



VISITING NURSE ASSOCIATION OF CHITTENDEN AND GRAND ISLE COUNTIES

Home Care for Adults and
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www.vnacares.org

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May 1, 2015

Donna Jerry
Health Policy Analyst
Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

RE: Docket No. GMCB-018-14con, Proposed Replacement and Expansion of Vermont Respite House

Dear Donna:

We are pleased to submit the following documents in support of the Visiting Nurse Association of Chittenden and Grand Isle Counties' application for a Certificate of Need for the Replacement and Expansion of the VNA's Respite House, a licensed home for the terminally ill:

1. Letter of Intent requesting expedited review;
2. Verification Under Oath;
3. Certificate of Need Application including:
 - a) A Narrative Description of the Project;
 - b) A detailed response to the applicable CON criteria, including the HRAP and CON standards;
 - c) Financial tables;
 - d) Schematic drawings; and
 - e) Other applicable attachments
4. Check for the application fee of \$20,000.

We look forward to working with you during the review process. Please feel free to contact Beverly Boget, Director of Planning and Government Relations at (802) 860-4441 or at boget@vnacares.org if you have any questions about this application or need any additional information.

Sincerely,

Judy Peterson
President and CEO





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May 1, 2015

Donna Jerry
Health Policy Analyst
Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

RE: Docket No. GMCB-018-14con, Proposed Replacement and Expansion of Vermont Respite House

Dear Donna:

On behalf of the Visiting Nurse Association of Chittenden and Grand Isle Counties, I am writing to request an expedited review of our Certificate of Need application for the Replacement and Expansion of the VNA Respite House. We believe that this application meets the criteria set forth for an expedited review in the Green Mountain Care Board's Certificate of Need processes and procedures as outlined in Rule 4 subsection 4.304.

We believe that this application is likely to be uncontested as it is a continuation of services that the VNA already provides, and we are the only licensed home for the terminally ill in Vermont. Additionally, the University of Vermont Medical Center, the primary referral source to the current facility and a provider of palliative care, supports this project, as indicated by their letter of support for this project submitted as part of the Certificate of Need Application.

Further, this project does not substantially alter services as evidenced by the following:

- The proposed project does not raise any significant health care policy or planning concerns, as it is consistent with the Health Resources Allocation Plan, and it is consistent with the Triple Aim of Health Care Reform;
- The proposed project will have no significant impact on the services provided, as the VNA Respite House will continue to provide the same services as we provide in the existing facility;



United Way
of Chittenden County

- The expenditures associated with the proposed project will not increase the cost of health care, as it is being funded through community contributions and, therefore, will not significantly impact reimbursement rates;
- The project expenditures do not impact the financial strength of the VNA, as the new facility is projected to break even in its third year of operation, and the VNA has the financial capacity to absorb any operating losses in the first two years of operation as evidenced by our balance sheet. In addition, the fundraising campaign for the capital costs of the project will include the establishment of an endowment that will help to support the operations of the new VNA Respite House.

The proposed project will enable the VNA to replace a 25-year old facility that is too small, out-of-date and no longer ideally suited for the provision of inpatient hospice care for the residents and families that we are serving. It will also allow us to better meet the future end-of-life care needs of Vermont residents and their families.

For these reasons, we believe that the VNA Respite House Replacement and Expansion Project meets the criteria for an expedited review.

Sincerely,



Judy Peterson
President and CEO

Form A – Verification Form

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: Proposed Replacement and)
Expansion of Vermont Respite House) Docket No. GMCG-018-14con
Submitted by: Visiting Nurse Association)
of Chittenden and Grand Isle Counties)

Exhibit A – Form of Verification Under Oath when filing a Certificate of Need Application

Judy Peterson, being duly sworn, states on oath as follows:

1. My name is Judy Peterson. I am President and CEO. I have reviewed the Certificate of Need Application.
2. Based on my personal knowledge, after diligent inquiry, the information contained in the Certificate of Need Application is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact necessary to make the statement made therein not misleading, except as specifically noted herein.
3. My personal knowledge of the truth, accuracy and completeness of the information contained in the Certificate of Need Application is based upon either my actual knowledge of the subject information or, where identified below, upon information reasonably believed by me to be reliable and provided to me by the individuals identified below who have certified that the information they have provided is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact necessary to make the statement made therein not misleading.
4. I have evaluated, within the 12 months preceding the date of this affidavit, the policies and procedures by which information has been provided by the certifying individuals identified below, and I have determined that such policies and procedures are effective in ensuring that all information submitted or used by the Visiting Nurse Association of Chittenden and Grand Isle Counties in connection with the Certificate of need program is true, accurate, and complete. I have disclosed to the Board of Directors all significant deficiencies, of which I have personal knowledge after diligent inquiry, in such policies and procedures, and I have disclosed to the Board of Directors any misrepresentation of facts, whether or not material, that involves management or any other employee participating in providing information submitted or used by the Visiting Nurse Association of Chittenden and Grand Isle Counties in connection with the Certificate of need program.

5. The following certifying individuals have provided information or documents to me in connection with the Certificate of Need Application, and each such individual has certified, based on his or her actual knowledge of the subject information or, where specifically identified in such certification, based on information reasonably believed by the certifying individual to be reliable, that the information or documents they have provided are true, accurate and complete, do not contain any untrue statement of a material fact, and do not omit to state a material fact necessary to make the statement made therein not misleading:

- a) James E. Manahan, CFO, Visiting Nurse Association of Chittenden and Grand Isle Counties
 - Accuracy of all financial information submitted, included the Financial Tables

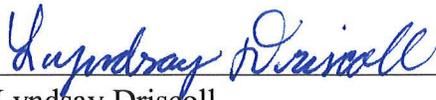
- b) Liza Kilcoyne, architect, Gardner Kilcoyne Architects
 - Accuracy of all information in the application describing construction work to be performed, including the project's consistency with the FGI guidelines and the schematic drawings submitted with the application.

6. In the event that the information contained in the Certificate of Need Application becomes untrue, inaccurate or incomplete in any material respect, I acknowledge my obligation to notify the Green Mountain Care Board, and to supplement the Certificate of Need Application, as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.



Judy Peterson
President and CEO
Visiting Nurse Association of Chittenden and Grand Isle Counties

On April 29, 2015, Judy Peterson appeared before me and swore to the truth, accuracy and completeness of the foregoing.



Lyndsay Driscoll
Notary public
My commission expires 2/10/2019

Division of Health Care Administration
89 Main Street, Drawer 20, Montpelier, Vermont 05620-3601

Certificate of Need Application Form

Name of Applicant	<u>Visiting Nurse Association of Chittenden and Grand Isle Counties</u>
Date of Application	<u>May 1, 2015</u>
Project Title	<u>Proposed Replacement and Expansion of Vermont Respite House</u>
Address Street 1	<u>1110 Prim Road</u>
Street 2	<u></u>
City/Town	<u>Colchester</u>
State	<u>Vermont</u>
Zip Code	<u>05446</u>
Telephone number	<u>802-860-4441</u>
FAX	<u>802-860-4477</u>
E-mail address	<u>Boget@VNACares.org</u>

Project Type & Amount (indicate project category below)

Non-Hospital Categories

- Construction, development, purchase, renovation, or other establishment of a health care facility, or any capital expenditure by or on behalf of a health care facility, for which the capital cost exceeds \$1,500,000.
- A change from one licensing period to the next in the number of licensed beds of a health care facility through addition or conversion, or through relocation from one physical facility or site to another.
- Offering any home health service.
- The purchase, lease, or other comparable arrangement of a single piece of diagnostic or therapeutic equipment for which the cost, or in the case of a donation, the value, is in excess of \$1,000,000.¹
- Offering of a health care service or technology having an annual operating expense which exceeds \$500,000 for either of the next two budgeted fiscal years, if the service or technology was not offered or employed by the health care facility within the previous three fiscal years.
- A project which is exempt from the requirements above solely because the cost or value does not exceed financial thresholds, if the cost or value is greater than \$750,000 or, in the case of medical equipment, \$500,000 and if the commissioner finds that the proposed development:
 1. may be inconsistent with the health resource allocation plan;
 2. has the potential for significantly increasing utilization or rates; or
 3. may substantially change the type, scope or volume of service.

¹ For purposes of this subdivision, the purchase or lease of one or more articles of medical equipment which are necessarily interdependent in the performance of their ordinary functions or which would constitute any health care facility as determined by the commissioner, are considered together in calculating the amount of an expenditure.

Certificate of Need Application Form

Project Type & Amount, continued

Hospital Categories

- Construction, development, purchase, renovation, or other establishment of a health care facility, or any capital expenditure by or on behalf of a health care facility, for which the capital cost exceeds \$3,000,000.
- The purchase, lease, or other comparable arrangement of a single piece of diagnostic or therapeutic equipment for which the cost, or in the case of a donation, the value, is in excess of \$1,000,000.²
- Offering a health care service or technology having an annual operating expense which exceeds \$500,000 for either of the next two budgeted fiscal years, if the service or technology was not offered or employed by the hospital within the previous three fiscal years.
- Change from one licensing period to the next in the number of licensed beds of a health care facility through addition or conversion, or through relocation from one physical facility or site to another.

Proposed Capital Expenditure (Total from Table 1 in application) \$ 7,920,054

Proposed Lease Amount (payment times term) \$ N/A

Please note:

The Chief Executive Officer of the applying entity must sign and attach verification form 'A'.

² See footnote 1.

Certificate of Need Application

Proposed Replacement and Expansion of Vermont Respite House

Docket Number GMCB-018-14con

**Submitted by the
Visiting Nurse Association of Chittenden and Grand Isle Counties**

May 1, 2015

Section 1: Introduction and Background

The Visiting Nurse Association of Chittenden and Grand Isle Counties (VNA) is a non-profit, Medicare-certified home health and hospice agency that has provided a wide-range of home and community-based services in Chittenden and Grand Isle Counties for over 100 years. These services include a comprehensive array of end-of-life care programs and services from palliative care to bereavement support, as shown on **Attachment A**.

The Vermont Respite House, a 13-bed facility in Williston, Vermont that provides 24-hour inpatient care for individuals needing hospice services, is a part of the VNA End-of-Life Care Division. As shown in **Attachment B**, a House Administrator, who oversees the operations of the House including the support provided by volunteers, and a clinical supervisor, who oversees the care provided to the residents by the nurses and licensed nurse assistants, reports to the End-of-Life Care Director. The Medical Director, Social Workers, Volunteer Coordinator, Chaplain, and Bereavement Coordinator support all VNA hospice patients and families including Vermont Respite House residents and families. While nurses and LNAs are dedicated to either the community or Vermont Respite House, some staff are cross-trained to provide care in either setting.

Vermont Respite House was founded in 1991 by a group of community volunteers who saw the need for a home to help people at the end of life. The VNA Hospice Program was a partner from the start, providing the clinical care for residents. At the request of the community volunteers who operated the House, the VNA began to manage the entire operations of the House and in 1997 Vermont Respite House formally became a part of the VNA. In 2006, Vermont Respite House was certified by Medicare as an inpatient hospice facility, enabling us to receive funding from Medicare for eligible patients needing this higher level of care.

Acknowledging that the Vermont Respite House was close to full capacity and that the need for its services would likely continue to increase as the population aged and more people were choosing hospice services at the end of life, the VNA has convened several groups of staff and Board members to gather information. Over the last several years, these groups have quantified the need, evaluated options to meet this need, analyzed the financial feasibility of the various options, and determined community support for replacing and expanding the Vermont Respite House. As part of this work, the VNA engaged the firm of Scott + Partners, an architectural and project management firm, to assist with this analysis. This proposed project to replace and expand the current Vermont Respite House from 13-beds to 21-beds, along with our continued strong commitment to supporting individuals and families at home, represents the VNA's assessment of the best way to meet the growing need for high quality end-of-life care in our community.

Section 2: Project Description

A. Current Services

The Vermont Respite House is the only licensed Home for the Terminally Ill in Vermont. Approximately 90% of the residents are from Chittenden and Grand Isle Counties; however, the Vermont Respite House is open to individuals from throughout the state and beyond. Though we care for individuals with a wide-range of terminal illnesses, over half are for cancer diagnoses. The other most common illnesses are cardiac, kidney, and pulmonary disease and Alzheimer's Disease and other dementias.

Current residents

The House serves individuals who have a serious, life limiting illness with a prognosis of six months or less to live. On average, residents stay at the House for 17 days but that can range from less than 24 hours to several months. Most residents who come to Vermont Respite House are in their last days of life and will end up dying at the House. On occasion, residents will come to the House for a short stay to help with an exacerbation in pain or other symptoms or improve enough with the care they receive that they are able to be discharged back to their own home or another setting.

All residents have elected to receive hospice services, which means they have chosen to receive only palliative care and are no longer electing any treatments that would be considered curative in nature. As with our community-based hospice program, the goal of Vermont Respite House is to help keep people comfortable and living the highest quality of life possible.

Residents choose to receive their end-of-life care at Vermont Respite House for a variety of reasons. Vermont Respite House is a good option for people who have complex care needs requiring 24-hour care and supervision, such as individuals with mobility impairments or individuals who have pain or other symptoms that are difficult to control. The House also serves individuals who do not have family or other support systems that are able to help them meet their needs in their own home, do not have a home that is suited to their care needs, or want to be closer to family nearby.

While some residents are mobile and can provide some self care, the typical Vermont Respite House resident increasingly requires inpatient level care reflective of a more complex end-of-life care plan. These residents may be using oxygen and other medical technology to support their comfort, may require full assist with transfers and repositioning, and require ongoing assessing and adjusting medications daily to provide the highest level of palliative support.

Current facility

The current facility, located at 99 Allen Brook Lane, was built 25 years ago. It includes 7,870 gross square feet on a 2.38-acre property. Residents each have their own private room with a half-bath (toilet and sink). Residents also have use of two shared bathrooms, one equipped

with a shower and a tub and a second with just a shower. Residents and their guests have access to a shared living room, dining room, chapel/reflection room, and outdoor spaces. Outdoor spaces include the front porch, two smaller side porches, a gazebo, patio and gardens. Office space includes rooms for the Administrator, the Clinical Nurse Manager, the nursing staff, and a shared office for the Medical Director, Social Worker and Volunteers. The Licensed Nurse Assistants share minimal space in the dually-purposed copy/mail room. Support spaces including a kitchen, locked medication room, laundry and utility rooms, and storage spaces make up the remainder of the facility space. A site plan, floor plan and elevation drawing for the current House are in **Attachment C**.

The current House is too small, outdated, and no longer ideally suited for the provision of inpatient hospice care for the residents and families that we serve. The size and configuration of the current House provide challenges for residents, family members, staff and volunteers. Some of the most pressing challenges/areas that need improvement are:

- Patient rooms are small, especially when multiple family members are visiting. The ensuite bathrooms do not easily accommodate residents who need special assistance;
- Patients able to have a shower or bath must travel down public corridors to shared shower/bath rooms;
- Patient rooms provide limited places for family members who often stay overnight. The space in the patient room when the pull out bed is in use is limited and makes it difficult for staff providing care; there are few quiet spaces for families to take a break or talk with other family members outside the patient room; and there are no shower facilities for family members;
- There is limited space for members of the hospice team to document or hold confidential family and staff meetings;
- Parking is limited on site. The current House has only 17 spaces for use by families, visitors, staff and volunteers, which causes people parking in non-designated spaces and along the roadway;
- Space for staff and volunteers is limited for care planning and coordination, documentation, and much needed breaks from the care routine;
- The medication room is essentially a small closet and barely allows for more than one staff person in the space at a time, which increases the risk of confusion and potential errors when more than one staff person needs to use the space concurrently; and
- Storage space is inadequate leading to inefficiencies in providing care and support. For example, food and kitchen supplies are stored in various spaces throughout the building.

Current services

In addition to their room, all residents have access to the following services and amenities:

- 24/7 nursing and personal care services
- On-site oversight by our medical director
- Physical and occupational therapists as needed

- Social and emotional support for resident and family
- Spiritual support for residents
- Bereavement support for family
- Volunteer services to provide additional supports when family or friends are not available
- Meals and snacks provided at any time
- Medications
- Medical equipment

B. Proposed Project (Including Scalable Schematic Drawings)

The VNA has completed a needs assessment that has identified an estimated need for 21 facility-based hospice beds to meet the needs of our aging community in 2020. To meet this need, the VNA is proposing to build a new 21-bed home in Colchester, Vermont. The proposed facility would provide the same services as are provided in the current.

Proposed Site

As shown in **Attachment D**, the proposed site is a 25-acre parcel located on Route 7 North in Colchester approximately 3 miles North of Interstate 89 Exit 16. The site is currently part of a larger 89-acre undeveloped parcel owned by the Munson family. Most of the property is an open, level site with a wooded ravine and a stream on the southern portion of the property. The prospective buyer, who is also is the owner of and project director from the design/build firm for this project, has an option to purchase the property and has committed to subdividing the larger property and selling the southern-most 25-acre parcel with access from Route 7 to the VNA upon receipt of a Certificate of Need. The Colchester zoning regulations allow for Hospice Homes to be built on the current site. Based on the zoning of this property, the town will allow subdivided parcels of 25 acres or more.

Proposed Building

Per the drawings in **Attachment D**, the proposed House would include 24,000 gross square feet. The building would include 21 private resident rooms each with a full private bathroom and space for family and visitors. Furnishings will be included that enable a family member to stay overnight in the resident room. Family members will be able to use the private bathroom and will have access to a family/resident kitchenette. In addition to space within the resident room, the proposed building will have spaces for residents and family members to gather in small or large groups outside of the resident room both inside and outside of the building.

The proposed home would be consistent with the current standards of similar homes across the country. It would include:

- Enhanced space for patient rooms to better accommodate the higher acuity care provided today at the House. This includes piped in oxygen and bathrooms with shower facilities in each room;

- Spaces to accommodate families and friends of the resident, including spaces for families to talk privately with other family members, and obtain support and information that they need to manage during this difficult time;
- Work space that enables staff to be accessible to residents and family members, efficient in delivering care, able to provide coordinated interdisciplinary care, and have a designated staff space for breaks, reflection, and respite; and
- Ancillary spaces including kitchen, laundry and storage spaces that support the care of residents and efficient operations.

If possible, the VNA would like to begin construction in the fall of 2015 with project completion planned for June 2016.

Equipment

A list of furnishings, fixtures and equipment for the proposed House is in **Attachment E**. These costs are included on Tables 1 and 2. It includes:

- Furniture for additional 8 resident rooms and shared living and dining spaces;
- Routine equipment for additional 8 resident rooms such as wheelchairs, walkers, commodes, and shower chairs;
- Specialized equipment for clinical care such as the oxygen distribution system, systems to help lift patients from their beds for transfers and repositioning, a nurse call system and motion sensors;
- Workstations and office furniture for staff spaces;
- Kitchen, laundry and housekeeping equipment;
- Security system for main and staff entrances; and
- Information technology components discussed in more detail below.

