	0	0	0	0	0	0
Total Gross Revenue	$ 179,615,977.00	$ 196,856,286.00	$ 210,036,877.00	$ 209,949,572.00	$ 247,313,417.00	$ 211,414,625.00	$ 202,382,082.00	$ 241,085,104.00	$ 240,211,511.00	$ 230,185,097.00
Total Gross Outpatient Revenue	$ 121,132,569.00	$ 132,792,452.00	$ 149,253,373.00	$ 147,563,792.00	$ 145,118,916.00	$ 138,953,718.00	$ 151,780,272.00	$ 190,692,365.00	$ 200,481,138.00	$ 188,730,633.00
Total Gross Inpatient Revenue	$ 58,483,408.00	$ 64,063,834.00	$ 60,783,504.00	$ 62,385,780.00	$ 102,194,501.00	$ 72,460,907.00	$ 50,601,810.00	$ 50,392,739.00	$ 39,730,373.00	$ 41,454,464.00
Revenue and Gains in Excess of Expenses and Losses	$ (5,841,823.00)	$ 16,513,514.00	$ (10,092,796.00)	$ (8,369,952.00)	$ 38,637,569.00	$ 6,477,190.00	$ (10,170,093.00)	$ (4,459,370.00)	$ (11,569,196.00)	$ (12,008,796.00)
Total Net Revenue	$ 39,996,552.00	$ 63,825,651.00	$ 39,170,365.00	$ 39,046,677.00	$ 84,041,291.00	$ 38,562,460.00	$ 42,950,229.00	$ 52,803,842.00	$ 43,791,433.00	$ 41,198,745.00
Total Operating Expenses	$ 45,892,020.00	$ 47,312,722.00	$ 49,263,161.00	$ 47,416,629.00	$ 45,403,722.00	$ 32,085,270.00	$ 53,120,322.00	$ 57,263,212.00	$ 55,359,886.00	$ 53,202,750.00

(Note: The table above captures the 10-year data trend available through VHI data. Please note that the facility's case study may utilize updated internally reported numbers for certain years due to data discrepancies or to maintain financial comparisons where accouting changes occurred between years)



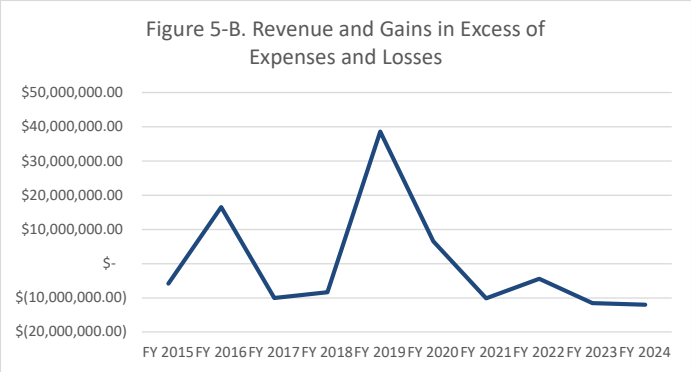
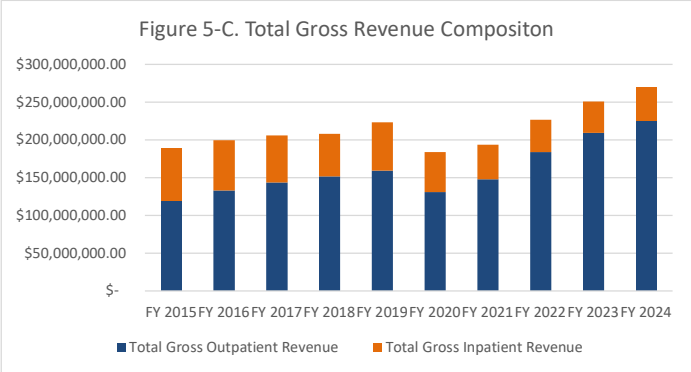


Table 5-B. Bon Secours Southern Virginia Medical Center

Source: Virginia Health Information (VHI) Annual Licensure Survey Data and Hospital Detail Reports, FY 2015-2024

Metric	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Licensed Beds	80	80	80	80	80	80	80	80	80	80
Staffed Beds	80	80	80	80	80	73	73	80	73	73
Patient Days	7,180	6,322	5,801	5,396	6,312	4,735	4,565	3,718	3,374	3,216
ED Visits	14,358	14,105	14,676	15,195	15,285	11,975	12,928	14,970	14,864	15,267
Total Surgical Procedures	1,166	910	563	681	947	590	741	11,543	1,193	1,615
Outpatient Surgical Procedures	1,029	802	506	654	874	532	707	9,138	1,113	1,586
Inpatient Surgical Procedures	137	108	57	27	73	58	34	2,405	80	29
L&D Licensed Beds	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
L&D Staffed Beds	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
L&D Deliveries	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Total Gross Revenue	$ 188,259,447.00	$ 199,541,471.00	$ 205,873,254.00	$ 208,002,057.00	$ 223,258,497.00	$ 183,898,466.00	$ 193,424,382.00	$ 226,835,907.00	$ 250,713,603.00	$ 269,252,865.00
Total Gross Outpatient Revenue	$ 119,092,993.00	$ 133,211,112.00	$ 143,920,008.00	$ 151,823,025.00	$ 159,258,408.00	$ 131,213,674.00	$ 147,781,233.00	$ 183,999,908.00	$ 209,152,573.00	$ 225,234,397.00
Total Gross Inpatient Revenue	$ 69,166,454.00	$ 66,330,359.00	$ 61,953,246.00	$ 56,179,032.00	$ 64,000,089.00	$ 52,684,792.00	$ 45,643,149.00	$ 42,835,999.00	$ 41,561,030.00	$ 44,018,468.00
Revenue and Gains in Excess of Expenses and Losses	$ (8,293,981.00)	$ (8,826,352.00)	$ (10,723,742.00)	$ (10,857,572.00)	$ (11,915,767.00)	$ (2,780,815.00)	$ (5,813,793.00)	$ (2,118,029.00)	$ (2,021,831.00)	$ (1,270,625.00)
Total Net Revenue	$ 34,958,590.00	$ 33,379,574.00	$ 22,146,691.00	$ 23,965,671.00	$ 23,001,090.00	$ 22,584,045.00	$ 22,848,918.00	$ 27,457,206.00	$ 25,530,921.00	$ 29,749,614.00
Total Operating Expenses	$ 43,252,571.00	$ 42,205,926.00	$ 33,273,755.00	$ 34,823,243.00	$ 34,916,857.00	$ 25,364,860.00	$ 28,661,487.00	$ 29,300,860.00	$ 27,401,068.00	$ 30,686,334.00

(Note: The table above captures the 10-year data trend available through VHI data. Please note that the facility's case study may utilize updated internally reported numbers for certain years due to data discrepancies or to maintain financial comparisons where accouting changes occurred between years)



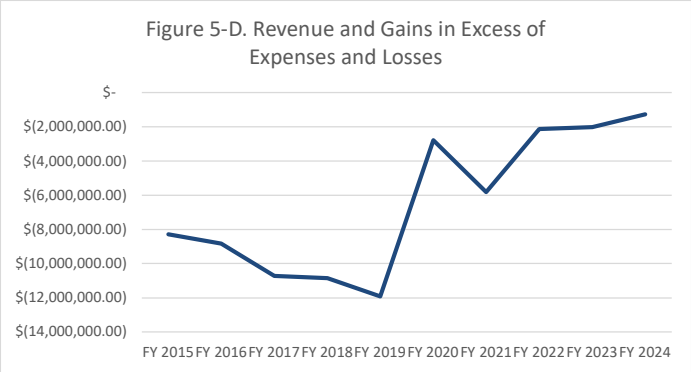
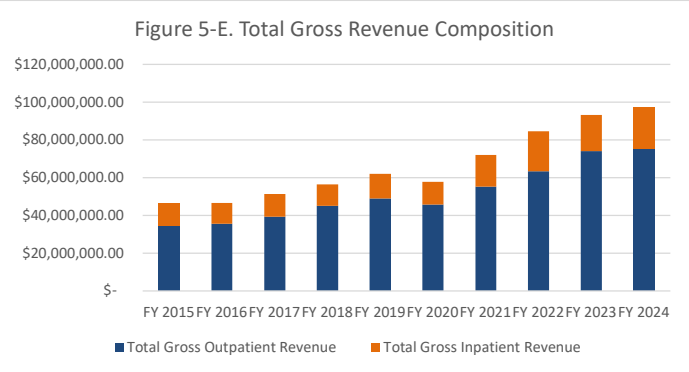


Table 5-C. Carilion Tazewell Community Hospital

Source: Virginia Health Information (VHI) Annual Licensure Survey Data and Hospital Detail Reports, FY 2015-2024

