



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

2450 N STREET, NW, WASHINGTON, DC 20037-1127
PHONE 202-828-0400 FAX 202-828-1125

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SUNSHINE PERIOD

96-45

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MAY - 6 1997

Federal Communications Commission
Office of Secretary

September 9, 1996

John Clark
FCC
2100 M St. NW
Room 8619
Washington, D.C. 20554

Dear Mr. Clark:

In response to your request, I am faxing you a table listing U.S. medical schools which offer an opportunity to take clinical rotations in a rural setting and the schools that require it.

I hope this information will be helpful. If you require further assistance, please call me at (202) 828-0647.

Sincerely,

A handwritten signature in cursive script that reads "Donna J. Williams".

Donna J. Williams
Director, Institutional Profile System
Section for Operational Studies

Enclosure

AAMC Code	name	Opportunity in rural setting	Required
101	Alabama	Yes	Yes
102	Albany	Yes	Yes
103	Arkansas	Yes	No
104	Baylor	Yes	No
105	Boston	Yes	No
106	Bowman Gray	Yes	Yes
107	SUNY Buffalo	Yes	No
108	San Francisco	Yes	No
109	Los Angeles	Yes	No
110	Chgo Medical	Yes	No
111	Pritzker	Yes	No
112	Cincinnati	Yes	No
113	Colorado	Yes	No
114	Columbia U	Yes	No
115	Cornell	Yes	No
116	Creighton	Yes	No
117	Florida	Yes	Yes
118	Dartmouth	Yes	Yes
119	Duke	Yes	No
120	Einstein	Yes	No
121	Emory	Yes	No
122	Georgetown	Yes	No
123	Geo Washington	Yes	No
124	Georgia	Yes	No
126	Harvard	Yes	No
127	Howard	Yes	No
128	Illinois	Yes	Yes
129	Indiana	Yes	Yes
130	Irvine	Yes	No
131	Iowa	Yes	No
132	Jefferson	Yes	No
133	Johns Hopkins	Yes	No
134	Kansas	Yes	Yes
135	Kentucky	Yes	Yes
136	SUNY Brooklyn	Yes	No
137	New Orleans	Yes	No
138	Louisville	Yes	Yes
139	Loyola, Stritch	Yes	Yes
140	Miami	Yes	Yes
141	Med Coll Wisc	Yes	No
142	Maryland	Yes	No
143	Loma Linda	Yes	No
144	Meharry	Yes	Yes
145	U Michigan	Yes	No
146	Minneapolis	Yes	No
147	Mississippi	Yes	Yes
148	Mo. Columbia	Yes	Yes
149	Nebraska	Yes	Yes
150	New Mexico	Yes	Yes
151	NY Medical	Yes	No

152 NY University	No	Yes
153 North Carolina	Yes	Yes
154 North Dakota	Yes	Yes
155 Northwestern	Yes	No
156 Ohio State	Yes	No
157 Oklahoma	Yes	Yes
158 Oregon	Yes	Yes
159 U Pennsylvania	Yes	No
160 San Antonio	Yes	No
161 Puerto Rico	Yes	No
162 Pittsburgh	Yes	No
163 Rochester	Yes	No
164 Saint Louis	Yes	No
165 South Carolina	Yes	No
166 South Dakota	Yes	Yes
167 Southern Calif	Yes	No
168 Southwestern	Yes	Yes
169 Stanford	Yes	No
170 UMD - New Jersey	No	Yes
171 SUNY Syracuse	Yes	Yes
172 Temple	Yes	No
173 Tennessee	Yes	No
174 Galveston	Yes	No
175 Tufts	Yes	No
176 Tulane	Yes	No
177 Utah	Yes	No
178 Vanderbilt	Yes	No
179 Vermont	Yes	No
180 UMD - R W Johnson	Yes	No
181 U Virginia	Yes	No
182 Med Coll Va	Yes	Yes
183 Washington	Yes	No
184 Washington U	Yes	No
185 Wayne State	Yes	No
186 Case Western Res	Yes	No
187 West Virginia	Yes	Yes
← 188 U Wisconsin	Yes	No
190 Connecticut	Yes	No
191 Yale	Yes	No
192 Brown	Yes	No
193 Arizona	Yes	Yes
194 San Diego	Yes	No
195 Massachusetts	Yes	No
196 Michigan State	Yes	No
197 Hawaii	Yes	No
198 Penn State	Yes	No
801 Mount Sinai	No	No
802 Davis	Yes	No
803 Ohio, Toledo	Yes	Yes
804 Shreveport	Yes	No
805 SUNY Stony Brook	Yes	No

