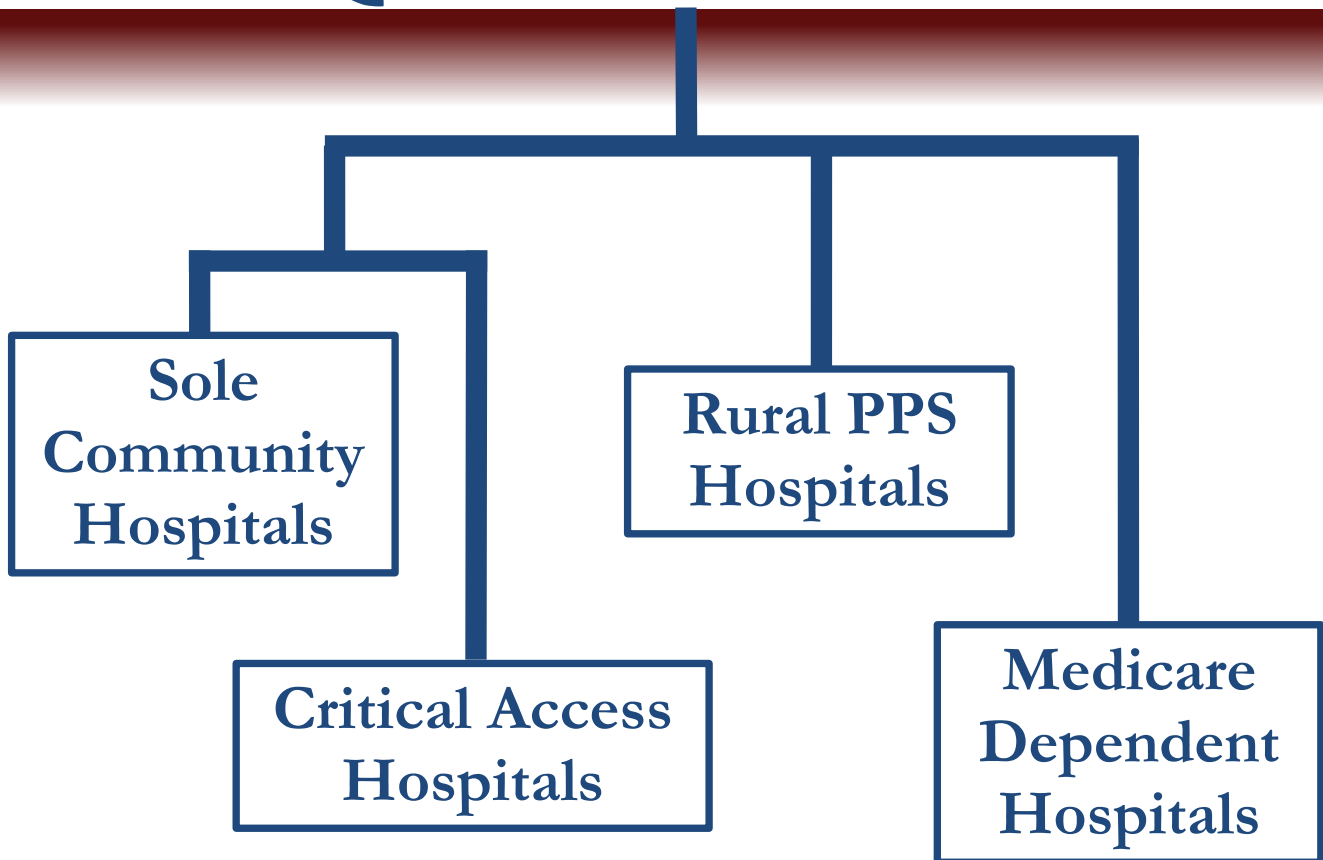


MEDICARE SEQUESTRATION



IMPACT ON RURAL AMERICA

[Alabama Statistics Included]

Overview

Table of Contents

Definition of Hospital Types	page 3
Macro Trends and Impact Analysis	pages 4-7
State Specific Impact Estimates	pages 8-9
Glossary	page 10