Metric	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Licensed Beds	56	56	56	56	56	56	56	56	56	56
Staffed Beds	8	6	5	4	5	9	9	10	8	15
Patient Days	2,462	2,194	2,096	1,800	2,088	1,926	2,648	3,409	2,815	3,080
ED Visits	10,728	10,060	9,934	9,814	9,709	8,425	8,284	9,056	9,878	10,482
Total Surgical Procedures	167	76	0	0	0	0	0	0	0	0
Outpatient Surgical Procedures	167	76	0	0	0	0	0	0	0	0
Inpatient Surgical Procedures	0	0	0	0	0	0	0	0	0	0
L&D Licensed Beds	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
L&D Staffed Beds	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
L&D Deliveries	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Total Gross Revenue	$ 46,711,462.00	$ 46,676,975.00	$ 51,270,952.00	$ 56,372,076.00	$ 62,008,894.00	$ 57,945,546.00	$ 72,052,309.00	$ 84,561,982.00	$ 93,201,701.00	$ 97,063,289.00
Total Gross Outpatient Revenue	$ 34,794,898.00	$ 35,618,776.00	$ 39,401,552.00	$ 45,065,238.00	$ 49,010,259.00	$ 45,742,589.00	$ 55,242,122.00	$ 63,437,263.00	$ 74,147,728.00	$ 75,011,645.00
Total Gross Inpatient Revenue	$ 11,916,564.00	$ 11,058,199.00	$ 11,869,400.00	$ 11,306,838.00	$ 12,998,635.00	$ 12,202,957.00	$ 16,810,187.00	$ 21,124,719.00	$ 19,053,973.00	$ 22,051,644.00
Revenue and Gains in Excess of Expenses and Losses	$ (1,516,726.00)	$ (1,512,033.00)	$ (3,070,979.00)	$ (3,250,033.00)	$ (2,914,878.00)	$ (2,395,741.00)	$ (3,306,011.00)	$ (4,815,988.00)	$ (6,893,659.00)	$ (6,165,832.00)
Total Net Revenue	$ 15,539,383.00	$ 14,366,868.00	$ 11,481,013.00	$ 12,360,811.00	$ 13,869,218.00	$ 14,890,371.00	$ 16,295,022.00	$ 19,684,597.00	$ 19,170,985.00	$ 21,530,476.00
Total Operating Expenses	$ 17,056,678.00	$ 15,879,236.00	$ 14,753,223.00	$ 15,611,871.00	$ 16,790,594.00	$ 17,288,535.00	$ 19,700,549.00	$ 24,501,049.00	$ 26,064,792.00	$ 27,696,470.00

(Note: The table above captures the 10-year data trend available through VHI data. Please note that the facility's case study may utilize updated internally reported numbers for certain years due to data discrepancies or to maintain financial comparisons where accouting changes occurred between years)



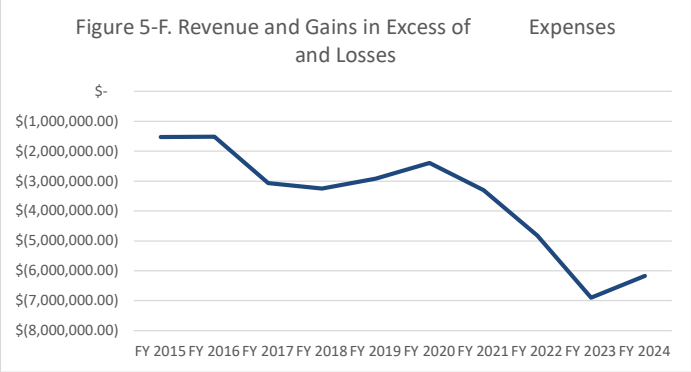
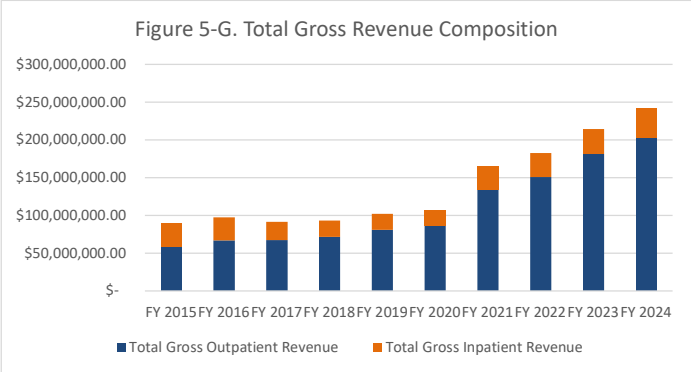


Table 5-D. Carilion Giles Community Hospital

Source: Virginia Health Information (VHI) Annual Licensure Survey Data and Hospital Detail Reports, FY 2015-2024

Metric	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Licensed Beds	25	25	25	25	25	25	25	25	25	25
Staffed Beds	17	14	10	9	12	13	17	20	17	25
Patient Days	6,037	5,782	5,177	4,784	4,421	4,182	5,427	5,487	5,932	6,165
ED Visits	11,891	12,204	11,859	11,673	11,658	10,440	9,806	10,480	11,243	12,440
Total Surgical Procedures	1,037	1,068	819	663	758	611	687	849	895	0
Outpatient Surgical Procedures	869	919	747	574	691	538	629	771	839	0
Inpatient Surgical Procedures	168	149	72	89	67	73	58	78	56	0
L&D Licensed Beds	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
L&D Staffed Beds	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
L&D Deliveries	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Total Gross Revenue	$ 90,030,961.00	$ 97,376,328.00	$ 91,718,230.00	$ 93,368,852.00	$ 102,107,168.00	$ 107,478,905.00	$ 164,758,336.00	$ 182,762,966.00	$ 214,444,866.00	$ 241,763,245.00
Total Gross Outpatient Revenue	$ 59,645,239.00	$ 66,949,295.00	$ 67,285,109.00	$ 71,446,155.00	$ 81,053,104.00	$ 86,477,544.00	$ 134,154,177.00	$ 150,946,900.00	$ 181,307,878.00	$ 203,092,591.00
Total Gross Inpatient Revenue	$ 30,385,722.00	$ 30,427,033.00	$ 24,433,121.00	$ 21,922,697.00	$ 21,054,064.00	$ 21,001,361.00	$ 30,604,159.00	$ 31,816,066.00	$ 33,136,988.00	$ 38,670,654.00
Revenue and Gains in Excess of Expenses and Losses	$ 557,450.00	$ (737,676.00)	$ 6,367,140.00	$ 2,638,453.00	$ (4,677,058.00)	$ (784,438.00)	$ 926,741.00	$ (995,188.00)	$ 1,362,191.00	$ (1,987,682.00)
Total Net Revenue	$ 34,185,992.00	$ 35,615,585.00	$ 33,160,321.00	$ 30,022,706.00	$ 32,054,316.00	$ 38,263,579.00	$ 66,949,720.00	$ 80,350,256.00	$ 92,480,340.00	$ 92,995,584.00
Total Operating Expenses	$ 31,104,322.00	$ 33,961,053.00	$ 30,877,641.00	$ 30,357,376.00	$ 31,998,917.00	$ 37,345,124.00	$ 71,994,020.00	$ 85,592,520.00	$ 93,771,790.00	$ 95,074,308.00

(Note: The table above captures the 10-year data trend available through VHI data. Please note that the facility's case study may utilize updated internally reported numbers for certain years due to data discrepancies or to maintain financial comparisons where accouting changes occurred between years)



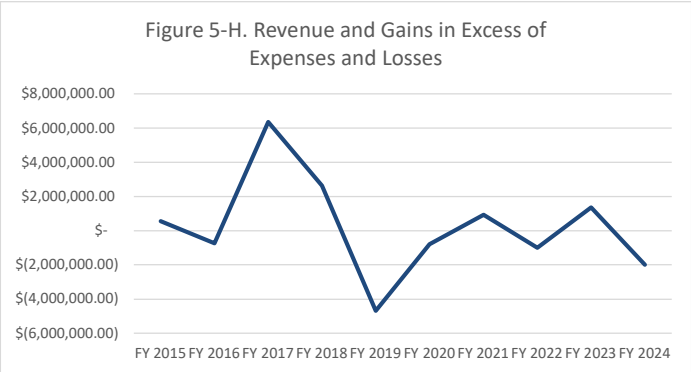
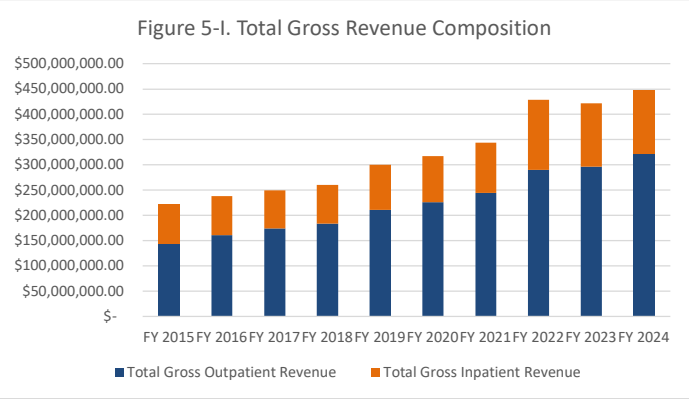