This list assumes that we will bring existing furnishings where possible from the current House.

IT Components

The information technology systems costs of \$100,000 are included in the total furnishings, fixtures and equipment cost table in **Attachment F**. These costs include:

- Computers for staff work spaces, including hardware and software;
- Network routers and wireless access points to serve residents, guests, staff and volunteers;
- A server;
- Audiovisual equipment for the conference room; and
- Telephones for additional work stations.

As with the furnishings, fixtures and equipment, this list assumes that we will bring our existing computer work stations, telephones and other equipment as possible from the current House.

Section 3: Consistency with the Triple Aim

A. Improving individual experience of care

Hospice is a holistic model of care that uses an interdisciplinary team approach to providing care based on a plan developed with each patient and their family to help meet their goals for the end of their life. Most individuals choose and are able to receive these services in their home. For others that is not an option, as they may not have appropriate family or informal support to meet all of their care needs, their pain or symptoms may need more continuous management than they can get in their home, or their living situation is not conducive to meeting their care needs in their home. For these people, an inpatient hospice home, such as Vermont Respite House, provides an alternative to nursing home or hospital care.

Research has shown that individuals with terminal diagnoses who receive hospice care live longer than patients who do not get hospice care. A 2007 article published in the *Journal of Pain and Symptom Management* that looked at 4,493 Medicare beneficiaries with some of the most common diagnoses leading to death, found that patients who received hospice services lived on average 29 days longer than those who did not receive hospice care. This confirmed what an earlier study in the same magazine found in 2004. It too looked at patients with the most common terminal diagnoses and researchers found that hospice patients lived from 20 to 69 days longer.

VNA patients and family members report high levels of satisfaction with services at Vermont Respite House. According to our most recent family survey, 97% of families rated their overall satisfaction with Vermont Respite House as excellent, the highest score possible. Ninety six percent rated the pain relief and relief of other physical symptoms to be very good or excellent, and 97% rated their care for emotional and mental health issues as very good or excellent.

As part of the planning for this project, we held two focus groups with family members to better understand their experience at Vermont Respite House. They told us that not only did Vermont Respite House support their family member, but it also provided invaluable support for them. Specific comments included:

- The quality of the care was absolutely superb.
- We were treated with thoughtfulness and compassion by everyone.
- This place became our family.
- We were regularly asked how we were doing, not just our family member.
- Appreciated the consistent schedule of care and the consistency of the quality of care provided by every staff member.
- Appreciated that they asked us for input into care planning and that they were willing to listen to suggestions from family members (i.e. using different wound care product that family had researched).
- They treat you like a person here.
- I trusted the people here.

- They made a bad situation better.

B. Improving the health of populations

The World Health Organization's definition of health is "not merely the absence of disease, but optimal physical, mental, and social well-being." Applied to the dying, this definition is viewed as including attention to the relief of pain and suffering, maintenance of an individual's functional abilities and social relationships to the extent possible, reflections on the meaning of life, peaceful life closure and support for grieving family members.

Hospice and the Vermont Respite House embody these values, therefore increasing access to hospice can be viewed as promoting the health of populations near the end of life. Hospice also goes beyond the traditional medical model by including the family in both the unit of care and the caregiving team, by working to relieve caregiver burden, and by maintaining supportive contact with grieving family members after their loved one's death. This notion of health promotion for the dying and their families is consistent with health care reform efforts to enhance quality of life and health for populations.

C. Reducing the per capital costs of care for populations

Literature shows that individuals at the end-of-life who receive hospice and palliative care services use fewer hospital services. In addition to reducing the anxiety and stress that these hospital encounters can cause, it also reduces the cost of care during the last years of life.

One study, published in *Health Affairs* in March 2013, was conducted at the Icahn School of Medicine at Mt. Sinai. It looked at Medicare patients with all diagnoses and found that hospice patients had significantly lower rates of hospital and intensive care use, hospital readmissions, and in-hospital death when compared with matched non-hospice patients.

A study reported in the November 2014 edition of the *Journal of the American Medical Association*, looked at Medicare patients with poor-prognosis cancers who died in 2011. Patients with these types of cancer had fewer hospitalizations, used less intensive care, and had fewer invasive procedures than a similar sample of patients who were not enrolled in hospice services. Total costs over the last year of life were \$62,819 for hospice patients compared to \$71,517 for non-hospice patients.

Vermont Respite House enables more people in our community to get hospice and palliative care outside of the hospital. In addition to reducing the need for more inpatient hospital beds, it also is a less expensive place to receive care. According to a 2013 Commonwealth Fund study, the average cost of a day in the hospital is \$2,156 versus the average cost per day of \$588 for Vermont Respite House.

Section 4: Consistency with the HRAP Standards (CON Statutory Criterion 1)

CON STANDARD 1.3: To the extent neighboring health care facilities provide the services proposed by a new health care project, an applicant shall demonstrate that a collaborative approach to delivering the service has been taken or is not feasible or appropriate.

The VNA collaborates closely with the University of Vermont Medical Center (UVMCC) in providing care to patients with serious and life threatening illnesses needing palliative and hospice care. UVMCC refers many patients to Vermont Respite House. We contract with the UVMCC for the Hospice Medical Director who, in that role, provides care for hospice patients in both the community setting and in Vermont Respite House and serves on the VNA Professional Advisory Committee. The Vermont Respite House provides on-site training opportunities for University of Vermont nursing and medical students. We also participate on the UVM College of Medicine's Palliative Care Collaborative.

Vermont Respite House is the only licensed Home for the Terminally Ill in the state. Patients needing inpatient level care who cannot access Vermont Respite House if a bed is not available can receive care in the hospital or in a nursing home that has 24 hour nursing care. The VNA has contracts with both the University of Vermont Medical Center and Starr Farm Nursing Center to provide this inpatient level care for our hospice patients if needed.

In exploring options and alternatives to building a new house, the VNA did explore the possibility of converting some nursing home beds for inpatient hospice care; however, we found that option to not be feasible. Nursing home occupancy in Chittenden County is very high, an average of 94% in the most recent DAIL report from February 2015, making bed availability extremely limited. While nursing homes do provide care for their residents at end-of-life, the nursing home setting does not offer the same home-like environment, amenities and supports that are available at Vermont Respite House.

We have also had multiple conversations with the University of Vermont Medical Center about this project. They agree that the hospital is not the ideal environment for patients that have a prognosis of six months or less to live and are no longer receiving curative care and that it is not the best use of the hospital facilities and staff. As they note in the attached letter, the University of Vermont Medical Center refers many patients to Vermont Respite House and have encouraged us to increase the capacity for inpatient hospice care in our community. In FY14, 101 of the 214 admissions to Vermont Respite House were from the UVMCC.

Another way that we are collaborating with other providers on end-of-life care is through our membership in OneCare Vermont and Community Health Accountable Care. Recently, OneCare Vermont prepared a report on hospice use among its enrollees and based on those findings its Clinical Advisory Committee has made the increase of hospice utilization a priority. To support this, the VNA has developed educational materials for OneCare providers to help physicians in making referrals for their patients.

CON STANDARD 1.4: If an application proposes services for which a higher volume of such service is positively correlated to better quality, the applicant shall show that it will be able to maintain appropriate volume for the service and that the addition of the service at the facility will not erode volume at any other Vermont facility in such a way that quality at that facility could be compromised.

The Vermont Respite House is the only Home for the Terminally Ill in Vermont. We are proposing an expansion of its capacity from 13 beds to 21 beds to meet a projected increase in community need based on a projected growth in population of individuals 65 and older and increased waiting days at our current House. We do not anticipate any negative impact on any other facilities as a result of this project.

CON STANDARD 1.6: Applicants seeking to develop a new health care project shall explain how the applicant will collect and monitor data relating to health care quality and outcomes related to the proposed new health care project. To the extent practicable, such data collection and monitoring shall be aligned with related data collection and monitoring efforts, whether within the applicant's organization, other organizations or the government.

National and State Requirements

As a Medicare-certified hospice organization, the VNA collects and reports data on a regular basis to monitor our quality and outcomes. Per recent regulations, we will begin administering the new Center for Medicare and Medicaid Services (CMS) Hospice Quality Reporting and Quality Assurance and Performance Improvement (QAPI) requirements which include reporting of a Hospice Item Set of seven process measures completed within certain time frames on admission and at discharge. We also collect and submit patient/family satisfaction data to CMS for the Hospice CAHPS (originally the Family Evaluation of Hospice Care). This data and the patient and family satisfaction data will be publicly reported in 2017. We also monitor and report quarterly state required home care and hospice data, such as patient concerns not resolved within seven days.

Outcomes

Prior to the new national quality reporting requirements above, the VNA surveyed families to determine the quality of their experience with the care that was received. Quality reporting for Vermont Respite House residents is included in the data with all VNA hospice patients. The data below are from the Family Satisfaction Survey that we send to family members 3 months post death.

Outcome: Patients had their pain and symptoms under control
98.1% received the right amount of pain medicine
96.9% of patients received the right amount of help with breathing

Outcome: Patients and Families were provided the emotional support they needed
95.4% of patients received the right amount of help with anxiety and sadness
95.4% of families received the right amount of emotional support PRIOR to death
94.8% of families received the right amount of emotional support AFTER death
All of these measures are at or above the state and national benchmarks.

Quality Improvement

The VNA has begun using the LEAN process improvement principles to enhance the efficiency and effectiveness of our care processes. Our most recent LEAN project team is reviewing the process of admitting residents to Vermont Respite House to make it as efficient as we can so that we will be able to readily accommodate the projected increase in admissions.

CON STANDARD 1.7: Applicants seeking to develop a new health care project shall explain how such project is consistent with evidence-based practice. Such explanation may include a description of how practitioners will be made aware of evidence based practice guidelines and how such guidelines will be incorporated into ongoing decision making. (2005 State Health Plan, page 48.)

The VNA hospice and palliative care teams, including those at the Vermont Respite House, follow the National Hospice and Palliative Care standards as well as the Visiting Nurse Association of America Blueprint, which includes evidence-based best practice standards for home health and hospice care.

The NHPCO Standards of Practice for Hospice Programs have been organized around the ten components of the quality in hospice care, which provide a framework for developing and implementing quality improvement.

The Ten Standards of Care are:

Patient and Family Centered Care

Providing care and services that are responsive to the needs and exceed the expectations of those we serve.

Ethical Behavior and Consumer Rights

Upholding high standards of ethical conduct and advocating for the rights of patients and their family caregivers.

Clinical Excellence and Safety

Ensuring clinical excellence and promoting safety through standards of practice.

Inclusion and Access

Promoting inclusiveness in our community by ensuring that all people — regardless of race, ethnicity, color, religion, gender, disability, sexual orientation, age or other characteristics — have access to our programs and services.

Organizational Excellence

Building a culture of quality and accountability within our organization that values collaboration and communication and ensures ethical business practices.

Workforce Excellence

Fostering a collaborative, interdisciplinary environment that promotes inclusion, individual accountability and workforce excellence, through professional development, training, and support to all staff and volunteers.

Standards

Adopting the NHPCO Standards of Practice for Hospice Programs and/or the National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care as the foundation for an organization.

Compliance with Laws and Regulations

Ensuring compliance with all applicable laws, regulations, and professional standards of practice, and implementing systems and processes that prevent fraud and abuse.

Stewardship and Accountability

Developing a qualified and diverse governance structure and senior leadership who share the responsibilities of fiscal and managerial oversight.

Performance Measurement

Collecting, analyzing, and actively using performance measurement data to foster quality assessment and performance improvement in all areas of care and services.

The *VNAA Blueprint for Excellence: Pathways to Best Practice* is a comprehensive quality improvement and workforce training resource designed to provide information and tools for care providers to improve care transitions and care at the end of life. It provides evidence-based best practices in the following areas:

- Care Initiation
- Patient and Caregiver Engagement
- Clinical Conditions and Symptom Management
- Patient Safety

CON STANDARD 1.9: Applicants proposing construction projects shall show that costs and methods of the proposed construction are necessary and reasonable. Applicants shall show that the project is cost-effective and that reasonable energy conservation measures have been taken.

To ensure that the project costs are reasonable, the VNA compared our proposed project to other similarly sized hospice homes across the country. Based on the table below, we believe

that the scale and size of our project, at 1,143 square feet per bed, is in the middle of the range of other homes and is below the 1,200 square foot average.

Name	Location	Date	# of Beds	SF	SF per bed
Hubbard Hospice	Charleston, WV	2001	12	14,000	1,167
Caldwell Hospice	Hudson, NC	2010	12	15,000	1,250
Androscoggin Hospice House	Auburn, ME	2005	14	13,400	957
Randolph House	Asheboro, NC	2011	16	20,000	1,250
Dunlap Caring Center	Cary, NC	2010	20	21,500	1,075
Woltz Hospice Home	Dobson, NC	2008	20	22,000	1,100
Kaplan Family Hospice	Danvers, MA	2000	20	23,500	1,175
Hospice House	Lincoln, MA	2014	20	27,500	1,375
Hospice of Charleston	Mount Pleasant, SC	2006	20	20,000	1,000
VNA Respite House	Colchester, VT	2015	21	24,000	1,143
Merrimack Valley Hospice	Haverville, ME	2009	21(7+14)	29,000	1,381
Kobacker House Hospice	Columbus , OH	2011	24	36,000	1,500
Hospice House	Greenville, SC	2007	30	37,000	1,233
				Ave. Sq. Ft./bed	1,200

Our design and site selection decisions were also made with a balance of quality and cost effectiveness in mind. These strategies include:

- The building is a single story structure and built on a level lot. This simplifies building and site construction and provides full accessibility to building occupants without constructing ramps, stairs, or elevators.
- The building is framed with wood frame panel wall construction and sided with durable cement board siding. The sloped roof is framed with cost-effective wood truss roof construction covered with asphalt shingle roofing.
- The mechanical system is planned to be economical, energy efficient gas boilers and radiation heat, along with tempered make-up air and centrally distributed air conditioning.

Additionally, as a best practice, the VNA will use the services of a cost estimator periodically during the project to help ensure the project costs are appropriate and to enable informed value-management decisions.

The Vermont Respite House design includes energy conservation measures as required by the State of Vermont Commercial Building Energy Standards and anticipates a close relationship with Efficiency Vermont throughout the project to optimize energy saving measures including: high efficiency HVAC equipment and water heaters; low flow toilets and shower heads to save water; LED lighting; occupancy sensors; Energy Star appliances where applicable; high r-value insulation and air-sealing of the entire building envelope including the foundation, walls, and attic.

CON STANDARD 1.10: Applicants proposing new health care projects requiring construction shall show such projects are energy efficient. As appropriate, applicants shall show that Efficiency Vermont, or an organization with similar expertise, has been consulted on the proposal.

One of the reasons that the VNA selected the new construction option was to be able to achieve the most optimal energy efficiency for the House. Construction standards have changed a great deal since the current facility was built 25 years ago and we hope to be able to decrease operating costs by building a house with mechanical systems utilizing newer technology and controls, better insulation, and state of the art windows that meet or exceed the current Energy Code Standards.

To do this, the VNA will retain a professional design team including architect, mechanical, and electrical engineers to work in conjunction with our project manager from Efficiency Vermont. The design team will develop an overall energy efficient design strategy that will be tested with energy modeling. Consistent with the Vermont Commercial Building Energy Standards, modeling will help us to ensure the building shell, lighting and mechanical systems comply with the 2015 Energy Code. Elements of this design will include: LED light fixtures, occupancy sensors, and consultations with Efficiency Vermont over the course of the project to realize the greatest energy efficiency in this project. Once the project is built, a test of the mechanical systems will be commissioned to verify that the equipment is running at optimum performance and meets the standards they were designed to achieve.

Additionally, as a best practice, the VNA will use the services of a cost estimator periodically during the project to help ensure the project costs are appropriate and to enable informed value-management decisions.

The Vermont Respite House design includes energy conservation measures as required by the State of Vermont for Commercial Buildings and anticipates a close relationship with Efficiency Vermont throughout the project to optimize energy savings – including high efficiency HVAC equipment, LED lighting and occupancy sensors, Energy Star appliances, quality insulation and air-sealing, blower door testing, and commissioning.

CON STANDARD 1.11: Applicants proposing new health care projects requiring new construction shall demonstrate that new construction is the more appropriate alternative when compared to renovation.

The VNA undertook an extensive process to review and analyze options to meet the projected need for inpatient hospice services for our service area. Using an RFP process, the VNA retained the firm of Scott + Partners to help us with this process. Scott + Partners is an architectural and project management firm located in Essex Junction, Vermont with experience in senior residential living and health care related projects.

This analysis examined the following options:

- Option A: Renovating and expanding on the current site
- Option B: New construction on the existing site
- Option B1: New construction on an expanded site with purchase and renovation building on adjacent property
- Option B2: New construction on an expanded site with purchase and demolition of building on adjacent property
- Option C: Renovation of an existing building on a new site
- Option D: New construction on a new site

We compared the capital costs and did a net present value analysis to determine the impact on operating costs for each option. We also compared each option to determine how well they allowed us to meet the goals of the project. These goals are:

- Provide space to support 21 residents in single occupancy rooms (with an option to expand to serve additional residents in the future)
- All resident rooms will have a room for family members to stay overnight, views to the outside, and a full bathroom
- The building should support efficient and effective staff care, ideally designed for a staff team to easily care for between 6 and 8 residents depending on their acuity
- The facility should maintain its non-institutional, home-like feel
- The site should be pastoral if possible, offering a sense of nature, calm and quiet surroundings
- Minimal disruption of current operations

Option A was the lowest cost option but it did not allow us to achieve our project goals. Only the new resident rooms would have their own full bathrooms and adequate family space. It would create tiered options where some residents would have nicer rooms than others. It would not provide for space to accommodate additional staff that would be needed to operate the larger building and would require giving up all of the outdoor gardens and spaces to offer sufficient parking. Perhaps the biggest reason this option was found to be inadequate was the disruption that the construction would cause for current operations. Some shutdown time

would be required. It was felt to be unaffordable and infeasible to find a temporary site to sustain operations during the construction period.

Option B, B1, and B2 were similarly determined to be infeasible as demolition of the current site and construction of a new site would completely disrupt operations for at least eight months.

This left us with the purchase of an existing building that we could renovate on a new site or the construction of a new building on a new site. A search of possible sites for renovation did not identify any that would easily lend themselves to this project. Given the unique and specialized needs of the facility, the cost of renovation almost equaled the cost of new construction while not as completely achieving the goals of the project, especially in creating a home-like environment.

Option D, new construction, allowed us to meet all of the project goals and build a house that would provide us with the highest efficiency in terms of resident care and building operations/energy efficiency.