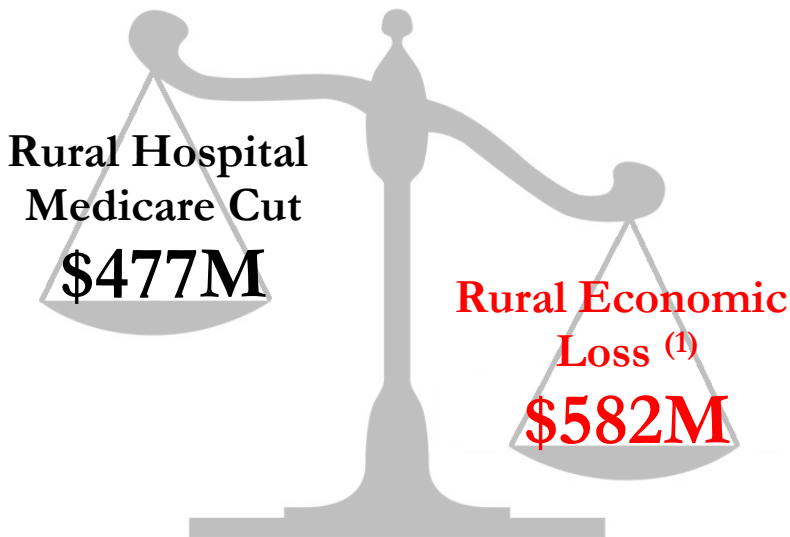
Background

On August 2, 2011, President Obama signed the Budget Control Act of 2011 into law ("BCA"). This law tasked a newly appointed Joint Select Committee on Deficit Reduction ("Super Committee") to devise a budget to decrease projected federal deficit by at least \$1.5 trillion over the period of fiscal years 2012 to 2021. With the failure of Super Committee members to compromise on a solution by December 23, 2011, BCA automatically set forth across-the-board reductions in federal spending; also known as "Sequestration". On January 2, 2013 the President is stipulated to order the Sequestration with up to a 2% reduction in Medicare spending.

Purpose

This Report includes an analysis estimating the potential impact of the Sequestration as it relates to decreases in Medicare Payments to Rural Hospitals. Only hospitals considered general short-term facilities are included in this study. Estimates are based on 2009 cost reports sourced from the Centers of Medicare and Medicaid Services. All figures are based in terms of 2009 dollars. All Economic Loss and Job Loss findings on Rural Hospitals are based on the assumption that every Medicare Sequestration dollar results in an exclusive reduction in hospital employment.

Contents herein are meant to provide a basis for collaboration among all stakeholders working to stop Medicare Sequestration as it would apply to Rural Hospitals. The detrimental affects on rural economies far outweigh the nominal deficit reduction.



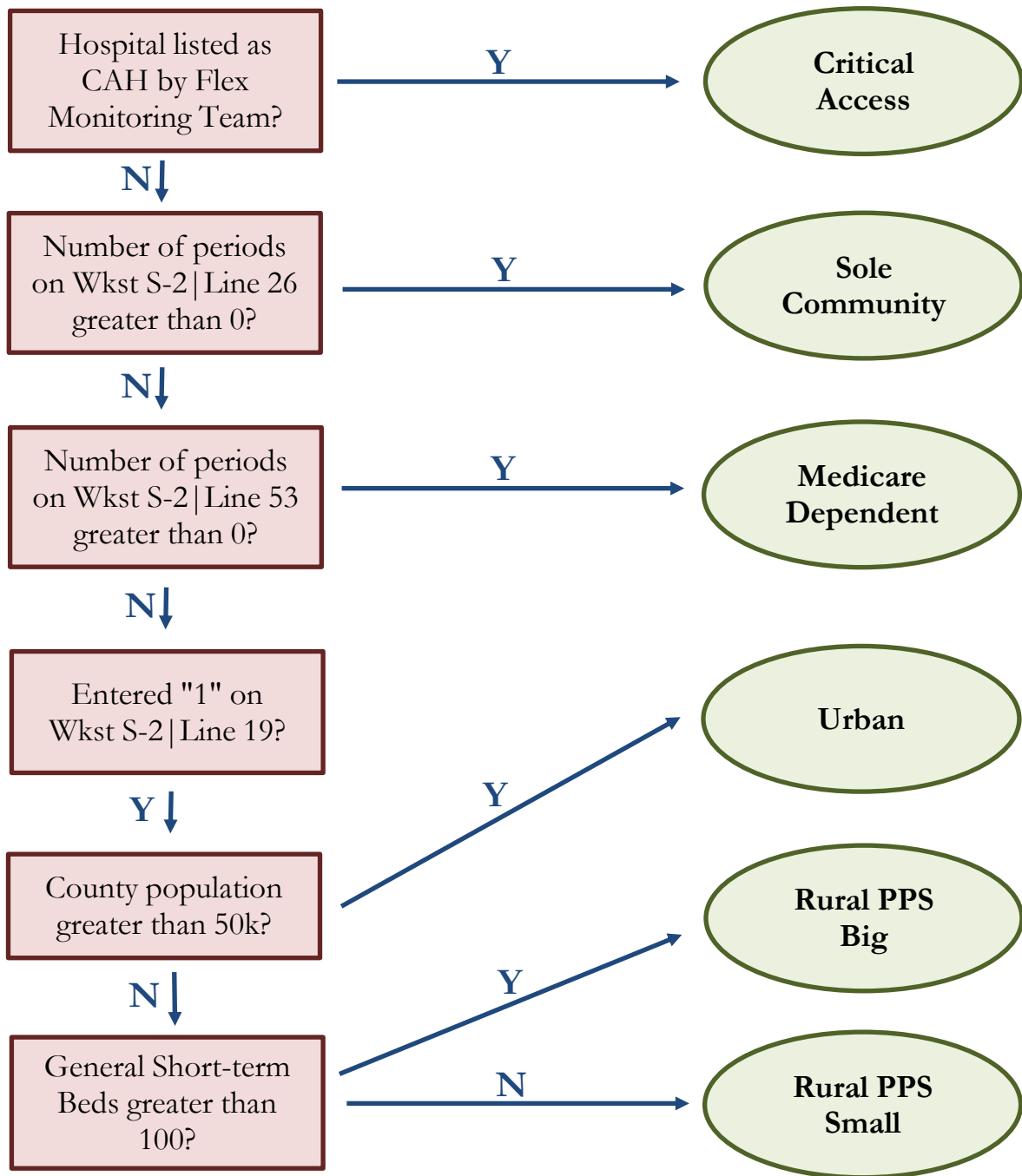
Reducing Medicare Payments forces hospitals to layoff staff. This loss ripples through the small communities resulting in further unemployment.