Table 5-E. VCU Health Community Memorial Hospital

Source: Virginia Health Information (VHI) Annual Licensure Survey Data and Hospital Detail Reports, FY 2015-2024

Metric	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Licensed Beds	99	99	99	85	70	70	70	70	70	70
Staffed Beds	68	68	68	74	80	80	80	80	80	80
Patient Days	13,589	13,573	12,657	12,474	14,614	14,492	15,966	17,061	15,034	15,372
ED Visits	22,680	22,937	23,781	22,531	23,733	22,423	22,175	23,534	24,488	26,183
Total Surgical Procedures	5,133	5,485	5,233	5,233	5,442	4,836	3,712	2,780	5,096	5,182
Outpatient Surgical Procedures	4,360	4,663	4,602	4,602	4,460	3,923	2,993	2,268	4,253	4,504
Inpatient Surgical Procedures	773	822	631	631	982	913	719	512	843	678
L&D Licensed Beds	*N/A*	*N/A*	*N/A*	2	4	4	4	4	4	4
L&D Staffed Beds	*N/A*									
L&D Deliveries	*N/A*	*N/A*	17	1	1	1	231	180	224	269
Total Gross Revenue	$ 222,131,840.00	$ 237,906,042.00	$ 249,364,690.00	$ 260,605,004.00	$ 299,864,540.00	$ 317,168,977.00	$ 343,583,756.00	$ 428,496,287.00	$ 421,895,877.00	$ 448,298,275.00
Total Gross Outpatient Revenue	$ 144,404,386.00	$ 160,970,030.00	$ 173,992,221.00	$ 183,539,345.00	$ 210,847,281.00	$ 226,000,108.00	$ 244,573,128.00	$ 290,449,576.00	$ 296,058,336.00	$ 321,594,668.00
Total Gross Inpatient Revenue	$ 77,727,454.00	$ 76,936,012.00	$ 75,372,469.00	$ 77,065,659.00	$ 89,017,259.00	$ 91,168,869.00	$ 99,010,628.00	$ 138,046,711.00	$ 125,837,541.00	$ 126,703,607.00
Revenue and Gains in Excess of Expenses and Losses	$ 33,507,939.00	$ 10,027,853.00	$ 45,673,772.00	$ 37,540,932.00	$ 11,913,994.00	$ 26,167,048.00	$ 7,246,227.00	$ (50,719,997.00)	$ (26,084,948.00)	$ (7,832,837.00)
Total Net Revenue	$ 77,258,504.00	$ 85,870,903.00	$ 72,926,448.00	$ 69,763,765.00	$ 83,626,539.00	$ 96,065,712.00	$ 106,494,013.00	$ 118,140,927.00	$ 101,803,205.00	$ 108,043,998.00
Total Operating Expenses	$ 69,247,655.00	$ 79,787,513.00	$ 65,170,777.00	$ 67,866,023.00	$ 73,783,886.00	$ 84,076,474.00	$ 106,836,937.00	$ 167,144,467.00	$ 127,907,030.00	$ 118,255,977.00

(Note: The table above captures the 10-year data trend available through VHI data. Please note that the facility's case study may utilize updated internally reported numbers for certain years due to data discrepancies or to maintain financial comparisons where accouting changes occurred between years)



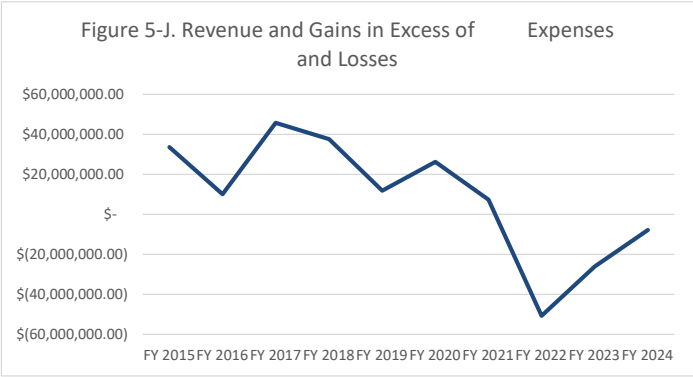
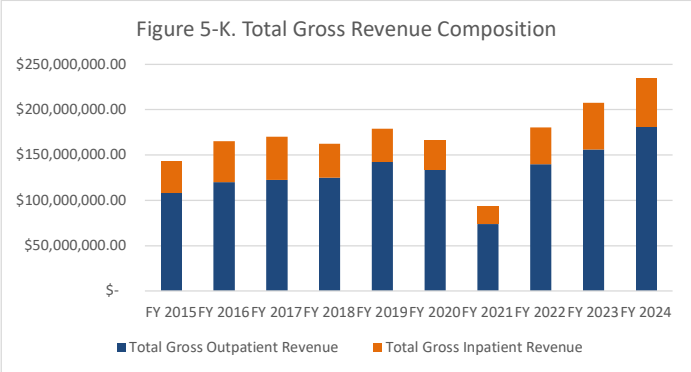


Table 5-F. Riverside Tappahannock Hospital

Source: Virginia Health Information (VHI) Annual Licensure Survey Data and Hospital Detail Reports, FY 2015-2024

Metric	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Licensed Beds	67	67	67	67	67	67	67	67	67	67
Staffed Beds	15	16	18	16	16	15	25	25	25	37
Patient Days	5,154	5,473	6,327	5,455	5,385	5,308	4,525	1,530	7,071	6,505
ED Visits	20,470	19,683	19,335	17,760	18,423	15,238	8,254	17,294	19,393	19,638
Total Surgical Procedures	3,887	3,864	3,145	3,263	2,588	1,965	1,360	1,791	2,068	1,094
Outpatient Surgical Procedures	3,599	3,627	2,415	2,755	2,220	1,737	1,263	1,633	1,804	859
Inpatient Surgical Procedures	288	237	730	508	368	228	97	158	264	235
L&D Licensed Beds	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
L&D Staffed Beds	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
L&D Deliveries	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Total Gross Revenue	$ 143,484,320.00	$ 165,364,060.00	$ 170,161,862.00	$ 162,491,011.00	$ 178,917,096.00	$ 165,747,566.00	$ 92,960,711.00	$ 180,355,500.00	$ 207,592,750.00	$ 235,011,627.00
Total Gross Outpatient Revenue	$ 108,295,933.00	$ 120,277,694.00	$ 122,754,479.00	$ 125,206,371.00	$ 142,451,614.00	$ 133,707,029.00	$ 73,911,906.00	$ 140,113,788.00	$ 156,105,321.00	$ 181,521,802.00
Total Gross Inpatient Revenue	$ 35,188,387.00	$ 45,086,366.00	$ 47,407,383.00	$ 37,284,640.00	$ 36,465,482.00	$ 32,040,537.00	$ 19,048,805.00	$ 40,241,712.00	$ 51,487,429.00	$ 53,489,825.00
Revenue and Gains in Excess of Expenses and Losses	$ 4,290,000.00	$ 2,926,000.00	$ 1,164,000.00	$ (2,901,000.00)	$ 417,000.00	$ 4,275,000.00	$ 278,028.00	$ (2,721,652.00)	$ (1,123,758.00)	$ (6,554,962.00)
Total Net Revenue	$ 56,930,509.00	$ 61,177,165.00	$ 52,447,650.00	$ 48,550,052.00	$ 55,836,494.00	$ 58,689,021.00	$ 28,313,225.00	$ 51,661,739.00	$ 60,052,229.00	$ 61,108,641.00
Total Operating Expenses	$ 52,640,509.00	$ 58,251,165.00	$ 52,058,901.00	$ 51,451,052.00	$ 55,420,404.00	$ 54,414,021.00	$ 28,077,324.00	$ 54,358,921.00	$ 61,175,987.00	$ 67,653,603.00

(Note: The table above captures the 10-year data trend available through VHI data. Please note that the facility's case study may utilize updated internally reported numbers for certain years due to data discrepancies or to maintain financial comparisons where accouting changes occurred between years)



