



**PROTECT YOUR VALUE:  
HOW TO CREATE STRONGER  
PARTNERSHIPS FOR RURAL HOSPITALS**

June 17, 2026

# MEET THE SPEAKERS:



**Jeffrey Sommer, MPP**  
Managing Director

[jsommer@stroudwater.com](mailto:jsommer@stroudwater.com)  
(T) 207-221-8255

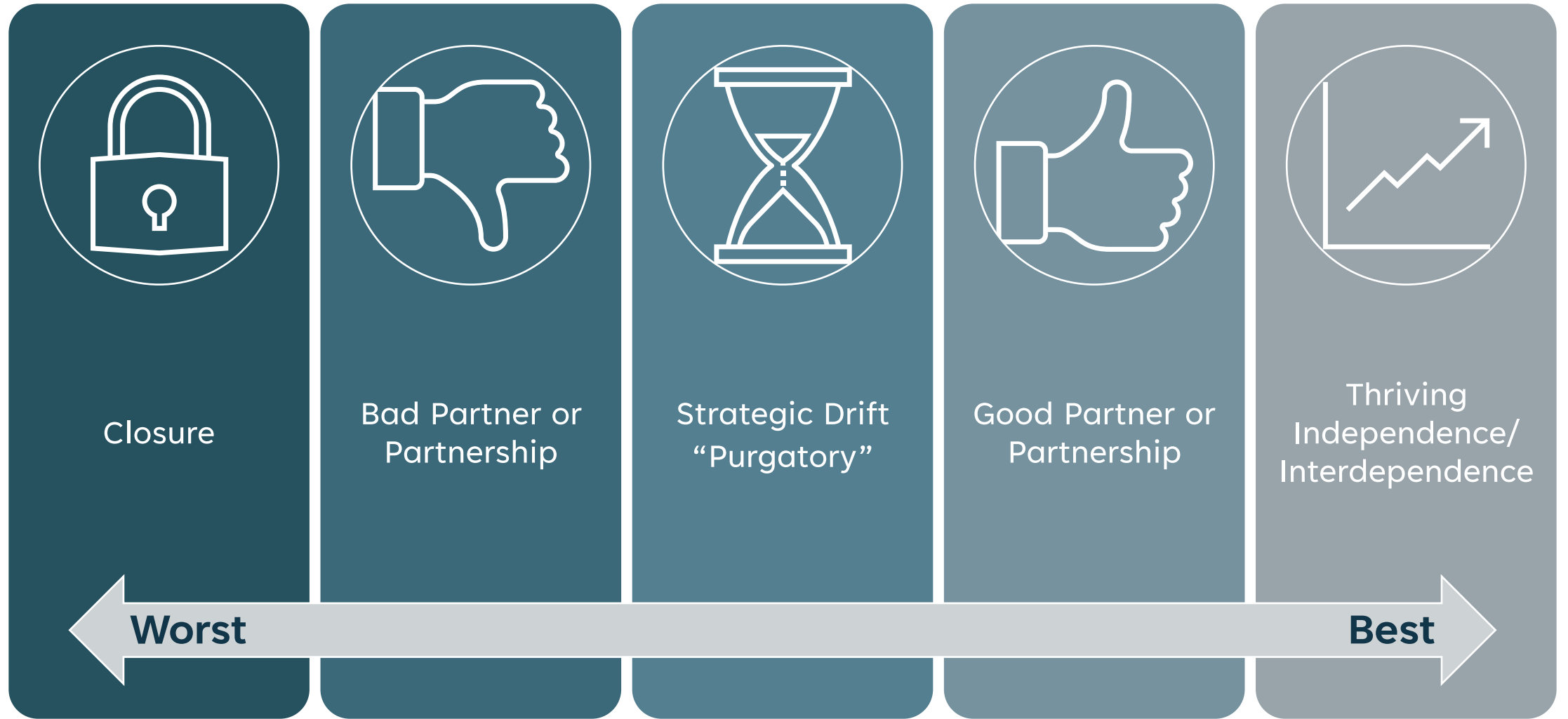


**Clare Kelley, MPH**  
Senior Consultant

[ckelley@stroudwater.com](mailto:ckelley@stroudwater.com)  
(T) 207-221-8267

Stroudwater is a leading national healthcare consulting firm specializing in mission-critical **strategic, operational, and financial opportunities** for **healthcare leaders' most pressing challenges.**

# COMMON OUTCOMES FOR RURAL HOSPITALS



+/-80% of hospitals are within these three options



# POLLING QUESTION

---

*If you're in a partnership, how would you rate the performance of the partnership?*

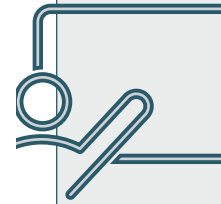
- High value
- Moderate value
- Mixed bag
- Limited value
- No value / destructive of value



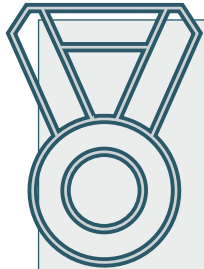
# WHAT DO RURAL LEADERS NEED TO KNOW?



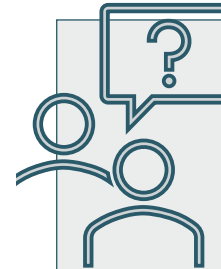
For the 60% of rural hospitals in a partnership, most systems miss critical aspects of rural value



No one is going to stumble across your value unless you quantify it and show the path to operationalizing it



Identify win-wins with existing partners—it's about making better decisions and better allocating scarce resources



Does a partner understand your value?

- Variable vs. fixed costs
- Contribution margin vs. fully allocated costs
- Incremental cost vs. reallocated costs
- The value of incremental referrals



The Four Know/Nos:

- **Know your risk profile**
- **Know your value**
- **No one else will promote your value**
- **No risk-free options**





# WHAT ARE WE GETTING WRONG?

# AFFILIATE ACCRETIVE VALUE

- Our client was a Northeastern seven-hospital system, including a 120-bed community hospital affiliate
- System allocates \$25M of overhead to the affiliate's general ledger, resulting in a **\$13M operating loss**
  - As a result, the system slashed capital investment at the affiliate
  - The operating loss included \$7M in non-cash depreciation expense and excluded \$3M in non-operating income
- Of the \$25M in system-allocated overhead costs, only 20% were estimated to be variable (or incremental) while the remaining were estimated to be fixed (reallocation of existing costs)
  - The fixed portion should not have been considered when evaluating the contribution margin of the affiliate
- Actual contribution margin to the system, before considering the value of incremental patient volume from the affiliate service area, was \$17M
- The affiliate provided \$22M in incremental contribution margin to the system from additional service area referrals
- **Total contribution margin to the system from the rural affiliate: \$39M**



# A FREQUENT ERROR IN RURAL PARTNERSHIPS

The accretive value of existing and prospective rural affiliates is almost always misunderstood.