CON STANDARD 1.12: New construction health care projects shall comply with the Guidelines for Design and Construction of Health Care Facilities as issued by the Facility Guidelines Institute (FGI), 2014 edition.

The VNA Respite House project shall meet all applicable standards set forth in the 2014 FGI Guidelines – Guidelines for Residential Health, Care and Support Facilities, including design criteria for plumbing, electrical, HVAC, data systems, and surface and furnishing systems.

CON STANDARD 3.12: Any applicant seeking to expand services for potentially terminally ill patients shall explain what efforts the applicant has taken or will undertake which support high quality, patient centered palliative and end of life care. Such efforts should include training and collaboration with other health care and hospice providers to facilitate high quality, patient centered end of life care.

Providing high quality, patient-centered palliative and end-of-life care is core to the mission of the VNA. This project is illustrative of the VNA's commitment to ensuring that our community has the access to a full array of end-of-life care choices, including inpatient hospice care.

Wide-Range of Programs and Services

The VNA was part of the initial Medicare pilot in 1978 to provide hospice services for Medicare beneficiaries. We offer a full-range of end-of-life care services from palliative care to hospice care in homes to inpatient level hospice care at Vermont Respite House. We work with DVHA as part of the Pediatric Palliative Care Program. We also provide a family Bereavement Camp called Camp Knock Knock each June and a special group of hospice volunteers called the

Noyana Singers that bring their restful, meditative music to the bedside of those near the end of life.

An important part of this commitment to high quality care is the experience and expertise of our staff. The VNA Hospice Program seeks staff who have experience in working with individuals with a life threatening illness. All staff complete a statewide certification for intravenous infusion and complete annual competencies for IV Therapy and titration of pain medication via CADD infusion pump. We also provide continuing in-service and training opportunities for staff, and encourage and support nurses and licensed nurse assistants in obtaining a hospice and palliative care certificate from the Hospice and Palliative Care Nursing Association. Our End-of-Life Care Director completed several national training courses by the End-of-Life Nurse Education Consortium and the Roxane Scholars Program for Pain Management. Our Director has also provided a leadership role in hospice and palliative care locally and nationally as the President of the Hospice and Palliative Care Council of Vermont from 2010 to 2014 and by contributing to the Visiting Nurse Association of America best practice guidelines for hospice care.

Community and Professional Education

The VNA has been a leader, on its own and in collaboration with other community partners, to increase the awareness of end-of-life care options. The Madison-Deane Initiative (MDI), an educational program of the VNA founded in 1997 to educate the general public and medical professionals about quality of care at the end of life, offers educational presentations and supports development of resources for providers and the community to raise awareness of this important topic.

Through MDI, we directly provide and support educational programs to community groups on issues related to palliative care, hospice care, and advance care planning. Nationally and internationally recognized experts in end-of-life care are brought to the area and provide presentations and facilitate discussions among physicians and other health care providers; medical, nursing and allied health care students; and the general public.

MDI also created an award-winning documentary, *Pioneers of Hospice: Changing the Face of Dying*, that tells the story of the modern hospice movement through the words of the original pioneers including interviews with Dame Cicely Saunders and Elisabeth Kubler-Ross prior to their deaths. The film is used in many educational venues including college classes for medical students, social workers and others interested in the topic of death and dying.

The VNA is also a member of the Hospice and Palliative Care Council of Vermont whose mission is to assure access to high quality palliative and end-of-life care to all Vermonter's who need it. Members include all 11 Vermont hospice providers, the Vermont Ethics Network, as well as several hospital representatives. This group serves as a resource and advocates for public policy discussions related to end-of-life care, promotes community education concerning hospice and palliative care, and provides a resources for professional education and peer support statewide.

More recently, the VNA, in collaboration with VNAs of Vermont and the Vermont Ethics Network, developed the Start the Conversation initiative aimed at further increasing awareness of end-of-life care options in the public-at-large. This model utilizes small community discussion forums and written materials to support individuals in having conversations about their end-of-life care preferences with family members and those important to them even before any illness or diagnosis that might require this decision making. Community discussions can happen in any venue, such as local libraries, physician offices and private homes. More information can be found at www.starttheconversationvt.org.

Despite all of these initiatives, the VNA recognizes that Vermont still ranks 48th in hospice use among all states according to the Dartmouth Atlas. This is surprising given the availability of hospice services in every city and town in Vermont, the extensive efforts at public and professional education on the topic, and the strong health policy that has supported end-of-life care options for Vermonters. The VNA is spearheading a study to better understand why hospice use in our state is among the lowest in the nation, how and where Vermonters are dying if not in hospice, and what barriers are keeping Vermonters from utilizing the hospice services available throughout the state. This study is being commissioned by MDI, with support from the VNAs of Vermont. The Muskie School of Public Service at the University of Southern Maine has been selected to conduct the research, including interviews and surveys of a variety of constituents to help better understand the factors behind these statistics and understand where best to focus future interventions. A completed report is expected in September.

Innovative Care Models

In addition to great care and education, the VNA is committed to evolving the model of care to reflect the current changes in our patients' needs. As more individuals receive curative care for longer periods of time, reflecting advances in medical care, it has resulted in shorter periods for patients on hospice care. This means that patients and families don't always have time to fully benefit from the support and care that our hospice program can offer.

There are also gaps in care created by the current regulatory and reimbursement model. Patients must choose to give up all curative care when they choose the hospice model. However, we know that patients who receive hospice and palliative care earlier in their illness typically live longer and with a higher quality of life and use fewer hospital services. With this in mind, the VNA has been working in collaboration with a variety of partners to develop an enhanced end-of-life care model that would enable individuals and their families to get support with pain and symptom management and advance care planning earlier in their disease process.

One model we are testing through Blue Cross and Blue Shield is the Supportive Care Model. It allows a subset of Blue Cross beneficiaries, UVMHC employees, to access these supportive services while concurrently receiving medical treatment. Due to the small sample size and the younger average age of this pilot group, we have not seen enough utilization of this option in

the first two years of the pilot to draw any conclusions about outcomes. We are currently working with Blue Cross to expand this pilot to additional beneficiaries and more widely inform members about this option.

With the idea of expanding upon this model, we have also applied to be one of 30 pilot sites nationally for the Medicare Care Choices pilot that would enable Medicare beneficiaries to similarly receive concurrent curative and supportive care. We also worked with the UVMHC Given Primary Care Practice to develop an integrated supportive care model that included physician home visits and a shared plan of care as well as providing nurse visits, advanced care planning and access to a 24 hour on-call service. We submitted this proposal to the Vermont Health Care Innovation Program for funding but did not receive one of their grants. We continue to look for funding opportunities to develop and test enhanced palliative and supportive care models to better meet the Triple Aim of health care reform.

Section 5: Consistency with CON Statutory Criteria 2-8

CON Statutory Criteria 2. The cost of the project is reasonable because:

- (A) The applicant's financial condition will sustain any financial burden likely to result from the completion of the project;**
- (B) The project will not result in an undue increase in the costs of medical care;**
- (C) Less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate.**

(A) Impact on VNA financial status

Given the projected need for services, the VNA anticipates that this project will break even from operations within three years. In the interim two years, the VNA will continue to cover any losses with community support as it has in past years. In addition, we are planning to raise funds for a dedicated endowment to support the operations of the House as part of the fund raising campaign for this project.

Despite years of limited increases in reimbursement from Medicare and Medicaid, which account for 80% of the VNA's overall revenues, the VNA has been able to maintain a strong balance sheet with a fund balance of \$19.5 million. We have done this by finding operating efficiencies wherever we can, working collaboratively with community partners, and through the support of our community. This financial position will enable the VNA to absorb any losses not covered by community giving until the operations reach break even financially.

Based on our financial projections, the proposed cost of care per occupied bed day will be less than the costs of the existing House, as we will be able to achieve some economies of scale with the larger house and operating efficiencies that come with new construction. The cost per occupied bed day in FY14 was \$588 and is projected to be \$569 in FY19.

(B) Costs of Care

Seventy two percent of the reimbursement for Vermont Respite House comes from Medicare and Medicaid. The current Medicare and Medicaid payment method is a per diem model based on the patient's level of acuity. For patients at the highest level of acuity (also referred to as general inpatient level), the reimbursement covers both the "room and board" costs as well as clinical and supportive care services. When a resident's status is more stable and their care is reimbursed at the routine level of care rate, which covers only the clinical and supportive care services. Residents who choose to remain at the House during these times pay the "room and board" costs. This fee covers the cost of the room, meals, and housekeeping services and is set on a sliding fee scale based upon the individual's ability to pay.

The reimbursement for patient care does not cover the costs of operating the House as Medicare and Medicaid do not cover the full costs of the care and there is little ability to shift those costs to commercial insurers due to the small number of residents with that insurance. The VNA has historically made up the difference from the generosity of the community through individual contributions, special events, the United Way, VNA endowment funds and other fund raising.

(C) Less Expensive Alternatives

Vermont Respite House is a less expensive alternative for providing end-of-life care for individuals whose needs cannot be met at home. Without an inpatient hospice home, these patients would need to receive care in a nursing home or hospital setting. Most individuals prefer to receive hospice care in a more home-like, less institutionalized environment such as Vermont Respite House, which is designed specifically to meet the unique and specialized needs of individuals and family members at the end of life. It is also less costly to receive services at Vermont Respite House. The average cost of one day of care at Vermont Respite House in FY14 was \$588 versus \$2,156 in a hospital.

As we begin to prepare for a future value-based payment model consistent with health care reform efforts, increased use of care models, such as those provided at Vermont Respite House, can contribute to overall decreased costs of care.

CON Statutory Criteria 3. There is an identifiable, existing, or reasonably anticipated need for the proposed project which is appropriate for the applicant to provide;

As shown on Table 1 below, the number of patients served by the VNA hospice program in both individual homes and at Vermont Respite House has increased significantly over the last 10 years. The number of hospice patients in our community hospice program has increased by over 50% with Vermont Respite House seeing an increase of 46%. While the number of residents served at Vermont Respite House has grown significantly, the number of days of care has begun to level off as we reach the capacity that the House can serve. We have been able to accommodate this growth within the current capacity of the House through prioritization of

patients with the highest care needs, which is reflected in the decreasing length of stay for residents at the House. However, we also know that this constrained capacity has resulted in some patients dying in the hospital or nursing home when they and their family would have preferred to be in a more home-like setting.

Table 1: VNA Hospice and Vermont Respite House Utilization, FY06-FY15 Annualized

	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY 15 YTD Annl	% Change
Hospice Pts	252	261	270	270	325	334	387	438	407	509	50.5%
VRH Pts	122	119	118	133	140	137	157	188	212	226	46.1%
Hospice Days	9,625	12,259	14,565	12,652	12,007	13,700	14,706	16,309	17,794	17,799	45.9%
VRH Days	3,816	3,867	3,984	3,846	3,745	4,068	3,953	3,736	3,792	3,920	2.7%
VRH LOS	31.28	32.5	33.76	28.92	26.75	29.69	25.18	19.87	17.89	17.33	-80.5%

As part of our internal analysis of need for inpatient hospice services, we developed a population-based model to project need for inpatient hospice beds in our community. Table 2 below compares the key factors used in the model based on actual data from FY14 and projected to FY2020 resulting in an estimated need of approximately 21 beds.

Table 2: Forecast Need for Inpatient Hospice Beds in Chittenden and Grand Isle Counties

	FY2014 Actual	FY2020 Projected
Population 65+ for Chittenden & Grand Isle Counties	20,613	29,523
VNA Hospice Penetration	3.0%	3.85%
Total VNA Hospice Patients Annually	619	1,137
% of VNA Hospice Patients Using VRH	34%	35%
Total VRH Residents	212	398
Average Length of Stay	18 days	16 days
Occupancy %	83%	85%
Occupied Bed Days	3,792	6,368
Number of Beds/Projected Beds Needed	13	21

The key methods and assumptions used in this model are:

1. While Vermont Respite House serves people from all across Vermont as well as those moving here to be nearer to family, the model is based on the population of people 65 and older in Chittenden and Grand Isle Counties as forecasted by the Vermont Department of Aging and Independent Living for 2020, as that is where the majority of our residents reside prior to admission;
2. Estimates for the number of people who will use hospice services of this population is based on the VNA's current utilization patterns;
3. The model assumes an increase in hospice penetration, from 3% to 3.85%, based on the VNA and community-wide efforts to increase hospice use in the state;
4. The model assumes that a small increase, from 34% to 35%, in the percentage of total Medicare beneficiaries that utilized hospice in our two counties will receive hospice care at Vermont Respite House;
5. Assuming that average length of stay at VRH will stabilize at 16 days due to the larger capacity and ability to take a mix of patients with varying levels of acuity;
6. The project bed need is based upon an occupancy rate of 85% which, due to normal turnover time between residents, we view as full capacity.

CON Statutory Criteria 4. The project will improve the quality of health care in the state or provide greater access to health care for Vermont's residents, or both;

As a country and a state, we are trying to come to terms with what constitutes good end-of-life care in a time where most people no longer die a quick death from infection, heart attack or child birth but now die after prolonged medical treatment of an incurable condition such as advanced cancer, progressive organ failure or multiple chronic conditions. Popular writers such as Atul Gawande and Ellen Goodman have been leaders in this national discussion with books and articles advocating for physicians to better understand what their patients really want from their last days and encouraging families to talk with each other about our wishes for what is important to us at this time.

In Vermont, despite statewide access to hospice care, our utilization of hospice services is lower than all but two other states in the country. Allan Ramsay, a family practice physician and former VNA Hospice Medical Director, as well as a member of the Green Mountain Care Board, has been urging health care providers to do more to increase hospice utilization in Vermont. Representative Sandy Haas and other members of the Vermont legislature and the Vermont Ethics Network have also been engaging providers and the public in this discussion. OneCare

Vermont, a statewide Accountable Care Organization has also recognized the value of hospice care and has made it a priority to increase referrals for hospice care.

Research shows that hospice care can help extend and improve the quality of life near the end. Studies indicate that patients who receive hospice care have the same or sometimes even better survival time than patients without hospice care. A study commissioned by the National Hospice and Palliative Care Organization and published in the *Journal of Pain and Symptom Management* in March 2007 found that the mean survival for hospice patient was 29 days longer than for non-hospice patients. The article suggests that this is caused by multiple factors, including reduced risks of medical interventions, improved monitoring and treatment of pain and symptoms, and enhanced psychological supports. As the article states, "This extra time might be particularly important to patients and their families, as it may allow some people to use the end of life as a time of resolution and closure."

The Coping with Cancer study, funded by the National Cancer Institute and the National Institute of Mental Health, also showed that terminally ill cancer patients who received intensive interventions such as ventilator care had a worse quality of life in their last week than those who did not receive those interventions. The same study also showed that their caregivers were more likely to be depressed after their deaths.

Inpatient hospice homes like Vermont Respite House help to increase hospice utilization by providing a range of options for patients seeking high quality end-of-life care. As the population ages and as the awareness of and demand for less institutionalized end-of-life options grows, our community will need additional capacity to meet these needs.

For some patients, receiving hospice care in their own homes is not an option. This can be due to a lack of a caregiver or a home setting that can accommodate their care needs. It may also be that their clinical condition requires round-the-clock care to manage their pain and other symptoms.

Our data show that the current capacity is not adequate to meet current and projected needs. At times, prospective residents cannot be admitted to Vermont Respite House or need to delay their admission when all of the beds are full. Projections show that, based on changing population demographics alone, more people will need inpatient level of care than the current capacity. We have designed the proposed facility in such a way that it can easily be expanded at some time in the future, with state approval as required, if the demand increases even further based on public and provider engagement and education and health care reform initiatives.

CON Statutory Criteria 5. The project will not have an undue adverse impact on any other existing services provided by the applicant;

As shown in our financial table, the VNA has the financial capacity to undertake a project of this scope. The capital costs of the project will be financed entirely by community fund raising. To ensure that this amount of money could be raised for this project, the VNA engaged a local

fund raising consultant with extensive expertise in advising local non-profit organizations undertaking similar projects. She conducted 24 interviews with 33 individuals and determined that our community was very supportive of this project and that it was feasible for the VNA to raise the funds needed to support the cost of this proposed project. The feasibility study also determined that it was possible to raise a small amount of additional funds to help support some of the operating costs of the new house.

The attached financial tables also show that after three years the VNA will break even on the operations of the House. While the square footage of the building per patient room will increase, operational efficiencies will be gained by:

- Increasing the energy efficiency of the House by using more efficient HVAC systems and building materials;
- Sharing the fixed costs of the infrastructure across the reimbursement from an increased number of residents, resulting in a lower cost per day of care once at full occupancy; and
- Streamlining operations using quality improvement tools, such as the LEAN process.

CON Statutory Criteria 6. The project will serve the public good;

Because this project will increase quality of end-of-life care by allowing more Vermonters to have access to hospice services and help to reduce the cost of care for individuals at the end-of-life, we believe that the expansion and replacement of Vermont Respite meets the public good.

In addition to improving care as described above in the quality of care section, studies show that hospice care makes good economic sense. Twenty-five per cent of all Medicare spending is for the five per cent of patients who are in their final year of life, and most of that money goes for care in their last couple of months, which is of little apparent benefit. One day of hospital care costs on average \$2,156, while a day at Vermont Respite House costs \$588.

The VNA Board, made up of 18 community volunteers, reached the conclusion that they felt the project was worthy of community investment by the non-profit VNA after an extensive multi-year, deliberative planning process by the VNA Board of Directors that led to the decision to put this proposal forward. As volunteer Board members of a non-profit organization, they are charged with making decisions on behalf of the community as to how to best utilize the VNA's resources to best meet the community's needs.

The Board engages in a strategic planning process every three to five years to ensure that they are adequately taking into account the changing needs of the community. These discussions highlighted the aging of our population and the need for innovative care models that were holistic, patient-centered, integrated among health care settings, and helped to reduce health care costs. This combined with the aging of the existing Vermont Respite House infrastructure and the increasing utilization of the House led our Board to further analyze this important program. A committee of both Board and staff members met for over a year and looked at

current utilization and the status of the current facility. As described above, we developed a population-based model to project future needs and determined that additional capacity was needed by 2020.

Again after considerable deliberations, the VNA Board felt that expanding the inpatient hospice capacity was a fit with our mission and strategic plan and was a priority for the VNA. We selected a consultant through a public request-for-proposal process to help us determine the best way to proceed in meeting this need, as discussed above in the options and alternatives section. This six month process resulted in the recommendation to build a new facility with expanded capacity to serve more residents.

By consolidating inpatient level hospice care in one larger facility, we can make the best use of the extensive infrastructure and highly skilled staff needed to provide this specialized type of care in a compassionate, holistic, and patient and family-centered way.