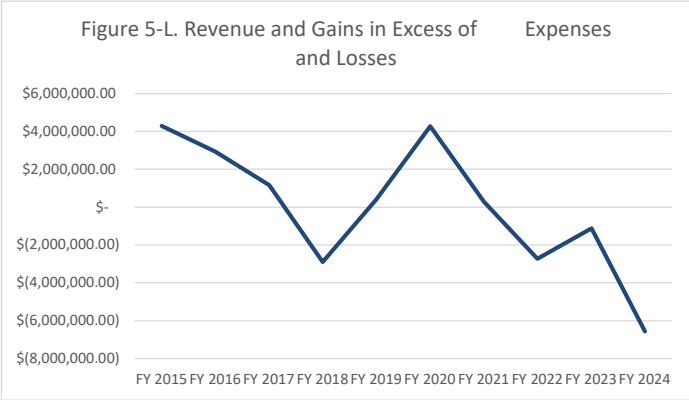
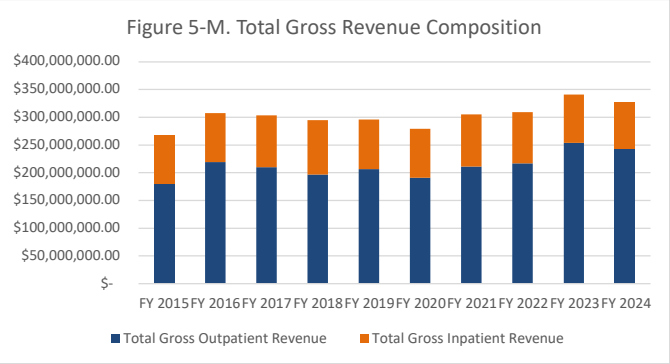


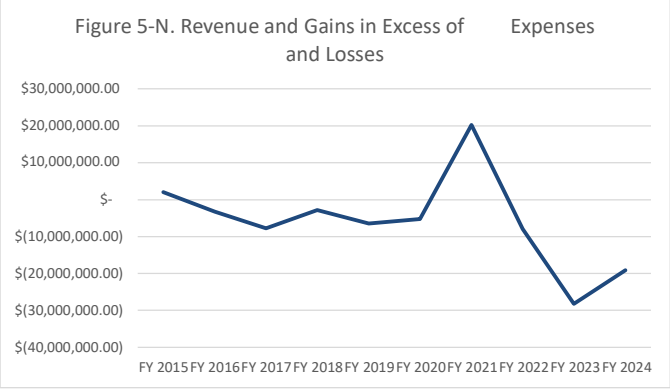
Table 5-G. Sentara Halifax Regional Hospital

Source: Virginia Health Information (VHI) Annual Licensure Survey Data and Hospital Detail Reports, FY 2015-2024

Metric	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Licensed Beds	173	192	192	192	192	192	192	192	192	192
Staffed Beds	85	74	74	61	61	61	61	54	50	44
Patient Days	13,589	15,633	15,515	15,345	14,815	12,923	12,801	11,720	9,907	9,005
ED Visits	27,758	27,366	23,991	25,746	25,508	21,966	21,431	23,069	25,669	21,563
Total Surgical Procedures	4,060	3,972	3,593	3,639	9,105	3,658	4,352	1,203	1,139	934
Outpatient Surgical Procedures	3,451	3,404	2,980	3,115	8,040	3,052	3,790	878	864	749
Inpatient Surgical Procedures	609	568	613	524	1,065	606	562	325	275	185
L&D Licensed Beds	15	15	15	15	15	15	15	15	15	15
L&D Staffed Beds	6									
L&D Deliveries	446	7	2	0	1	1	286	241	126	3
Total Gross Revenue	$ 269,015,370.00	$ 307,536,813.00	$ 303,494,363.00	$ 294,576,590.00	$ 296,240,103.00	$ 279,469,170.00	$ 305,216,000.00	$ 309,122,102.00	$ 341,148,455.00	$ 327,271,181.00
Total Gross Outpatient Revenue	$ 180,489,916.00	$ 219,399,063.00	$ 210,097,131.00	$ 196,955,188.00	$ 206,626,328.00	$ 190,661,040.00	$ 211,359,999.00	$ 216,900,040.00	$ 254,087,827.00	$ 242,755,797.00
Total Gross Inpatient Revenue	$ 88,525,454.00	$ 88,137,750.00	$ 93,397,232.00	$ 97,621,402.00	$ 89,613,775.00	$ 88,808,130.00	$ 93,856,001.00	$ 92,222,062.00	$ 87,060,628.00	$ 84,515,384.00
Revenue and Gains in Excess of Expenses and Losses	$ 2,078,074.00	$ (3,251,724.00)	$ (7,746,711.00)	$ (2,830,266.00)	$ (6,493,729.00)	$ (5,236,799.00)	$ 20,228,830.00	$ (7,907,894.00)	$ (28,192,183.00)	$ (19,108,029.00)
Total Net Revenue	$ 83,527,615.00	$ 108,178,352.00	$ 93,891,651.00	$83,618,679.00	$87,263,055.00	$85,323,431.00	$88,078,090.00	$ 94,451,675.00	$ 99,207,688.00	$ 99,089,085.00
Total Operating Expenses	$ 79,581,672.00	$ 114,556,148.00	$ 106,169,549.00	$86,504,414.00	$93,818,784.00	$90,407,230.00	$76,612,260.00	$ 107,477,569.00	$ 131,000,871.00	$ 123,713,114.00

(Note: The table above captures the 10-year data trend available through VHI data. Please note that the facility's case study may utilize updated internally reported numbers for certain years due to data discrepancies or to maintain financial comparisons where accouting changes occurred between years)





Appendix 6: Virginia Rural Hospital Inpatient Capacity and Utilization, 2015 vs. 2024

Source: Virginia Health Information Annual Licensure Survey Data and Hospital Detail Reports, 2015 and 2024
(A digital version of this appendix is available by request)

Hospital	Type	Payment Designation	FY 2015				FY 2024			
			Licensed Beds	Staffed Beds	Patient Days	Occ. % (Staffed)	Licensed Beds	Staffed Beds	Patient Days	Occ. % (Staffed)
Augusta Health Medical Center	Acute	SCH/RRC	238	210	41,788	54.5%	238	211	45,111	59%
Bath County Community Hospital	CAH	CAH	25	10	2,117	58.0%	25	14	1,436	28%
Bon Secours Southampton Memorial	Acute	SCH	90	102	6,606	17.7%	90	80	2,445	8%
Buchanan General Hospital	Acute	SCH	134	49	5,187	29.0%	111	49	3,325	19%
Carilion Franklin Memorial Hospital	Acute	PPS	37	15	4,957	90.5%	37	25	6,733	74%
Carilion Giles Community Hospital	CAH	CAH	25	17	6,037	97.3%	25	25	6,165	68%
Carilion New River Valley Medical Center	Acute	MDH/RRC	146	102	34,627	93.0%	146	144	37,545	71%
Carilion Rockbridge Community Hospital	CAH	CAH	25	15	5,371	98.1%	25	25	5,476	60%
Carilion Tazewell Community Hospital	Acute	MDH	56	8	2,462	84.3%	56	15	3,080	56%
Centra Bedford Memorial Hospital	Acute	PPS	50	34	4,316	34.8%	50	34	4,616	37%
Centra Southside Community Hospital	Acute	SCH	116	98	12,464	34.8%	116	98	10,125	28%
Clinch Valley Medical Center (Lifepoint Health)	Acute	PPS	161	111	15,396	38.0%	150	65	9,994	42%
Dickenson Community Hospital (Ballad Health)	CAH	CAH	25	2	4	0.5%	25	7	1,836	72%
Fauquier Hospital (Lifepoint Health)	Acute	PPS	97	111	19,768	48.8%	97	108	9,470	24%
Lee County Community Hospital (Ballad Health)	CAH	CAH	—	—	—	—	6	3	645	59%
LewisGale Hospital Alleghany (HCA Virginia)	Acute	SCH	205	110	12,363	30.8%	205	110	8,513	21%
LewisGale Hospital Pulaski (HCA Virginia)	Acute	MDH	135	42	7,663	50.0%	147	26	9,099	96%
Lonesome Pine Hospital (Ballad Health)	Acute	RRC*	60	31	3,560	31.5%	60	8	1,050	36%
Valley Health Page Memorial Hospital	CAH	CAH	25	15	4,536	82.8%	25	25	4,633	51%
Pioneer Health Services of Patrick County	*Acute*	*N/A*	*25*	*25*	*3,966*	43.5%	*Closed*	*Closed*	*Closed*	*Closed*
Bon Secours Rappahannock General Hospital	CAH	CAH	75	59	5,449	25.3%	35	33	3,981	33%
Riverside Shore Memorial Hospital	Acute	SCH	143	29	9,974	94.2%	52	21	7,008	91%
Riverside Walter Reed Hospital	Acute	SCH*	67	28	10,149	99.3%	67	22	7,770	97%
Russell County Hospital (Ballad Health)	Acute	MDH	78	49	8,953	50.1%	78	44	7,112	44%
Sentara Halifax Regional Hospital	Acute	SCH/RRC	173	85	16,017	51.6%	192	44	9,005	56%
Sentara RMH Medical Center	Acute	SCH/RRC	238	260	53,015	55.9%	238	260	45,026	47%
Valley Health Shenandoah Memorial Hospital	CAH	CAH	25	20	6,015	82.4%	25	25	7,039	77%
Smyth County Community Hospital (Ballad Health)	Acute	MDH	44	44	6,555	40.8%	44	24	5,848	67%
Bon Secours Southern Virginia Medical Center	Acute	MDH	80	80	7,180	24.6%	80	73	3,216	12%
Sovah Health - Danville (Lifepoint Health)	Acute	RRC	250	157	37,721	65.8%	250	165	29,739	49%
Sovah Health - Martinsville (Lifepoint Health)	Acute	RRC	220	107	21,956	56.2%	220	107	20,959	54%
Twin County Regional Hospital (Duke Lifepoint Health	Acute	SCH	141	84	11,368	37.1%	141	65	8,152	34%
UVA Health Culpeper Medical Center	Acute	PPS	70	70	9,486	37.1%	70	66	15,306	64%
VCU Community Memorial Hospital	Acute	SCH	99	68	13,589	54.8%	70	80	15,372	53%
VCU Health Tappahannock Hospital	Acute	SCH	67	15	5,154	94.1%	67	37	6,505	48%
Valley Health Warren Memorial Hospital	Acute	PPS	60	53	6,996	36.2%	36	36	5,860	45%
Wellmont Mountain View Regional	*Acute*	*N/A*	*74*	*18*	*2,842*	43.3%	*Closed*	*Closed*	*Closed*	*Closed*
Wythe County Community Hospital (Lifepoint Health)	Acute	SCH	92	29	6,864	64.8%	100	40	5,511	38%
TOTAL			3,671	2,362	432,471	50.2%	3,399	2,214	374,706	46%