**Estimated Rural Job Loss⁽¹⁾
over 12,000**

Note 1: Assumes every Sequestration Dollar results in an exclusive reduction in employment.

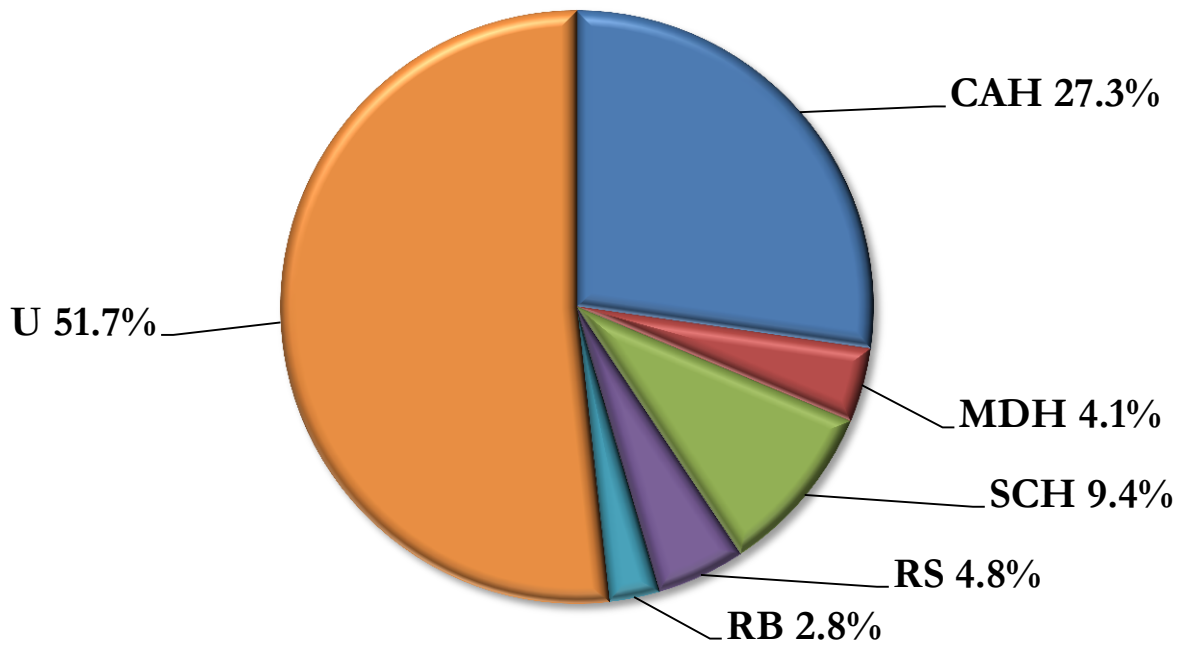
Hospital Types

The following diagram details the assignment of Hospital Type for each year. Red squares detail the data used to determine whether a hospital qualified as a certain type. Green ovals show the various Hospital Types.



*See glossary on last page for definition of each hospital type

Hospital Distribution by Number of Facilities



Rural hospital facilities comprise over 48% of all the short-term hospitals in the United States. While CAHs represent over 27% of all short-term hospitals, Medicare Payments to CAHs are less than 3% of the entire Medicare Budget.

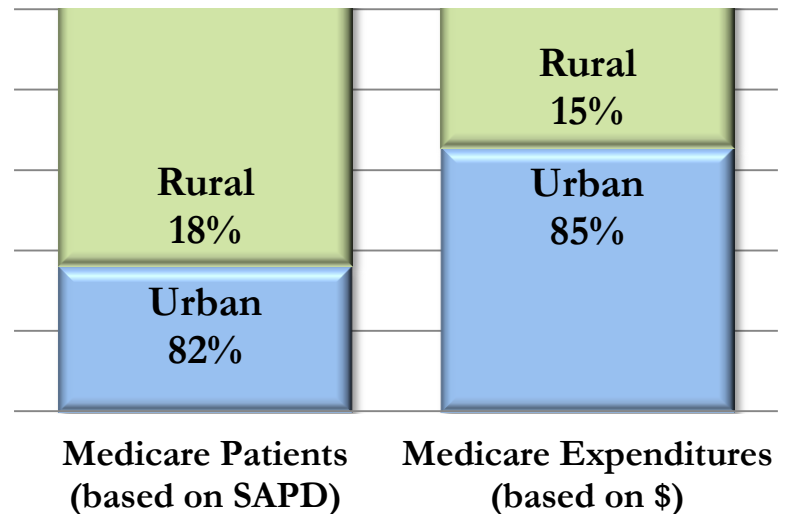
*See glossary on last page for definition of acronyms and other terms

Hospital Distribution of Medicare Services and Payments

Hospital Type	Patients*
Critical Access Hospitals	5.4%
Medicare Dependent Hospitals	1.8%
Sole Community Hospitals	6.5%
Rural PPS <100 Beds	1.5%
Rural PPS 100+ Beds	3.2%
Urban	81.6%

*Patient volume based on Stabilized Adjusted Patient Days in regards to Medicare Patients (see Glossary for more detail).