CON Statutory Criteria 7. The applicant has adequately considered the availability of affordable, accessible patient transportation services to the facility; and

In choosing the proposed site, the VNA was cognizant of the need to select a location that would be as accessible as possible. Our criteria included being within three miles of an Interstate 89 exit. Given the proximity to Interstate 89 and the planned development at the Severance Corners intersection in Colchester, we felt that the proposed site met this criteria.

We also felt that the potential for bus transportation to the site was another bonus. CCTA currently runs a bus from Burlington north on Route 7 with a stop at Severance Corners and in Milton. If this project is approved, the VNA would work with CCTA to determine the feasibility of adding an additional stop near the proposed site.

Residents arriving at Vermont Respite House are typically transported by family members or ambulance. The cost of the ambulance is covered by the VNA.

CON Statutory Criteria 8. If the application is for the purchase or lease of new health care information technology, it conforms with the health information technology plan established under section 9351 of this title.

This is not applicable, as this project will utilize the existing McKesson electronic medical record utilized at the current House and throughout the VNA.

List of Attachments:

Attachment A: VNA Programs Organizational Chart

Attachment B: VRH Organizational Chart

Attachment C: Drawings of Existing House

- Existing Site Plan
- Existing Plan
- Existing Elevation

Attachment D: Schematic Drawings of Proposed House

- Location Map
- Site Plan
- Floor Plan
- Resident Room
- Cross Section
- North East Elevation
- North West Elevation

Attachment E: Furnishings, Fixtures, and Equipment List

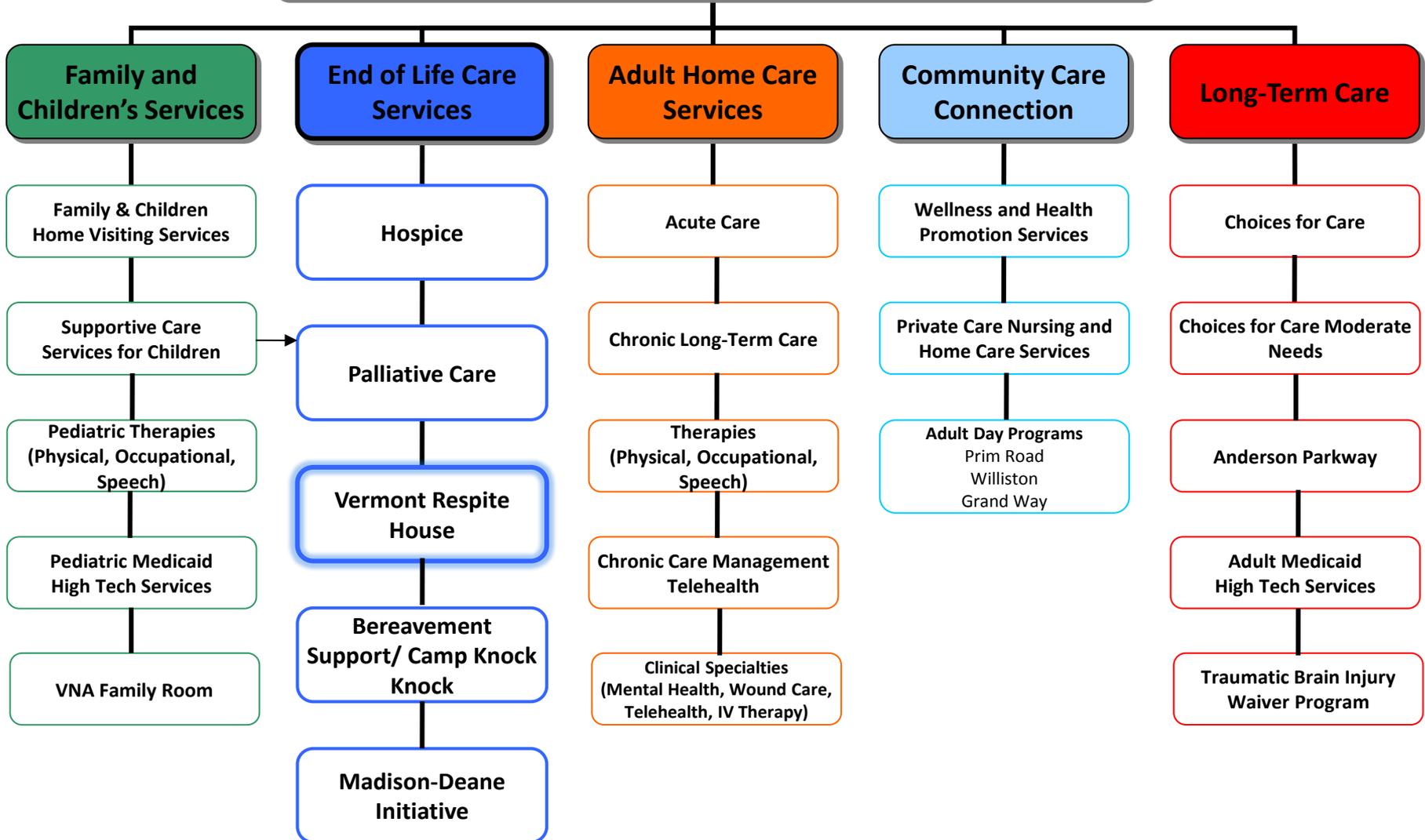
Attachment F: IT List

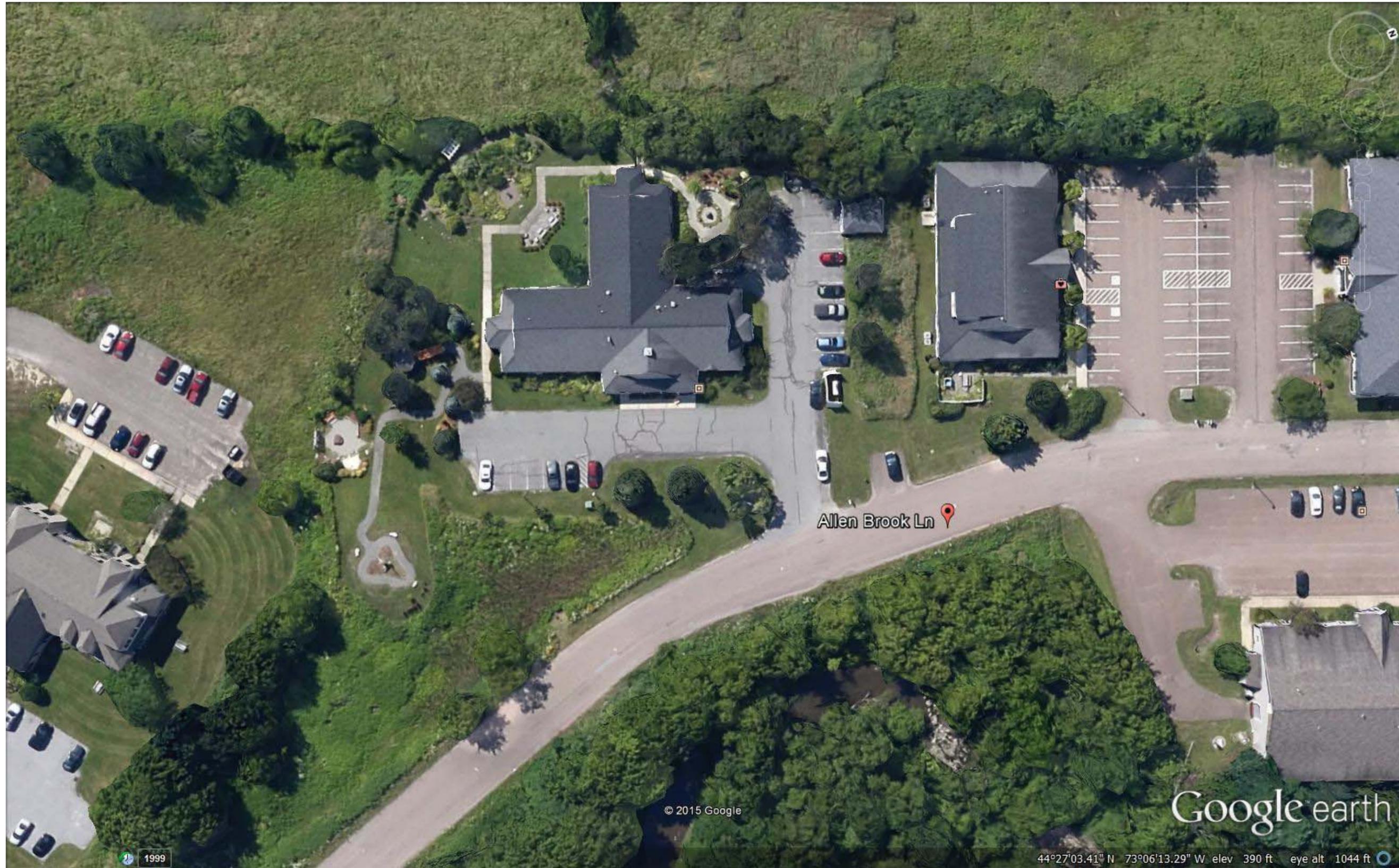
Attachment G: Letter of Support from UVMCC

Attachment H: Financial Tables and Financial Assumptions

Attachment I: Most Recent Audited Financial Statement

Clinical Program Organization



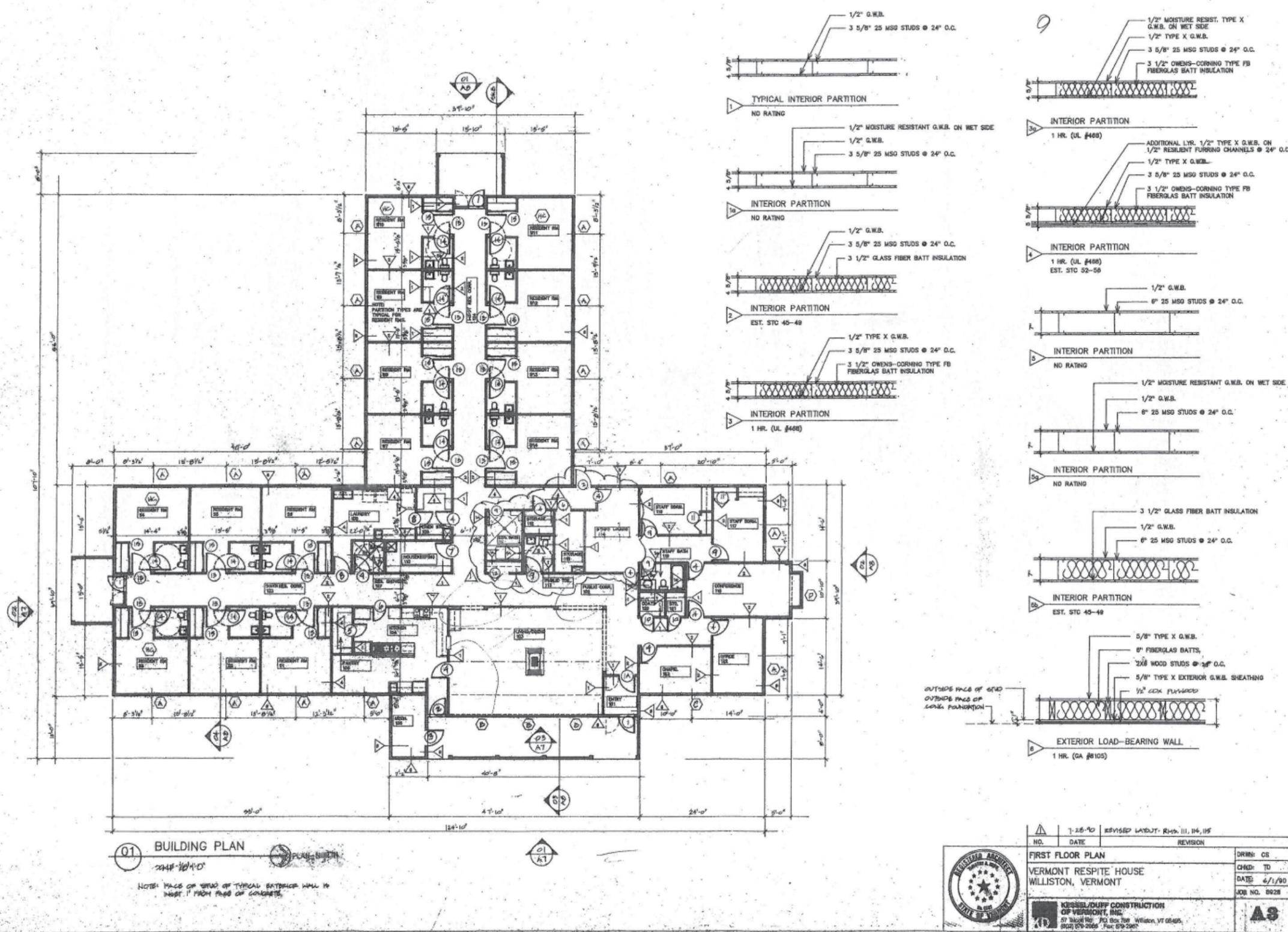


THE VERMONT RESPITE HOUSE
Allen Brook Lane, Williston, Vermont

Existing Site Plan

April 2015





NO.	DATE	REVISION
1	7-25-10	REVISED LAYOUT. RNS III, 114, 115
FIRST FLOOR PLAN		
VERMONT RESPITE HOUSE		DRWG: CS
WILLISTON, VERMONT		CHGD: TD
		DATE: 4/1/10
		JOB NO. 8928
		AS

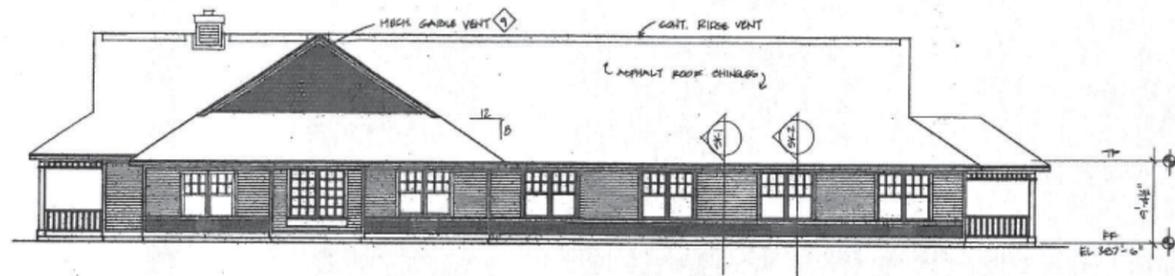


THE VERMONT RESPITE HOUSE
Allen Brook Lane, Williston, Vermont

Existing Plan

April 2015

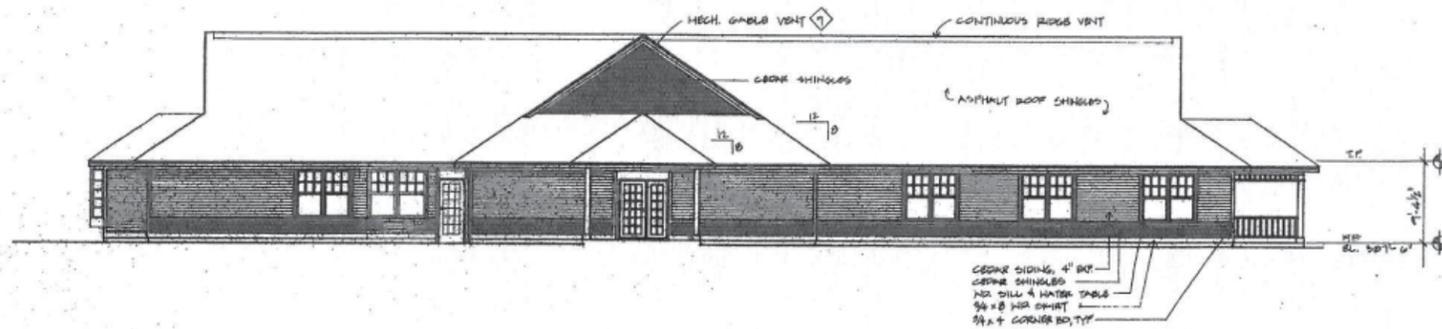




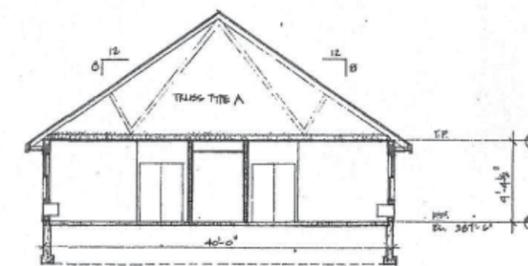
02 NORTH ELEVATION
SCALE: 1/8" = 1'-0"