**Adverse Outcome #1:** Key deal terms that would reinforce long-term value creation for the rural affiliate and system are absent



**Adverse Outcome #2:** Systems with rural affiliates miss value-added opportunities and fail to account for rural accretive contribution margin when evaluating performance and allocating resources



**Adverse Outcome #3:** Chronic underinvestment in rural affiliates



**Adverse Outcome #4:** System and rural affiliate long term performance is diluted and suboptimized



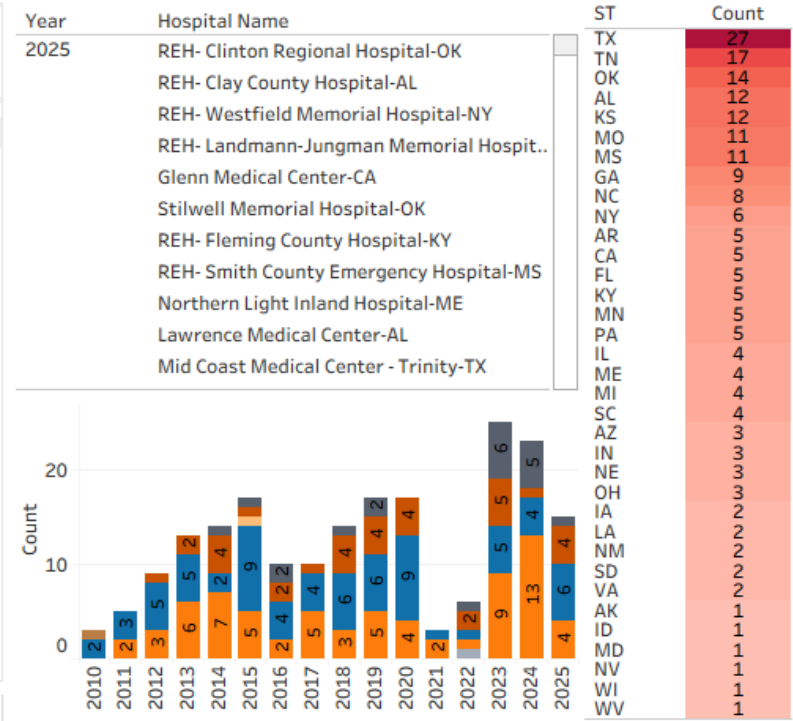
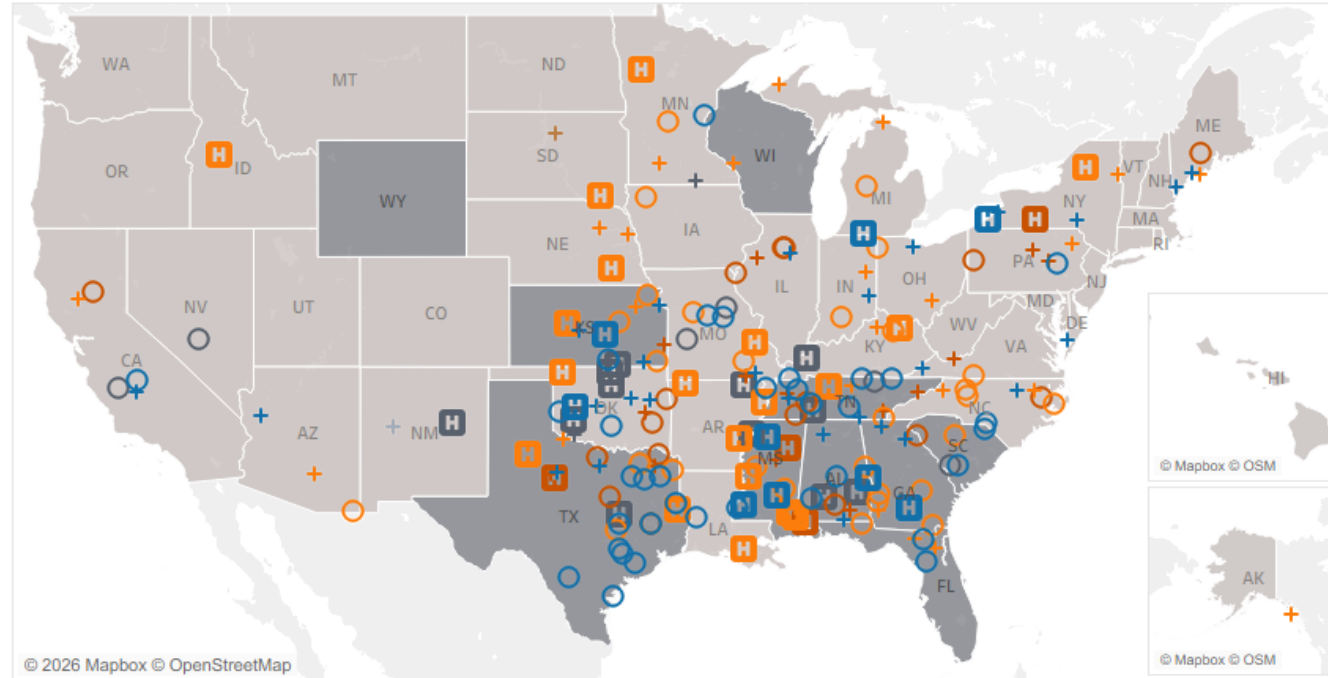


# HEALTH INDUSTRY FACTORS INCREASING STRATEGIC RISK

# RURAL HOSPITAL CLOSURES SINCE 2010

## 201 Closed or Converted Rural Hospitals

There have been 201 Rural Hospital closures or conversions since 2010 and 244 since 2005, these numbers include forty-four (44) REH Conversions since 2023



Year	Prospective Payment System	Critical Access Hospital	Medicare Dependent Hospital	Sole Community Hospital	IHS	Re-based Sole Community Hospital	Rural Referral Center	Total
2010	2	0	0	0	0	1	0	3
2011	2	0	0	0	0	0	0	2
2012	3	0	0	0	0	0	0	3
2013	5	2	0	0	0	0	0	7
2014	2	5	1	1	0	0	0	9
2015	4	2	1	1	0	0	1	9
2016	4	2	2	2	0	0	1	11
2017	4	5	1	1	0	0	0	11
2018	6	3	4	1	0	0	0	14
2019	6	5	4	2	0	0	0	17
2020	9	4	4	2	0	0	0	19
2021	1	2	0	0	0	0	0	3
2022	1	1	2	1	1	0	0	6
2023	5	9	5	6	0	0	0	25
2024	4	13	1	5	0	0	0	23
2025	6	4	4	1	0	0	0	15
Total	72	71	35	20	1	1	1	201

Count

**Medicare Payment Type**  
■ Prospective Payment System  
■ Critical Access Hospital  
■ Medicare Dependent Hospital  
■ Sole Community Hospital  
■ Re-based Sole Community Hospital  
■ Rural Referral Center  
■ IHS

**Current Status**  
H REH  
O Complete Closure  
+ Convert to Other

**Current Status of Medicaid Expansion Decision**  
 Adopted the Medicaid Expansion  
 Not Adopting the Medicaid Expansion at this Time

Updated: 3/25/2026

Sources: The North Carolina Rural Health Research Program (NC RHRP) at the Cecil G. Sheps Center for Health Services Research & kff.org

