HOSPITAL CLOSURE: 1987

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EXECUTIVE SUMMARY

PURPOSE

This inspection was conducted to describe the phenomenon of hospital closures in the United States. It examines the characteristics of, reasons for, and impact of closures in 1987.

BACKGROUND

In recent years, the closure of general, acute care hospitals has generated increasing public and congressional concern. According to recent studies, more hospitals are expected to close their doors in coming years. Numerous questions have been raised about the reasons for and the effects of hospital closure, as well as the implications for public policy. Legislation was passed in 1987 to provide Rural Health Care Transition Grants to help communities address the kinds of changes that may lead to hospital closure.

FINDINGS

This inspection found that for 1987:

Sixty-nine general, acute care hospitals closed. They were located in 27 States. Thirteen new hospitals opened in 1987, and 8 of the 69 which closed in 1987 reopened in 1988.

Rural and urban hospitals closed in roughly equal proportion to their numbers nationally.

Hospitals that closed were small. Rural hospitals that closed were about half the size of the average rural hospital. Urban hospitals that closed were just over one-third as large as the average urban hospital.

Occupancy rates for both rural and urban hospitals that closed were much lower than the national averages.

When compared to national norms, there were no significant differences in either the Medicare or the Medicaid utilization rates of hospitals that closed.

There was no single factor or event which caused hospitals to close. Rather, a set of factors relating to hospital financing gradually diminished hospital viability. Hospitals that closed were reported to have had:

- declining revenues due to fewer admissions, lower third-party reimbursement, and more uncompensated care; and
- rising costs due to increasing demands for new medical technology, skilled personnel, and facility maintenance, renovation, or replacement.

Emergency services and inpatient care are accessible to most people living in communities where hospitals closed in 1987.

SUMMARY

Hospitals that closed in 1987 were small and had low occupancy rates. When the hospitals closed, few patients were affected. Most could get medical care nearby.

FUTURE STUDIES

The Office of Inspector General will look further into actions communities can take to maintain access to medical care in the face of possible hospital closure.

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INTRODUCTION

BACKGROUND

Congress and the public have shown increasing interest in hospital closings. They raise concerns about access to inpatient care and emergency services, particularly for older people in rural areas.

The American Hospital Association (AHA) reported 96 hospitals closed in 1987. According to a 1984 study by Arthur Anderson & Company, health industry policymakers estimate that 700 of the nation's hospitals will have closed by 1995.[1] A recent Touche Ross survey found that 48 percent of 419 hospital executives believe their hospitals may fail within 5 years.[2] The Government Research Corporation estimates that over 40 percent of all hospitals in the United States will close or be converted to other uses by the year 2000.[3]

PURPOSE

This inspection was designed to describe the phenomenon of hospital closures in the United States. It examines the characteristics of, reasons for, and impact of these closures.

SCOPE

The study examined hospitals that closed in Calendar Year 1987, the latest year for which sufficient data are available on the characteristics of hospitals.

For purposes of this study, the following definitions were used:

Hospital: A facility that provides general, short-term, acute medical and surgical inpatient services.

Closed Hospital: One that stopped providing general, short-term, acute inpatient services in 1987. If a hospital merged with or was sold to another hospital and the physical plant remained open for inpatient acute care, it was not considered a closure. If a hospital closed and reopened in 1987, it also was not considered a closure.

METHODS

Information for this study was obtained from an AHA list of 1987 hospital closures and Health Care Financing Administration (HCFA) data bases. Additional information came from contacts with State hospital associations, State licensing and certification agencies, State health planning agencies, officials associated with closed hospitals or hospitals nearby, and local public officials.

When the AHA list was compared with HCFA data on Medicare hospitals and information from State Government agencies, only 61 of the 96 hospitals listed by the AHA fit the definitions used in this study.

The list comparison showed that 22 of the hospitals on the AHA list were psychiatric, rehabilitation and other specialty hospitals which did not meet the study criteria. Ten other hospitals on the list had closed in a year other than 1987. Three hospitals on the list were still operating. The inspection also uncovered eight hospital closures in 1987 that did not appear on the list.

More information appears in appendix A on data collection methods.

FINDINGS

The Inspector General's study of hospitals closed in 1987 found that:

- sixty-nine general, acute care hospitals closed in 1987;
- size and occupancy levels appear to be the major factors in hospital viability;
- because of the small size and low occupancy of hospitals that closed, few patients were affected; and
- hospital closures do not appear to have resulted in major health care access problems.