03 BUILDING SECTION
SCALE: 1/8" = 1'-0"

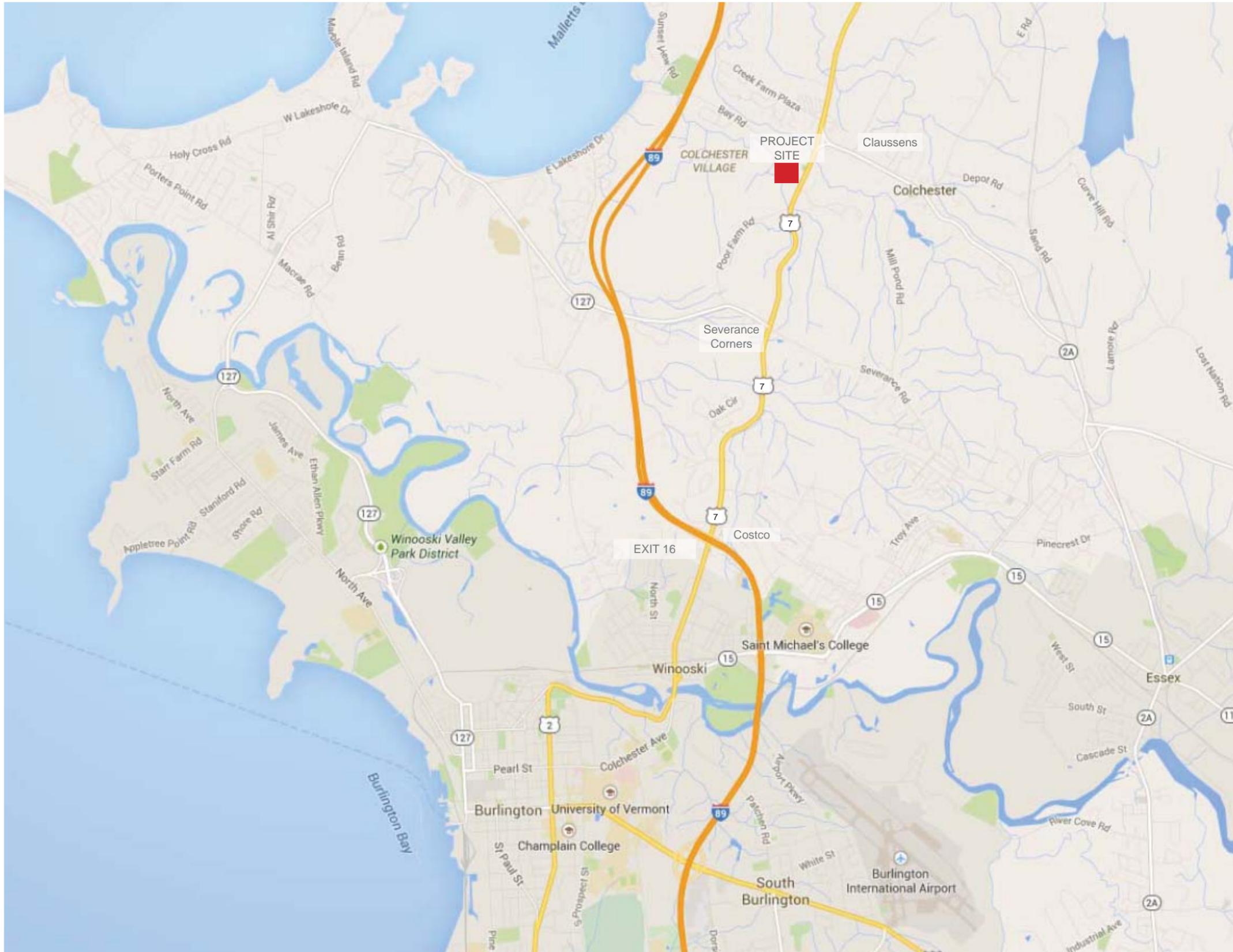


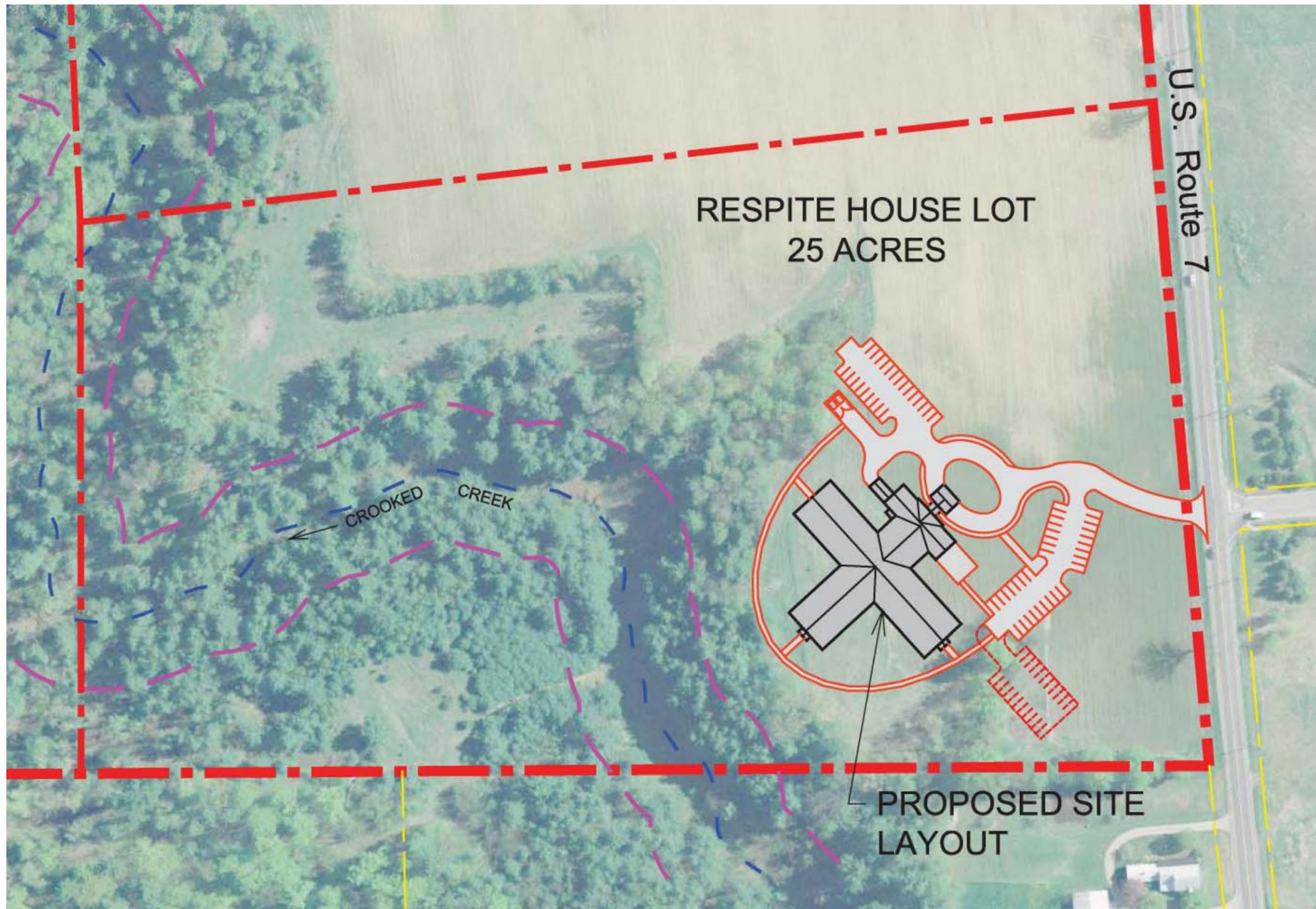
01 WEST ELEVATION
SCALE: 1/8" = 1'-0"



04 BUILDING SECTION
SCALE: 1/8" = 1'-0"

NO.	DATE	REVISION
ELEVATIONS		
VERMONT RESPITE HOUSE WILLISTON, VERMONT		
		DRWN: CS CHKD: TD DATE: 01/1/80 JOB NO. 8828
 KESSELOUFF CONSTRUCTION OF VERMONT, INC. <small>57 Talcott Rd. P.O. Box 756 Williston, VT 05405 (802) 578-2966 Fax: 578-2967</small>		A8





Scale: 1" = 150'



VNA RESPITE HOUSE
U.S. Route 7, Colchester, Vermont

Site Plan

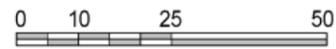
LD Lamoureux & Dickinson
Consulting Engineers, Inc.
14 Morse Drive, Essex, VT 05452
802-878-4450 www.LDengineering.com

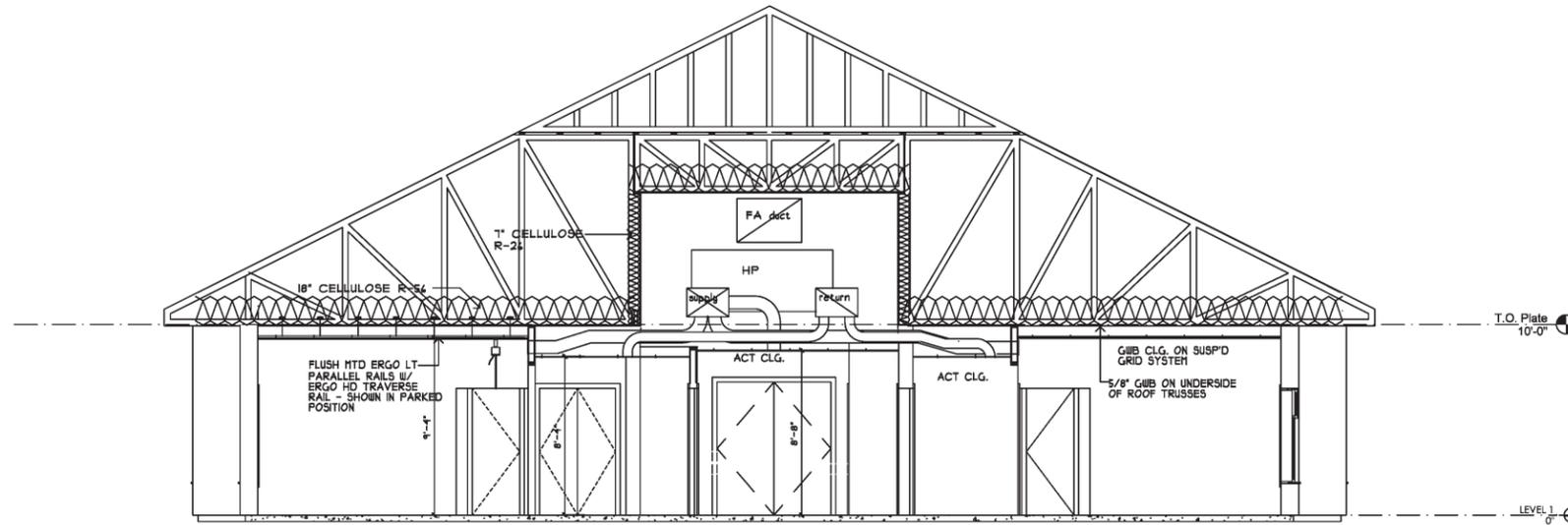
April 2015



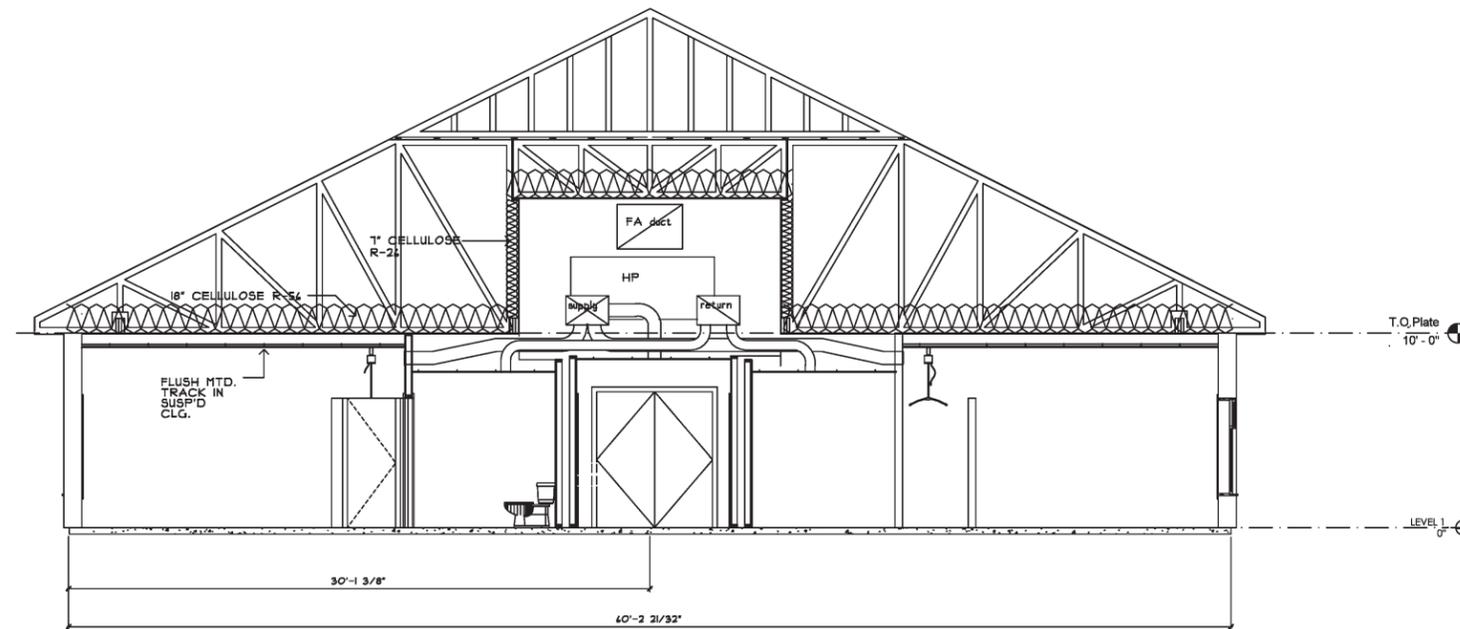
LEGEND

- Public-Family Spaces
- Resident Rooms
- Staff-Volunteer Spaces
- Support Spaces





SECTION A-A



SECTION B-B





VNA RESPITE HOUSE
U.S. Route 7, Colchester, Vermont

North East Elevation

April 2015





VNA RESPITE HOUSE
U.S. Route 7, Colchester, Vermont

North West Elevation

April 2015



VNA Respite House
Furnishings, Fixtures, and Equipment

Items		Estimated Cost	Calculation Remarks
Public Family Space	Front Porch, Pod Porches, & Patio	\$5,000	porch seating, outdoor furniture at patio, grill
	Reception/ Entry	\$2,000	reception desk, chair
	Family Living/ Dining Rooms	\$25,000	furniture, fireplace,
	Family kitchenette/ prep/ café area	\$8,000	stools, counter, appliances
	Multi-purpose meeting room (lg)	\$23,000	AV equipment, furniture, counter
	Children's area	\$1,000	Tables, chairs, etc.
	Family Room furnishing	\$12,000	\$6000 x 2 fam rms & reuse existing LR furn for 1 fam rm
	Reflection Room	\$7,500	chairs, feature wall, move stained glass
	Family soft seating at Core	\$3,000	furniture
Total Family Area Fitup		\$86,500	
Resident Rooms	Resident Room- Furniture	\$213,150	\$10,150/ room
	Reuse 13 resident beds	(\$52,000)	\$4000 each x 13 beds from existing house
	Reuse 14 recliners	(\$19,600)	\$1400 each x 14 recliners from existing house
	Reuse 14 sleeper sofas	(\$24,500)	\$1750 each x 14 sleeper sofas from existing house
	Equipment storage cabinet at bed head	\$42,000	\$2000 each? Need a unit for O2 conn, light, sharps, etc
	Resident Bath & Equipment	\$10,500	\$500/ room: wheelchair, commode, shower chair, curtain & rod
	TOTAL Resident Room Fitup	\$169,550	approx \$12,650 per resident room
Staff- Volunteer Space	Nursing/ LNA	\$7,000	5 workstations, tables, chairs
	Offices- 4	\$6,000	office furniture
	Meds	\$2,000	lockable cabinets, refrig, workcounter
	Shared offices- Social Worker/ Volunteers	\$5,000	lockers, work counters, chairs
	Staff Office/ Work Room/ Copy	\$1,000	storage shelving, work counters
	Staff Break room with kitchenette	\$4,000	furniture, cabinets, appliances
	Staff entry, mud room, coats, boots	\$3,000	coat closet, bench, lockers
	Staff/ Small Conferences	\$6,000	\$2k / room; 1 room at each pod
	Total Staff- Volunteer Space Fitup	\$34,000	
Healthcare equipment & Support Space Equipment	Kitchen equipment	\$150,000	Hood-\$30k, walk-ins- \$20k, cabinets-\$25k, appliances-\$46k, pot sink-\$10k.
	Laundry	\$26,500	Need 1 new washer, 2 new dryers, booster water heater, small stackable w/d, and shelving
	Housekeeping/ Janitor	\$10,000	Floor cleaning machines and equipment
	Vacuum Equipment	\$20,000	Option A- vacuum cleaners; Option B- central vac system
	Storage- shelving for all store rms	\$10,000	
	Hoyer Lifts- 1 per pod	\$6,000	\$2k per lift
	Resident Lift system	\$210,000	\$10k each room- investigating savings of track installation only
	Oxygen Distribution system	\$105,000	21 rms- NFPA 99 compliant system; plus Airgas leased equipmt
	Interior Design: Window Treatments, etc.	\$85,000	\$1k /pair of windows, \$10k artwork, etc.
	IT budget	\$100,000	Total Data and IT budget, incl computers, servers, cabling
	Security System	\$30,000	
Patient Care Technology	\$20,000	Nurse call system, motion sensors	
Total Support Space		\$772,500	
TOTAL FFE		\$1,062,550	

VNA Respite House Projected IT Expenses

Equipment Description	Qty	Cost	Total Cost
Computers	20	\$ 1,710	\$ 34,200
Microsoft Office	20	\$ 350	\$ 7,000
Network Routers	4	\$ 3,800	\$ 15,200
Telephones	10	\$ 400	\$ 4,000
Wireless Access Points	10	\$ 400	\$ 4,000
Audio Visual	1	\$ 5,000	\$ 5,000
Networking Cabling (hours)	100	\$ 100	\$ 10,000
Server	1	\$ 5,000	\$ 5,000
Technical Setup (hours)	35	\$ 160	\$ 5,600
Contingency	1	\$ 10,000	\$ 10,000
Total IT Cost			\$ 100,000

THE
University of Vermont
MEDICAL CENTER

April 14, 2015

EXECUTIVE OFFICE

Judy Peterson, President and CEO
VNA of Chittenden and Grand Isle Counties
1110 Prim Road
Colchester, VT 05446

MAIN CAMPUS

Patrick 3
111 Colchester Avenue
Burlington, VT 05401

Dear Judy,

I am glad to write to confirm the conversations that we have had over the course of the last year about the VNA's plans to replace and expand the Vermont Respite House. The University of Vermont Medical Center refers many patients to Vermont Respite House. We see it as an important end-of-life care option for our patients who are no longer seeking curative care but are not able to get their care needs met in their own homes.

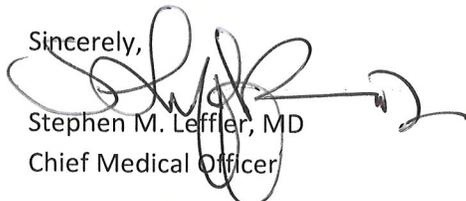
Over the last several years, we have experienced times when a patient may not be able to be admitted to Vermont Respite House because a bed was not available or might have to wait several days until one was open. We know that when possible, patients prefer to receive care their final days outside of the hospital and we agree that the hospital setting is better used for patients receiving curative care.

As we all partner together through OneCare Vermont and in other collaborations, we are seeking ways to meet the Triple Aim. We need sufficient capacity in the community so that patients can receive care in the setting of their choice; patients and family members can have the best possible quality of life in their final days; and that we can best use our collective health care facilities and dollars to meet our community's needs. This project will allow us to work together to ensure that our patients receive care in the right setting, by the right people, at the right time.

This project fits with the OneCare Vermont Clinical Advisory Board's priority to increase hospice utilization. We appreciate the work you have done so far to help educate the ACO's providers about the hospice referral process.

With the aging of our population and our initiatives to increase hospice utilization, the timing of this expansion project is just right for meeting the growing needs of our community. We look forward to continuing to collaborate with the VNA through our direct affiliation as well as through OneCare Vermont, to continue to find ways to best serve patients at the end of life.