806 South Florida	Yes	No
807 Nevada	Yes	Yes
808 Mo. Kansas City	Yes	No
809 Houston	Yes	No
— 810 Southern Ill	Yes	Yes
812 Rush	Yes	Yes
813 East Carolina	Yes	No
814 Texas Tech	Yes	No
815 Duluth	Yes	Yes
816 South Alabama	Yes	No
817 Mayo	Yes	No
818 Eastern Va	Yes	No
819 Wright State	Yes	No
820 USC, Columbia	Yes	No
— 821 Uniformed Services	Yes	No
823 Texas A&M	Yes	No
824 Northeastern Ohio	Yes	No
825 Morehouse	Yes	Yes
7 826 E Tenn State	Yes	No
828 Marshall	Yes	Yes
829 Ponce	Yes	No
830 Del Caribe	Yes	No
832 Mercer	Yes	Yes
833 MCF/Hahnemann	Yes	No

24
124

Total



LINCOLN TRAIL LIBRARIES SYSTEM

Supporting library cooperation in East Central Illinois

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April 23, 1997

The Honorable Susan Ness, Commissioner
Federal Communications Commission
1919 M Street NW-Room 844
Washington, DC 20544

RECEIVED
MAY 6 1997
Federal Communications Commission
Office of Secretary

Re: CC Docket #96-45 - Universal Service to Libraries and Schools

Dear Commissioner Ness:

Attached is a copy of a resolution passed by the Board of Directors of the Lincoln Trail Libraries System at its meeting of April 21, 1997 in support of the implementation of meaningful discounted telecommunications rates for public libraries and schools. The proposed discounted rate structure will be a critical factor in assuring full access for our citizens to the Internet and other sources of electronic information, as envisioned by Congress in the Telecommunications Act of 1996 and in the Recommended Rules of the Federal-State Joint Board.

Lincoln Trail Libraries System is a multitype library consortium serving 118 member academic, public, school, and special libraries and 424,000 citizens in a 5,900 square mile, 9-county area in East Central Illinois. We coordinate a wide range of cooperative activities designed to facilitate interlibrary resource sharing among libraries in our region. Our member libraries include many small rural libraries serving communities as small as 850 residents. An obstacle to universal access to all citizens is the fact that high-speed telecommunications connections to the Internet are more expensive for the most remote libraries with the least ability to afford them. The discounts under consideration will help to make universal access to information a reality for all.

Thank you for your efforts in working to achieve universal access to the world of electronic information for our citizens and our students. Our citizens and society at large will benefit from the widest possible access to information.

Sincerely,

LINCOLN TRAIL LIBRARIES SYSTEM

Jan Ison
Executive Director

J1/mw
Enclosure

MAY 14 24 PM '97

OFFICE OF
COMMISSIONER
SUSAN NESS

Resolution of the Board of Directors of Lincoln Trail Libraries System

WHEREAS, in passing the Telecommunications Act of 1996, Congress expressed the intent that libraries and schools should be afforded meaningful discounts for access to the Internet and other online information resources, and

WHEREAS, under the identifying title, CC Docket #96-45 - Universal Service to Libraries and Schools, the Federal Communications Commission has issued Federal-State Joint Board Proposed Rules regarding affordable telecommunications rates for libraries and schools, and

WHEREAS, the proposed rules allow for favorable rates, consisting of 20%-90% discounts to schools and public libraries for high speed telecommunications services and critical non-telecommunications services necessary to assure affordable access to information for our citizens and students, and

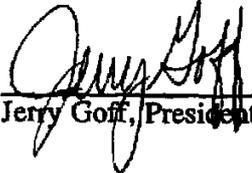
WHEREAS, access to affordable telecommunications rates is a critical component to enable schools and public libraries, especially in the rural areas of East Central Illinois, to provide universal access to this wide range of information,

NOW, THEREFORE, BE IT RESOLVED on April 21, 1997 that the Board of Directors and Staff of Lincoln Trail Libraries System strongly support the recommended discounts on telecommunications rates for schools and libraries as embodied in the Telecommunications Act of 1996, and hereby urge the Federal Communications Commission and the Illinois Commerce Commission to adopt rules implementing such discounts.