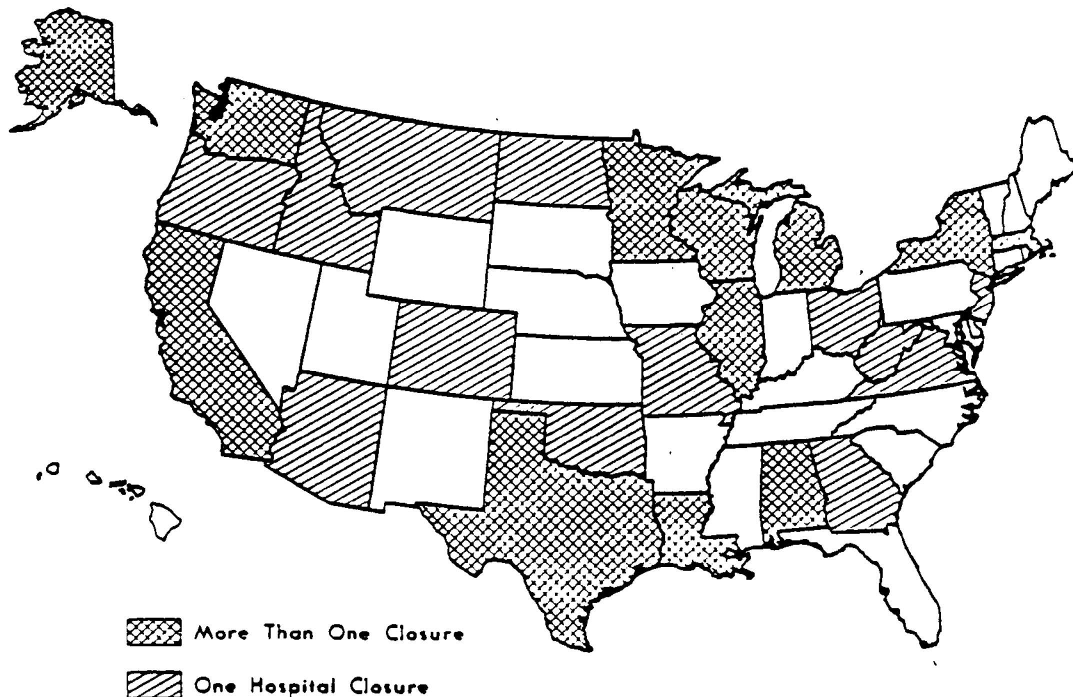
EXTENT AND NATURE OF HOSPITAL CLOSURES

How many closed?

In 1987, there were more than 6,800 hospitals in the United States. Of those, 5,143 were general, short-term, acute care hospitals shown in HCFA's data base as participating in the Medicare program. Forty-eight percent are rural and 52 percent are urban.

Sixty-nine hospitals closed in 1987--1.3 percent of all hospitals nationally. When they closed, the general acute care inpatient bed supply was reduced by 4,233 beds, or one-half percent.

Where were they?



The closed hospitals were located in 27 States. One-half of these States had only one hospital closure. The greatest number of closures was in Texas (14), followed by Michigan (6), California (5), and Minnesota (5). Appendix B shows a list of the 1987 closures and the number of rural and urban hospital closures by State.

Rural and urban hospitals closed at a rate roughly proportional to their numbers nationally. Thirty-seven of the closed hospitals (54 percent) were rural; 32 (46 percent) were urban.

		RURAL		URBAN	
TOTAL:	5143	2,489	(48%)	2,654	(52%)
CLOSED:	69	37	(54%)	32	(46%)

How many opened?

While 69 hospitals *closed* in 1987, 13 new general, acute care hospitals *opened,* adding back 1,116 beds to the national bed supply. Eight of the 69 hospitals which closed in 1987 reopened in 1988, adding back 261 beds.

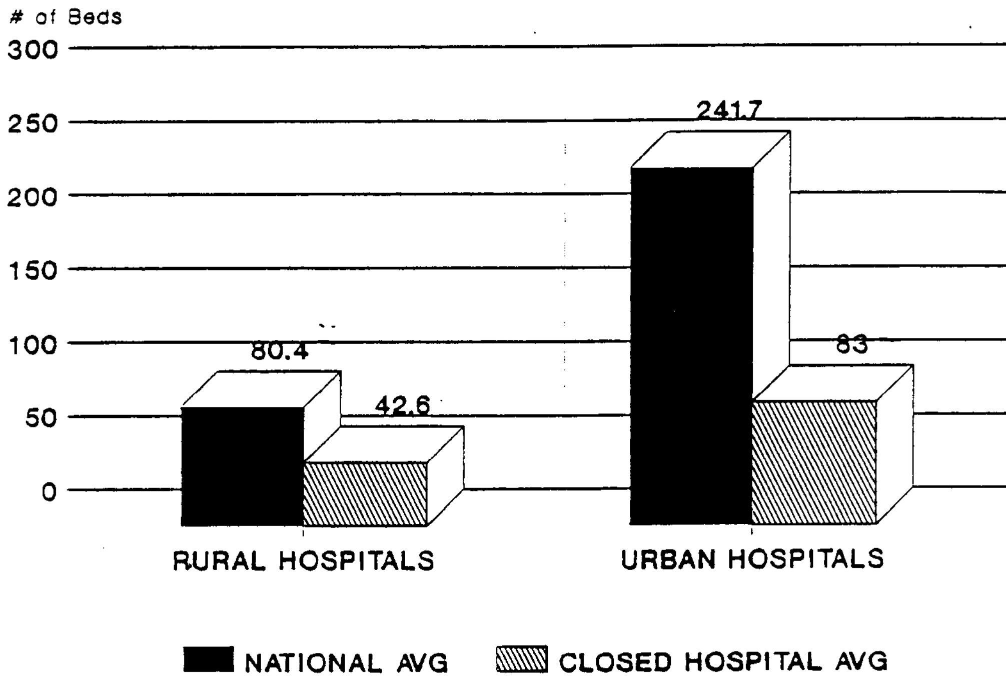
What were these hospitals like?