Sincerely,



Stephen M. Leffler, MD
Chief Medical Officer

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 1
PROJECT COSTS

Construction Costs	
1. New Construction	\$ 4,352,000
2. Renovation	\$0
3. Site Work	676,000
4. Fixed Equipment	301,500
5. Design/Bidding Contingency	
6. Construction Contingency	\$510,000
7. Construction Manager Fee	-
8. Other (please specify)	-
Subtotal	\$ 5,839,500
Related Project Costs	
1. Major Moveable Equipment	\$ 100,000
2. Furnishings, Fixtures & Other Equip.	\$761,050
3. Architectural/Engineering Fees	\$512,000
4. Land Acquisition	500,000
5. Purchase of Buildings	-
6. Administrative Expenses & Permits	\$100,000
7. Debt Financing Expenses (see below)	87,504
8. Debt Service Reserve Fund	-
9. Working Capital	-
10. Other (please specify)	20,000
Subtotal	\$ 2,080,554
Total Project Costs	\$ 7,920,054

Debt Financing Expenses	
1. Capital Interest	\$ 87,504
2. Bond Discount or Placement Fee	-
3. Misc. Financing Fees & Exp. (issuance costs)	-
4. Other	-
Subtotal	\$ 87,504
Less Interest Earnings on Funds	
1. Debt Service Reserve Funds	\$ -
2. Capitalized Interest Account	-
3. Construction Fund	-
4. Other	-
Subtotal	\$ -
Total Debt Financing Expenses	\$ 87,504
feeds to line 7 above	



**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 2
DEBT FINANCING ARRANGEMENT, SOURCES & USES OF FUNDS

Sources of Funds		
1. Financing Instrument	Loan	
a. Interest Rate	4.5%	
b. Loan Period	Oct 2015 To: Sep 2016	
c. Amount Financed		\$ 3,000,000
2. Equity Contribution		-
3. Other Sources		
a. Working Capital		-
b. Fundraising		4,920,054
c. Grants		-
d. Other		-
Total Required Funds		\$ 7,920,054

Uses of Funds		
<u>Project Costs (feeds from Table 1)</u>		
1. New Construction		\$ 4,352,000
2. Renovation		-
3. Site Work		676,000
4. Fixed Equipment		301,500
5. Design/Bidding Contingency		-
6. Construction Contingency		510,000
7. Construction Manager Fee		-
8. Major Moveable Equipment		100,000
9. Furnishings, Fixtures & Other Equip.		761,050
10. Architectural/Engineering Fees		512,000
11. Land Acquisition		500,000
12. Purchase of Buildings		-
13. Administrative Expenses & Permits		100,000
14. Debt Financing Expenses		87,504
15. Debt Service Reserve Fund		-
16. Working Capital		-
17. Other (please specify)		20,000
Total Uses of Funds		\$ 7,920,054

Total sources should equal total uses of funds.

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 3A
INCOME STATEMENT
WITHOUT PROJECT

	Latest Actual	Budget	Proposed	Proposed	Proposed
	2014	2015	Year 1	Year 2	Year 3
	2017		2018	2019	
Revenues					
Inpatient Care Revenue	\$ -	\$ -	\$ -	\$ -	\$ -
Outpatient Care Revenue	26,461,826	28,159,563	27,680,823	27,858,429	28,387,034
Chronic/Rehab Revenue	-	-	-	-	-
SNF/ECF Patient Care Revenue	-	-	-	-	-
Swing Beds Patient Care Revenue	-	-	-	-	-
Gross Patient Care Revenue	\$ 26,461,826	\$ 28,159,563	\$ 27,680,823	\$ 27,858,429	\$ 28,387,034
Disproportionate Share Payments	\$ -	\$ -	\$ -	\$ -	\$ -
Free Care & Bad Debt	(402,323)	(382,176)	(669,303)	(350,000)	(355,000)
Deductions from Revenue	(1,392,667)	(1,394,432)	(1,447,338)	(1,400,000)	(1,400,000)
Net Patient Care Revenue	\$ 24,666,836	\$ 26,382,955	\$ 25,564,182	\$ 26,108,429	\$ 26,632,034
Other Operating Revenue	1,131,706	1,297,550	1,070,487	1,091,897	1,108,275
Total Operating Revenue	\$ 25,798,542	\$ 27,680,505	\$ 26,634,669	\$ 27,200,326	\$ 27,740,309
Operating Expense					
Salaries (Non-MD)	\$ 15,892,526	\$ 16,721,901	\$ 16,064,348	\$ 16,385,635	\$ 16,713,348
Frings Benefits (Non-MD)	3,801,458	4,142,631	3,848,463	3,925,432	4,003,941
Physician Fees/Salaries/Contracts/Fring	-	-	-	-	-
Health Care Provider Tax	-	-	-	-	-
Depreciation/Amortization	342,516	406,467	338,129	344,892	351,790
Interest	-	-	-	-	-
Other Operating Expense	7,485,520	7,764,137	7,836,493	7,993,223	8,153,087
Total Operating Expense	\$ 27,522,020	\$ 29,035,136	\$ 28,087,433	\$ 28,649,182	\$ 29,222,166
Net Operating Income (Loss)	\$ (1,723,478)	\$ (1,354,631)	\$ (1,452,764)	\$ (1,448,856)	\$ (1,481,857)
Non-Operating Revenue	2,113,340	1,624,666	1,456,639	1,485,772	1,530,345
Excess (Deficit) of Rev Over Exp	\$ 389,862	\$ 270,035	\$ 3,875	\$ 36,916	\$ 48,488

Latest actual numbers should tie to the hospital budget process.

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 3B
INCOME STATEMENT
PROJECT ONLY

	Latest Actual 2014	Budget 2015	Proposed Year 1 2017	Proposed Year 2 2018	Proposed Year 3 2019
Revenues					
Inpatient Care Revenue	N/A	\$ 2,503,838	\$ 3,533,416	\$ 3,780,132	\$ 4,062,330
Outpatient Care Revenue	N/A	-	-	-	-
Chronic/Rehab Revenue	N/A	-	-	-	-
SNF/ECF Patient Care Revenue	N/A	-	-	-	-
Swing Beds Patient Care Revenue	N/A	-	-	-	-
Gross Patient Care Revenue		\$ 2,503,838	\$ 3,533,416	\$ 3,780,132	\$ 4,062,330
Disproportionate Share Payments	N/A	\$ -	\$ -	\$ -	\$ -
Free Care & Bad Debt	N/A	(163,904)	(231,449)	(247,608)	(266,089)
Deductions from Revenue	N/A	(92,308)	(130,191)	(139,279)	(149,675)
Net Patient Care Revenue		\$ 2,247,626	\$ 3,171,776	\$ 3,393,245	\$ 3,646,566
Other Operating Revenue	N/A	200	500	500	500
Total Operating Revenue		\$ 2,247,826	\$ 3,172,276	\$ 3,393,745	\$ 3,647,066
Operating Expense					
Salaries (Non-MD)	N/A	\$ 1,200,262	\$ 1,425,655	\$ 1,536,179	\$ 1,632,427
Fringes Benefits (Non-MD)	N/A	326,250	379,048	403,032	424,197
Physician Fees/Salaries/Contracts/Fringes	N/A	102,588	232,314	236,961	241,700
Health Care Provider Tax	N/A	-	-	-	-
Depreciation/Amortization	N/A	33,944	413,302	413,302	413,302
Interest	N/A	-	87,504	-	-
Other Operating Expense	N/A	701,690	818,511	844,617	870,944
Total Operating Expense		\$ 2,364,734	\$ 3,356,334	\$ 3,434,091	\$ 3,582,570
Net Operating Income (Loss)		\$ (116,908)	\$ (184,058)	\$ (40,346)	\$ 64,496
Non-Operating Revenue	N/A	397,455	3,737,426	1,641,301	895,213
Excess (Deficit) of Rev Over Exp		\$ 280,547	\$ 3,553,368	\$ 1,600,955	\$ 959,709

Latest actual numbers should tie to the hospital budget process.

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 3C
INCOME STATEMENT
WITH PROJECT

	Latest Actual 2014	Budget 2015	Proposed Year 1 2017	Proposed Year 2 2018	Proposed Year 3 2019
Revenues					
Inpatient Care Revenue	#VALUE!	\$ 2,503,838	\$ 3,533,416	\$ 3,780,132	\$ 4,062,330
Outpatient Care Revenue	#VALUE!	28,159,563	27,680,823	27,858,429	28,387,034
Chronic/Rehab Revenue	#VALUE!	-	-	-	-
SNF/ECF Patient Care Revenue	#VALUE!	-	-	-	-
Swing Beds Patient Care Revenue	#VALUE!	-	-	-	-
Gross Patient Care Revenue	#VALUE!	\$ 30,663,401	\$ 31,214,239	\$ 31,638,561	\$ 32,449,364
Disproportionate Share Payments	#VALUE!	\$ -	\$ -	\$ -	\$ -
Free Care & Bad Debt	#VALUE!	(546,080)	(900,752)	(597,608)	(621,089)
Deductions from Revenue	#VALUE!	(1,486,740)	(1,577,529)	(1,539,279)	(1,549,675)
Net Patient Care Revenue	#VALUE!	\$ 28,630,581	\$ 28,735,958	\$ 29,501,674	\$ 30,278,600
Other Operating Revenue	#VALUE!	1,297,750	1,070,987	1,092,397	1,108,775
Total Operating Revenue	#VALUE!	\$ 29,928,331	\$ 29,806,945	\$ 30,594,071	\$ 31,387,375
Operating Expense					
Salaries (Non-MD)	#VALUE!	\$ 17,922,163	\$ 17,490,003	\$ 17,921,814	\$ 18,345,775
Frings Benefits (Non-MD)	#VALUE!	4,468,881	4,227,511	4,328,464	4,428,138
Physician Fees/Salaries/Contracts/Fring	#VALUE!	102,588	232,314	236,961	241,700
Health Care Provider Tax	#VALUE!	-	-	-	-
Depreciation/Amortization	#VALUE!	440,411	751,431	758,194	765,092
Interest	#VALUE!	-	87,504	-	-
Other Operating Expense	#VALUE!	8,465,827	8,655,004	8,837,840	9,024,031
Total Operating Expense	#VALUE!	\$ 31,399,870	\$ 31,443,767	\$ 32,083,273	\$ 32,804,736
Net Operating Income (Loss)	#VALUE!	\$ (1,471,539)	\$ (1,636,822)	\$ (1,489,202)	\$ (1,417,361)
Non-Operating Revenue	#VALUE!	2,022,121	5,194,065	3,127,073	2,425,558
Excess (Deficit) of Rev Over Exp	#VALUE!	\$ 550,582	\$ 3,557,243	\$ 1,637,871	\$ 1,008,197

Latest actual numbers should tie to the hospital budget process.

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 4A
BALANCE SHEET - UNRESTRICTED FUNDS
WITHOUT PROJECT

ASSETS	Latest Actual 2014	Budget 2015	Proposed Year 1 2017	Proposed Year 2 2018	Proposed Year 3 2019
Current Assets					
Cash & Investments	\$ 18,063,376	\$ 18,063,376	\$ 17,886,092	\$ 18,270,357	\$ 18,290,508
Patient Accounts Receivable, Gross	3,515,787	3,956,566	3,577,307	4,566,307	5,316,307
Less: Allowance for Uncollectable Accts.	(456,023)	(896,802)	(720,214)	(720,214)	(720,214)
Due from Third Parties	59,190	59,190	59,190	59,190	59,190
Other Current Assets	350,043	350,043	391,354	391,354	391,354
Total Current Assets	\$ 21,532,373	\$ 21,532,373	\$ 21,193,729	\$ 22,566,994	\$ 23,337,145
Board Designated Assets					
Funded Depreciation	\$ -	\$ -	\$ -	\$ -	\$ -
Escrowed Bond Funds					
Other	52,622	52,622	52,622	52,622	52,622
Total Board Designated Assets	\$ 52,622	\$ 52,622	\$ 52,622	\$ 52,622	\$ 52,622
Property, Plant & Equipment					
Land, Buildings & Improvements	\$ 4,580,942	\$ 4,672,442	\$ 11,386,834	\$ 11,478,334	\$ 11,569,834
Fixed Equipment					
Major Moveable Equipment	5,201,106	5,800,259	6,494,521	6,953,401	7,412,281
Construction in Progress					
Total Property, Plant & Equipment	\$ 9,782,048	\$ 10,472,701	\$ 17,881,355	\$ 18,431,735	\$ 18,982,115
Less: Accumulated Depreciation					
Land, Buildings & Improvements	\$ (2,073,242)	\$ (2,196,388)	\$ (2,588,187)	\$ (3,012,987)	\$ (3,437,787)
Fixed Equipment	(3,864,618)	(3,878,734)	(3,878,734)	(3,878,734)	(3,878,734)
Major Moveable Equipment	(793,400)	(938,092)	(1,003,792)	(1,190,986)	(1,378,180)
Total Accumulated Depreciation	\$ (6,731,260)	\$ (7,013,214)	\$ (7,470,713)	\$ (8,082,707)	\$ (8,694,701)
Total Net Property, Plant & Equipment	\$ 3,050,788	\$ 3,459,487	\$ 10,410,642	\$ 10,349,028	\$ 10,287,414
Other Long-Term Assets	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL ASSETS	\$ 24,635,783	\$ 25,044,482	\$ 31,656,993	\$ 32,968,644	\$ 33,677,181
LIABILITIES AND FUND BALANCE					
Current Liabilities					
Accounts Payable	\$ 2,874,005	\$ 2,872,396	\$ 2,900,751	\$ 2,900,751	\$ 2,900,751
Salaries, Wages & Payroll Taxes Payable	807,071	807,071	807,523	807,523	807,523
Estimated Third-Party Settlements	259,863	259,863	248,653	248,653	248,653
Other Current Liabilities	1,189,780	1,189,780	1,189,780	1,189,780	1,189,780
Current Portion of Long-Term Debt			3,000,000		
Total Current Liabilities	\$ 5,130,719	\$ 5,129,110	\$ 8,146,707	\$ 5,146,707	\$ 5,146,707
Long-Term Debt					
Bonds & Mortgages Payable	\$ -	\$ -	\$ -	\$ -	\$ -
Capital Lease Obligations	-	-	-	-	-
Other Long-Term Debt	-	-	-	-	-
Total Long-Term Debt	\$ -	\$ -	\$ -	\$ -	\$ -
Total Other Non-Current Liabilities	\$ -	\$ -	\$ -	\$ -	\$ -
Total Liabilities	\$ 5,130,719	\$ 5,129,110	\$ 8,146,707	\$ 5,146,707	\$ 5,146,707
Fund Balance	\$ 19,505,064	\$ 19,915,372	\$ 23,510,286	\$ 27,821,937	\$ 28,530,474
TOTAL LIABILITIES & FUND BALANCE	\$ 24,635,783	\$ 25,044,482	\$ 31,656,993	\$ 32,968,644	\$ 33,677,181

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 5A
STATEMENT OF CASH FLOWS
WITHOUT PROJECT

	Latest Actual 2014	Budget 2015	Proposed Year 1 2017	Proposed Year 2 2018	Proposed Year 3 2019
Beginning Cash	\$ 1,398,371	\$ 1,869,710	\$ 1,869,710	\$ 1,692,426	\$ 2,076,691
Operations					
Excess revenues over expenses	23,570	270,035	3,875	36,916	48,488
Depreciation / Amortization	377,364	406,467	338,129	344,892	351,790
(Increase)/Decrease Patient A/R	(295,425)	-	202,671	(989,000)	(750,000)
(Increase)/Decrease Other Changes	656,369	(1,609)	2,976,286	(3,000,000)	-
Subtotal Cash from Operations	\$ 761,878	\$ 674,893	\$ 3,520,961	\$ (3,607,192)	\$ (349,722)
Investing Activity					
Capital Spending					
Capital					
Capitalized Interest					
Change in accum depr less depreciation	-	(124,513)	119,370	267,102	260,204
(Increase) Decrease in capital assets	(356,463)	(690,653)	(7,408,654)	(550,380)	(550,380)
Subtotal Capital Spending	\$ (356,463)	\$ (815,166)	\$ (7,289,284)	\$ (283,278)	\$ (290,176)
(Increase) / Decrease					
Funded Depreciation		-	-	-	-
Other LT assets & escrowed bonds & other		-	-	-	-
Subtotal (Increase) / Decrease	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotal Cash from Investing Activity	\$ (356,463)	\$ (815,166)	\$ (7,289,284)	\$ (283,278)	\$ (290,176)
Financing Activity					
Debt (increase) decrease					
Bonds & mortgages		-	-	-	-
Repayment		-	-	-	-
Capital lease & other long term debt	-	-	-	-	-
Subtotal Cash from Financing Activity	\$ -	\$ -	\$ -	\$ -	\$ -
Other Changes (please describe)					
Manual adjustment					
Other					
Change in fund balance less net income	65,924	140,273	3,591,039	4,274,735	660,049
Other					
Subtotal Other Changes	\$ 65,924	\$ 140,273	\$ 3,591,039	\$ 4,274,735	\$ 660,049
Net Increase (Decrease) in Cash	\$ 471,339	\$ -	\$ (177,284)	\$ 384,265	\$ 20,151
Ending Cash	\$ 1,869,710	\$ 1,869,710	\$ 1,692,426	\$ 2,076,691	\$ 2,096,842

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 5B
STATEMENT OF CASH FLOWS
PROJECT ONLY

	Latest Actual 2014	Budget 2015	Proposed Year 1 2017	Proposed Year 2 2018	Proposed Year 3 2019
Beginning Cash	N/A	\$ -	\$ -	\$ -	\$ -
Operations					
Excess revenues over expenses	N/A	280,547	3,553,368	1,600,955	959,709
Depreciation / Amortization	N/A	33,944	413,302	413,302	413,302
(Increase)/Decrease Patient A/R	N/A	-	-	-	-
(Increase)/Decrease Other Changes	N/A	-	-	-	-
Subtotal Cash from Operations	N/A	\$ 314,491	\$ 3,966,670	\$ 2,014,257	\$ 1,373,011
Investing Activity					
Capital Spending					
Capital	N/A				
Capitalized Interest	N/A				
Change in accum depr less depreciation	N/A	(33,944)	(413,302)	(413,302)	(413,302)
(Increase) Decrease in capital assets	N/A	-	-	-	-
Subtotal Capital Spending	N/A	\$ (33,944)	\$ (413,302)	\$ (413,302)	\$ (413,302)
(Increase) / Decrease					
Funded Depreciation	N/A	-	-	-	-
Other LT assets & escrowed bonds & other	N/A	-	-	-	-
Subtotal (Increase) / Decrease	N/A	\$ -	\$ -	\$ -	\$ -
Subtotal Cash from Investing Activity	N/A	\$ (33,944)	\$ (413,302)	\$ (413,302)	\$ (413,302)
Financing Activity					
Debt (increase) decrease					
Bonds & mortgages	N/A	-	-	-	-
Repayment	N/A	-	-	-	-
Capital lease & other long term debt	N/A	-	-	-	-
Subtotal Cash from Financing Activity	N/A	\$ -	\$ -	\$ -	\$ -
Other Changes (please describe)					
Manual adjustment	N/A				
Other	N/A				
Change in fund balance less net income	N/A	(280,547)	(3,553,368)	(1,600,955)	(959,709)
Other	N/A				
Subtotal Other Changes	N/A	\$ (280,547)	\$ (3,553,368)	\$ (1,600,955)	\$ (959,709)
Net Increase (Decrease) in Cash	N/A	\$ -	\$ -	\$ -	\$ -
Ending Cash	N/A	\$ -	\$ -	\$ -	\$ -