SUBMITTED ON BEHALF OF THE BOARD OF DIRECTORS

LINCOLN TRAIL LIBRARIES SYSTEM


Jerry Goff, President


Jan Ison, Executive Director

THE BOARD OF DIRECTORS

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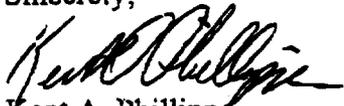
Federal Communications Commission
Office of Secretary

John Clark
Universal Services Branch
Federal Communications Commission

Dear John;

I am sending a table which shows the break down of community colleges according to the degree of urbanicity for each college. The information included comes from data files released by the National Center for Education Statistics, a branch of the U.S. Department of Education. As you will note, there are several degrees of urbanicity indicated in this information. The degree of urbanicity is assigned by the data collectors, not the institutions themselves. If you have any questions, I would be happy to answer them.

Sincerely,



Kent A. Phillippe
Research Associate

Degree of Urbanicity of Community Colleges by Sector, 1995

Control of college	Degree of Urbanicity	Number of Colleges
Public	Large City	99
	Mid-size City	245
	Urban Fringe of Large City	171
	Urban Fringe of Mid-size City	56
	Large Town	47
	Small Town	286
	Rural	87
	Not Assigned	45
Subtotal Public		1036
Private not-for-profit	Large City	29
	Mid-size City	38
	Urban Fringe of Large City	22
	Urban Fringe of Mid-size City	3
	Large Town	2
	Small Town	15
	Rural	15
	Not Assigned	6
Subtotal Private not-for profit		130
Private for-profit	Large City	16
	Mid-size City	15
	Urban Fringe of Large City	11
	Large Town	0
	Small Town	0
	Not Assigned	5
Subtotal Private for-profit		47
All Sectors	Large City	144
	Mid-size City	298
	Urban Fringe of Large City	204
	Urban Fringe of Mid-size City	59
	Large Town	49
	Small Town	306
	Rural	149
	Not Assigned	195
Grand Total		1213

Source: IPEDS Data files; US Department of Education

C O V E R

FAX

S H E E T

To: Astrid Carlson
Fax #: 418-7361
Subject: Rural Colleges
Date: March 31, 1997
Pages: 3, including this cover sheet.

COMMENTS:

Astrid;

Here is the information you requested. If you have any questions, please let me know.



From the desk of...

Kent A. Phillippe
Research Associate
American Association of Community Colleges
One Dupont Circle, NW, Suite 410
Washington, DC 20036-1176

kphillippe@aacc.nche.edu
(202)728-0200 ext. 222
Fax: (202)833-2467

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AHA Center for Health Care Leadership
Section for Small or Rural Hospitals

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MAY - 6 1997

Federal Communications Commission
Office of Secretary

A Profile of Nonmetropolitan Hospitals 1991-95



American Hospital Association

AHA catalog no. 184100

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Acknowledgments

The AHA Section for Small or Rural Hospitals would like to thank the following individuals for their contributions to the development of *A Profile of Nonmetropolitan Hospitals, 1991-1995*. This report was made possible through funding from the AHA Center for Health Care Leadership, Barbara Z. Harness, vice president. Data for the report are from AHA's Annual Survey of Hospitals and was processed for this purpose by the Trends Analysis Group, Joe Martin, vice president.

Special recognition is due Scott Bates, AHA Trends Analysis Group for his preparation and review of data for use by the author. Additional thanks goes to Wei-Wei Li, AHA Trends Analysis Group; Mike Jankowiak, AHA Data and Information Business Group; Louise Mirkin, AHA Editorial Services; Eileen O'Keefe, AHA Office of the Constituency Sections; Jane Gibson, AHA Section for Small or Rural Hospitals; Lisa Potetz, AHA Division of Policy Development and Deborah Williams, AHA Division of Policy Development for their review of and input into the report.

Our congratulations to Deborah Reczynski on her well written report. Ms. Reczynski has contributed to the AHA's *Environmental Assessment for Rural Hospitals 1992*, *Environmental Assessment for Urban Hospitals 1992*, and the Hospital Trends section of the 1995-96 edition of *Hospital Stat*.