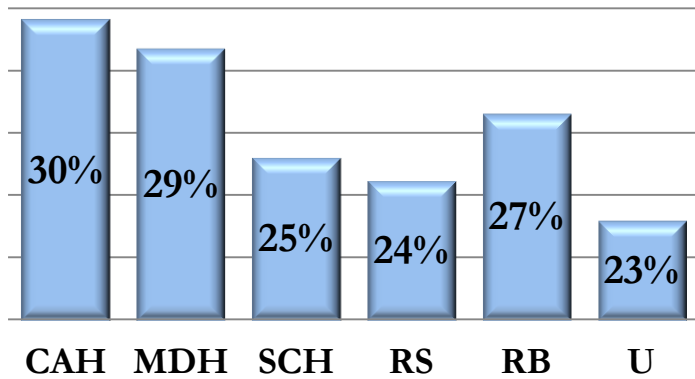
Short-term Hospital Medicare Market Share



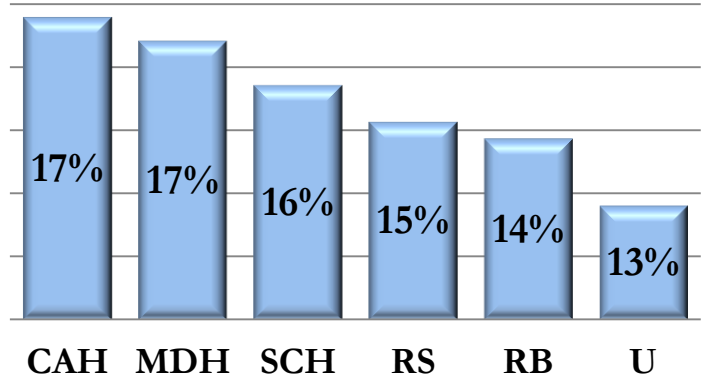
While Rural Hospitals service over 18% of Medicare beneficiaries' inpatient, outpatient and long-term needs; Rural Hospitals receive only 15% of Medicare Payments to short-term hospitals.

Hospital Revenue from Medicare Payments

Medicare Payments as % of Net Patient Revenue
[Median by Hospital Type]



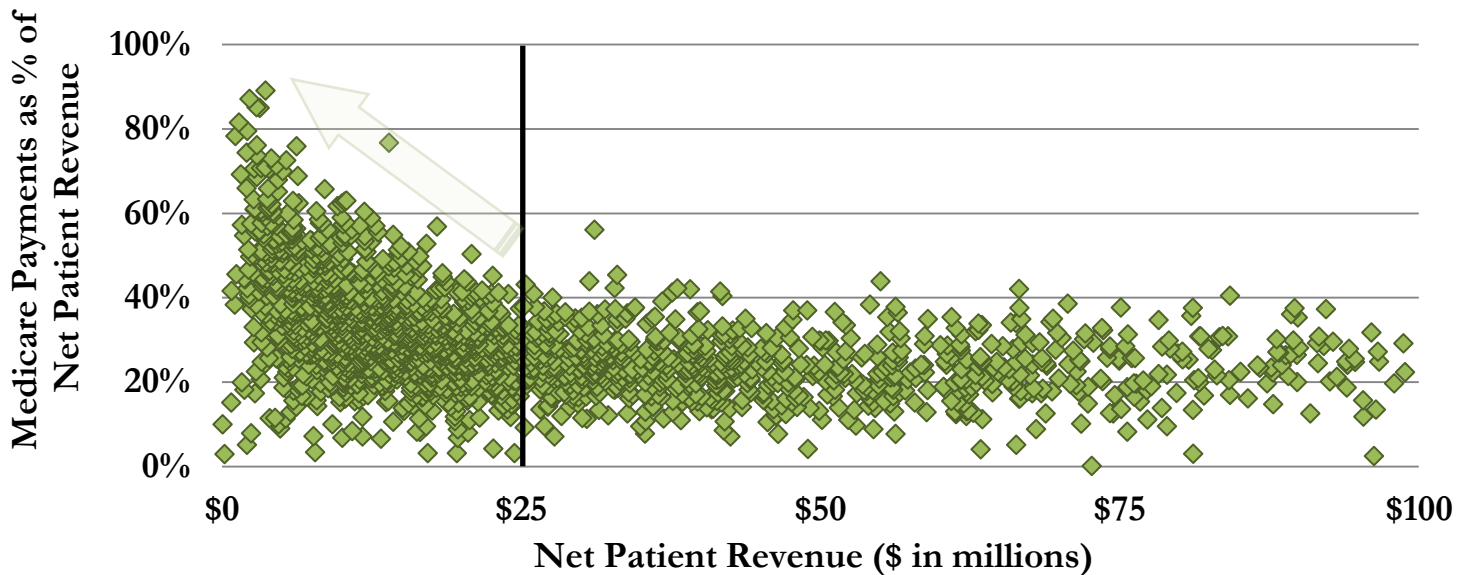
65+ Population as % of Total Population



The metric in the left graph above could be described as "Medicare Revenue Dependency". The higher the dependency, the more Medicare Patients serviced. Nearly one-third of CAH and MDH Net Patient Revenue comes from payments made by the government for Medicare services. The graph on the right shows a larger Medicare population within the Rural Hospitals' service areas; a primary reason for the higher Medicare Revenue Dependency at the Rural Hospitals.