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 5C
STATEMENT OF CASH FLOWS
WITH PROJECT

	Latest Actual 2014	Budget 2015	Proposed Year 1 2017	Proposed Year 2 2018	Proposed Year 3 2019
Beginning Cash	#VALUE!	\$ 1,869,710	\$ 1,869,710	\$ 1,692,426	\$ 2,076,691
Operations					
Excess revenues over expenses	#VALUE!	550,582	3,557,243	1,637,871	1,008,197
Depreciation / Amortization	#VALUE!	440,411	751,431	758,194	765,092
(Increase)/Decrease Patient A/R	#VALUE!	-	202,671	(989,000)	(750,000)
(Increase)/Decrease Other Changes	#VALUE!	(1,609)	2,976,286	(3,000,000)	-
Subtotal Cash from Operations	#VALUE!	\$ 989,384	\$ 7,487,631	\$ (1,592,935)	\$ 1,023,289
Investing Activity					
Capital Spending					
Capital	#VALUE!	-	-	-	-
Capitalized Interest	#VALUE!	-	-	-	-
Change in accum depr less depreciation	#VALUE!	(158,457)	(293,932)	(146,200)	(153,098)
(Increase) Decrease in capital assets	#VALUE!	(690,653)	(7,408,654)	(550,380)	(550,380)
Subtotal Capital Spending	#VALUE!	\$ (849,110)	\$ (7,702,586)	\$ (696,580)	\$ (703,478)
(Increase) / Decrease					
Funded Depreciation	#VALUE!	-	-	-	-
Other LT assets & escrowed bonds & other	#VALUE!	-	-	-	-
Subtotal (Increase) / Decrease	#VALUE!	\$ -	\$ -	\$ -	\$ -
Subtotal Cash from Investing Activity	#VALUE!	\$ (849,110)	\$ (7,702,586)	\$ (696,580)	\$ (703,478)
Financing Activity					
Debt (increase) decrease					
Bonds & mortgages	#VALUE!	-	-	-	-
Repayment	#VALUE!	-	-	-	-
Capital lease & other long term debt	#VALUE!	-	-	-	-
Subtotal Cash from Financing Activity	#VALUE!	\$ -	\$ -	\$ -	\$ -
Other Changes (please describe)					
Manual adjustment	#VALUE!	-	-	-	-
Other	#VALUE!	-	-	-	-
Change in fund balance less net income	#VALUE!	(140,274)	37,671	2,673,780	(299,660)
Other	#VALUE!	-	-	-	-
Subtotal Other Changes	#VALUE!	\$ (140,274)	\$ 37,671	\$ 2,673,780	\$ (299,660)
Net Increase (Decrease) in Cash	#VALUE!	\$ -	\$ (177,284)	\$ 384,265	\$ 20,151
Ending Cash	#VALUE!	\$ 1,869,710	\$ 1,692,426	\$ 2,076,691	\$ 2,096,842

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 6A
REVENUE SOURCE PROJECTIONS
WITHOUT PROJECT

	Latest Actual 2014	% of Total	Budget 2015	% of Total	Proposed Year 1 2017	% of Total	Proposed Year 2 2018	% of Total	Proposed Year 3 2019	% of Total
Gross Inpatient Revenue										
Medicare	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!
Gross Outpatient Revenue										
Medicare	\$ 9,523,798	34.5%	\$ 9,193,898	31.2%	\$ 9,348,850	32.5%	\$ 10,007,419	34.6%	\$ 10,197,307	34.6%
Medicaid	12,013,419	43.5%	14,141,833	48.0%	13,387,791	46.6%	12,658,013	43.7%	12,898,195	43.7%
Commercial	2,813,098	10.2%	2,755,524	9.4%	2,838,688	9.9%	2,965,841	10.2%	3,022,117	10.2%
Self Pay	2,111,511	7.7%	2,068,308	7.0%	2,105,534	7.3%	2,227,156	7.7%	2,269,415	7.7%
Free Care / Bad Debt	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other	1,131,706	4.1%	1,297,550	4.4%	1,070,447	3.7%	1,091,897	3.8%	1,108,275	3.8%
	\$ 27,593,532	100.0%	\$ 29,457,113	100.0%	\$ 28,751,310	100.0%	\$ 28,950,326	100.0%	\$ 29,495,309	100.0%
Gross Other Revenue										
Medicare	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!
Medicaid	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!
Gross Patient Revenue										
Medicare	\$ 9,523,798	34.5%	\$ 9,193,898	31.2%	\$ 9,348,850	32.5%	\$ 10,007,419	34.6%	\$ 10,197,307	34.6%
Medicaid	12,013,419	43.5%	14,141,833	48.0%	13,387,791	46.6%	12,658,013	43.7%	12,898,195	43.7%
Commercial	2,813,098	10.2%	2,755,524	9.4%	2,838,688	9.9%	2,965,841	10.2%	3,022,117	10.2%
Self Pay	2,111,511	7.7%	2,068,308	7.0%	2,105,534	7.3%	2,227,156	7.7%	2,269,415	7.7%
Free Care / Bad Debt	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other	1,131,706	4.1%	1,297,550	4.4%	1,070,447	3.7%	1,091,897	3.8%	1,108,275	3.8%
	\$ 27,593,532	100.0%	\$ 29,457,113	100.0%	\$ 28,751,310	100.0%	\$ 28,950,326	100.0%	\$ 29,495,309	100.0%
Deductions from Revenue										
Medicare	\$ 220,501	12.3%	\$ 194,771	11.0%	\$ 211,039	10.0%	\$ 192,500	11.0%	\$ 190,000	10.8%
Medicaid	811,774	45.2%	876,597	49.3%	882,653	41.7%	857,500	49.0%	860,000	49.0%
Commercial	360,392	20.1%	323,064	18.2%	353,646	16.7%	350,000	20.0%	350,000	19.9%
Self Pay	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Free Care / Bad Debt	402,323	22.4%	382,176	21.5%	669,303	31.6%	350,000	20.0%	355,000	20.2%
Other	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
	\$ 1,794,990	100.0%	\$ 1,776,608	100.0%	\$ 2,116,641	100.0%	\$ 1,750,000	100.0%	\$ 1,755,000	100.0%
Net Patient Revenue										
Medicare	\$ 9,303,297	36.1%	\$ 8,999,127	32.5%	\$ 9,137,811	34.3%	\$ 9,814,919	36.1%	\$ 10,007,307	36.1%
Medicaid	11,201,645	43.4%	13,265,236	47.9%	12,505,138	47.0%	11,800,513	43.4%	12,038,195	43.4%
Commercial	2,452,706	9.5%	2,432,460	8.8%	2,485,042	9.3%	2,615,841	9.6%	2,672,117	9.6%
Self Pay	2,111,511	8.2%	2,068,308	7.5%	2,105,534	7.9%	2,227,156	8.2%	2,269,415	8.2%
Free Care / Bad Debt	(402,323)	-1.6%	(382,176)	-1.4%	(669,303)	-2.5%	(350,000)	-1.3%	(355,000)	-1.3%
Other	1,131,706	4.4%	1,297,550	4.7%	1,070,447	4.0%	1,091,897	4.0%	1,108,275	4.0%
DSP*	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
	\$ 25,798,542	100.0%	\$ 27,680,505	100.0%	\$ 26,634,669	100.0%	\$ 27,200,326	100.0%	\$ 27,740,309	100.0%

Latest actual numbers should tie to the hospital budget process.

* Disproportionate share payments

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 6B
REVENUE SOURCE PROJECTIONS
PROJECT ONLY

	Latest Actual 2014	% of Total	Budget 2015	% of Total	Proposed Year 1 2017	% of Total	Proposed Year 2 2018	% of Total	Proposed Year 3 2019	% of Total
Gross Inpatient Revenue										
Medicare	N/A		\$ 1,487,995	59.4%	\$ 2,099,146	59.4%	\$ 2,245,196	59.4%	\$ 2,413,321	59.4%
Medicaid	N/A		160,200	6.4%	226,171	6.4%	241,960	6.4%	260,021	6.4%
Commercial	N/A		468,920	18.7%	660,342	18.7%	706,978	18.7%	759,249	18.7%
Self Pay	N/A		386,723	15.4%	547,757	15.5%	585,998	15.5%	629,739	15.5%
Free Care / Bad Debt	N/A		-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other	N/A		-	0.0%	-	0.0%	-	0.0%	-	0.0%
	N/A		\$ 2,503,838	100.0%	\$ 3,533,416	100.0%	\$ 3,780,132	100.0%	\$ 4,062,330	100.0%
Gross Outpatient Revenue										
Medicare	N/A		\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!
Medicaid	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Commercial	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Self Pay	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Free Care / Bad Debt	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Other	N/A		-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	N/A		\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!	\$ -	#DIV/0!
Gross Other Revenue										
Medicare	N/A		\$ -	0.0%	\$ -	0.0%	\$ -	0.0%	\$ -	0.0%
Medicaid	N/A		-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	N/A		-	0.0%	-	0.0%	-	0.0%	-	0.0%
Self Pay	N/A		-	0.0%	-	0.0%	-	0.0%	-	0.0%
Free Care / Bad Debt	N/A		-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other	N/A		200	100.0%	500	100.0%	500	100.0%	500	100.0%
	N/A		\$ 200	100.0%	\$ 500	100.0%	\$ 500	100.0%	\$ 500	100.0%
Gross Patient Revenue										
Medicare	N/A		\$ 1,487,995	59.4%	\$ 2,099,146	59.4%	\$ 2,245,196	59.4%	\$ 2,413,321	59.4%
Medicaid	N/A		160,200	6.4%	226,171	6.4%	241,960	6.4%	260,021	6.4%
Commercial	N/A		468,920	18.7%	660,342	18.7%	706,978	18.7%	759,249	18.7%
Self Pay	N/A		386,723	15.4%	547,757	15.5%	585,998	15.5%	629,739	15.5%
Free Care / Bad Debt	N/A		-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other	N/A		200	0.0%	500	0.0%	500	0.0%	500	0.0%
	N/A		\$ 2,504,038	100.0%	\$ 3,533,916	100.0%	\$ 3,780,632	100.0%	\$ 4,062,830	100.0%
Deductions from Revenue										
Medicare	N/A		\$ 26,305	10.3%	\$ 37,249	10.3%	\$ 39,849	10.3%	\$ 42,824	10.3%
Medicaid	N/A		3,877	1.5%	5,425	1.5%	5,803	1.5%	6,236	1.5%
Commercial	N/A		62,126	24.2%	87,517	24.2%	93,627	24.2%	100,615	24.2%
Self Pay	N/A		-	0.0%	-	0.0%	-	0.0%	-	0.0%
Free Care / Bad Debt	N/A		163,904	64.0%	231,449	64.0%	247,608	64.0%	266,089	64.0%
Other	N/A		-	0.0%	-	0.0%	-	0.0%	-	0.0%
	N/A		\$ 256,212	100.0%	\$ 361,640	100.0%	\$ 386,887	100.0%	\$ 415,764	100.0%
Net Patient Revenue										
Medicare	N/A		\$ 1,461,690	65.0%	\$ 2,061,897	65.0%	\$ 2,205,347	65.0%	\$ 2,370,497	65.0%
Medicaid	N/A		156,323	7.0%	220,746	7.0%	236,157	7.0%	253,785	7.0%
Commercial	N/A		406,794	18.1%	572,825	18.1%	613,351	18.1%	658,634	18.1%
Self Pay	N/A		386,723	17.2%	547,757	17.3%	585,998	17.3%	629,739	17.3%
Free Care / Bad Debt	N/A		(163,904)	-7.3%	(231,449)	-7.3%	(247,608)	-7.3%	(266,089)	-7.3%
Other	N/A		200	0.0%	500	0.0%	500	0.0%	500	0.0%
DSP*	N/A		N/A		N/A		N/A		N/A	
	N/A		\$ 2,247,826	100.0%	\$ 3,172,276	100.0%	\$ 3,393,745	100.0%	\$ 3,647,066	100.0%

Latest actual numbers should tie to the hospital budget process.

* Disproportionate share payments

5/1/2015

Health Care Administration

Final CON_Tables (Jim), Table 6B

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 6C
REVENUE SOURCE PROJECTIONS
WITH PROJECT

	Latest Actual 2014	% of Total	Budget 2015	% of Total	Proposed Year 1 2017	% of Total	Proposed Year 2 2018	% of Total	Proposed Year 3 2019	% of Total
Gross Inpatient Revenue										
Medicare	\$ -	#DIV/0!	\$ 1,487,995	59.4%	\$ 2,099,146	59.4%	\$ 2,245,196	59.4%	\$ 2,413,321	59.4%
Medicaid	-	#DIV/0!	160,200	6.4%	226,171	6.4%	241,960	6.4%	260,021	6.4%
Commercial	-	#DIV/0!	468,920	18.7%	660,342	18.7%	706,978	18.7%	759,249	18.7%
Self Pay	-	#DIV/0!	386,723	15.4%	547,757	15.5%	585,998	15.5%	629,739	15.5%
Free Care / Bad Debt	-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other	-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%	-	0.0%
	\$ -	#DIV/0!	\$ 2,503,838	100.0%	\$ 3,533,416	100.0%	\$ 3,780,132	100.0%	\$ 4,062,330	100.0%
Gross Outpatient Revenue										
Medicare	\$ 9,523,798	34.5%	\$ 9,193,898	31.2%	\$ 9,348,850	32.5%	\$ 10,007,419	34.6%	\$ 10,197,307	34.6%
Medicaid	12,013,419	43.5%	14,141,833	48.0%	13,387,791	46.6%	12,658,013	43.7%	12,898,195	43.7%
Commercial	2,813,098	10.2%	2,755,524	9.4%	2,838,688	9.9%	2,965,841	10.2%	3,022,117	10.2%
Self Pay	2,111,511	7.7%	2,068,308	7.0%	2,105,534	7.3%	2,227,156	7.7%	2,269,415	7.7%
Free Care / Bad Debt	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other	1,131,706	4.1%	1,297,550	4.4%	1,070,447	3.7%	1,091,897	3.8%	1,108,275	3.8%
	\$ 27,593,532	100.0%	\$ 29,457,113	100.0%	\$ 28,751,310	100.0%	\$ 28,950,326	100.0%	\$ 29,495,309	100.0%
Gross Other Revenue										
Medicare	\$ -	#DIV/0!	\$ -	0.0%	\$ -	0.0%	\$ -	0.0%	\$ -	0.0%
Medicaid	-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Commercial	-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Self Pay	-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Free Care / Bad Debt	-	#DIV/0!	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other	-	#DIV/0!	200	100.0%	500	100.0%	500	100.0%	500	100.0%
	\$ -	#DIV/0!	\$ 200	100.0%	\$ 500	100.0%	\$ 500	100.0%	\$ 500	100.0%
Gross Patient Revenue										
Medicare	\$ 9,523,798	34.5%	\$ 10,681,893	33.4%	\$ 11,447,996	35.5%	\$ 12,252,615	37.4%	\$ 12,610,628	37.6%
Medicaid	12,013,419	43.5%	14,302,033	44.7%	13,613,962	42.2%	12,899,973	39.4%	13,158,216	39.2%
Commercial	2,813,098	10.2%	3,224,444	10.1%	3,499,030	10.8%	3,672,819	11.2%	3,781,366	11.3%
Self Pay	2,111,511	7.7%	2,455,031	7.7%	2,653,291	8.2%	2,813,154	8.6%	2,899,154	8.6%
Free Care / Bad Debt	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other	1,131,706	4.1%	1,297,750	4.1%	1,070,947	3.3%	1,092,397	3.3%	1,108,775	3.3%
	\$ 27,593,532	100.0%	\$ 31,961,151	100.0%	\$ 32,285,226	100.0%	\$ 32,730,958	100.0%	\$ 33,558,139	100.0%
Deductions from Revenue										
Medicare	\$ 220,501	12.3%	\$ 221,076	10.9%	\$ 248,288	10.0%	\$ 232,349	10.9%	\$ 232,824	10.7%
Medicaid	811,774	45.2%	880,474	43.3%	888,078	35.8%	863,303	40.4%	866,236	39.9%
Commercial	360,392	20.1%	385,190	18.9%	441,163	17.8%	443,627	20.8%	450,615	20.8%
Self Pay	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Free Care / Bad Debt	402,323	22.4%	546,080	26.9%	900,752	36.3%	597,608	28.0%	621,089	28.6%
Other	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
	\$ 1,794,990	100.0%	\$ 2,032,820	100.0%	\$ 2,478,281	100.0%	\$ 2,136,887	100.0%	\$ 2,170,764	100.0%
Net Patient Revenue										
Medicare	\$ 9,303,297	36.1%	\$ 10,460,817	35.0%	\$ 11,199,708	37.6%	\$ 12,020,266	39.3%	\$ 12,377,804	39.4%
Medicaid	11,201,645	43.4%	13,421,559	44.8%	12,725,884	42.7%	12,036,670	39.3%	12,291,980	39.2%
Commercial	2,452,706	9.5%	2,839,254	9.5%	3,057,867	10.3%	3,229,192	10.6%	3,330,751	10.6%
Self Pay	2,111,511	8.2%	2,455,031	8.2%	2,653,291	8.9%	2,813,154	9.2%	2,899,154	9.2%
Free Care / Bad Debt	(402,323)	-1.6%	(546,080)	-1.8%	(900,752)	-3.0%	(597,608)	-2.0%	(621,089)	-2.0%
Other	1,131,706	4.4%	1,297,750	4.3%	1,070,947	3.6%	1,092,397	3.6%	1,108,775	3.5%
DSP*	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
	\$ 25,798,542	100.0%	\$ 29,928,331	100.0%	\$ 29,806,945	100.0%	\$ 30,594,071	100.0%	\$ 31,387,375	100.0%

Latest actual numbers should tie to the hospital budget process.