John T. Supplitt, director
Section for Small or Rural Hospitals
Section for Metropolitan Hospitals

A PROFILE OF NONMETROPOLITAN HOSPITALS, 1991-1995

For the 20 percent of Americans who live in rural areas, the local hospital is an essential source of health care, but it is often much more. Rural hospitals¹ are frequently the largest or second-largest employers in their communities, and their presence serves to attract physicians and new business to those communities.

Rural hospitals also provide many valuable social services, including transportation for the elderly, home-delivered meals, and meeting facilities.

During the 1980s, dramatic changes in the health care environment threatened to shut down many rural hospitals. But hospitals adapted to these changes through various strategies, and most survived. Among the most common strategies were reconfiguring services to provide an entire continuum of care, from preventive care to long-term management of chronic conditions; conversion to outpatient or long-term care facilities, with a minimal number of beds for inpatient acute care; and developing networks or affiliations with other hospitals, physicians, and other health care providers.

¹ In this report, rural hospitals are equated with nonmetropolitan hospitals, which are defined as those located outside of any metropolitan statistical area (MSA) as designated by the U.S. Census Bureau. The Census Bureau defines an MSA as an area containing a city with a population of at least 50,000 or an urban area of at least 50,000 and a total metropolitan population of at least 100,000.

Underlying all of these strategies is a recognition that the mission of a community hospital is to serve the community and that any changes in service offerings should be made with the needs of the community in mind. Reflecting this community focus, 63.9 percent of rural hospitals reported in 1995 that they are working with other providers, public agencies, or community representatives to conduct health status assessments within their communities. Moreover, 54.5 percent reported that they use health status indicators for defined populations to design new services or modify existing ones.

This profile paints a picture of rural hospitals using selected data that best characterizes how these hospitals have evolved over the five-year period from 1991 to 1995. The information in this report is derived from the American Hospital Association's Annual Survey of Hospitals and includes:

- Size and ownership breakdowns
- Recent trends in inpatient and outpatient utilization, staffing levels, and hospital finances, including costs, payer mix, and revenue margins
- Data on system, network, and alliance participation

Data reported for utilization, finances and staffing are for the total facility inclusive of acute and nursing home type units or facilities owned and operated by the hospital.

RURAL HOSPITAL CHARACTERISTICS

In 1995, 2,236 community hospitals, or 42 percent of all community hospitals in the United States, were classified as rural.² Most rural hospitals are small, with fewer than 100 beds set up and staffed for use (table 1); as a group, the nation's rural hospitals maintained more than 183,000 beds in 1995.

Table 1. Distribution of Rural Hospitals and Staffed Beds, by Bed-size 1991 and 1994-1995

Rural Hospitals and Staffed Beds	1991	1994	1995	% Change 1991-95
Hospitals				
6 to 49 Beds	903	883	934	3.4%
50 to 99 Beds	759	705	683	-10.0%
100+ Beds	631	648	619	-1.9%
Total	2,293	2,236	2,236	-2.5%
Staffed Beds				
6 to 49 Beds	30,374	29,298	30,377	0.0%
50 to 99 Beds	54,130	49,615	48,530	-10.3%
100+ Beds	106,240	108,463	104,127	-2.0%
Total	190,744	187,376	183,034	-2.0%

² Modifications to the MSA system announced in July 1994 created several new MSAs. As a result, some hospitals that had been classified as nonmetropolitan were now metropolitan. In this report, those hospitals are considered metropolitan, and data for years prior to 1994 were adjusted to reflect the revised classification.

Rural hospitals can be broken down into three ownership categories (tables 2 and 3). In 1995, nearly half (49.4 percent) of the rural hospitals in the United States were owned by private, nonprofit entities. Private nonprofit hospitals are typically run by a board of trustees and are exempt from federal tax requirements. State or local government bodies, agencies, or departments owned and operated 42.2 percent of all rural hospitals. Only 8.4 percent were investor-owned.

A comparison of rural hospitals and urban hospitals by ownership (table 2) indicates that rural hospitals are much more likely to be government owned. Many rural government-owned hospitals are run by local health systems agencies such as districts, authorities, cities, or counties.