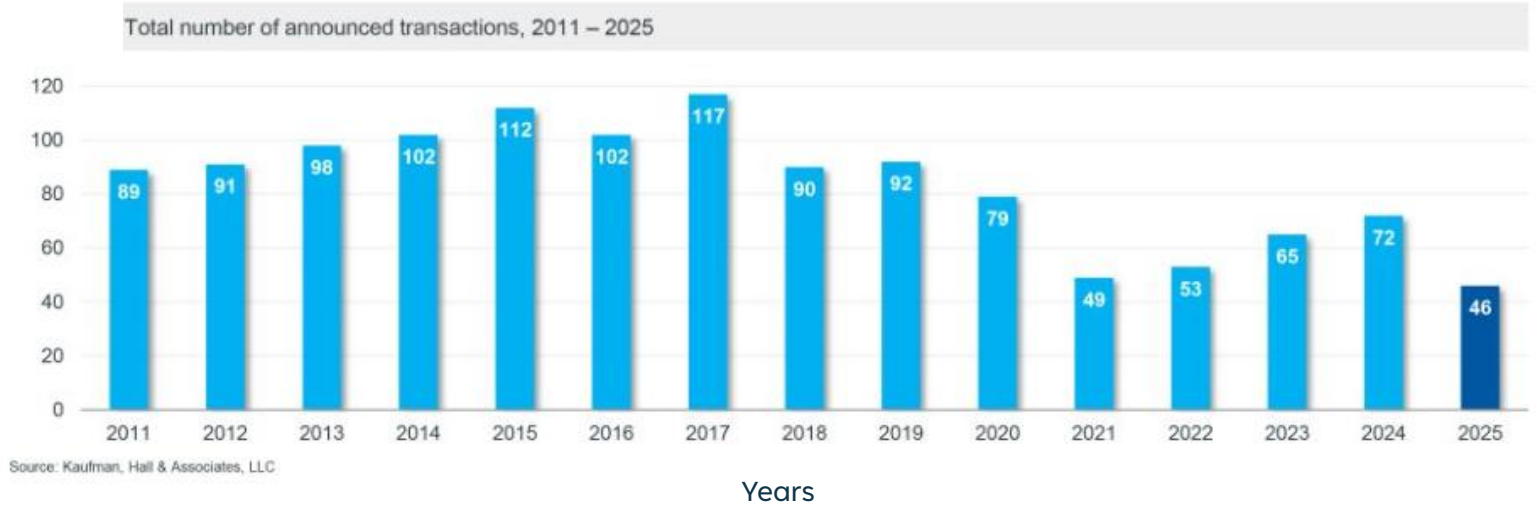


# RURAL AFFILIATION DRIVERS: INDUSTRY CONSOLIDATION

## Catalysts

- Margin pressure
- Heightened competition
- Staffing crisis
- Increasing bad debt from high-deductible health plans
- Medicare Advantage
- Declining inpatient admissions
- Changing payment models
- Quality initiatives
- Provider shortages
- Economies of skill

Number of Hospital Affiliations



Annual Revenue



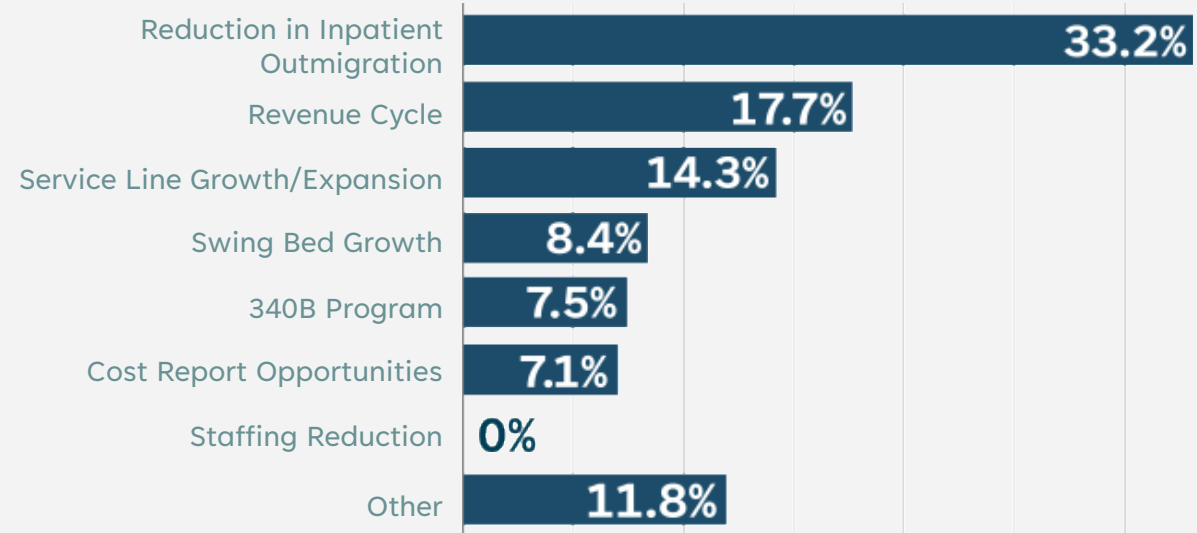
# RISK MITIGATION VIA IMPROVED PERFORMANCE

- Nearly 30 rural performance improvement projects led by Stroudwater over 30 months delivered a median of \$1.7M in financial improvement per organization, equating to nearly 8% of net patient revenue per organization
- These engagements spanned an array of functional areas, with the average share of total improvement realized broken out as follows:

Impact % of Net Pt Revenue	
25th	4.1%
Median	7.8%
75th	11.1%

Total Estimated Impact	
25th	\$ 1,300,000
Median	\$ 1,700,919
75th	\$ 3,727,000

The improvements were identified across several functional areas – expressed as a percentage of the total improvements identified:





# WHEN TO THINK ABOUT PARTNERSHIPS

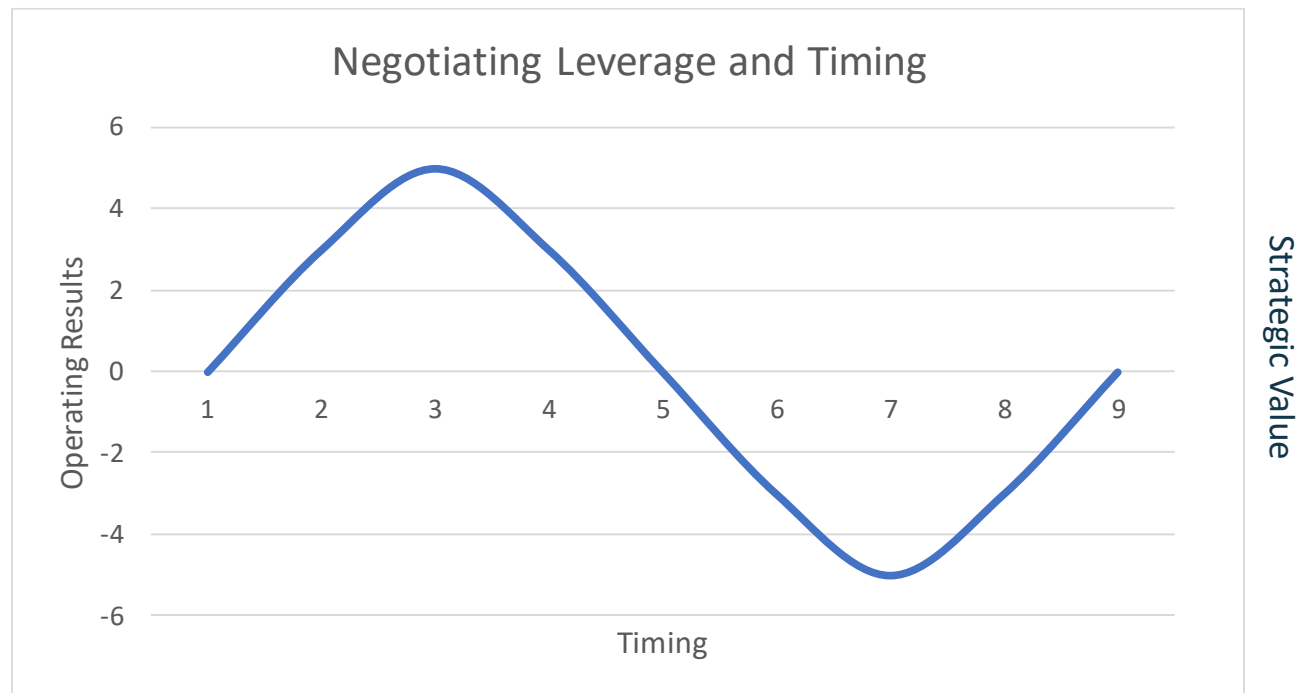
# TIME IS NEVER A NEUTRAL FACTOR

A struggling rural hospital must weigh the pros and cons of the following timing factors:

Time to demonstrate results from a performance improvement plan

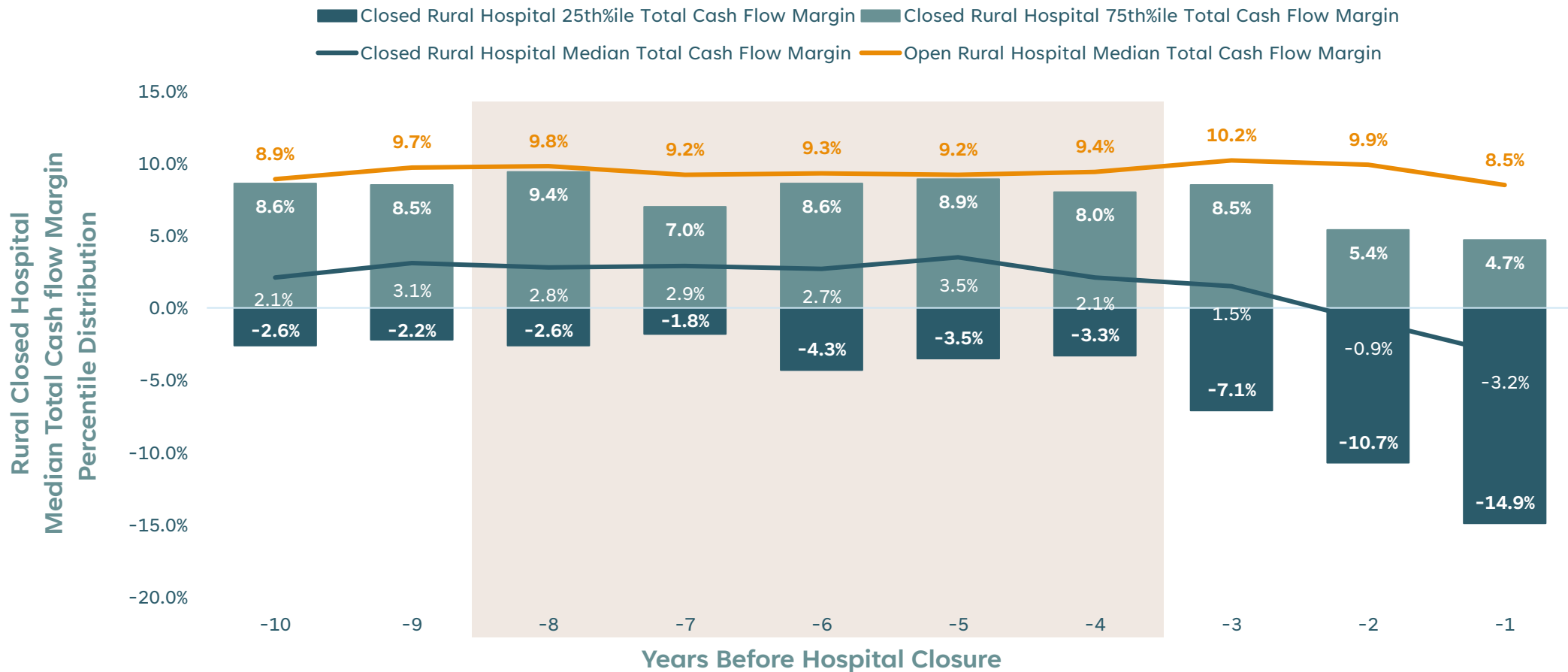
Time for major developments

Time for adverse market developments to have an effect (state and federal budgets, competitor response, etc.)

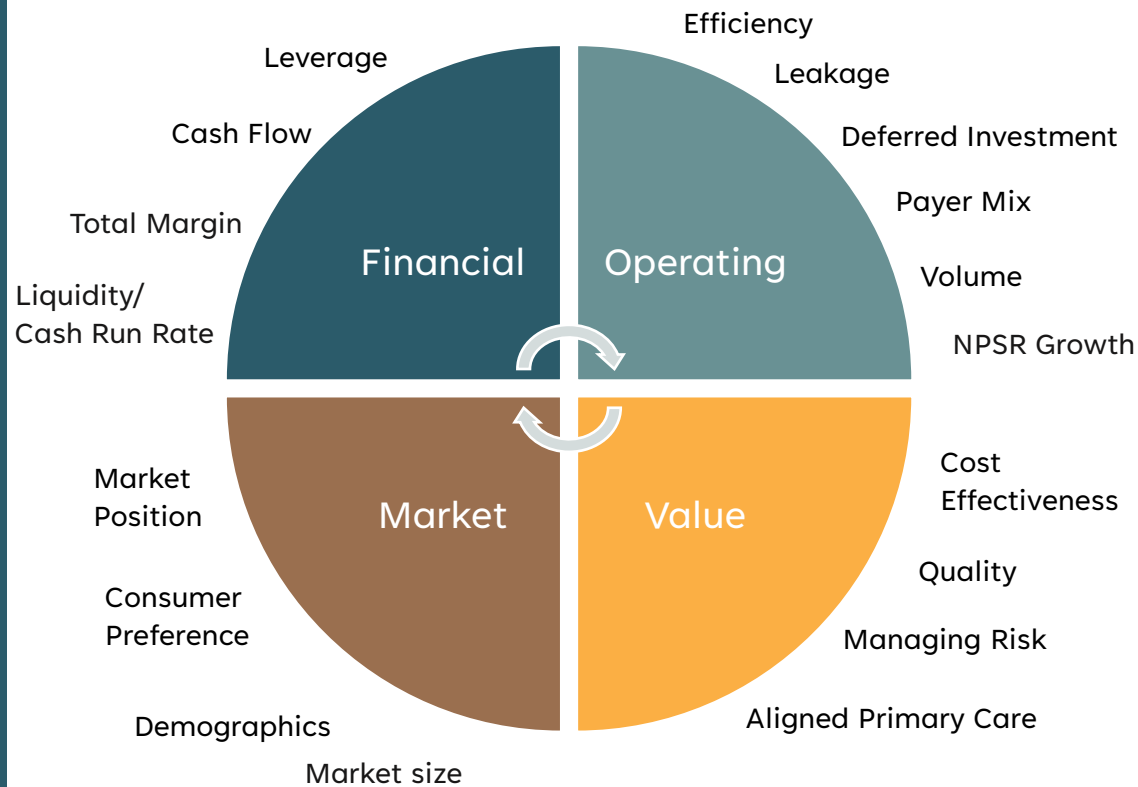


# RURAL HOSPITAL TOTAL CASH FLOW MARGIN - CRITICAL ACTION ZONE CLOSED VS. OPEN HOSPITALS

- The years between -8 and -4 years prior to rural hospital closure become a critical time for acting prior to negative trends accelerating
- Time lags in data availability require proactive management of multi-year trends, including cash flow
- Waiting to act on declining trends reduces latitude to maneuver and increases the magnitude of required turnaround