Size: Hospitals that closed in 1987 were small. Forty-three of them--almost two-thirds--had fewer than 50 beds. Only 12 had more than 100 beds.

SIZE OF CLOSED HOSPITALS

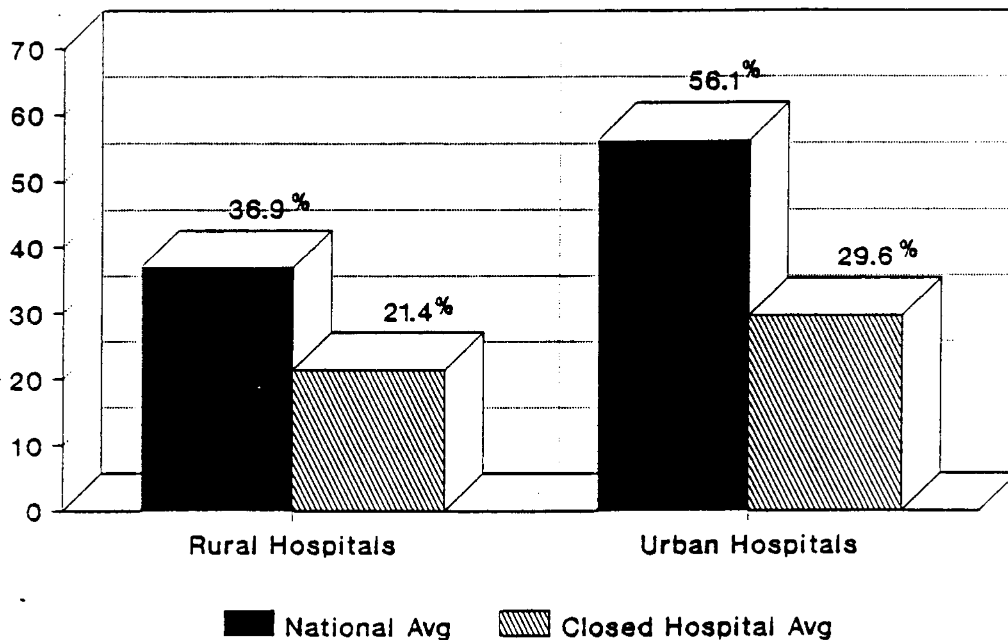
NUMBER OF BEDS	HOSPITALS			
	Rural	Urban	Total	Percent
0 - 29	15	5	20	29.0%
30 - 49	13	10	23	33.3%
50 - 99	6	8	14	20.3%
100 - 199	3	5	8	11.6%
200 - 299	0	4	4	5.8%
300 +	0	0	0	0%
TOTALS	37	32	69	100%

Compared to the *average* size of general, acute care hospitals nationally, both the rural and urban hospitals that closed in 1987 were a great deal smaller. Rural hospitals that closed were about half the size of the average rural hospital. Urban hospitals that closed were just over one-third as large as the average urban hospital nationally.



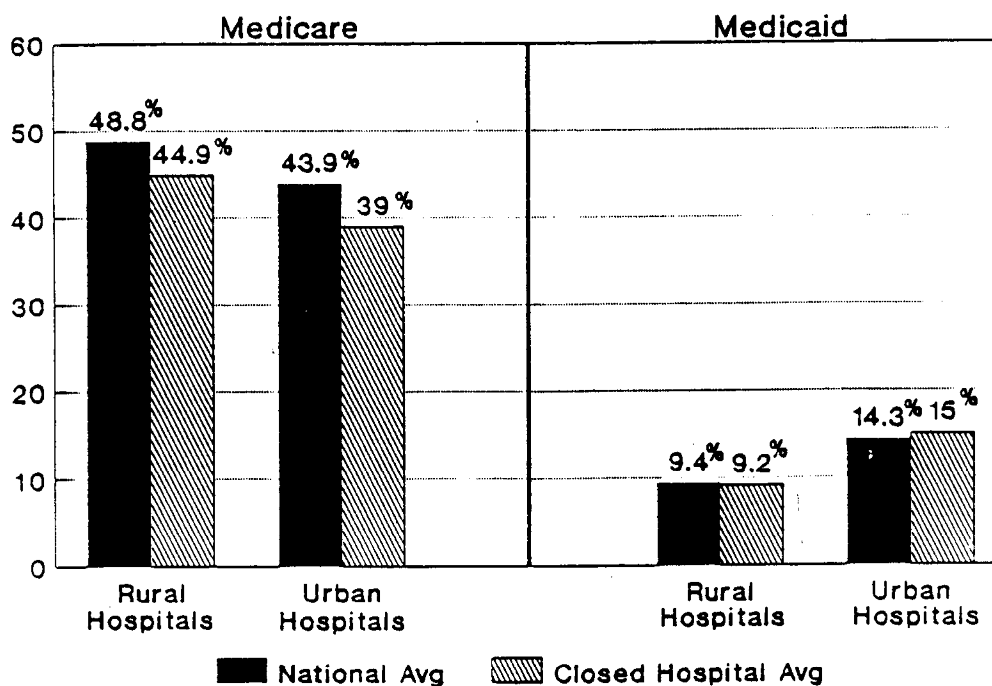
Occupancy: Occupancy rates for both rural and urban hospitals that closed in 1987 were much lower than the national averages.

