

An Early Look at Profitability Before and After Conversion to Rural Emergency Hospital

Aditya Pillutla; George Pink, PhD; Kristie Thompson, MA; Mark Holmes, PhD

KEY FINDINGS

The Rural Emergency Hospital (REH) designation became effective on January 1, 2023, as part of the Consolidated Appropriations Act of 2021.¹ REHs are required to submit annual cost reports to the Centers for Medicare & Medicaid Services (CMS). Medicare cost reports for 32 hospitals before and after conversion to REH show the following:

- Early results of profitability after conversion to REH appear to be promising. Although some REHs are not yet profitable, most have seen a substantial increase in total margin and operating margin since conversion to REH.
- Median total margin improved from **-17.9% immediately before conversion to 7.4% immediately after conversion**, an increase of **25.3 percentage points**. Median operating margin showed a similar increase, rising from **-22.2% immediately before conversion to 5.4% immediately after conversion**, an increase of **27.6 percentage points**.
- These results should be interpreted cautiously because ratios based on less than a full year of data may not reflect annual profitability.

BACKGROUND

The Rural Emergency Hospital (REH) designation is designed to maintain access to emergency and outpatient hospital services in communities that may not be able to support or sustain a Critical Access Hospital or small rural hospital. REHs are required to provide 24-hour emergency and observation services and can elect to furnish other outpatient services. An REH cannot have inpatient beds, except those furnished in a distinct part unit licensed as a skilled nursing facility.²

Converting to REH may provide struggling, low-volume rural hospitals with a more stable financial model by eliminating unprofitable inpatient services in exchange for some significant financial benefits:³

- Monthly facility payments: REHs receive a significant, consistent monthly payment from Centers for Medicare & Medicaid Services (CMS). In 2026, the monthly payment is \$295,052 after sequestration.
- Enhanced Medicare reimbursement: Emergency and outpatient services are reimbursed at 105% of the Outpatient Prospective Payment System (OPPS) rate.
- Reduced operational costs: By closing underutilized inpatient units, hospitals can significantly reduce staffing and overhead costs while maintaining 24/7 emergency care.
- Financial stability for low-volume facilities: The model provides a predictable revenue stream that allows hospitals to focus on strategic management versus constantly putting out fires.

Since 2021, REHs have been a central focus of the North Carolina Rural Health Research Program. In briefs and peer-reviewed publications, we have estimated the number of rural hospitals that might convert to a REH,⁴ described the characteristics of small rural hospitals with low-volume emergency departments that may convert to a REH,^{5,6} found

REH-converting hospitals more similar to those that closed than those that remained open,⁷ and developed key considerations for a rural hospital assessing conversion to REH.⁸ Our early empirical analysis found 1) large differences among selected financial and operational measures for three rural hospitals with known interest in REH conversion, and 2) REH conversion may attract a wider range of hospitals than we estimated in our 2021 study.⁹ More recently, we found that the REHs operating at the end of their first year (2023) tend to serve communities with higher levels of disadvantage.¹⁰ In addition, we continue to track conversions to REH and provide data about them on a publicly accessible website.¹¹ As of February 2026, 47 hospitals had converted to REHs, four of which have since closed or converted to another hospital designation.

To understand how these early REHs are performing, we compared total margins and operating margins (see Table 2a and Table 2b) from the four Medicare Cost Report (MCR) reporting periods leading up to conversion with the margins from the first two MCR reporting periods after conversion to REH.

Sample of REHs

Our analytical sample included REHs that were operating as of February 2026 and had at least one period of complete post-conversion MCR data. We excluded REHs that have either (a) closed or converted to another hospital designation (4 REHs) or (b) have missing and/or incomplete post-conversion MCR data (11 REHs). Table 1a and 1b include the number of operating REHs by state and by Medicare payment designation that were included in our analytical sample of 32 REHs.