# FACTORS THAT AFFECT STRATEGIC RISK



- The four risk domains depicted to the left describe the major sources of strategic risk in today’s environment
- Poor performance in one domain will have collateral or “spillover” effects on one or more of the other domains
- Key trends within each risk category should be monitored annually, and long-term trends should be quantified. Over time, the cumulative impacts can be very significant.

**Boards may not appreciate the cumulative effects of changes in risk factors that can take place over several years.**



# POLLING QUESTION

---

*How confident are you that your Board truly “understands” your organization’s strategic risk profile?*

- Extremely confident
- Confident
- Not very confident
- Not at all confident
- Unknown

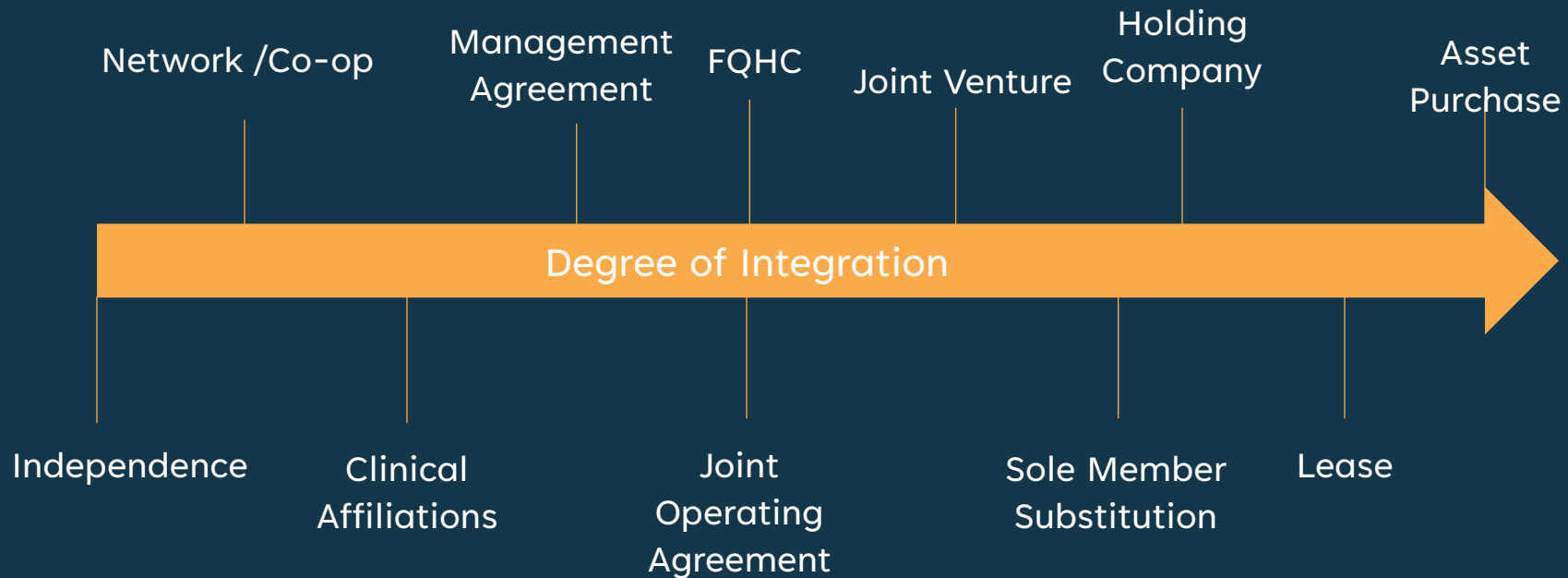




# HOW TO ENSURE YOUR PARTNERSHIP CREATES VALUE

# CONTINUUM OF PARTNERSHIP STRUCTURES

- There are a variety of partnership structures at different degrees of integration