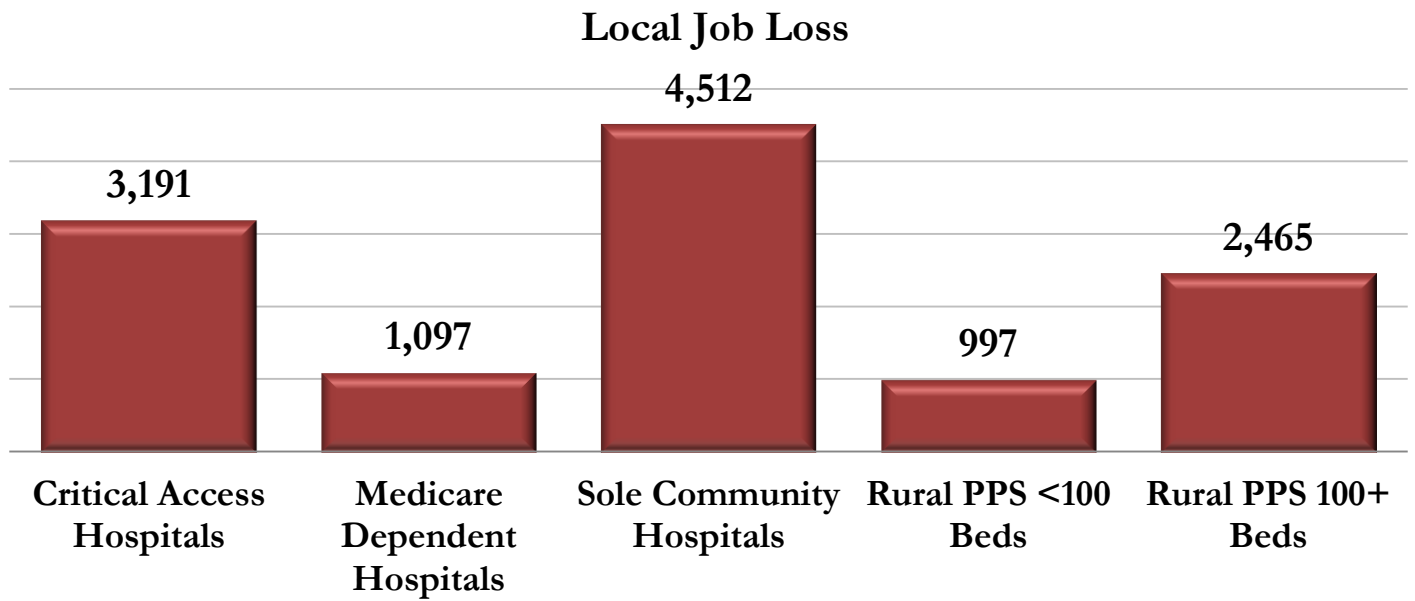
*See glossary on last page for definition of acronyms and other terms

Small Rural Hospitals Servicing Greater Proportion of Medicare



The graph above plots all Rural Hospitals under \$100M NPR based on size (X-axis: NPR) and Medicare Revenue Dependency (Y-axis: Medicare Payments as % of NPR). The Medicare Revenue Dependency is consistent among hospitals above \$25M NPR. Many hospitals below \$25M NPR have higher Medicare Revenue Dependency. As demonstrated by the graph above, the lower the NPR the higher probability the hospital services a greater proportion of Medicare Patients.