Table 1a. Number of Operating REHs Included in Sample by State as of February 2026

Number of REHs per State	States
5	AR, MS
4	OK, TX
3	KS
1	AL, GA, KY, LA, MI, MN, MO, NE, NM, NY, TN

Table 1b. Number of Operating REHs Included in Sample by Previous Medicare Payment Designation

Previous Medicare Payment Designation	Number of REHs
Critical Access Hospital	16
Prospective Payment System Hospital	4
Sole Community Hospital	10
Medicare Dependent Hospital	2
Total operating REHs included in sample	32

METHODS

We obtained financial data from the 12-31-2025 Medicare Cost Report update included in the CMS Healthcare Cost Report Information System (HCRIS).¹² We included hospitals with at least one post-conversion MCR and complete (non-missing) profitability data, which resulted in a sample of 32 REHs. We then calculated profitability ratios (total margin and operating margin) for each MCR reporting period before and after conversion to REH. Table 2a shows revenue, expense, and income definitions, and Table 2b shows profitability ratio definitions, explanations, and the MCR data location information.

Table 2a. Revenue, Expense, and Income Definitions

Element	Definition
Operating revenue	Revenue generated directly from core health care activities, primarily patient care services plus related operational activities like cafeterias, parking, and gift shops.
Operating expense	Expenses incurred for core health care activities and related operational activities.
Operating income	Operating revenue minus operating expense.
Total revenue	Sum of operating revenue and revenue generated from activities unrelated to core patient care services, such as investment income, philanthropic donations, government grants, and rental income.
Total expense	Expenses incurred for core health care activities and all other activities.
Net income	Total revenue minus total expense.

Table 2b. Profitability Ratio Definition, Explanation and MCR Data

Profitability Ratio	Definition	Explanation	Numerator	Denominator
Total margin	Net income / Total revenue	Measures total expenses relative to total revenues	MCR Worksheet G-3, Line 29	MCR Worksheet G-3, Line 3 + 25
Operating margin	Operating income / Operating revenue	Measures operating expenses relative to operating revenue (net patient and other revenue)	MCR Worksheet G-3, (Line 3 + Lines 8 to 22 + Line 24 – Line 4)	MCR Worksheet G-3, (Line 3 + (Line 8 to 22) + Line 24)

The MCR reporting periods before and after conversion to REH are shown in Table 3. Ideally, each MCR would have 365 or 366 days in period. However, the average MCR reporting periods immediately before and after conversion to REH were less than 365 days (257 and 264 days, respectively), likely because the effective REH conversion date occurred sometime during an MCR fiscal year. This is a study limitation because ratios based on a reporting period of less than 365 days may not reflect annual profitability.

Table 3. MCR Reporting Periods Before and After Conversion to REH

Reporting period	4th to Last MCR Before Conversion	3rd to Last MCR Before Conversion	2nd to Last MCR Before Conversion	Last MCR Before Conversion	1st MCR After Conversion	2nd MCR After Conversion
>366 days	0	0	0	3	6	0
=365 or 366 days	30	31	31	5	3	13
<365 days	1	1	1	24	23	0
Total MCRs	31	32	32	32	32	13
Average days	365	362	356	257	264	366

RESULTS

We use box plots to present the results. Each box plot summarizes the distribution of results for a given Medicare Cost Report period, showing where most values fall, the typical value, the degree of variation, and the presence of unusually high or low results.

Figure 1 shows a boxplot of the total margins, and Figure 2 shows a boxplot of the operating margins in four MCR reporting periods before and two MCR reporting periods after conversion to REH for the study sample of 32 REHs (there are only 13 REHs with two MCR reporting periods after conversion). Each shaded box represents the 25th to 75th percentile margins, the horizontal line in each represents the median, and the X is the mean. The “whiskers” are lines extending from the central box that represent the variability outside the upper and lower quartiles, showing the spread of data up to 1.5 times the Interquartile Range (IQR). The dots above or below the whiskers represent outliers. A longer whisker on one side suggests the data is skewed in that direction. Outliers clearly display unusual values or potential anomalies in the data.