# VALUE LEVERS FOR RURAL HEALTH SYSTEMS

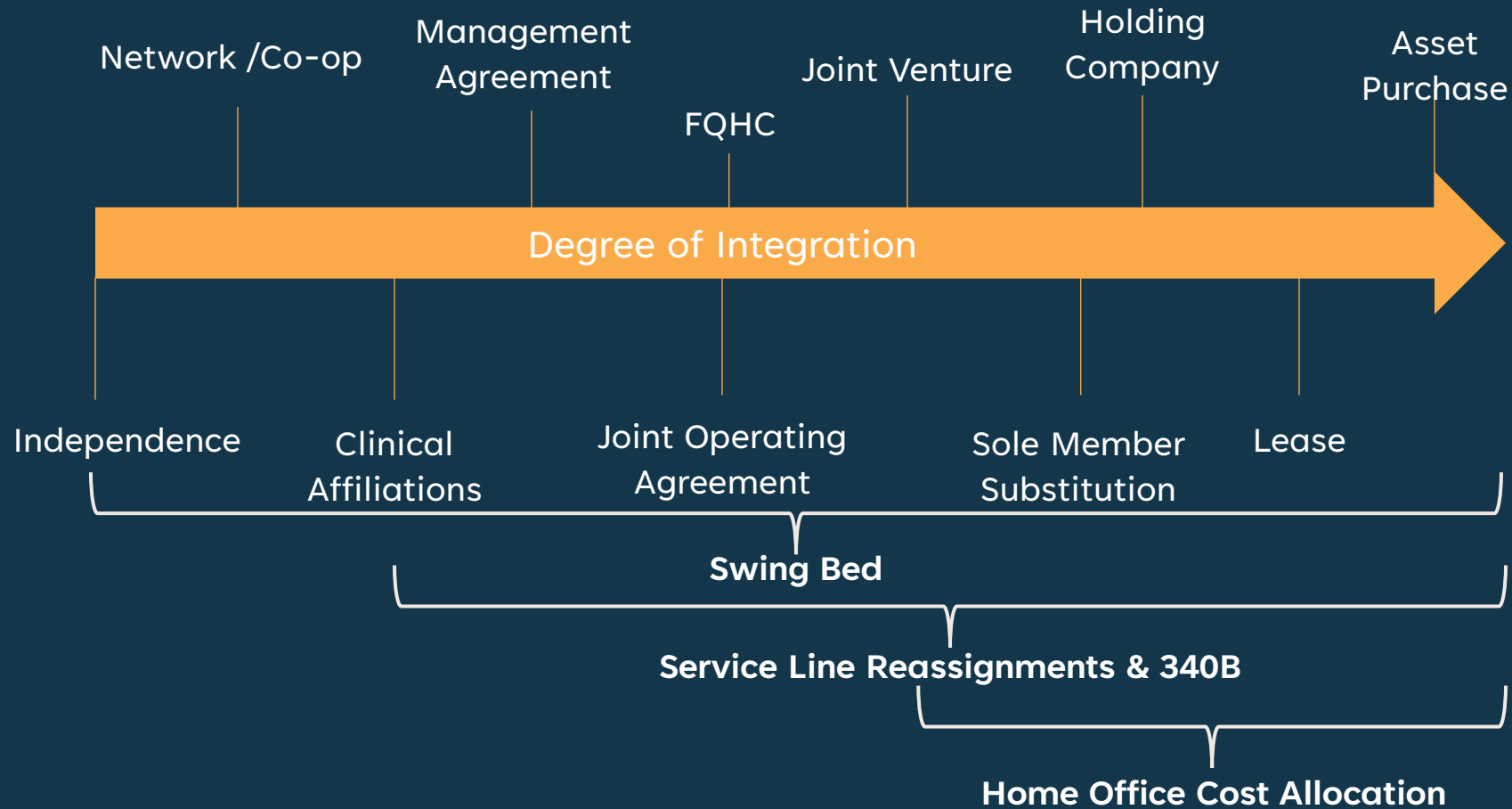


- The following value levers are often misunderstood or undervalued by existing and potential partners:
  - Cost-based payment
  - Cost report optimization opportunities
  - Home office cost allocation
  - 340B eligibility and post-Genesis ruling opportunities
  - Swing beds
  - Rural health clinics (RHCs)
  - Decanting volume and utilizing Critical Access Hospitals (CAHs) as specialized components of the continuum of care
  - The value of attributed lives and a primary care base that is cash flow positive
  - The “true” value of incremental referrals



# CONTINUUM OF PARTNERSHIP STRUCTURES

- There are a variety of partnership structures at different degrees of integration



# FQHC COLLABORATION OPPORTUNITIES

## Opportunities

- Often, higher clinic payments for FQHC Medicaid patients: important for rural L&D programs
  - However, grandfathered RHCs may have higher cost-based clinic visit payments
- FTCA provides significant liability protection for FQHC employees
- Section 330 grants for expanding FQHC capacity to serve underserved populations
- Partnership with local FQHC keeps governance local, albeit not necessarily aligned

## Constraints

- 51%+ of the Governing Board of the FQHC must be FQHC patients
- Private FP or 501c3 ownership of an FQHC is prohibited
- Ownership of FQHCs restricted to public agencies: County, City or Municipal Governments, Hospital Districts and Hospital Authorities
- HRSA audits and compliance complexity for FQHCs
- Legacy relationship baggage with the hospital



# EXAMPLES OF FQHC COLLABORATIVE APPROACHES



## Case Study #1

- Contractual agreement between hospital and FQHC
- Non-controlling cross-board representation
- FQHC operates primary care clinics
- Hospital operates specialty care clinics
- No shared ownership
- Hospital limits primary care subsidy
- FQHC focuses on core services/mission
- Long-standing, successful collaborative model
- Stable, consistent leadership at FQHC
- Limited leadership transitions at the hospital



## Case Study #2

- Adversarial prior relationship between hospital and FQHC; duplication of services
- Interim Shared Leadership opportunity
- Developed a shared management model
- However, remained two separate entities
  - Two separate boards
  - Shared CEO time: 51% FQHC/49% CAH
  - Cross representation by two members of each board
  - Shared IT, maintenance, marketing, and executive assistant
  - All PCPs in FQHC
  - Specialty in hospital



# PARTNERING IS NOT A RISK-FREE ENDEAVOR

## PROSPECTIVE PARTNERS

- Vet and select a strategically aligned partner
- Assess their track record
- Select an affiliation structure that fits your strategic objectives and constraints
- Craft contractually enforceable terms that reflect the rural value proposition

## EXISTING PARTNERS

- Ensure that your partner understands your value proposition
- Ensure your affiliation structure enhances the value provided by the partnership for both parties
- Identify and quantify any missed/potential opportunities
- Quantify the ROI of investments to reflect the unique rural value proposition



# PROCESS FOR ENHANCING EXISTING PARTNERSHIPS

- Unleashing previously untapped value should benefit both the rural affiliate and the parent
- Quantify opportunities with a pragmatic and realistic mindset—do not overpromise and under-deliver
- Get some early wins on the board to build confidence and buy-in
- Prioritize opportunities based on:
  - Low cost to implement
  - Quick ROI/time for payback
  - Ability to execute
  - Value to partner, affiliate, and system
  - Strategic fit of the opportunity
- Focus on educating colleagues about recurring benefits and including benefits in future capital allocation decisions



# A COSTLY STRATEGIC ERROR AVOIDED



**A health system with four Critical Access Hospitals totaling \$55M in operating revenue believed these rural affiliates were a significant drag on operating results**

The system engaged Stroudwater to perform an in-depth financial and operational analysis of its rural affiliates



**The operational and financial evaluation found a total of \$6M in annual missed operating cash flow improvement opportunities**



**The review also found an additional \$9M in errors in the System's evaluation of the contribution margin of these rural affiliates**



**Combined, the \$15M in missed opportunities and performance evaluation mistakes painted a misleading picture of the rural affiliate's contribution margin to the system and revealed previously hidden opportunities**



**The evaluation provided the system with an actionable roadmap to realize the true accretive value of its rural affiliates**



# PROCESS RECOMMENDATIONS FOR NEW PARTNERSHIPS

Have prospective partners compete for the privilege of being your partner

- Use the process to gather information about your options
- Use the process to educate prospective partners as to your value
- Assess whether a partner is willing to adjust terms and commitments to reflect the quantification of your value
- Leverage the analyses of your value, the competitive process, and the asymmetry of information to negotiate improved terms
- Evaluate prospective partners' track records with their rural affiliates
- Do not sign an exclusive Letter of Intent (LOI) until you have an acceptable term sheet in hand



# ADDITIONAL CASE STUDIES IN APPENDIX

- There are additional case studies appended that describe various risks and potential mistakes related to partnering
  - [Cost of Delay](#)
  - [Non-Competitive Process](#)
  - [Wrong Preferred Partner](#)
  - [Did Not Understand Rural Value](#)
  - [Wrong Partner/Structure](#)
  - [Quantifying Your Value](#)
- We would be pleased to discuss any of these case studies and how they might be relevant to your circumstances



# POLLING QUESTION

---

***How important is it for your organization to explore a new partnership or improve an existing partnership within the next 2 years?***

- Very important
- Important
- We are thinking about it
- Unimportant
- Very unimportant