OCCUPANCY[4]



Medicare and Medicaid Utilization: There was no significant difference in average Medicare occupancy between hospitals that closed and all hospitals nationally. Similarly, there were only marginal differences in average Medicaid utilization between hospitals that closed and all hospitals nationally.

UTILIZATION[5]



Medicare Compliance and Program Integrity: According to HCFA, five of the closed hospitals had been involuntarily removed from the Medicare program for failure to meet Medicare's conditions of participation. Further, HCFA had taken adverse actions against 11 more of the closed hospitals for noncompliance with conditions of participation in recent years.

Eleven of the closed hospitals had been reported to the Office of Inspector General's Office of Investigations for possible violations of Medicare or Medicaid laws. Of these 11 cases, 1 resulted in a civil monetary penalty; 1 resulted in administrative recoupment of Medicare funds; 3 were referred to the U.S. Attorney (but were not accepted for prosecution); 5 were closed with no violation found; and 1 case is pending.

Why did they close?

The many health care professionals interviewed in the course of this inspection reported no single reason for hospital closure. Rather, they suggested a number of factors which gradually weakened the financial condition of these hospitals. As occupancy declined, revenues lagged; but costs continued to rise. Operating margins shrank and ultimately there was no choice but to sell, merge with another hospital, or close the doors.

Declining Occupancy: Hospital occupancy is a function of the number of admissions and the lengths of hospital stay. Respondents cite fewer admissions as the main cause of declining occupancy.

Physicians control where patients are admitted for inpatient care. For most of the 69 hospitals that closed in 1987, physician referrals were said to have dwindled for a number of reasons:

- **Physician availability was a problem in rural areas.**

  In several rural communities where hospitals closed in 1987, the town's physician retired, died, or moved his practice and no replacement was found.

  Rural areas are less able to attract and retain physicians. The smaller population base often means that the physician practices alone and is always on call. Many physicians find rural practice, under these conditions, to be unattractive.

- **Physicians lost confidence in the local hospital.**

  Many of the hospitals included in this study were old and needed renovation and modernization. They lacked the high technology diagnostic and treatment equipment which physicians value.

  In cases where newer and better equipped hospitals are available nearby, physicians tend to shift their admissions to those facilities.

- **Patients, too, preferred other hospitals.**

  People are becoming better informed about health and medical care. They want the best care available, and they are more likely to question quality. Although they may be uncertain how to measure quality in technical terms, many will choose a large hospital over a small one; a newer, better equipped facility over one which shows its age. Many of the hospitals which closed in 1987 did not inspire patient confidence.

- **Medicare peer review organizations (PRO) are more carefully scrutinizing the necessity of hospital admissions.**

  The PROs are responsible for reviewing hospital admissions for appropriateness, and may sanction individual physicians for unnecessary hospitalization. Where there are only a few physicians admitting to a hospital, the likelihood of a physician being included in the PROs' sample increases. This factor is said to have made physicians more cautious in admitting marginally sick Medicare patients, which, consequently, has lowered hospital admissions.

  A more subtle effect of the PROs' diligence is also at play. Patients who were less sick and *might* have been admitted before the advent of PRO review are less likely to be admitted. Without these "cheap cases," hospitals are less able to offset the higher cost of unquestionably necessary admissions.

- **Competition among hospitals is intense.**

  People interviewed for this study reported that competition with other hospitals was a factor in many of the closures. Hospitals with limited resources are hard-pressed to compete with newer or larger hospitals which aggressively market their services, maintain a healthy capital reserve, and offer higher salaries to nursing and technical staff.

- **People are more mobile.**

  With better roads and improved transportation there is increased access to distant medical facilities. Now physicians and their patients can choose a hospital on the basis of quality or reputation rather than solely on proximity.

- **Practice patterns are changing.**

  Medical advances and new technology have allowed some procedures which formerly required a hospital stay to be performed on an outpatient basis.

One respondent noted that, as if competition by other *hospitals* were not enough, now hospitals are in competition with doctors, urgent care clinics, and surgical centers. With the added factors of better transportation and greater mobility, patients now have less expensive and more convenient alternatives to hospitalization.