*Likely payment desigantion but records were not available to confirm

Appendix 7: Virginia Rural Hospital Service Volumes, 2015 vs. 2024

Source: Virginia Health Information Annual Licensure Survey Data and Hospital Detail Reports, 2015 and 2024

(A digital version of this appendix is available by request)

Hospital	FY 2015							FY 2024						
	ED Visits	IP Surgical Volume	OP Surgical Volume	Total Surgeries	L&D Licensed Beds	L&D Staffed Beds	Total Deliveries	ED Visits	IP Surgical Volume	OP Surgical Volume	Total Surgeries	L&D Licensed Beds	L&D Staffed Beds	Total Deliveries
Augusta Health Medical Center	61,125	4,150	15,310	19,460	16	16	1,216	64,991	3,757	19,667	23,424	18	18	1367
Bath County Community Hospital	3,204	0	226	226	—	—	0	3,122	0	555	555	—	—	—
Bon Secours Southampton Memorial	15,000	441	1,769	2,210	10	10	144	15,026	67	1,040	1,107	—	—	—
Buchanan General Hospital	11,995	249	732	981	—	—	—	10,660	89	473	562	—	—	—
Carilion Franklin Memorial Hospital	21,131	261	1,577	1,838	—	—	—	21,564	196	3,134	3,330	—	—	—
Carilion Giles Community Hospital	11,891	168	869	1,037	—	—	—	12,440	51	1,048	1,099	—	—	—
Carilion New River Valley Medical Center	29,733	1,454	8,275	9,729	16	8	1186	31,415	1,488	7,984	9,472	16	10	824
Carilion Rockbridge Community Hospital	14,958	178	1,565	1,743	—	—	—	14,169	184	1,959	2,143	—	—	—
Carilion Tazewell Community Hospital	10,728	0	167	167	—	—	—	10,482	0	0	0	—	—	—
Centra Bedford Memorial Hospital	16,229	139	1,112	1,251	—	—	—	21,846	61	1,408	1,469	—	—	—
Centra Southside Community Hospital	36,765	743	3,190	3,933	19	14	391	29,342	418	3,609	4,027	19	14	280
Clinch Valley Medical Center (Lifepoint Healt	20,762	815	3,129	3,944	9	9	336	15,770	571	3,142	3,713	9	6	125
Dickenson Community Hospital (Ballad Health	7,270	—	—	—	—	—	—	7,026	—	—	—	—	—	—
Fauquier Hospital (Lifepoint Health)	32,026	1,532	5,749	7,281	11	11	763	21,067	342	2,065	2,407	11	11	576
Lee County Community Hospital (Ballad Healt	—	—	—	—	—	—	—	12,559	—	—	—	—	—	—
LewisGale Hospital Alleghany (HCA Virginia)	13,725	290	1,816	2,106	—	—	—	15,803	393	1,328	1,721	—	—	—
LewisGale Hospital Pulaski (HCA Virginia)	16,803	300	1,644	1,944	—	—	—	17,757	124	2,723	2,847	—	—	—
Lonesome Pine Hospital (Ballad Health)	21,150	298	866	1,164	9	9	255	10,206	0	2,887	2,887	—	—	—
Valley Health Page Memorial Hospital	12,389	2	489	491	—	—	—	13,798	—	—	—	—	—	—
Pioneer Health Services of Patrick County	*6,038*	*7*	*286*	293	—	—	—	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*
Bon Secours Rappahannock General Hospital	8,363	122	846	968	—	—	—	13,079	23	894	917	—	—	—
Riverside Shore Memorial Hospital	17,491	435	2,205	2,640	8	2	354	25,222	257	1,231	1,488	6	2	280
Riverside Walter Reed Hospital	23,022	533	4,294	4,827	—	—	—	28,388	369	1,908	2,277	—	—	—
Russell County Hospital (Ballad Health)	14,467	3	112	115	—	—	—	12,824	—	—	—	—	—	—
Sentara Halifax Regional Hospital	27,758	609	3,451	4,060	15	6	446	21,563	185	749	934	15	0	0
Sentara RMH Medical Center	73,583	3,030	17,956	20,986	22	22	1,709	64,448	1,995	12,118	14,113	—	—	—
Valley Health Shenandoah Memorial Hospital	17,788	374	2,037	2,411	—	—	—	21,449	167	1,404	1,571	—	—	—
Smyth County Community Hospital (Ballad Hea	17,949	279	2,083	2,362	—	—	—	16,717	108	1,169	1,277	—	—	—
Bon Secours Southern Virginia Medical Center	14,358	137	1,029	1,166	—	—	—	15,267	29	1,586	1,615	—	—	—
Sovah Health - Danville (Lifepoint Health)	45,295	1,898	4,230	6,128	15	9	772	36,016	1,006	3,679	4,685	15	9	850
Sovah Health - Martinsville (Lifepoint Health)	41,455	1,051	4,388	5,439	19	10	401	33,165	931	4,066	4,997	8	0	0
Twin County Regional Hospital (Duke Lifepoint	23,218	892	4,219	5,111	10	8	279	16,746	432	2,462	2,894	17	8	207
UVA Health Culpeper Medical Center	23,383	743	630	1,373	8	8	405	38,393	1,002	2,654	3,656	12	4	510
VCU Community Memorial Hospital	22,680	773	4,360	5,133	—	—	—	26,183	678	4,504	5,182	4	4	235
VCU Health Tappahannock Hospital	20,470	288	3,599	3,887	—	—	—	19,638	235	859	1,094	—	—	—
Valley Health Warren Memorial Hospital	25,608	337	2,114	2,451	8	8	355	25,283	336	1,855	2,191	—	—	—
Wellmont Mountain View Regional	*10,846*	*193*	*740*	933	—	—	—	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*
Wythe County Community Hospital (Lifepoint	19,500	577	3,270	3,847	9	2	301	20,556	336	2,572	2,908	9	2	339

ABBREVIATIONS: ED = Emergency Department; IP = Inpatient; OP = Outpatient ; L&D = Labor and Delivery

(Note: surgical volumes were defined as either number of procedures or visits based on the facility's reporting and availability of data)

Appendix 8: Virginia Rural Hospital Financial Data, 2015 vs. 2024

Source: Virginia Health Information Annual Licensure Survey Data and Hospital Detail Reports, 2015 and 2024
(A digital version of this appendix is available by request)