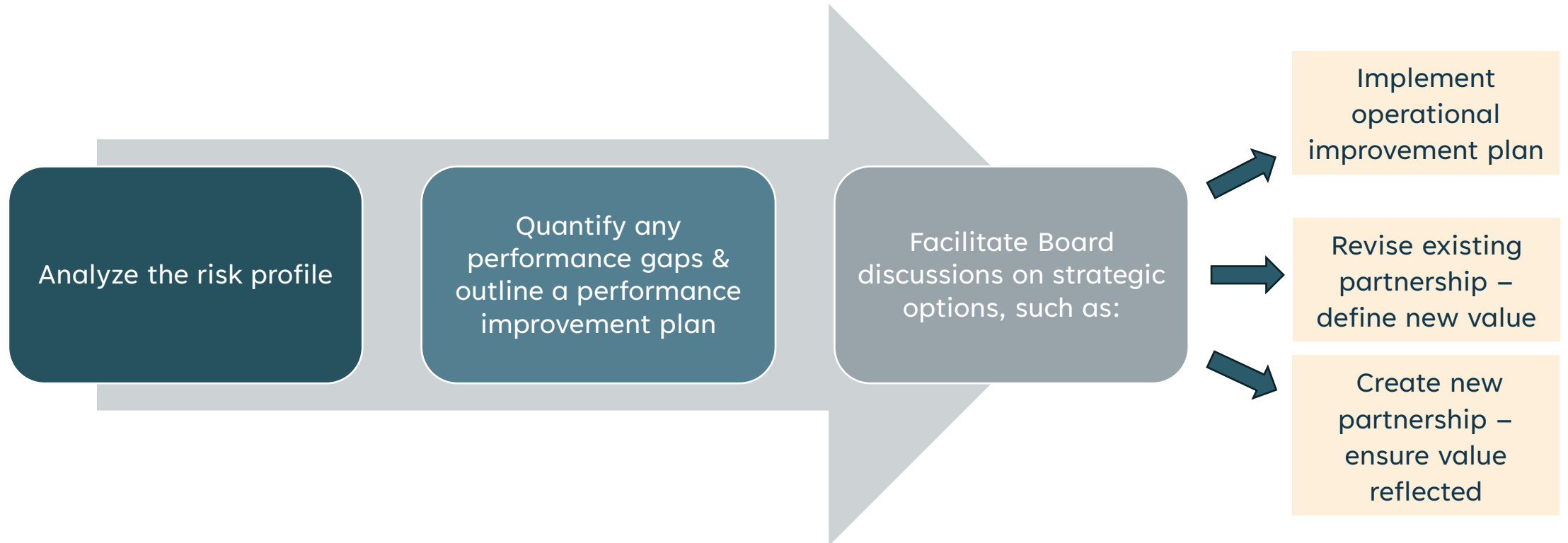




# RURAL PARTNERSHIP KEY TAKEAWAYS

# KEY POINT: SOUND OPERATIONS UNDERPIN ALL OPTIONS

When we discuss strategic options with a rural client, we focus on mitigating strategic risks. Sound operating results are foundational to those efforts, regardless of the strategic option selected. From there, we can evaluate strategic options to find the right strategy based on the organization's risk profile.



# NAVIGATING FORBEARANCE AGREEMENTS

- Should be treated as a “critical warning” requiring urgent course correction
- Signal for both turnaround *and* partnership options
- Three examples:

## Cooperative with creditor:

- focus on turnaround

## Adversarial with lender:

- performance improvement and partnership; positive outcome for community

## Bondholders take control:

- 2<sup>nd</sup> forbearance agreement
- Bondholders out of patience – performance improvement insufficient
- Non-binding promises to bondholders short-circuit partnership process – wait and see



# A RECENT PARTNERSHIP CLIENT CASE STUDY



In 2025, Stroudwater was retained by a 133-licensed-bed, PPS, county-owned hospital



With \$120M in annual NPSR, the organization had experienced \$28M in operating cash flow losses over the last three years



While the facility had received recent upgrades, the hospital was deferring needed capital investment in chillers/boilers, elevators and an EHR



Without intervention the organization was projected to deplete cash and reserves within 18 months



The hospital had entered into a forbearance agreement with a lender



Both the hospital board and county commissioners determined it was necessary to explore a partnership process as well as operational performance improvement



# RECENT PARTNERSHIP CLIENT, CONT.

## Performance Improvement Outcome:

- \$8M in enhanced annual cash flow
- Cash flow break-even and three consecutive months in the black for the first time in years

## Partnership Process Outcome:

- \$130M+ in investment over 10 years by a high-quality NFP partner
  - Defeasance of \$12M in debt at closing
  - \$2M toward transaction costs
  - \$25M+ community foundation
  - A minimum of \$90M in cap ex over 10-years
  - Maintain core services for 10 years



# THE KEY LESSONS LEARNED



**OPERATIONAL  
PERFORMANCE IS  
FOUNDATIONAL  
TO ANY  
STRATEGIC  
OPTION**



**TIME IS NEVER  
A NEUTRAL  
FACTOR; DON'T  
KICK THE CAN  
DOWN THE  
ROAD**



**KNOW YOUR  
VALUE, DO THE  
HOMEWORK**



**THERE ARE NO  
RISK-FREE  
STRATEGIC  
OPTIONS**



**PROCESS,  
PARTNER,  
STRUCTURE,  
TERMS**





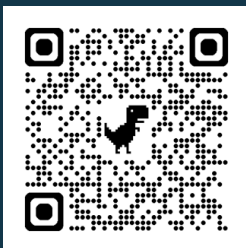
# STROUDWATER

**COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.**

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.



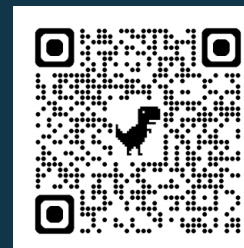
**Jeffrey Sommer,**  
**Managing Director**  
[jsommer@stroudwater.com](mailto:jsommer@stroudwater.com)  
(T) 207-221-8255



Let's Connect!  
Scan my QR Code



**Clare Kelley,**  
**Senior Consultant**  
[ckelley@stroudwater.com](mailto:ckelley@stroudwater.com)  
(T) 207-221-8267



Let's Connect!  
Scan my QR Code



# APPENDIX

## Additional Case Studies

# RATING AGENCY OUTLOOK

	Fitch	S&P
Sector Outlook	Neutral	Stable-leaning
Overall characterization	Continued but uneven recovery; risk of deterioration if macro pressures worsen	Mixed across the sector; significant variation by market, scale, and financial position
Margin Outlook	Median operating margins forecast at 1–2% through 2026; improving due to reduced contract labor, lower turnover, and better staffing	Not specified at sector level; varies by individual organization
Balance Sheet / financial strength	Strong balance sheets providing resilience against macroeconomic and reimbursement headwinds	Large systems (e.g., AdventHealth, Advocate Aurora, Atrium Health) carry stable outlooks, suggesting solid financial positioning
Key Risks	<ul style="list-style-type: none"> <li>• H.R. 1 / OBBBA Medicaid cuts expected to weigh on margins post-2026</li> <li>• Persistent labor and reimbursement pressures</li> <li>• Macro headwinds</li> </ul>	<ul style="list-style-type: none"> <li>• Meaningful subset of organizations carry negative outlooks, especially in challenged markets</li> <li>• Uneven recovery across systems</li> </ul>
Credit Differentiation	Credit "trifurcation": top systems reinvest and expand; weaker providers face increasing strain	Mix of stable, negative, and some positive outlooks across rated systems; selective credit strength noted
Capital Spending	Capex rising, especially for outpatient access points, technology, and patient towers	Not specified
Policy Considerations	Systems accelerating cost control and revenue strategies ahead of expected Medicaid cuts	Policy-driven risks noted as a contributing factor to negative outlooks in select markets

Note: Moody's winter 2026 NFP healthcare outlook was not available in sourced materials.