Lagging Revenues: Lower occupancy means less income for hospitals. Other factors were also mentioned by respondents as reasons for declining hospital revenue:

- **Patients without hospital insurance, or with inadequate insurance, create substantial losses for the hospital.**

  There are estimated to be 37 million people in the United States who have no medical insurance. Others carry minimal coverage for hospitalization.[6] When hospitals admit these patients they accept losses which appear on the books as "charity" and "bad debt"-- uncompensated care. In Mississippi, uncompensated care is reported to have totaled $443 million in 1987, up almost $70 million from 1986.[7]

  Historically, hospitals covered these losses by "cost shifting" to patients who were insured or could afford to pay. Hospitals set their charges high enough to cover the cost of the insured patient's care *plus* a portion of the uncompensated care. More and more insurers are refusing to accept these cost shifts.

- **Insurers are better controlling their costs.**

  Both public and private insurers are pressed to control their hospital outlays. Some have reduced the percentage of hospital charges or costs they will reimburse. Others have changed from charge-based reimbursement to paying a scheduled amount per case, usually based on diagnosis and intensity of care required.

  Many respondents pointed out that, with these changes, payments from some insurers no longer cover the actual cost of care. Several mentioned Medicaid in particular.

  When payments do not cover costs, hospitals must either recoup the difference from the patient, shift the cost to another payor, or take a loss.

- **Medicare pays rural hospitals less.**

  Medicare reimbursement rates are based on average costs for the geographic area. Since rural costs have historically been lower than urban, rural hospitals' reimbursement rates are lower. Respondents suggested that hospitals classified as "rural" by HCFA but located in the same labor market as urban hospitals are particularly disadvantaged by such payment formulas.

Rising Costs: According to many respondents, hospital costs are rising despite efforts to curb them. On a per-case basis, costs increased by 9.5 percent in 1987 over 1986.[8]

Some of the important factors cited by respondents are:

- **New medical technology is a major capital expense.**

  While beneficial in speeding up diagnosis and treatment, technology is very costly. If a hospital fails to provide this modern equipment to physicians, they will take their patients elsewhere. Small hospitals can least afford such purchases.

- **Labor costs are increasing, and nursing and technical staff are scarce.**

  Shortages of skilled hospital personnel have made it difficult for hospitals to attract and retain staff. Rural hospitals in particular have problems competing in the regional and metropolitan markets. They must offer salaries equal to or better than suburban hospitals to balance the disincentives to rural medical practice.

- **Deteriorating facilities require major capital investments to renovate and modernize.**

  Many of the hospitals that closed in 1987 are old facilities in need of repair or renovation. These alterations are expensive. With declining revenues, smaller hospitals are often unable to make the needed changes.

Health care planners, regulators, and hospital administrators contacted during the course of this inspection described these factors--occupancy, revenue, and cost--as intricately related and interdependent. Hospital viability was said to depend on the stability of all three. The weakening of one may begin a chain reaction eventually leading to hospital closure.

When a hospital's patient census begins to slide, patient revenues necessarily decline. If a substantial proportion of the remaining patients are uninsured and poor, the cost of providing care is no longer covered by operating revenue.

In order to make payroll and pay the bills, the hospital diverts funds which would ordinarily be deposited to capital reserves. Needed maintenance and renovation must then be postponed. The hospital forgoes purchase of expensive high technology equipment. Soon it is unable to compete with neighboring hospitals.

Physicians begin admitting their patients to other hospitals which better meet their needs. This further erodes occupancy and patient revenues. The hospital may make every effort to reduce its costs, which may diminish its attractiveness to doctors and patients even more. But fixed costs remain, and now must be supported by fewer and fewer patients.

The hospital's operating margin shrinks to the point that all possible solutions become too expensive. The range of options narrows to merger, sale, or closure.

Small hospitals are least able to defend against this downward spiral. Hospitals which closed in 1987 were significantly smaller than average. Every one of them was said to have encountered some or all of the problems described here.

IMPACT OF HOSPITAL CLOSURES

Through interviews with local hospital and Government officials, the inspection assessed:

- the number of patients affected;
- the availability of inpatient care;
- access to emergency medical services; and
- present use of the closed hospital buildings.

Inpatient and emergency care were found to be accessible to most communities where hospitals closed in 1987. Respondents indicated that access to care was less convenient for some, but not a major problem.

How many patients were affected?

Few patients were affected by hospital closure. For rural hospitals that closed in 1987, the average daily census was about nine patients. Therefore, when a rural hospital closed, presuming that those hospital stays were necessary and that the demand remained constant, only nine beds needed to be found nearby. In the urban areas, 25 beds needed to be found.

WHEN HOSPITALS CLOSED, HOW MANY PATIENTS WERE AFFECTED?

	Rural Hospitals	Urban Hospitals
Average Number of Beds	42.6	83.0
Average Occupancy Rate	x 21.4%	x 29.6%
Average Patient Census	9.1	24.6

Medicare utilization data were analyzed to determine the number of elderly affected by hospital closure. In rural hospitals that closed the average census was nine patients at the time of closure. Only four were Medicare beneficiaries. In urban hospitals that closed, only 10 of the average 25 occupied beds were filled by Medicare patients.