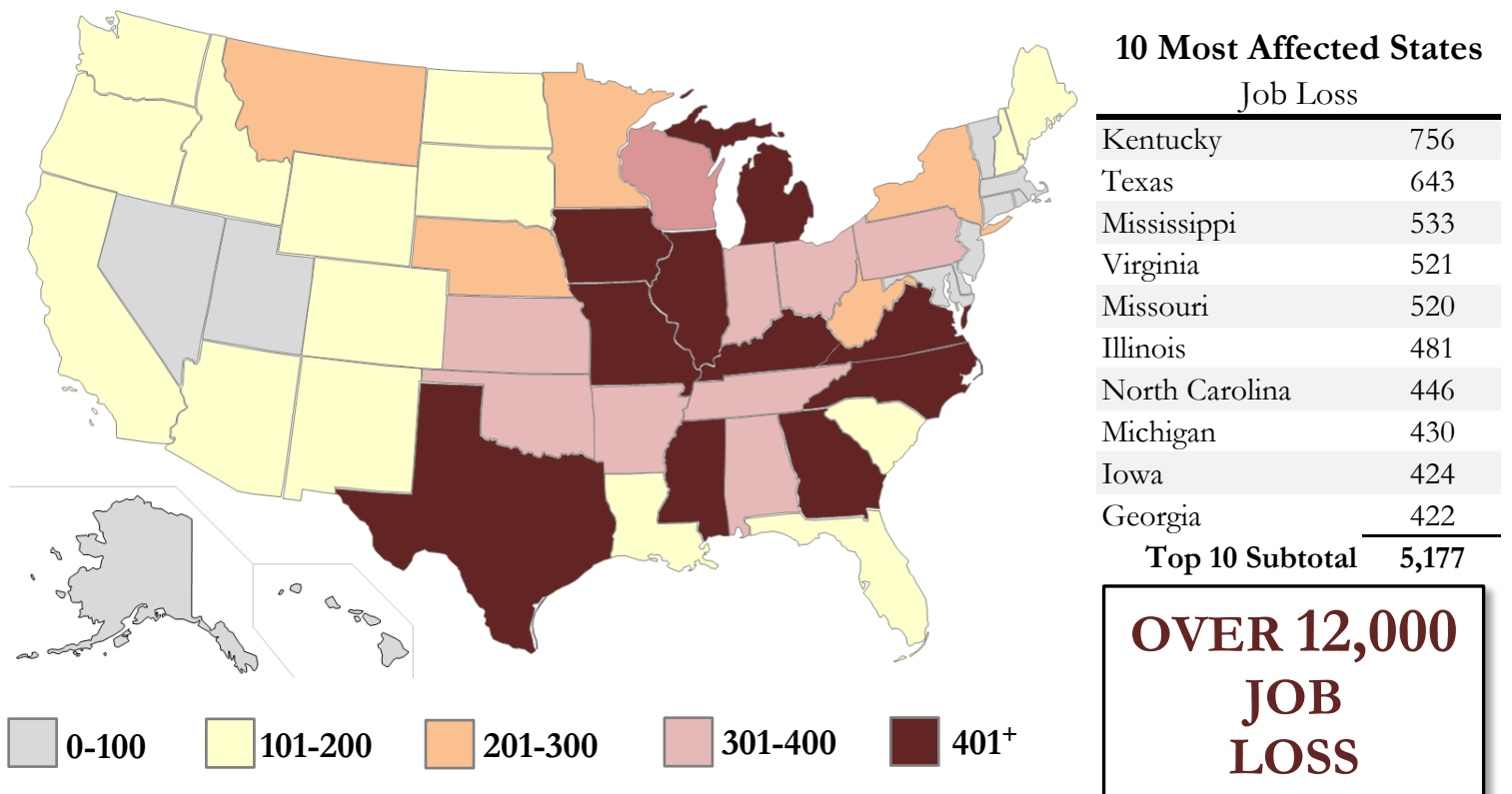
Job Loss in Rural America by Hospital Type



A decrease in revenue will likely force hospitals to layoff staff to offset the income reduction. Other businesses in the community will reduce their headcount as their customer volume declines. Medicare Cuts to Rural Hospitals could result in over 12,000 jobs lost in small towns across America. See page 7 "Method of Analysis" for more detail on how the estimates are calculated.

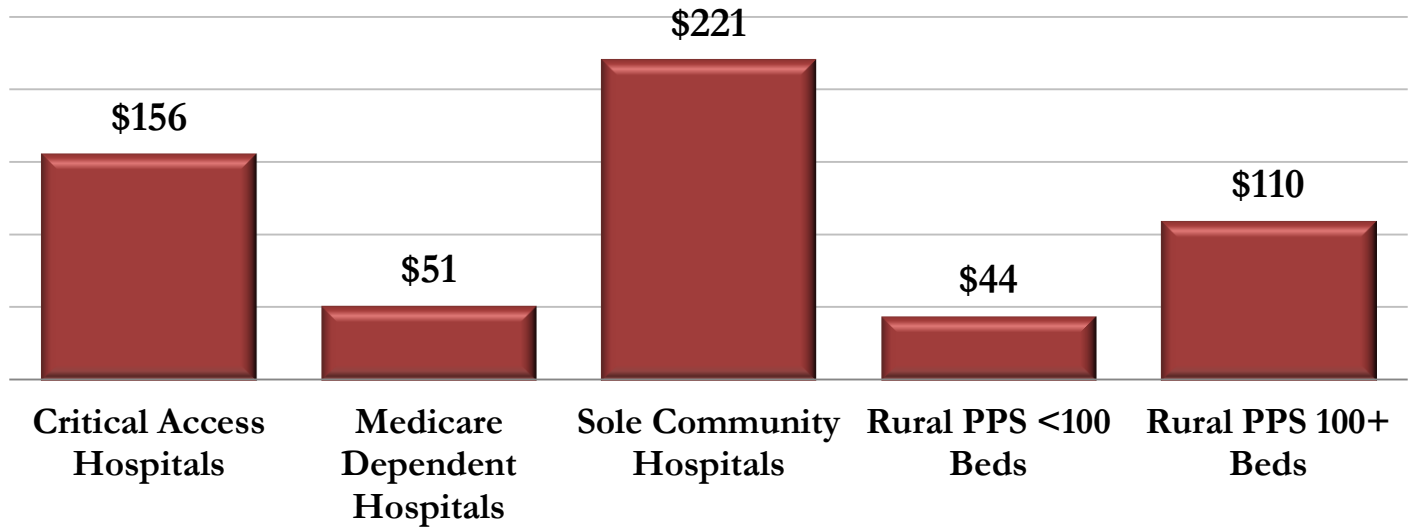
*See glossary on last page for definition of acronyms and other terms