The boxplots show declining profitability before conversion to REH and an increase in profitability after conversion. Both median total margin and median operating margin continuously declined (became more negative) in each of the four MCR reporting periods before conversion to REH. Median total margin increased by 25.3 percentage points from the last MCR reporting period before conversion (-17.9%) to the first MCR reporting period after conversion (+7.4%). Median operating margin increased by 27.6 percentage points from the last MCR reporting period before conversion (-22.2%) to the first MCR reporting period after conversion (+5.4%). Although there were only 13 REHs with two post-conversion MCRs, the second MCR reporting period after conversion shows continued positive margins (+5.0% median total margin and +4.7% median operating margin) similar to the first MCR reporting period.

Figure 1. Total Margins of 32 REHs in MCR Reporting Periods Before and After Conversion to REH

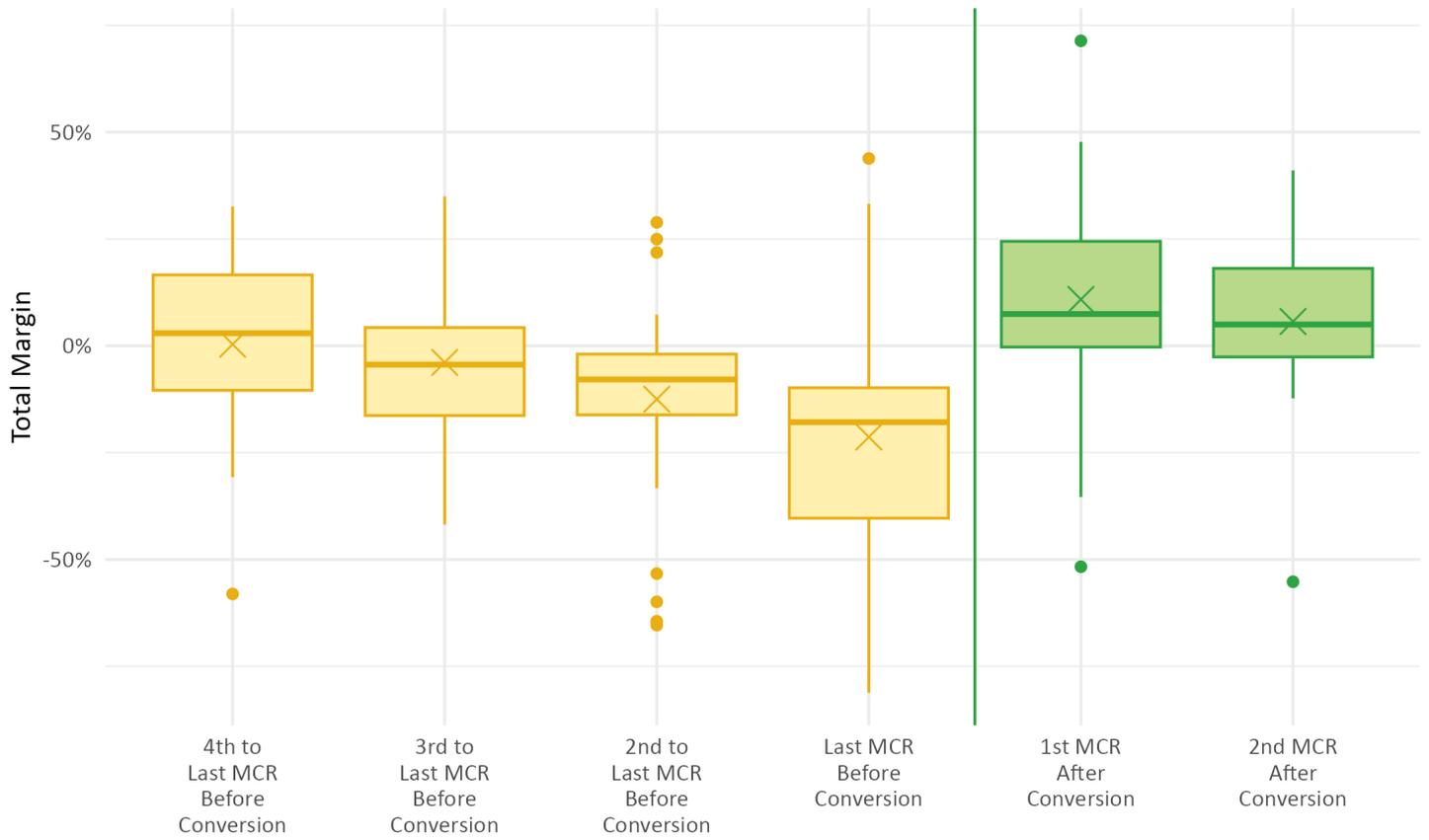
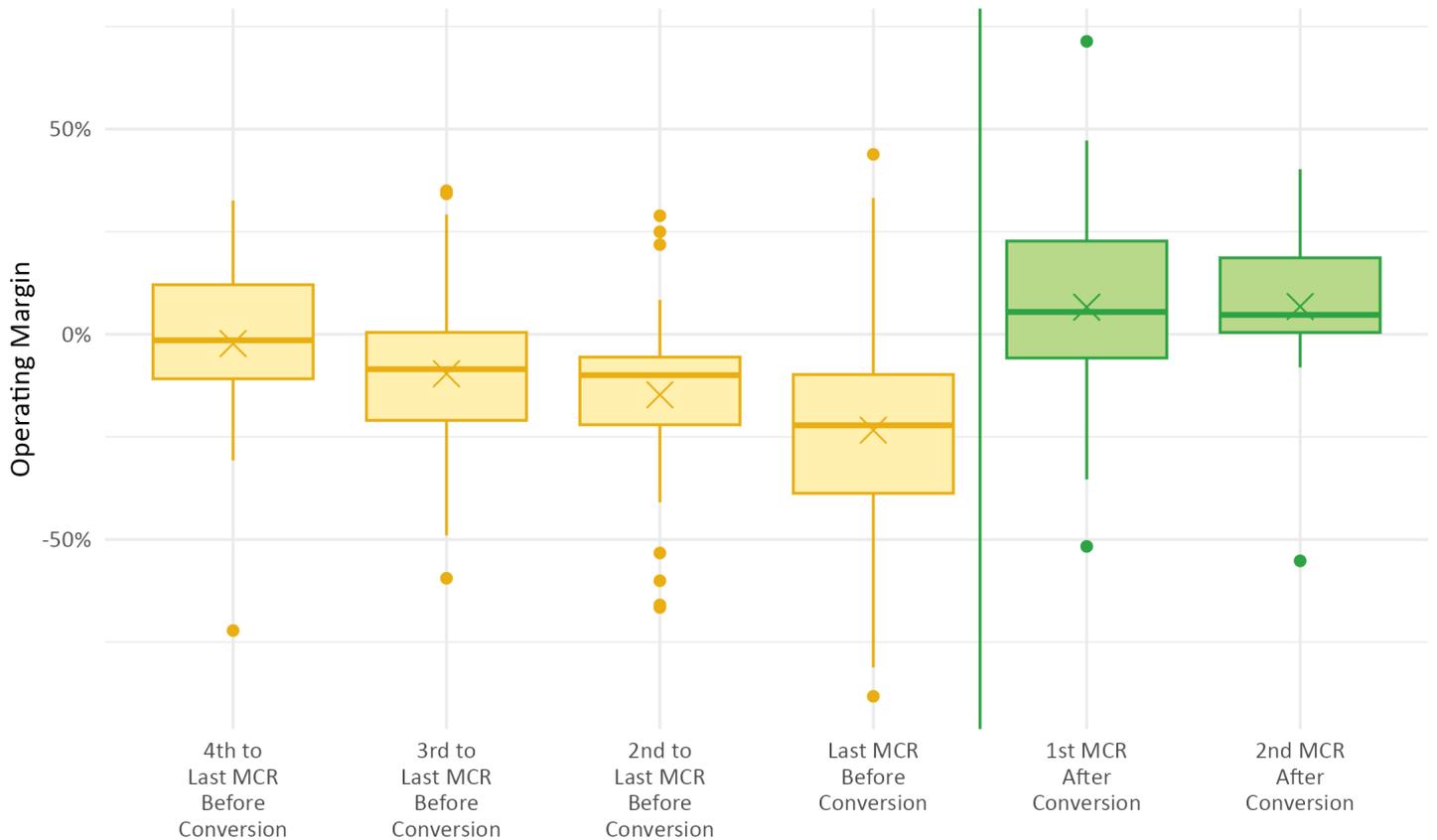