Table 2. Comparison of Rural and Urban Hospitals by Ownership, 1995

Ownership	Rural	Urban
Private Nonprofit	1,105	1,987
State or Local Government	944	406
Investor Owned (for profit)	187	565
Total	2,236	2,958

The bulk of the decrease in the number of rural hospitals between 1991 and 1995 occurred among government-owned institutions (table 3). During this period, the number of rural community hospitals decreased by 57; 52 of the 57

hospitals were government-owned. Of course, it is possible that not all of these hospitals closed. Some may have converted to outpatient or nonacute care

Table 3. Distribution of Rural Hospitals, by Ownership 1991 and 1994-1995

Ownership	1991	1994	1995	% Change 1991-95
State or Local Government	996	954	944	-5.2%
Private Nonprofit	1,108	1,102	1,105	-0.3%
Investor Owned (for profit)	189	180	187	-1.1%
Total	2,293	2,236	2,236	0.0%

facilities such as community health clinics or nursing homes. Also, some of the government-owned hospitals may still be operating as acute-care institutions, but under new ownership as a result of a merger with or acquisition by a private nonprofit or for-profit organization.

CHANGING PATTERNS OF UTILIZATION

Admissions

During the 1980s, hospitals in the United States experienced sharp reductions in inpatient volume. The declines were driven by advances in technology and changes in payment system incentives, such as the introduction of Medicare prospective pricing and the growth of managed care, which encouraged a

shifting of more and more care to outpatient settings. The drop in inpatient use was especially precipitous for rural hospitals: between 1980 and 1990, rural hospital admissions fell 37 percent and inpatient days dropped 31 percent.

Table 4. Inpatient Use of Rural Hospitals, by Bed-size 1991 and 1994-1995

Utilization	1991	1994	1995	% Change 1991-95	%Change 1994-95
Admissions					
6 to 49 Beds	718,683	732,150	788,254	9.7%	7.7%
50 to 99 Beds	1,367,625	1,236,746	1,266,814	-7.4%	2.4%
100+ Beds	3,028,290	3,030,123	2,975,511	-1.7%	-1.8%
Total	5,114,598	4,999,019	5,030,579	-1.6%	0.6%
Inpatient Days					
6 to 49 Beds	4,415,517	4,119,854	4,523,637	2.4%	9.8%
50 to 99 Beds	10,804,255	9,861,340	9,610,185	-11.1%	-2.5%
100+ Beds	24,764,305	24,380,849	23,518,656	-5.0%	-3.5%
Total	39,984,077	38,362,043	37,652,478	-5.8%	-1.8%
Length of Stay					
6 to 49 Beds	6.1	5.6	5.7	-6.6%	-2.0%
50 to 99 Beds	7.9	8.0	7.6	-4.0%	-4.9%
100 + Beds	8.2	8.0	7.9	-3.3%	-1.8%
Total	7.8	7.7	7.5	-4.3%	-2.5%

In the 1990s, admissions appear to have stabilized. Between 1991 and 1995, rural hospital admissions were down only 1.6 percent, and between 1994 and 1995, they rose by 0.6 percent (table 4).

The stabilization most likely can be attributed to continued growth in the elderly population, which is the segment of the population that uses hospitals most heavily. In addition, although technological advances and reimbursement continue to drive more care to outpatient settings, this shift may be slowing down.

Interestingly, the smallest bed-size group--hospitals with 6 to 49 beds--experienced the largest increase in admissions between 1991 and 1995. The largest declines in admissions during this period occurred among hospitals with 50 to 99 beds. In part, these trends can be explained by fluctuations in the number of hospitals in each bed-size group as hospitals add or remove beds from year to year. The number of hospitals in the 50 to 99 bed group has declined steadily since 1991. The number of hospitals in the 6 to 49 bed group had been falling, but increased sharply in 1995.

Alternative Care Settings

Many hospitals have added services aimed at meeting the needs of the growing elderly population and the disabled for long-term, nonacute care. In 1995, for

example, 811 rural hospitals maintained skilled nursing units within their facilities to provide physician services and continuous professional nursing supervision to patients not requiring acute care (table 5). Many rural hospitals also operate swing-bed programs, which allow them to use beds for either acute or nonacute care, as needed.

Table 5. Growth in Alternative Care Settings Offered by Rural Hospitals

Service	1991	1994	1995	% Change 1991-95
Skilled Nursing Care	678	792	811	19.6%
Hospice Facility	285	462	498	74.7%
Home Health Service	828	1,063	1,138	37.4%

A service area that has seen especially rapid growth in recent years is hospice care. Between 1991 and 1995, the number of rural hospitals with hospice facilities increased by 74.7 percent, from 285 to 498.