Hospital	Table 7-A. Gross Inpatient Revenue									
	FY 2015					FY 2024				
	Medicare	Medicaid	Other Government Payors	Commercial and Other Payors	Total	Medicare	Medicaid	Other Government Payors	Commercial and Other Payors	Total
Augusta Health Medical Center	$ 185,420,454.00	$ 20,543,127.00	$ 508,365.00	$ 85,942,505.00	$ 292,414,451.00	$ 260,786,790.00	$ 54,313,594.00	$ 2,626,944.00	$ 100,939,298.00	$ 418,666,626.00
Bath County Community Hospital	$ 5,711,520.00	$ 3,298.00	$ -	$ 881,994.00	$ 6,596,812.00	$ 4,799,866.00	$ 50,287.00	$ -	$ 219,371.00	$ 5,069,524.00
Bon Secours Southampton Memorial	$ 27,402,315.00	$ 7,828,739.00	$ 1,807,133.00	$ 21,445,221.00	$ 58,483,408.00	$ 27,471,015.00	$ 6,170,056.00	$ 855,577.00	$ 6,957,816.00	$ 41,454,464.00
Buchanan General Hospital	$ 10,150,019.00	$ 1,373,805.00	$ -	$ 9,894,466.00	$ 21,418,290.00	$ 9,431,199.00	$ 5,501,533.00	$ -	$ 4,715,600.00	$ 19,648,332.00
Carilion Franklin Memorial Hospital	$ 21,136,491.00	$ 4,091,904.00	$ 266,438.00	$ 5,045,662.00	$ 30,540,495.00	$ 47,113,958.00	$ 7,579,086.00	$ 1,706,187.00	$ 7,357,558.00	$ 63,756,789.00
Carilion Giles Community Hospital	$ 21,978,912.00	$ 2,538,006.00	$ 246,138.00	$ 5,622,666.00	$ 30,385,722.00	$ 27,301,353.00	$ 6,025,834.00	$ 1,272,323.00	$ 4,071,144.00	$ 38,670,654.00
Carilion New River Valley Medical Center	$ 104,696,253.00	$ 24,087,010.00	$ 2,150,354.00	$ 52,064,112.00	$ 182,997,729.00	$ 231,695,529.00	$ 65,978,527.00	$ 13,928,826.00	$ 73,551,681.00	$ 385,154,563.00
Carilion Rockbridge Community Hospital	$ 19,038,646.00	$ 1,178,309.00	$ 423,625.00	$ 3,784,438.00	$ 24,425,018.00	$ 30,943,086.00	$ 4,704,557.00	$ 1,190,843.00	$ 6,733,589.00	$ 43,572,075.00
Carilion Tazewell Community Hospital	$ 9,197,020.00	$ 1,166,338.00	$ 88,841.00	$ 1,464,365.00	$ 11,916,564.00	$ 16,077,220.00	$ 2,880,295.00	$ 1,594,276.00	$ 1,499,853.00	$ 22,051,644.00
Centra Bedford Memorial Hospital	$ 14,036,344.00	$ 1,626,107.00	$ 195,445.00	$ 3,101,189.00	$ 18,959,085.00	$ 32,250,581.00	$ 3,483,828.00	$ 87,003.00	$ 7,660,507.00	$ 43,481,919.00
Centra Southside Community Hospital	$ 35,124,789.00	$ 10,738,576.00	$ 1,364,951.00	$ 11,826,584.00	$ 59,054,900.00	$ 65,921,024.00	$ 17,607,032.00	$ 1,266,632.00	$ 16,658,415.00	$ 101,453,103.00
Clinch Valley Medical Center (Lifepoint Health)	$ 77,562,231.00	$ 23,466,626.00	$ 5,864,508.00	$ 21,023,504.00	$ 127,916,869.00	$ 123,976,017.00	$ 35,970,886.00	$ 13,474,345.00	$ 15,808,381.00	$ 189,229,629.00
Dickenson Community Hospital (Ballad Health)	$ 20,479.00	–	–	–	$ 20,479.00	$ 2,074,484.00	$ 201,212.00	$ 37,042.00	$ 32,412.00	$ 2,345,150.00
Fauquier Hospital (Lifepoint Health)	$ 78,991,249.00	$ 11,457,192.00	$ 1,491,609.00	$ 50,144,777.00	$ 142,084,827.00	$ 59,625,806.00	$ 3,367,882.00	$ 46,357,664.00	$ 38,687,594.00	$ 148,038,946.00
Lee County Community Hospital (Ballad Health)	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*	$ 3,350,561.00	$ 543,064.00	$ 244,530.00	$ 291,483.00	$ 4,429,638.00
LewisGale Hospital Alleghany (HCA Virginia)	$ 50,070,803.00	$ 3,502,694.00	$ 338,167.00	$ 9,719,596.00	$ 63,631,260.00	$ 60,902,294.00	$ 11,615,002.00	$ 3,029,688.00	$ 8,208,471.00	$ 83,755,455.00
LewisGale Hospital Pulaski (HCA Virginia)	$ 46,222,595.00	$ 4,254,610.00	$ 169,174.00	$ 11,535,581.00	$ 62,181,960.00	$ 52,465,890.00	$ 21,742,801.00	$ 2,520,093.00	$ 8,826,302.00	$ 85,555,086.00
Lonesome Pine Hospital (Ballad Health)	$ 22,950,805.00	$ 8,802,759.00	$ -	$ 15,065,411.00	$ 46,818,975.00	$ 91,684,089.00	$ 30,610,797.00	$ 3,908,355.00	$ 13,917,883.00	$ 140,121,124.00
Valley Health Page Memorial Hospital	$ 8,441,338.00	$ 303,410.00	$ 10,913.00	$ 820,443.00	$ 9,576,104.00	$ 33,540,096.00	$ 2,784,918.00	$ -	$ 4,036,113.00	$ 40,361,127.00
Pioneer Health Services of Patrick County	*$ 5,843,958.00*	*$ 236,323.00*	*$ -*	*$ 417,467.00*	*$ 6,498,348.00*	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*
Bon Secours Rappahannock General Hospital	$ 11,367,972.00	$ 1,247,514.00	$ 31,188.00	$ 2,947,251.00	$ 15,593,925.00	$ 7,255,149.00	$ 1,330,777.00	$ 138,920.00	$ 1,353,863.00	$ 10,078,709.00
Riverside Shore Memorial Hospital	$ 30,505,531.00	$ 7,939,560.00	$ 361,897.00	$ 14,713,771.00	$ 53,520,759.00	$ 34,666,453.00	$ 12,261,774.00	$ 897,359.00	$ 7,428,308.00	$ 55,253,894.00
Riverside Walter Reed Hospital	$ 39,353,083.00	$ 1,840,510.00	$ 995,499.00	$ 18,181,128.00	$ 60,370,220.00	$ 46,148,657.00	$ 7,898,875.00	$ 2,365,835.00	$ 8,933,579.00	$ 65,346,946.00
Russell County Hospital (Ballad Health)	$ 23,217,900.00	$ 7,360,566.00	$ 111,555.00	$ 7,653,403.00	$ 38,343,424.00	$ 25,665,711.00	$ 8,608,897.00	$ 838,041.00	$ 2,189,866.00	$ 37,302,515.00
Sentara Halifax Regional Hospital	$ 58,856,205.00	$ 10,301,890.00	$ -	$ 19,367,359.00	$ 88,525,454.00	$ 62,379,962.00	$ 10,991,510.00	$ 989,332.00	$ 10,154,580.00	$ 84,515,384.00
Sentara RMH Medical Center	$ 187,964,037.00	$ 23,843,911.00	$ 1,387,012.00	$ 89,813,045.00	$ 303,008,005.00	$ 245,605,876.00	$ 55,580,453.00	$ 8,341,073.00	$ 76,901,811.00	$ 386,429,213.00
Valley Health Shenandoah Memorial Hospital	$ 19,788,128.00	$ 1,410,984.00	$ 87,858.00	$ 6,668,616.00	$ 27,955,586.00	$ 24,158,251.00	$ 3,098,920.00	$ -	$ 6,064,554.00	$ 33,321,725.00
Smyth County Community Hospital (Ballad Health)	$ 35,748,947.00	$ 2,642,687.00	$ 206,801.00	$ 8,469,768.00	$ 47,068,203.00	$ 34,871,796.00	$ 5,513,897.00	$ 1,191,953.00	$ 4,365,656.00	$ 45,943,302.00
Bon Secours Southern Virginia Medical Center	$ 34,983,979.00	$ 9,664,313.00	$ -	$ 24,518,162.00	$ 69,166,454.00	$ 28,418,596.00	$ 9,171,266.00	$ 980,087.00	$ 5,448,519.00	$ 44,018,468.00
Sovah Health - Danville (Lifepoint Health)	$ 194,908,639.00	$ 42,071,594.00	$ 9,545,423.00	$ 56,031,691.00	$ 302,557,347.00	$ 288,623,214.00	$ 99,032,370.00	$ 26,642,265.00	$ 48,949,955.00	$ 463,247,804.00
Sovah Health - Martinsville (Lifepoint Health)	$ 81,676,322.00	$ 4,357,393.00	$ 4,686,119.00	$ 60,454,069.00	$ 151,173,903.00	$ 229,246,754.00	$ 55,054,048.00	$ 20,759,638.00	$ 26,046,154.00	$ 331,106,594.00
Twin County Regional Hospital (Duke Lifepoint Healthc	$ 42,404,176.00	$ 2,896,091.00	$ 1,043,700.00	$ 22,689,309.00	$ 69,033,276.00	$ 61,265,332.00	$ 26,843,941.00	$ 3,926,529.00	$ 9,408,834.00	$ 101,444,636.00
UVA Health Culpeper Medical Center	$ 38,758,994.00	$ 5,229,307.00	$ 81,102.00	$ 16,613,267.00	$ 60,682,670.00	$ 73,509,586.00	$ 24,293,408.00	$ 1,888,089.00	$ 26,181,496.00	$ 125,872,579.00
VCU Community Memorial Hospital	$ 51,778,649.00	$ 8,079,225.00	$ -	$ 17,869,580.00	$ 77,727,454.00	$ 85,654,330.00	$ 22,720,686.00	$ 2,209,373.00	$ 16,119,218.00	$ 126,703,607.00
VCU Health Tappahannock Hospital	$ 25,427,996.00	$ 1,136,397.00	$ 55,832.00	$ 8,568,162.00	$ 35,188,387.00	$ 38,560,075.00	$ 8,206,303.00	$ 765,197.00	$ 5,958,250.00	$ 53,489,825.00
Valley Health Warren Memorial Hospital	$ 20,093,692.00	$ 4,902,221.00	$ 235,323.00	$ 8,516,117.00	$ 33,747,353.00	$ 36,598,029.00	$ 6,978,904.00	$ -	$ 11,375,063.00	$ 54,951,996.00
Wellmont Mountain View Regional	–	–	–	–	–	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*
Wythe County Community Hospital (Lifepoint Health)	$ 33,126,094.00	$ 5,656,499.00	$ 236,846.00	$ 13,752,224.00	$ 52,771,663.00	$ 25,066,099.00	$ 1,557,150.00	$ 58,518,862.00	$ 5,345,783.00	$ 90,487,894.00
TOTAL	**$ 1,673,956,565.00**	**$ 267,780,095.00**	**$ 33,991,816.00**	**$ 706,626,903.00**	**$ 2,682,355,379.00**	**$ 2,529,104,728.00**	**$ 640,274,370.00**	**$ 224,552,881.00**	**$ 592,398,960.00**	**$ 3,986,330,939.00**