WHEN HOSPITALS CLOSED,
HOW MANY MEDICARE PATIENTS WERE AFFECTED?

	Rural Hospitals	Urban Hospitals
Average Patient Census	9.1	24.6
Average Medicare Utilization Rate	x 44.9%	x 39.0%
Average Medicare Patients	4.1	9.6

Is inpatient care accessible?

Urban: In urban areas whose hospitals closed, residents of only one community must travel over 10 miles for inpatient care. In Wasco, California, the nearest hospital is located 19 miles away in Delano.

One other urban community had a similar situation. During the time the hospital in New Boston, Texas was closed, residents had to travel 23 miles to Texarkana. However, New Boston General Hospital reopened in 1988.

Rural: In three-quarters of the rural communities studied, another general hospital is located within 20 miles. Prior to the closure of these rural hospitals, many residents and physicians were already bypassing the local hospital and traveling to other nearby facilities for care.

Residents of only three of the 37 rural communities must travel further than 30 miles for inpatient care. In San Manuel, Arizona, residents must go 50 miles to one of several hospitals located in Tucson. In Mullen, Nebraska, the nearest hospital is located 75 miles away in North Platte. In Alaska, Glennallen's Faith Hospital no longer operates as a full-service hospital, but provides emergency care to stabilize patients before they are transported by air to Anchorage 200 miles away.

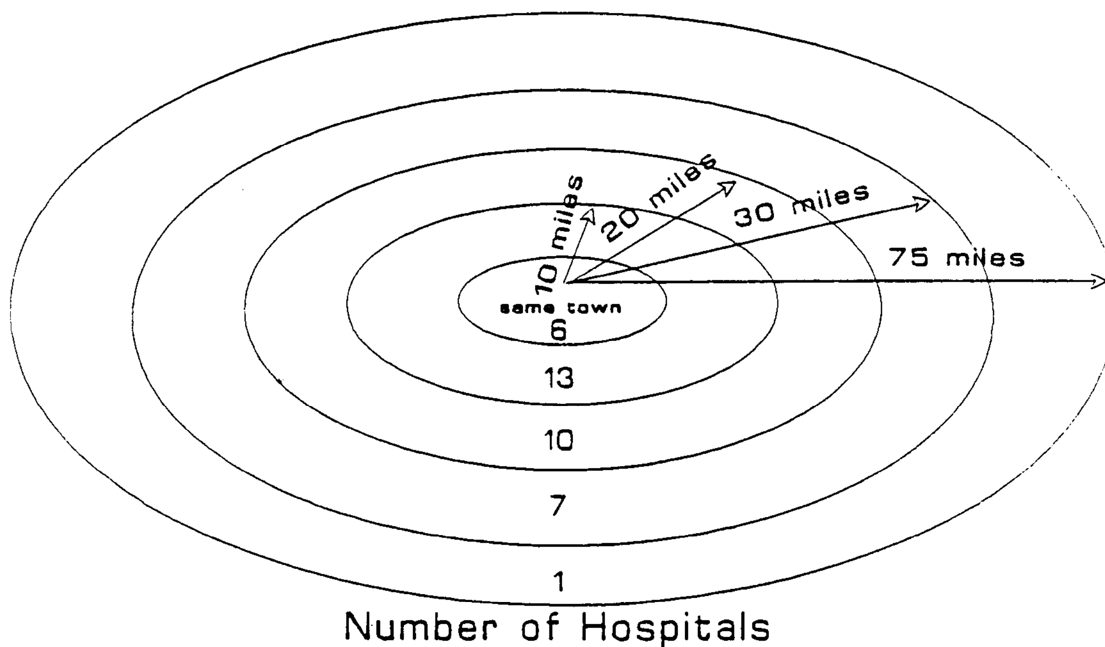
Is emergency care available?

When a hospital closes, the community loses not only inpatient beds, but also emergency services. Generally, respondents did not report significant problems with access to emergency care in the communities studied in this inspection. In rural areas, where more problems might be expected, emergency stabilization and transportation systems are said to work rather well overall.

Urban: In urban areas, all but one of the 32 communities whose hospitals closed in [illegible] had emergency care available within 10 miles. Most urban communities have several hospitals

which provide both inpatient and emergency care, so the closure of one hospital has little effect on the community's emergency care system. Residents of only one community studied here--Wasco, California--have to travel further, to Delano 19 miles away.

Rural: In only eight of the 37 rural communities whose hospitals closed, residents had to travel more than 20 miles for emergency care. In those eight communities, ground or air ambulance services were available. Only in Mullen, Nebraska was the travel time over 30 minutes, to North Platte about an hour's ride by ambulance.



What happened to the buildings?

In almost half of the 69 cases of 1987 hospital closures, the former hospital buildings are now used for some health care purpose.