Figure 2. Operating Margins of 32 REHs in MCR Reporting Periods Before and After Conversion to REH



DISCUSSION

Early results of profitability after conversion to REH appear to be promising. Although some REHs are not yet profitable, most have seen a substantial increase in total margin and operating margin since conversion to REH. These results should be interpreted cautiously because ratios based on less than a full year of data may not reflect annual profitability.

REFERENCES AND NOTES

1. HR 133 Consolidated Appropriations Act, 2021. <https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf>
2. RHI Hub. *Rural Emergency Hospitals*. <https://www.ruralhealthinfo.org/topics/rural-emergency-hospitals>
3. For additional information, see Rural Health Redesign Center, *Observed Factors Influencing REH Conversion Decisions*, <https://rhrco.org/reh-resource/observed-factors-influencing-reh-conversion-decisions/>
4. Pink GH, Thompson KW, Howard HA, Holmes GM. *How Many Hospitals Might Convert to a Rural Emergency Hospital*. NC Rural Health Research Program, UNC Sheps Center. July 2021.
5. Greenwood-Ericksen MB, Grant TJ, Gurzenda S, Malone TL, Budko A, Reiter KL, Pink GH. *Small Rural Hospitals with Low Volume ED that May Convert to a Rural Emergency Hospital*. NC Rural Health Research Program, UNC Sheps Center. October 2022.
6. Malone TL, Gurzenda S, Reiter KL, Pink GH, Greenwood-Ericksen MB. Suitability of Low-Volume Rural Emergency Departments to New Rural Emergency Hospital Designation. *Ann Emerg Med*. 2024 Feb;83(2):177-180. doi: 10.1016/j.annemergmed.2023.08.492. Epub 2023 Sep 23.
7. Kerr E, Malone TL, Thompson K, Pink GH, Holmes GM. Did Rural Emergency Hospital Converters Avoid Closure? *Ann Emerg Med*. 2026 Mar 11;S0196-0644(26)00078-8. doi: 10.1016/j.annemergmed.2026.02.004. Epub ahead of print. PMID: 41817486.
8. Reiter KL, Grant TJ, Gurzenda S, Budko A, Greenwood-Ericksen MB, Pink GH. *Key Considerations for a Rural Hospital Assessing Conversion to Rural Emergency Hospital*. NC Rural Health Research Program, UNC Sheps Center. October 2022.
9. Pink GH, Gurzenda S, Thompson K, Howard HA. *Characteristics of Rural Hospitals Eligible for Conversion to Rural Emergency Hospitals and Three Rural Hospitals Considering Conversion*. NC Rural Health Research Program, UNC Sheps Center. December 2022.
10. Kim YH, Perry JR, Thompson KW, Pink GH. *The First Year of Rural Emergency Hospitals: REHs Serve Relatively Disadvantaged Counties*. NC Rural Health Research Program, UNC Sheps Center. October 2024.
11. NC Rural Health Research Program, UNC Sheps Center. *Rural Emergency Hospitals*. <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-emergency-hospitals/>
12. CMS Healthcare Cost Report Information System, Centers for Medicare & Medicaid Services. Cost Reports.

Suggested Brief Citation

Pillutla A, Pink G, Thompson K, Holmes M. *An Early Look at Profitability Before and After Conversion to Rural Emergency Hospital*. NC Rural Health Research Program, UNC Sheps Center. March 2026.

This study was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement # U1CRH03714. The information, conclusions and opinions expressed in this brief are those of the authors and no endorsement by FORHP, HRSA, HHS, or The University of North Carolina is intended or should be inferred.



The University
of North Carolina
at Chapel Hill

North Carolina Rural Health Research Program
The Cecil G. Sheps Center for Health Services Research
The University of North Carolina at Chapel Hill
www.shepscenter.unc.edu/programs-projects/rural-health