Hospital	Table 7-B. Gross Outpatient Revenue										
	FY 2015					FY 2024				
	Medicare	Medicaid	Other Government Payors	Commercial and Other Payors	Total	Medicare	Medicaid	Other Government Payors	Commercial and Other Payors	Total
Augusta Health Medical Center	$ 245,479,609.00	$ 38,911,181.00	$ 2,048,664.00	$ 240,592,005.00	$ 527,031,459.00	$ 620,574,735.00	$ 155,330,750.00	$ 8,636,553.00	$ 399,191,182.00	$ 1,183,733,220.00
Bath County Community Hospital	$ 6,222,584.00	$ 308,743.00	$ -	$ 7,950,931.00	$ 14,482,258.00	$ 9,816,369.00	$ 4,472,280.00	$ -	$ 10,218,405.00	$ 24,507,054.00
Bon Secours Southampton Memorial	$ 39,240,139.00	$ 15,586,188.00	$ 3,322,802.00	$ 62,983,440.00	$ 121,132,569.00	$ 86,978,051.00	$ 42,032,718.00	$ 9,659,943.00	$ 50,059,921.00	$ 188,730,633.00
Buchanan General Hospital	$ 21,773,464.00	$ 12,190,838.00	$ -	$ 38,984,843.00	$ 72,949,145.00	$ 51,585,539.00	$ 30,091,564.00	$ -	$ 25,792,769.00	$ 107,469,872.00
Carilion Franklin Memorial Hospital	$ 38,468,477.00	$ 13,689,455.00	$ 779,986.00	$ 35,173,260.00	$ 88,111,178.00	$ 102,527,570.00	$ 51,870,981.00	$ 3,573,712.00	$ 70,045,420.00	$ 228,017,683.00
Carilion Giles Community Hospital	$ 27,117,985.00	$ 7,922,747.00	$ 595,301.00	$ 24,009,206.00	$ 59,645,239.00	$ 105,966,553.00	$ 32,828,133.00	$ 5,963,067.00	$ 58,334,838.00	$ 203,092,591.00
Carilion New River Valley Medical Center	$ 113,876,620.00	$ 28,157,129.00	$ 3,021,210.00	$ 153,043,018.00	$ 298,097,977.00	$ 305,139,128.00	$ 104,913,496.00	$ 13,821,152.00	$ 236,556,508.00	$ 660,430,284.00
Carilion Rockbridge Community Hospital	$ 31,334,764.00	$ 5,832,228.00	$ 946,586.00	$ 25,315,849.00	$ 63,429,427.00	$ 100,276,873.00	$ 31,229,152.00	$ 3,925,205.00	$ 66,345,248.00	$ 201,776,478.00
Carilion Tazewell Community Hospital	$ 14,142,896.00	$ 7,625,212.00	$ 416,433.00	$ 12,610,357.00	$ 34,794,898.00	$ 33,840,868.00	$ 21,141,109.00	$ 4,280,391.00	$ 15,749,277.00	$ 75,011,645.00
Centra Bedford Memorial Hospital	$ 16,949,294.00	$ 5,040,383.00	$ 701,546.00	$ 14,755,085.00	$ 37,446,308.00	$ 76,749,748.00	$ 33,761,961.00	$ 2,850,578.00	$ 63,417,200.00	$ 176,779,487.00
Centra Southside Community Hospital	$ 42,228,502.00	$ 19,951,694.00	$ 2,672,295.00	$ 41,700,577.00	$ 106,553,068.00	$ 149,575,720.00	$ 70,232,081.00	$ 5,156,140.00	$ 88,980,280.00	$ 313,944,221.00
Clinch Valley Medical Center (Lifepoint Health)	$ 113,923,452.00	$ 50,117,883.00	$ 10,534,663.00	$ 82,540,332.00	$ 257,116,330.00	$ 327,565,336.00	$ 142,948,268.00	$ 42,136,378.00	$ 128,033,569.00	$ 640,683,551.00
Dickenson Community Hospital (Ballad Health)	$ 8,803,449.00	$ 3,642,645.00	$ 120,344.00	$ 5,710,154.00	$ 18,276,592.00	$ 12,600,766.00	$ 7,677,489.00	$ 611,787.00	$ 4,965,368.00	$ 25,855,410.00
Fauquier Hospital (Lifepoint Health)	$ 80,038,624.00	$ 14,737,506.00	$ 2,794,220.00	$ 123,110,348.00	$ 220,680,698.00	$ 97,690,584.00	$ 2,029,288.00	$ 88,421,619.00	$ 166,168,349.00	$ 354,309,840.00
Lee County Community Hospital (Ballad Health)	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*	$ 16,146,632.00	$ 15,664,892.00	$ 1,006,836.00	$ 6,360,195.00	$ 39,178,555.00
LewisGale Hospital Alleghany (HCA Virginia)	$ 50,727,662.00	$ 12,368,445.00	$ 1,031,488.00	$ 42,180,498.00	$ 106,308,093.00	$ 115,697,461.00	$ 40,862,398.00	$ 6,055,271.00	$ 61,467,992.00	$ 224,083,122.00
LewisGale Hospital Pulaski (HCA Virginia)	$ 87,748,170.00	$ 26,918,961.00	$ 3,237,819.00	$ 74,446,768.00	$ 192,351,718.00	$ 211,316,099.00	$ 88,263,103.00	$ 20,041,163.00	$ 152,793,764.00	$ 472,414,129.00
Lonesome Pine Hospital (Ballad Health)	$ 103,144,224.00	$ 39,960,870.00	$ -	$ 67,706,128.00	$ 210,811,222.00	$ 403,584,192.00	$ 125,894,611.00	$ 20,530,842.00	$ 162,251,660.00	$ 712,261,305.00
Valley Health Page Memorial Hospital	$ 19,179,641.00	$ 5,750,872.00	$ 427,182.00	$ 20,135,885.00	$ 45,493,580.00	$ 24,884,972.00	$ 12,277,320.00	$ -	$ 17,892,955.00	$ 55,055,247.00
Pioneer Health Services of Patrick County	$ 9,447,337.00	$ 2,232,672.00	$ -	$ 6,038,211.00	$ 17,718,220.00	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*
Bon Secours Rappahannock General Hospital	$ 21,750,081.00	$ 3,202,923.00	$ 186,216.00	$ 12,104,068.00	$ 37,243,288.00	$ 70,318,286.00	$ 13,524,246.00	$ 1,470,311.00	$ 22,346,584.00	$ 107,659,427.00
Riverside Shore Memorial Hospital	$ 61,008,426.00	$ 13,685,934.00	$ 1,084,861.00	$ 39,867,996.00	$ 115,647,217.00	$ 161,399,364.00	$ 57,584,310.00	$ 6,408,670.00	$ 73,718,613.00	$ 299,110,957.00
Riverside Walter Reed Hospital	$ 61,698,417.00	$ 7,926,599.00	$ 4,310,318.00	$ 53,925,250.00	$ 127,860,584.00	$ 160,483,612.00	$ 46,890,842.00	$ 15,795,311.00	$ 98,581,801.00	$ 321,751,566.00
Russell County Hospital (Ballad Health)	$ 18,939,639.00	$ 11,748,718.00	$ 239,158.00	$ 15,454,407.00	$ 46,381,922.00	$ 56,149,944.00	$ 23,695,755.00	$ 1,282,664.00	$ 19,461,704.00	$ 100,590,067.00
Sentara Halifax Regional Hospital	$ 93,943,973.00	$ 21,195,432.00	$ -	$ 65,350,511.00	$ 180,489,916.00	$ 120,332,626.00	$ 46,692,214.00	$ 7,545,112.00	$ 68,185,845.00	$ 242,755,797.00
Sentara RMH Medical Center	$ 254,517,060.00	$ 43,490,975.00	$ 4,748,411.00	$ 288,352,294.00	$ 591,108,740.00	$ 464,075,018.00	$ 109,787,615.00	$ 28,116,597.00	$ 310,684,652.00	$ 912,663,882.00
Valley Health Shenandoah Memorial Hospital	$ 33,843,807.00	$ 8,701,345.00	$ 871,611.00	$ 36,693,836.00	$ 80,110,599.00	$ 71,818,755.00	$ 39,820,300.00	$ -	$ 66,130,141.00	$ 177,769,196.00
Smyth County Community Hospital (Ballad Health)	$ 49,985,937.00	$ 17,199,311.00	$ 1,201,891.00	$ 47,834,642.00	$ 116,221,781.00	$ 83,345,047.00	$ 40,651,193.00	$ 3,686,850.00	$ 43,096,137.00	$ 170,779,227.00
Bon Secours Southern Virginia Medical Center	$ 37,521,201.00	$ 19,361,937.00	$ -	$ 62,209,855.00	$ 119,092,993.00	$ 93,074,469.00	$ 61,749,894.00	$ 7,836,059.00	$ 62,573,975.00	$ 225,234,397.00
Sovah Health - Danville (Lifepoint Health)	$ 137,712,558.00	$ 48,189,576.00	$ 14,791,784.00	$ 98,905,533.00	$ 299,599,451.00	$ 415,315,884.00	$ 167,904,214.00	$ 53,402,961.00	$ 153,293,376.00	$ 789,916,435.00
Sovah Health - Martinsville (Lifepoint Health)	$ 121,412,161.00	$ 12,617,778.00	$ 14,085,283.00	$ 167,962,371.00	$ 316,077,593.00	$ 310,541,214.00	$ 130,696,908.00	$ 44,418,899.00	$ 101,179,467.00	$ 586,836,488.00
Twin County Regional Hospital (Duke Lifepoint Healthc	$ 55,335,747.00	$ 5,910,203.00	$ 5,213,937.00	$ 67,213,209.00	$ 133,673,096.00	$ 115,335,639.00	$ 71,786,948.00	$ 15,193,671.00	$ 60,194,079.00	$ 262,510,337.00
UVA Health Culpeper Medical Center	$ 39,138,803.00	$ 14,896,024.00	$ 1,087,776.00	$ 57,070,576.00	$ 112,193,179.00	$ 195,838,264.00	$ 102,222,722.00	$ 12,402,102.00	$ 172,142,510.00	$ 482,605,598.00
VCU Community Memorial Hospital	$ 70,383,013.00	$ 20,441,015.00	$ -	$ 53,580,358.00	$ 144,404,386.00	$ 152,516,407.00	$ 73,247,864.00	$ 8,602,382.00	$ 87,228,015.00	$ 321,594,668.00
VCU Health Tappahannock Hospital	$ 51,279,139.00	$ 8,249,773.00	$ 859,242.00	$ 47,907,779.00	$ 108,295,933.00	$ 91,961,268.00	$ 38,106,931.00	$ 2,785,121.00	$ 48,668,482.00	$ 181,521,802.00
Valley Health Warren Memorial Hospital	$ 31,774,803.00	$ 14,760,662.00	$ 1,633,996.00	$ 51,387,585.00	$ 99,557,046.00	$ 76,351,642.00	$ 45,011,712.00	$ -	$ 88,971,749.00	$ 210,335,103.00
Wellmont Mountain View Regional	—	—	—	—	—	*Closed*	*Closed*	*Closed*	*Closed*	*Closed*
Wythe County Community Hospital (Lifepoint Health)	$ 61,042,324.00	$ 18,418,456.00	$ 1,633,574.00	$ 67,612,775.00	$ 148,707,129.00	$ 61,735,357.00	$ 4,301,211.00	$ 227,035,466.00	$ 32,238,635.00	$ 325,310,669.00
TOTAL	$ 2,271,133,982.00	$ 600,942,313.00	$ 84,598,597.00	$ 2,312,419,940.00	$ 5,269,094,832.00	$ 5,553,109,992.00	$ 2,087,196,473.00	$ 672,652,813.00	$ 3,293,320,665.00	$ 11,606,279,943.00