Prior to discontinuing general, acute inpatient care, several hospitals provided more than one type of service. For example, Ashton Memorial Hospital in Idaho provided both acute and long-term care services. In 1987, the hospital closed its general, acute care services. It opened a chemical dependency unit and continues to offer nursing home care.

Other facilities were converted to a different type of health care use. Jay Memorial Hospital in Jay, Oklahoma, for example, is now a clinic. The following chart illustrates the current use of all 69 hospitals closed in 1987.

CURRENT USE OF HOSPITALS CLOSED IN 1987		
Use	Number of Hospitals*	
	Rural	Urban
Reopened Hospital	4	4
Speciality Treatment Facility (e.g. chemical dependency)	3	3
Long Term Care Facility	7	1
Outpatient Services/Clinic	4	12
Offices	1	2
Vacant	20	14

**Duplicate count. Eight of the 69 hospitals provide two separate services.*

FUTURE STUDIES

The OIG will look further into actions communities can take to maintain access to medical care in the face of possible hospital closure. Some communities have carefully analyzed their needs and are constructing affordable medical care systems that meet their needs. The OIG's follow-up analyses are intended to learn what steps these communities have taken and to make that information available to other communities facing the same dilemmas.

NOTES

1. Arthur Anderson & Co. and the American College of Hospital Administrators. *Health Care in the 1990s: Trends and Strategies*. 1984.

2. Touche Ross. *U.S. Hospitals: The Future of Health Care*. June 1988.

3. Larry S. Gage, Dennis P. Andrulis, and Virginia Beers, *American's Safety Net: A Report on the Situation in Our Nation's Metropolitan Areas*. National Association of Public Hospitals. October 1987.

4. Hospital occupancy rate is defined as the actual number of patient days divided by the total bed days available. National occupancy rate is defined as the sum of all hospitals' occupancy rates, divided by the number of hospitals.

5. Average Medicare utilization for closed urban and rural hospitals is defined as the percent of Medicare patient days compared to total patient days for each hospital, summed and divided by the number of hospitals. National average Medicare utilization is the percent of Medicare utilization for each hospital, summed and divided by the total number of hospitals. Medicaid utilization is calculated in the same way.

6. Larry S. Gage, Dennis P. Andrulis, and Virginia Beers, *American's Safety Net: A Report on the Situation in Our Nation's Metropolitan Areas*. National Association of Public Hospitals. October 1987. Page 20.

7. Survey by the Mississippi Hospital Association as reported by *Health Week*, June 6, 1988. Page 11.

8. Carol McCarthy, President of the American Hospital Association. Testimony to U.S. House of Representative Committee on the Budget. August 1, 1988.

APPENDIX A

METHODOLOGY

Phenomenon of closures

To determine how many hospitals closed in 1987, the study was started with a list from the AHA. The list was compared with the list of Medicare hospital terminations in 1987 in HCFA's Health Standards and Quality data base (RADARS). All 50 State licensing and certification agencies were contacted. State hospital associations and State health planning agencies also were contacted. When closures were found that met the definition of hospital closures or when discrepancies in data were found, contacts were made with officials associated with the closed hospitals and officials associated with the hospital nearest to the closed hospital.

To determine the number of hospitals in the U.S. and the bed capacity, the Hospital Cost Report Information System (HCRIS) maintained by HCFA was used. Only the general, short-term, acute care hospitals under Medicare's Prospective Payment System (PPS) were included in the universe. Five thousand one hundred fifty (5,150) hospitals were listed, less 7 with no data reported, which left 5,143. This was the universe of short-term, acute care, general hospitals on HCRIS for the fourth year of PPS (PPS 4).

Characteristics of closed hospitals

To analyze characteristics of closed hospitals, HCFA's HCRIS data were used. Cost reports were not available for 3 of the 69 closed hospitals. Two were not Medicare providers in the years prior to closure and one had not submitted a cost report since PPS began. For the remaining 66 hospitals, the latest cost reports prior to closure containing sufficient data were used. For example, if a hospital closed in October 1987 and its accounting year was on a July-June cycle, the provider's July 1, 1986 to July 20, 1987 report was used. Cost report data on 49 of the 69 hospitals were contained in HCRIS for PPS 4, and data on 61 of the 69 hospitals were contained in HCRIS for PPS 3.

Reasons for hospital closures

To determine the reasons for 1987 closures, officials of the following agencies were contacted.

- State hospital associations
- State health planning agencies
- State certification and licensing agencies
- closed hospitals; and
- nearest hospitals to closed hospitals.

Impact of hospital closures

The "impact" issues examined concentrated on those relating to access to medical care. To determine these impacts, many of the following were contacted:

- former hospital administrators, board members, and/or staff;
- hospital administrators and/or staff at the nearest hospitals;
- local police and health officials;
- local government officials;
- State health planning agencies;
- State certification and licensing agencies; and
- State hospital associations.