Length of Stay

As hospitals increasingly treat less severely ill patients more appropriately on an outpatient basis, patients who are admitted to the hospital tend to be those requiring more intensive and costly care and longer stays. Stays of patients in skilled nursing and hospice units along with those receiving long-term care in swing beds or other extended care units, have contributed to this. Longer-term

trends in average length of stay at rural hospitals reflect these factors. In the first half of the 1980s, rural patients stayed an average of 6.8 to 7.2 days; with average stays as high as 7.8 days in 1991.

Shorter-term trends indicate that length of stay at rural hospitals has been declining in recent years. In 1995, the average rural hospital stay was 7.5 days. This recent trend towards shorter stays most likely can be attributed to growing payer demands that patients be discharged as quickly as medically possible, along with the increased availability of home health services. In 1995, 1,138 rural hospitals offered home health care services, up from 828 hospitals in 1991.

Outpatient Utilization

Rural hospitals deliver a tremendous--and growing--amount of care on an outpatient basis. While rural hospitals admitted more than 5 million patients and chalked up nearly 38 million inpatient days in 1995, they recorded almost 82 million outpatient visits that year (table 6). The 1995 outpatient figure, which includes emergency department visits along with nonemergency visits to hospital-based outpatient clinics and departments, represents a 40 percent increase since 1991. Outpatient surgery has been a major force behind growth in outpatient visits. In 1995, 63.6 percent of surgeries performed at rural hospitals were done on an outpatient basis, up from 56.6 percent in 1991.

Table 6: Outpatient Visits to Rural Hospitals, by Bed-size 1991 and 1994-1995

Outpatient Visits	1991	1994	1995	% Change 1991-95	% Change 1991-95
Emergency					
6 to 49 Beds	2,930,433	3,450,474	3,950,766	34.8%	14.5%
50 to 99 Beds	5,500,012	5,445,208	5,853,861	6.4%	7.5%
100+ Beds	9,768,824	10,473,765	10,551,352	8.0%	0.7%
Total Emergency	18,199,269	19,369,447	20,355,979	11.9%	5.1%
Other					
6 to 49 Beds	7,003,839	10,915,480	13,189,110	88.3%	20.8%
50 to 99 Beds	11,580,648	14,360,537	16,418,437	41.8%	14.3%
100+ Beds	21,560,642	28,555,336	31,757,164	47.3%	11.2%
Total Other	40,145,129	53,831,353	61,364,711	52.9%	14.0%
Total Outpatient					
6 to 49 Beds	9,934,272	14,365,954	17,139,876	72.5%	19.3%
50 to 99 Beds	17,080,660	19,805,745	22,272,298	30.4%	12.5%
100+ Beds	31,329,466	39,029,101	42,308,516	35.0%	8.4%
Total Rural	58,344,398	73,200,800	81,720,690	40.1%	11.6%

The dramatic increase in outpatient service volume has had a marked effect on the share of revenue that rural hospitals derive from outpatient care: between 1991 and 1995, outpatient revenue rose from 31.5 percent to 40.1 percent of total gross patient revenue.

Growth in outpatient volume has been especially rapid among the smallest bed-size group (6 to 49 beds). Small, rural hospitals typically focus on the primary and secondary care needs of the community, while tertiary care is directed to larger, more specialized providers. As inpatient admissions and days plateau, these smaller hospitals have made the successful transition from inpatient to outpatient care. Nonemergency outpatient visits rose 88.3 percent for rural hospitals with 6 to 49 beds between 1991 and 1995.

These smallest hospitals also appear to serve an important role in treating emergency cases and stabilizing patients in need of more advanced emergency services. Emergency visits to rural hospitals with 6 to 49 beds increased 34.8 percent between 1991 and 1995.

Table 7: Outpatient Revenue as a Percent of Total Gross Patient Revenue, by Bed-size 1991 and 1994-1995

Rural Hospital Bed Size	1991	1994	1995
6 to 49 Beds	38.0%	46.7%	49.9%
50 to 99 Beds	34.2%	41.0%	43.4%
100+ Beds	29.3%	34.4%	36.6%
Total Outpatient Revenue	31.5%	37.5%	40.1%

Revenue figures reflect the heavy dependence of these smallest rural hospitals on outpatient care: in 1995, outpatient revenue accounted for nearly half of gross patient revenues at rural hospitals in the 6 to 49 bed group (table 7).