Table 7-C. Revenue and Gains in Excess of Losses		
Hospital	FY 2015	FY 2024
Augusta Health Medical Center	$ 20,634,752.00	$ 138,680,715.00
Bath County Community Hospital	$ 1,591,088.00	$ (1,139,891.00)
Bon Secours Southampton Memorial	$ (5,841,823.00)	$ (12,008,796.00)
Buchanan General Hospital	$ 389,895.00	$ (1,785,160.00)
Carilion Franklin Memorial Hospital	$ 2,365,102.00	$ 17,577,957.00
Carilion Giles Community Hospital	$ 557,450.00	$ (1,987,682.00)
Carilion New River Valley Medical Center	$ 26,410,602.00	$ 88,225,785.00
Carilion Rockbridge Community Hospital	$ 1,590,301.00	$ 12,464,905.00
Carilion Tazewell Community Hospital	$ (1,516,726.00)	$ (6,165,832.00)
Centra Bedford Memorial Hospital	$ 221,538.00	$ 6,248,587.00
Centra Southside Community Hospital	$ 14,645,184.00	$ 1,482,030.00
Clinch Valley Medical Center (Lifepoint Health)	$ 7,102,595.00	$ 11,243,644.00
Dickenson Community Hospital (Ballad Health)	$ (1,861,613.00)	$ (680,498.00)
Fauquier Hospital (Lifepoint Health)	$ 19,136,750.00	$ 6,718,429.00
Lee County Community Hospital (Ballad Health)	*Closed*	$ 2,548,019.00
LewisGale Hospital Alleghany (HCA Virginia)	$ 2,088,035.00	$ 11,682,040.00
LewisGale Hospital Pulaski (HCA Virginia)	$ 247,687.00	$ 9,718,304.00
Lonesome Pine Hospital (Ballad Health)	$ 977,056.00	$ 47,821,447.00
Valley Health Page Memorial Hospital	$ (3,673,052.00)	$ (1,408,127.00)
Pioneer Health Services of Patrick County	$ (1,046,382.00)	*Closed*
Bon Secours Rappahannock General Hospital	$ 2,194,266.00	$ (1,135,249.00)
Riverside Shore Memorial Hospital	$ 34,000.00	$ 11,753,878.00
Riverside Walter Reed Hospital	$ 7,995,000.00	$ 14,690,969.00
Russell County Hospital (Ballad Health)	$ (4,906,721.00)	$ 2,100,844.00
Sentara Halifax Regional Hospital	$ 2,078,074.00	$ (19,108,029.00)
Sentara RMH Medical Center	$ 46,526,000.00	$ 391,885.00
Valley Health Shenandoah Memorial Hospital	$ (2,829,887.00)	$ 12,630,957.00
Smyth County Community Hospital (Ballad Health)	$ (1,459,109.00)	$ 3,852,116.00
Bon Secours Southern Virginia Medical Center	$ (8,293,981.00)	$ (1,270,625.00)
Sovah Health - Danville (Lifepoint Health)	$ (1,721,052.00)	$ 35,427,008.00
Sovah Health - Martinsville (Lifepoint Health)	$ 6,339,162.00	$ 15,820,760.00
Twin County Regional Hospital (Duke Lifepoint Healthcare)	$ 4,689,103.00	$ 3,449,679.00
UVA Health Culpeper Medical Center	$ (312,213.00)	$ 27,446,075.00
VCU Community Memorial Hospital	$ 33,507,939.00	$ (7,832,837.00)
VCU Health Tappahannock Hospital	$ 4,290,000.00	$ (6,554,962.00)
Valley Health Warren Memorial Hospital	$ (8,575,875.00)	$ 13,707,050.00
Wellmont Mountain View Regional	—	*Closed*
Wythe County Community Hospital (Lifepoint Health)	$ 5,840,974.00	$ 12,941,782.00
TOTAL	$ 169,414,119.00	$ 447,547,177.00

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