Job Loss in Rural America by State



Economic Loss in Rural America by Hospital Type

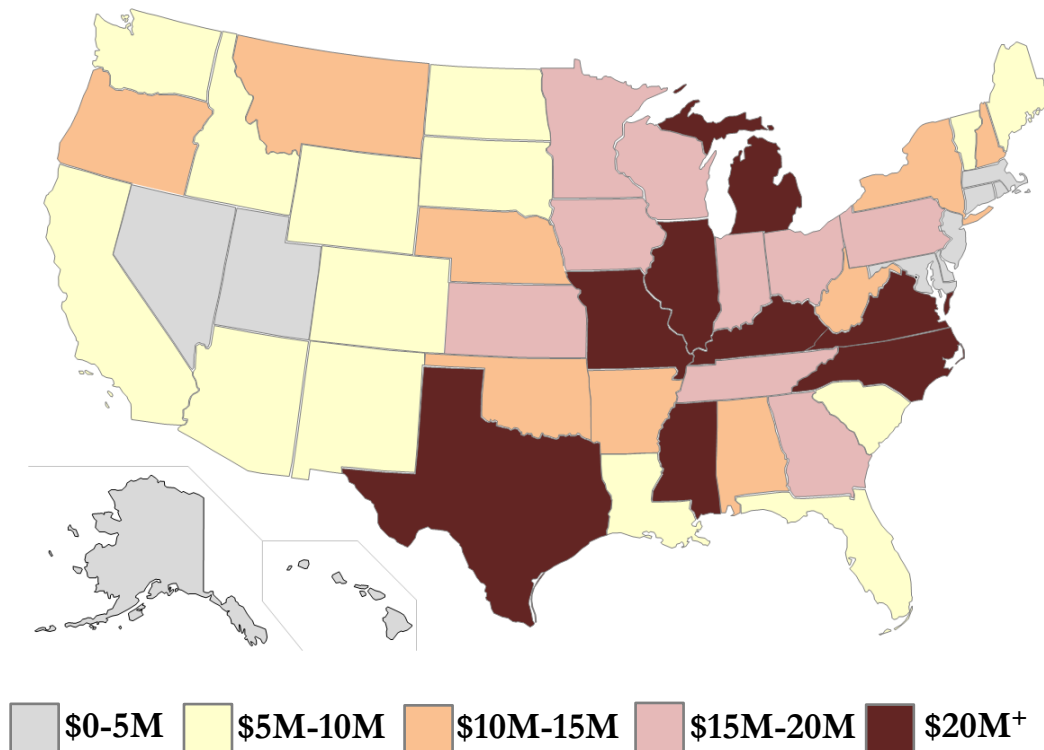
Local Economic Loss (\$ in millions)



Medicare Cuts to Rural Hospitals of approximately \$477M could cost rural economies in lost employment salaries and impact economies in these communities by nearly \$582M. The reduction of revenue for the hospital and resulting reduction in employment ripples through the community as less dollars are available to spend at local businesses; retail and service industries alike.

*See glossary on last page for definition of acronyms and other terms

Economic Loss in Rural America by State



10 Most Affected States (Economic \$ Loss in Millions)

Kentucky	\$32.4
Texas	\$26.9
Virginia	\$23.9
Mississippi	\$23.6
Missouri	\$23.4
Illinois	\$23.0
Michigan	\$21.7
North Carolina	\$20.6
Iowa	\$19.7
Georgia	\$18.4

Top 10 Subtotal \$233.7

**\$582,000,000
ECONOMIC
LOSS**

Hospital & Economy Impact - Method of Analysis

The following page summarize the estimated impact of the Medicare Sequestration on Rural Hospitals and the local economies in which they reside. The metrics in the analysis are calculated for each respective hospital then consolidated by:

- National
- State
- Congressional District (based on zip code of hospital)

Each summary displays the metrics as follows:

	# of Hospitals	% of Hospitals Operating in Red	Medicare Cut (\$ in millions)	Economic Impact (\$ in millions)	Total Local Economy Job Loss
Critical Access Hospitals	##	%	\$#. #	\$#. #	##
Medicare Dependent Hospitals	##	%	\$#. #	\$#. #	##
...					
Total	##	%	\$#. #	\$#. #	##

of hospitals based on Hospital Type identified (see page 2 "Hospital Types" for more detail)

Based on the hospitals revenue received from Worksheet Series E for the hospital and it's subprovider(s); including:

- PPS Part A [E part A]
- CAH Part A [E-3 part 2]
- Part B [E part B]
- Swing Beds [E-2]
- Subprovider[E-3 part 1]
- SNF [E-3 part 3]
- HHA [H7]
- RHC [M3]

The lost dollars from Medicare Cuts will impact the local economy based on 1.22 multiplier as evidenced through the work at National Center for Rural Health Works.