# CASE STUDY: COST OF DELAY

- The hospital was a strong rural PPS health system facing major capital investment needs
- Previously, the rural system had affiliated its multi-specialty group with a regional health system with a strong track record of operating multi-specialty groups
- The rural system Board elected to defer a proposed affiliation that met substantially all their requirements and included a \$25M capital infusion toward investment needs
- 12 months later, the regional system had entered into other commitments and had to pull back its capital commitment
- Six months later, the rural system elected to affiliate on the same terms negotiated previously, minus the \$25M investment commitment
- **Time is never a neutral factor**



# CASE STUDY: NON-COMPETITIVE PROCESS



A CAH retained Stroudwater to assist with a partnership process where the preferred partner had already been identified



The client had not run a competitive process. The preferred partner at the time was the third organization they had approached sequentially.



Due to the client's one-at-a-time approach, our client's leverage with negotiations was affected



Result: Without a competitive process, our client lost leverage, did not receive strong proposals, and missed out on capital and service continuation commitments



# CASE STUDY: THE WRONG PREFERRED PARTNER

- A distressed Critical Access Hospital (CAH) had a preferred affiliation candidate identified and a signed letter of intent when they approached Stroudwater for assistance because the affiliation process was stalled
- Their preferred partner—a large regional referral center—did not understand the value proposition of having a CAH as part of their health system
- Stroudwater recommended that the client conduct a process to evaluate a broader selection of affiliation options alongside their preferred partner
- Stroudwater educated all interested parties about the unique value proposition of having a CAH affiliate (home office cost allocation, rural health clinics, 340B eligibility, swing beds, cost-based payment, etc.)
- Despite these education efforts, their prior exclusive prospective partner could not incorporate these value drivers into their proposal
- Thankfully, an alternative preferred partner emerged with previous experience with distressed rural hospitals, a track record of successful turnarounds, and expertise in operating rural affiliates
- Our client vetted its options and selected the newly identified partner based on its expertise, track record, and the quality of the terms of its proposal



# CASE STUDY: DID NOT UNDERSTAND RURAL VALUE



- Our CAH client entered discussions with a large multi-state health system regarding a potential affiliation
- The large health system misunderstood the value of the home office cost allocation, placing only \$100K incremental value on this allocation vs. an estimated \$3M+ annual value calculated by Stroudwater
  - A greater than 50% share of cost-based payment
- The benefit of a modest change in referrals (+2.5% market share gain)
- Result: The prospective partner revised their offer from minimal capital commitment and virtually no local role in governance to an offer that included major investment commitments, major service commitments, and a significant continuing affiliate role in governance



# CASE STUDY: THE WRONG PARTNER/STRUCTURE

- Two financially stressed rural health systems combined into a single health system using a joint operating agreement (JOA)
- The JOA agreement called for the members to share profits and losses, while member boards and assets remained separate
- The practical effect was that the member who lost more was owed a check by the member who lost less
- Resentment, distrust, and hostility became the common language at the combined system and on each member board
- Stroudwater was called in to "fix" this situation
  - **Goal 1: Avoiding bankruptcy of one member and forestalling litigation among the parties**
  - **Goal 2: Find a partner(s) that could recapitalize each member and enter into separate affiliation agreements with each member, given the complete breakdown in trust**
- 18 months later, these goals were realized. Both communities maintained their health systems despite this multi-year misadventure.



# CASE STUDY: QUANTIFYING YOUR VALUE

CAH was projected to have a negative cash balance within two years and needed to partner

Using the value levers, Stroudwater determined our client would be able to fund investments and increase operating performance by about \$670K annually through a partnership – net of debt service on \$3.6M of needed investments

By quantifying the value levers, our client received robust proposals with strong commitments for the community

As of April 2024, our client signed an LOI with a preferred partner and closed on the definitive agreement on June 1, 2024



# CASE STUDY: QUANTIFYING YOUR VALUE, CONT.

Performance Improvement Initiatives	Client
Swing Bed Estimate	\$ 120,000
340b Opportunity	\$ 250,000
Cost Report Opportunity	\$ 170,610
Home Office Cost Allocation Low Estimate	\$ 470,000
Home Office Cost Allocation High Estimate	\$ 780,000
<b>Total Savings Low Estimate</b>	<b>\$ 1,010,610</b>
<b>Total Savings High Estimate</b>	<b>\$ 1,320,610</b>

- The table to the left demonstrates the savings incurred by different value levers for our client
- The table below demonstrates the effect of the performance improvement initiatives on operating performance, inclusive of required investments

Required Investment Over 5 Years	
Required Investment	3,587,639
Percentage Debt Financing	100%
Cost Based Reimbursement	40%

Projection Estimate									
	Year 1	Year 5	Year 10	Year 15	Year 20	Year 25	Year 30	Year 35	
Principal Balance Outstanding	\$ 3,587,639	\$ 3,114,290	\$ 2,491,503	\$ 1,684,434	\$ 777,344	\$ 350,054	\$ (0)		
Annual Depreciation Expense	\$ (160,148)	\$ (160,148)	\$ (160,148)	\$ (158,498)	\$ (140,165)	\$ (59,315)	\$ (39,254)	\$ -	
Annual Interest Expense	\$ (195,209)	\$ (174,450)	\$ (141,196)	\$ (98,039)	\$ (48,818)	\$ (22,109)	\$ (2,340)	\$ -	
Total Annual Depreciation Plus Interest	\$ (355,357)	\$ (334,598)	\$ (301,344)	\$ (256,537)	\$ (188,983)	\$ (81,424)	\$ (41,594)	\$ -	
Incremental Cost-Based Payments	\$ 141,041	\$ 132,802	\$ 119,603	\$ 101,820	\$ 75,007	\$ 32,317	\$ 16,509	\$ -	
Net Interest and Depreciation Cost	\$ (214,316)	\$ (201,796)	\$ (181,741)	\$ (154,718)	\$ (113,975)	\$ (49,107)	\$ (25,086)	\$ -	
Annual Principal Payment	\$ (84,575)	\$ (105,334)	\$ (138,588)	\$ (179,596)	\$ (201,854)	\$ (95,084)	\$ (77,897)	\$ -	
Total Annual Cost (after Cost Based Payment)	\$ (298,891)	\$ (307,130)	\$ (320,329)	\$ (334,314)	\$ (315,829)	\$ (144,191)	\$ (102,983)	\$ -	
<b>Projection Low Estimate</b>									
Total Annual Operating Improvements	\$ 1,010,610	\$ 1,010,610	\$ 1,010,610	\$ 1,010,610	\$ 1,010,610	\$ 1,010,610	\$ 1,010,610	\$ 1,010,610	\$ 1,010,610
Net Change In Operating Performance - Low Estimate	\$ 711,719	\$ 703,480	\$ 690,281	\$ 676,296	\$ 694,781	\$ 866,419	\$ 907,627	\$ 1,010,610	
<b>Projection High Estimate</b>									
Total Savings High Estimate	\$ 1,320,610	\$ 1,320,610	\$ 1,320,610	\$ 1,320,610	\$ 1,320,610	\$ 1,320,610	\$ 1,320,610	\$ 1,320,610	\$ 1,320,610
Net Change In Operating Performance - High Estimate	\$ 1,021,719	\$ 1,013,480	\$ 1,000,281	\$ 986,296	\$ 1,004,781	\$ 1,176,419	\$ 1,217,627	\$ 1,320,610	