APPENDIX B

1987 HOSPITAL CLOSURES

Number of Closures by State		Number of Rural	Number of Urban
Texas	14	8	6
Michigan	6	0	6
California	5	1	4
Minnesota	5	2	3
Illinois	4	2	2
Louisiana	4	3	1
Alabama	3	3	0
Arkansas	3	3	0
Washington	3	0	3
Massachusetts	2	0	2
Nebraska	2	2	0
New York	2	0	2
Wisconsin	2	2	0
Alaska	1	1	0
Arizona	1	1	0
Colorado	1	0	1
Georgia	1	1	0
Idaho	1	1	0
Missouri	1	1	0
Montana	1	1	0
North Dakota	1	1	0
New Jersey	1	0	1
Ohio	1	1	0
Oklahoma	1	1	0
Oregon	1	0	1
Virginia	1	1	0
West Virginia	1	1	0
27 States	69 Closures	37 Rural	32 Urban

1987 HOSPITAL CLOSURES
By Name and Location

Hospital Name	City	State	Rural/Urban
Faith Hospital	Glennallen	AK	rural
Guin Hospital	Guin	AL	rural
Livingston-Tombigbee	Livingston	AL	rural
John Andrew Community Hospital	Tuskegee Institute	AL	rural
Delta Medical Center	Brinkley	AR	rural
Gurdon Municipal Hospital	Gurdon	AR	rural
Lafayette County Memorial Hospital	Lewisville	AR	rural
San Manuel Division Hospital	San Manuel	AZ	rural
Kingsburg General Hospital	Kingsburg	CA	urban
Shasta General Hospital	Redding	CA	urban
North Kern Hospital	Wasco	CA	urban
Corning Memorial Hospital	Corning	CA	rural
Buena Park Community Hospital	Buena Park	CA	urban
Memorial Hospital	Greeley	CO	urban
Fort Gaines/Clay County Hospital	Ft. Gaines	GA	rural
Ashton Memorial Hospital	Ashton	ID	rural
Saunders Hospital	Avon	IL	rural
Provident Medical Center	Chicago	IL	urban
Walther Memorial Hospital	Chicago	IL	urban
Paxton Community Hospital	Paxton	IL	rural
Dixon Memorial Hospital	Denham Springs	LA	urban
Catahoula Memorial Hospital	Jonesville	LA	rural
Leesville General Hospital	Leesville	LA	rural
Regent Hospital Acadiana	Erath	LA	rural
Mary A. Alley Hospital	Marblehead	MA	urban
Parkwood Hospital	New Bedford	MA	urban
Lakeshore Hospital	Detroit	MI	urban
Metro Hospital & Health Center	Detroit	MI	urban
Milton Community Hospital	River Rouge	MI	urban
A. Blain Hospital	Detroit	MI	urban
Detroit Memorial Hospital	Detroit	MI	urban
Springwells Health Center	Dearborn	MI	urban
St. John's Hospital	Browerville	MN	rural
Community Memorial Hospital	Clarkfield	MN	rural
Samaritan Hospital	St. Paul	MN	urban
St. John's Eastside	St. Paul	MN	urban
Mounds Park Hospital	St. Paul	MN	urban
Poplar Bluff Hospital	Poplar Bluff	MO	rural
Missoula General Hospital	Missoula	MT	rural

1987 HOSPITAL CLOSURES
By Name and Location

Hospital Name	City	State	Rural/Urban
Rolette Community Hospital	Rolette	ND	rural
Grand Island Memorial Hospital	Grand Island	NE	rural
Pioneer Memorial Hospital	Mullen	NE	rural
South Bergen Hospital	Hasbrouck Heights	NJ	urban
Baptist Medical Center	Brooklyn	NY	urban
Sheridan Park Hospital	Tonawanda	NY	urban
Southern Hills Hospital	Portsmouth	OH	rural
Jay Memorial Hospital	Jay	OK	rural
Cascade Community Hospital	Central Point	OR	urban
Shelby General Hospital	Center	TX	rural
Foard County Hospital	Crowell	TX	rural
Dallas Medical & Surgical	Dallas	TX	urban
Northpark Hospital	El Paso	TX	urban
Continental Hospital North	Ft. Worth	TX	urban
Deaton Hospital	Galena Park	TX	urban
Hamilton General Hospital	Hamilton	TX	rural
Hospital in the Pines	Lone Star	TX	rural
Meridian Hospital	Meridian	TX	rural
New Boston General Hospital	New Boston	TX	urban
Rosebud Community Hospital	Rosebud	TX	rural
Brazos Valley Hospital	Sealy	TX	rural
Wortham Hospital	Wortham	TX	rural
Ysleta General Hospital	El Paso	TX	urban
Wytheville Hospital	Wytheville	VA	rural
Northgate General Hospital	Seattle	WA	urban
Shorewood Osteopathic	Seattle	WA	urban
Pacific Medical Center	Seattle	WA	urban
Algoma Memorial Hospital	Algoma	WI	rural
Buffalo Medical Center	Mondovi	WI	rural
Stevens Clinical Hospital	Welch	WV	rural