% of hospitals reporting less than \$0 in EBTDA after Medicare Cuts (Earnings Before Taxes, Depreciation, Amortization, and Other Income/Expenses). Note, many hospitals (Rural and Urban) record additional revenue subsidies as 'Other Income'; which is not included in this metric.

All Medicare cuts will result in an equal reduction in salary expenses to offset impact. Average salary per FTE (Rural State Average) was used to estimate resulting hospital job loss. These hospital job losses impact the jobs in the local economy based on 1.38 multiplier as evidenced through the work at National Center for Rural Health Works.

Impact on State of Alabama's Rural Hospitals & Economy

	# of Hospitals	% of Hospitals Operating in Red	Medicare Cut (\$ in millions)	Economic Impact (\$ in millions)	Total Local Economy Job Loss
Critical Access Hospitals	3	67%	\$0.23	\$0.28	7
Medicare Dependent Hospitals	6	50%	\$0.91	\$1.11	26
Sole Community Hospitals	10	60%	\$2.17	\$2.64	62
Rural PPS <100 Beds	24	38%	\$2.85	\$3.48	81
Rural PPS 100+ Beds	7	0%	\$5.75	\$7.01	163
Alabama's Rural Total	50	40%	\$11.91	\$14.52	338

Alabama's Most Affected Districts (All Rural Hospitals)

	# of Hospitals	% of Hospitals Operating in Red	Medicare Cut (\$ in millions)	Economic Impact (\$ in millions)	Total Local Economy Job Loss
Congressional District 2	17	41%	\$4.75	\$5.80	135
Congressional District 3	10	30%	\$3.15	\$3.84	89
Congressional District 4	8	25%	\$1.98	\$2.42	57
Congressional District 7	7	71%	\$1.00	\$1.22	28
Congressional District 1	4	25%	\$0.49	\$0.60	14
AL's Top 5 District(s) Total	46	39%	\$11.38	\$13.88	323

Impact on US Rural Hospitals & Economy

	# of Hospitals	% of Hospitals Operating in Red	Medicare Cut (\$ in millions)	Economic Impact (\$ in millions)	Total Local Economy Job Loss
Critical Access Hospitals	1,295	42%	\$127.86	\$155.99	3,191
Medicare Dependent Hospitals	193	34%	\$42.17	\$51.45	1,097
Sole Community Hospitals	445	29%	\$180.80	\$220.58	4,512
Rural PPS <100 Beds	229	34%	\$36.26	\$44.24	997
Rural PPS 100+ Beds	131	10%	\$89.87	\$109.64	2,465
United States Rural Total	2,293	36%	\$476.97	\$581.91	12,262

Glossary

The following acronyms for Hospital Types are used throughout this Report:

U	Short-term hospital residing in a county with a population greater than or equal to 50,000.
SCH	Sole Community Hospital
CAH	Critical Access Hospital
RS	Short-term hospital with less than 100 short-term hospital beds available residing in a county with a population less than 50,000.
RS	Short-term hospital with greater than or equal to 100 short-term hospital beds available residing in a county with a population less than 50,000.
MDH	Medicare Dependent Hospital

Other Definitions:

Rural Hospital	Hospital having the definition of CAH, SCH, MDH, RS or RB.
NPR	Net Patient Revenue as record on Worksheet G-3, Line 3, Column 1
SAPD	S tabilized A adjusted P atient D ays is similar to the traditional Adjusted Patient Day calculation utilized in the hospital industry except the underlying Inpatient Revenue per Day used to adjust Outpatient Revenue is stabilized across the entire dataset to establish a more consistent metric. For the purposes of this report, Inpatient Revenue per Day is based on Inpatient Medicare Program Expenditures (money received from both beneficiaries and the government) per Medicare Inpatient Days. Contact Paul Rudolph at Sano (prudolph@sanocapitalgroup.com) to obtain Sano's white paper about SAPDs.
Medicare Budget	Refers to all Medicare Expenditures, including all services and products outside of the hospital setting.
Medicare Patients	For the purpose of this report, Medicare Patients does not include beneficiaries receiving services under Medicare Advantage plans.
Medicare Payments	Based on the hospitals revenue received from the government (not including beneficiaries portion of deductible and coinsurance) recorded on the Worksheet Series E for the hospital and it's subprovider(s); including: Part A, Part B, Swing Beds, Subproviders, hospital-based SNF, hospital-based HHA and Rural Health Clinic. Short-term hospitals only.
Medicare Cuts	Refers to the Medicare Sequestration % applied to the Medicare Payments.
Medicare Revenue Dependency	Medicare Payments (as defined above) divided by Net Patient Revenue
Medicare Sequestration	Refers to automatic reduction in federal spending on Medicare program, as detailed in Budget Control Act of 2011
Population Figures	Based on 2010 census geographically determined by zip codes within respective Hospital Service Area as defined by Dartmouth Atlas of Health Care (http://www.dartmouthatlas.org)