* Disproportionate share payments

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 7
UTILIZATION PROJECTIONS
TOTALS

A: WITHOUT PROJECT			Proposed	Proposed	Proposed
	Latest Actual	Budget	Year 1	Year 2	Year 3
		1	2	3	4
Inpatient Utilization					
Occupied Bed Days	3,792	-	-	-	-
Routine Hospice Day	1,754	-	-	-	-
Inpatient Hospice Day	2,038	-	-	-	-
Number of Patients	212	-	-	-	-
Average Length of Stay	17.89	-	-	-	-
Med Director Visits	212	-	-	-	-

B: PROJECT ONLY			Proposed	Proposed	Proposed
	Latest Actual	Budget	Year 1	Year 2	Year 3
	0	1	2	3	4
Inpatient Utilization					
Occupied Bed Days	N/A	3,750	5,610	5,950	6,290
Routine Hospice Day	N/A	1,500	2,524	2,677	2,830
Inpatient Hospice Day	N/A	2,250	3,086	3,273	3,460
Number of Patients	N/A	212	330	350	370
Average Length of Stay	N/A	17.69	17.00	17.00	17.00
Med Director Visits	N/A	200	300	325	350

C: WITH PROJECT			Proposed	Proposed	Proposed
	Latest Actual	Budget	Year 1	Year 2	Year 3
	0	1	2	3	4
Inpatient Utilization					
Occupied Bed Days	3,792	3,750	5,610	5,950	6,290
Routine Hospice Day	1,754	1,500	2,524	2,677	2,830
Inpatient Hospice Day	2,038	2,250	3,086	3,273	3,460
Number of Patients	212	212	330	350	370
Average Length of Stay	18	18	17	17	17
Adjusted Patient Days	212	200	300	325	350

**Visiting Nurse Association of Chittenden & Grand Isle Counties, Inc.
Vermont Respite House Expansion/Replacement**

TABLE 9
STAFFING PROJECTIONS
TOTALS

A: WITHOUT PROJECT	Latest Actual	Budget	Proposed	Proposed	Proposed
	2014	2015	Year 1	Year 2	Year 3
			2016	2017	2018
Non-MD FTEs					
Administrative	2.1	0.0	0.0	0.0	0.0
Skilled Nursing	8.9	0.0	0.0	0.0	0.0
Licensed Nursing Aides	10.5	0.0	0.0	0.0	0.0
Social Worker	0.5	0.0	0.0	0.0	0.0
Chaplin	0.3	0.0	0.0	0.0	0.0
Total Non-MD FTEs	22.3	0.0	0.0	0.0	0.0
Physician FTEs	0.5	0.0	0.0	0.0	0.0
Direct Service Nurse FTEs					

B: PROJECT ONLY	Latest Actual	Budget	Proposed	Proposed	Proposed
	2014	2015	Year 1	Year 2	Year 3
			2016	2017	2018
Non-MD FTEs					
Administrative	N/A	2.5	1.6	2.0	2.0
Skilled Nursing	N/A	10.1	13.3	14.1	14.9
Licensed Nursing Aides	N/A	9.8	11.1	11.8	12.5
Social Worker	N/A	0.5	0.8	0.9	0.9
Chaplin	N/A	0.3	0.3	0.3	0.3
Total Non-MD FTEs	N/A	23.2	27.1	29.0	30.5
Physician Services	N/A	0.5	0.5	0.8	0.8
Direct Service Nurse FTEs	N/A				

C: WITH PROJECT	Latest Actual	Budget	Proposed	Proposed	Proposed
	2014	2015	Year 1	Year 2	Year 3
			2016	2017	2018
Non-MD FTEs					
Total General Services	#VALUE!	2.5	1.6	2.0	2.0
Total Inpatient Routine Services	#VALUE!	10.1	13.3	14.1	14.9
Total Outpatient Routine Services	#VALUE!	9.8	11.1	11.8	12.5
Total Ancillary Services	#VALUE!	0.5	0.8	0.9	0.9
Total Other Services	#VALUE!	0.3	0.3	0.3	0.3
Total Non-MD FTEs	#VALUE!	23.2	27.1	29.0	30.5
Physician Services	#VALUE!	0.5	0.5	0.8	0.8
Direct Service Nurse FTEs	#VALUE!	0.0	0.0	0.0	0.0

Vermont Respite House Replacement and Expansion Certificate of Need Application
Key Assumptions Included in Financial Tables

Tables 1 and 2: Project Costs and Sources and Uses of Funds

Construction Costs

1. New construction is projected to be \$180/square foot.
2. Site work includes septic, utilities, refuse, driveway, parking, landscaping, and walkways.
3. Fixed equipment is delineated in Attachment E along with the furnishings, fixtures and other equipment.
4. Other costs include funds to move existing furniture, equipment and supplies from the existing house to the new facility.

Related Projected Costs

1. The major moveable equipment includes the purchase of a new generator capable of operating the larger facility in the event of a power outage.
2. A list of the furnishings, fixtures, and other equipment is listed in Attachment E along with the fixed equipment. As shown on the table the VNA anticipates bringing furnishings and equipment from the current house wherever possible.
3. Architectural and engineering fees and other soft costs such as permit fees are included at 12% of construction costs.

Sources of Funds Including Debt Financing Expenses

1. The VNA will undertake a capital campaign to cover the construction and related project costs. We anticipate that we will raise the majority of the \$7,920,054 prior to completing the project. Some of these funds will be in pledges that will be paid over the course of three or four years.
2. For planning purposes we are assuming that:
 - We will obtain enough contributions to enable us to purchase the land, complete the planning for the project, and do the initial site work.
 - We anticipate that we may need a bridge loan of up to \$3 million to help pay for expenses until committed contributions are received and that we can obtain such a loan at an interest rate of 4.5%.
 - We anticipate receiving the remaining funds by the end of FY19.

Table 3A: Income Statement Without Project

1. This table represents the actual, budgeted and forecasted revenues and expenses for all VNA Programs and Services, excluding the current Vermont Respite House.
2. Projections are based on actual experience.
3. Revenues are projected to increase 1-1.5% per year based on historic trends with no increase in Medicaid reimbursement rates.
4. Expenses are projected to increase in aggregate at 2% per year.

Table 3B: Income Statement Project Only

1. The FY14 numbers in Budget 2015 represent the Vermont Respite House budget for the current fiscal year; 7/1/14-6/30/15.
2. Projected revenues and expenses are based upon utilization and staffing projections outlined in Tables 7 and 9.
3. The non-operating revenues, which include funds from community contributions, special events, United Way, the VNA endowment allocation, and other fund raising, and will likely increase as the number of patients increases, but are projected with minimal increases.
4. In years 1-3, FY17-19, the non-operating revenues also include receipt of capital campaign contributions as follows:
 - \$3,000,000 in FY17
 - \$1,250,000 in FY18
 - \$500,000 in FY19

These projections assume that we will receive the remainder of the contributions toward the total project cost in FY16.

Table 4A: Balance Sheet

1. The assets, liabilities and fund balance are shown for the VNA. Vermont Respite House is a program of the VNA and does not have its own balance sheet.
2. The figures in column 1 represent the most recent audited financial statement from FY14.
3. Column 2 represents the VNA's current year balance sheet for FY15.
4. The projected years in columns 3-5 represent the first year of project completion, FY17, and the subsequent two years. The projections are based on our historical data and forecasted operational utilization for this project.

Table 5ABC: Statement of Cash Flows

1. Figures flow from the income statement and balance sheet tables.

Table 6A: Revenue Projections Without Project

1. This table reflects revenues for the agency without the Vermont Respite House and is based on our historical payer mix. These revenues are listed under Outpatient Services, and reflect all of the home health and hospice services that we provide in homes and other community settings, excluding Vermont Respite House.
2. Medicaid rates are projected to remain level funded.
3. Self pay reflects costs paid by patients or family members.
4. Grants for patient care are listed under other revenue and non-operating revenues are excluded.

Table 6B: Revenue Projections Project Only

1. This table reflects the current budget for Vermont Respite House and projected utilization for the expanded replacement facility.
2. The revenues are listed under Inpatient Services as they represent the care provided in our inpatient hospice facility.
3. Revenues will increase based upon the increased utilization projected in table 7.

4. We project that the mix of patients reimbursed at the General Inpatient level of care will be level at 55% of patients, in the first three years.
5. Medicare, Medicaid and Commercial reimbursement rates increase at 1%, which is based on experience.

Table 7: Utilization Projections

1. This table shows actual and projected utilization for Vermont Respite House.
2. Actual utilization is based on FY14.
3. Utilization projections are based upon our forecasted need and related assumptions described in Section 4 of this application. The key methods and assumptions used in this model are:
 - The population of people 65 and older in Chittenden and Grand Isle Counties as forecasted by the Vermont Department of Aging and Independent Living for 2020 are projected to grow from 20,613 people in FY14 to 29,523 in FY2020.
 - The number of people using hospice services will grow from 619 in FY14 to 1,137 based on the growing population and a growing awareness of hospice services due to efforts on behalf of the VNA, the community, and beyond to increase the understanding and awareness of hospice services to health care professionals and the community-at-large.
 - Currently 34% of VNA hospice patients use Vermont Respite House and based upon the increased capacity of the proposed house, this was increased to 35% in the forecast model.
 - The average length of stay of residents at Vermont Respite House has been declining over the past years as has the length of stay for all hospice patients. Our model assumes that this LOS, which is currently 17.2 days, will stabilize at 16 days due to the larger capacity and ability to take a mix of patients with varying levels of acuity.
 - The projected bed need to serve this population is based upon an occupancy rate of 85% which, due to normal turnover time between residents, is considered full capacity.

Table 8: Not Applicable

Table 9: Staffing

1. This table shows current and projected staffing for Vermont Respite House.
2. The table assumes that we will operate with an average ratio of 1 RN and 1 LNA to no more than 7 residents.
3. It assumes that with a bigger house we will need to increase our staff time for the following positions:
 - Medical Director
 - Skilled Nursing
 - LNA's
 - Social Work
 - Cook
 - Administrative support

VISITING NURSE ASSOCIATION OF
CHITTENDEN AND GRAND ISLE COUNTIES, INC.
AUDITED FINANCIAL STATEMENTS
JUNE 30, 2014 AND 2013

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Independent Auditor's Report

Board of Directors
Visiting Nurse Association of Chittenden
and Grand Isle Counties, Inc.
Colchester, Vermont

We have audited the accompanying financial statements of Visiting Nurse Association of Chittenden and Grand Isle Counties, Inc., which comprise the balance sheets as of June 30, 2014 and 2013, the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control.

Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Visiting Nurse Association of Chittenden and Grand Isle Counties, Inc. as of June 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 5, 2014, on our consideration of the Association's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and important for assessing the results of our audit.

A handwritten signature in black ink, appearing to read 'A. D. [unclear]', located in the lower right quadrant of the page.

Concord, New Hampshire
November 5, 2014

VT Registration No. 92.0000625

VISITING NURSE ASSOCIATION OF
CHITTENDEN AND GRAND ISLE COUNTIES, INC.

BALANCE SHEETS

FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

ASSETS

	2014	2013
Current Assets		
Cash and cash equivalents	\$ 1,869,710	\$ 1,398,371
Patient accounts receivable, less allowances for uncollectible accounts of \$456,023 and \$440,634 at June 30, 2014 and 2013, respectively	3,059,764	2,764,339
Miscellaneous grants and other receivables	59,190	114,248
Other current assets	350,043	251,937
Total Current Assets	5,338,707	4,528,895
Investments	16,193,666	14,409,640
Other Assets	52,622	52,622
Property and Equipment, Net	3,050,788	3,071,689
TOTAL ASSETS	\$ 24,635,783	\$ 22,062,846

LIABILITIES AND NET ASSETS

Current Liabilities		
Accounts payable and accrued expenses	\$ 3,654,076	\$ 3,104,426
Due to third-party payers	259,863	143,310
Deferred revenue	525,360	492,146
Total Current Liabilities	4,439,299	3,739,882
Charitable Remainder Trust Liability	691,420	739,653
Total Liabilities	5,130,719	4,479,535
Net Assets		
Unrestricted	9,601,965	8,746,917
Temporarily restricted	3,127,151	2,086,189
Permanently restricted	6,775,948	6,750,205
Total Net Assets	19,505,064	17,583,311
TOTAL LIABILITIES AND NET ASSETS	\$ 24,635,783	\$ 22,062,846

(See accompanying notes to these financial statements)

VISITING NURSE ASSOCIATION OF
CHITTENDEN AND GRAND ISLE COUNTIES, INC.

STATEMENTS OF OPERATIONS

FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

	2014	2013
Operating Revenue		
Patient service revenue	\$ 26,873,593	\$ 24,446,409
Provision for bad debts	(171,145)	(299,065)
Net patient service revenue	26,702,448	24,147,344
Other operating revenue	1,220,491	1,122,596
Total Operating Revenue	27,922,939	25,269,940
Operating Expenses		
Salaries and benefits	21,131,128	20,809,279
Other operating expenses	8,196,208	5,847,727
Depreciation and amortization	377,364	362,981
Interest expense	-	1,503
Total Operating Expenses	29,704,700	27,021,490
OPERATING LOSS	(1,781,761)	(1,751,550)
Other Revenue and Gains (Losses)		
Municipal appropriations and United Way	561,830	577,398
Contributions and fundraising income	933,131	730,050
Investment income	139,447	151,581
Net assets released from restriction	360,652	349,888
Change in fair value of investments	641,749	348,355
Total Other Revenue and Gains	2,636,809	2,157,272
EXCESS (DEFICIT) OF REVENUE OVER EXPENSES	\$ 855,048	\$ 405,722

(See accompanying notes to these financial statements)

VISITING NURSE ASSOCIATION OF
CHITTENDEN AND GRAND ISLE COUNTIES, INC.

STATEMENTS OF CHANGES IN NET ASSETS
FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

	2014	2013
Unrestricted Net Assets:		
Excess (Defecit) of revenue over expenses	855,048	405,722
Increase (Decrease) in Unrestricted Net Assets	855,048	405,722
Temporarily Restricted Net Assets:		
Contributions	62,243	263,137
Investment income	199,846	165,876
Charitable remainder trust distribution	(28,923)	-
Change in fair value of investments	1,168,448	636,836
Net assets released from restriction	(360,652)	(349,888)
Increase in Temporarily Restricted Net Assets	1,040,962	715,961
Permanently Restricted Net Assets:		
Contributions	25,743	9,318
Increase (Decrease) in Permanently Restricted Net Assets	25,743	9,318
Change in Net Assets	1,921,753	1,131,001
Net assets, beginning of year	17,583,311	16,452,310
NET ASSETS, END OF YEAR	\$ 19,505,064	\$ 17,583,311

(See accompanying notes to these financial statements)

VISITING NURSE ASSOCIATION OF
CHITTENDEN AND GRAND ISLE COUNTIES, INC.

STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED JUNE 30, 2014 AND 2013

	2014	2013
Cash Flows From Operating Activities		
Change in net assets	\$ 1,921,753	\$ 1,131,001
Adjustments to reconcile change in net assets to net cash (used) provided by operating activities		
Depreciation	377,364	362,981
Bad debt expense	171,145	299,065
Change in fair value of investments	(1,810,197)	(985,191)
Restricted contributions	(87,986)	(272,455)
(Increase) decrease in the following assets:		
Patient accounts receivable	(466,570)	(430,426)
Miscellaneous grants and other receivables	55,058	(16,193)
Other current assets	(98,106)	23,784
Increase (decrease) in the following liabilities:		
Accounts payable and accrued expenses	549,650	201,772
Due to third-party payers	116,553	59,107
Deferred revenue	33,214	(27,684)
Net Cash Provided By Operating Activities	761,878	345,761
Cash Flows From Investing Activities		
Restricted contributions	87,986	272,455
Change in charitable remainder trust liability	(48,233)	739,653
Purchase of investments	(1,898,663)	(1,903,535)
Sale of investments	1,924,834	1,003,231
Capital expenditures, net of dispositions	(356,463)	(246,846)
Net Cash Used By Investing Activities	(290,539)	(135,042)
Cash Flows From Financing Activities		
Pledge payments	-	3,000
Net Cash Provided By Financing Activities	-	3,000
Net Increase (Decrease) in Cash and Cash Equivalents	471,339	213,719
Cash and cash equivalents, beginning of year	1,398,371	1,184,652
CASH AND CASH EQUIVALENTS, END OF YEAR	\$ 1,869,710	\$ 1,398,371

(See accompanying notes to these financial statements)

VISITING NURSE ASSOCIATION OF
CHITTENDEN AND GRAND ISLE COUNTIES, INC.

NOTES TO FINANCIAL STATEMENTS

JUNE 30, 2014 AND 2013

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

The Association is a non-profit corporation organized in Vermont. The Association's primary purpose is to provide home care services to residents of the City of Burlington and the surrounding communities.

Income Taxes

The Association is a public charity under Section 501(c)(3) of the Internal Revenue Code. As a public charity, The Association is exempt from state and federal income taxes on income earned in accordance with its tax exempt purpose. Unrelated business income is subject to state and federal income tax. Management has evaluated the Association's tax positions and concluded that the Association has no unrelated business income or uncertain tax positions that require adjustment to the financial statements. Management believes the Agency is no longer subject to income tax examinations for years prior to 2011.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding assets limited as to use. Short-term highly liquid investments with an original maturity of more than three months are classified as temporary investments.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Investments

Investments in equity and debt securities are reported at fair value. Investment income and the recognized change in fair value are included in the excess of revenue over expenses unless otherwise stipulated by the donor or State law.

Investments, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. As such, it is reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the balance sheets, statements of operations, and changes in net assets.

Accounts Receivable

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Association analyzes its past history and identifies trends for all funding sources in the aggregate. Management regularly reviews data about revenue in evaluating the sufficiency of the allowance for doubtful accounts. Amounts not collected after all reasonable collection efforts have been exhausted are applied against the allowance for doubtful accounts. The Association has not changed its methodology for estimating the allowance for doubtful accounts during the years ended June 30, 2014 or June 30, 2013.

A reconciliation of the allowance for uncollectible accounts at June 30, 2014 and 2013 follows:

	<u>2014</u>	<u>2013</u>
Balance, beginning of year	\$ 440,634	\$ 284,088
Provision for bad debts	171,145	299,065
Write-offs	<u>(155,756)</u>	<u>(142,519)</u>
Balance, end of year	<u>\$ 456,023</u>	<u>\$ 440,634</u>

Assets Limited As To Use

Assets limited as to use consist of assets restricted by donors.

Property and Equipment

Property and equipment are carried at cost. Maintenance repairs and minor renewals are expensed as incurred and renewals and betterments are capitalized. Depreciation is computed on the straight-line method and is provided over the estimated useful life of each class of depreciable asset.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Association has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Association in perpetuity.

Patient Service Revenue

Standard charges for services to all patients are recorded as revenue when services are rendered. Patients unable to pay full charge, who do not have other third-party resources, are charged a reduced amount based on the Association's published sliding fee scale. Reductions in full charge are recognized when the service is rendered.

Donor Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received, which is then treated as cost. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets.

When a donor restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statement of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as unrestricted contributions in the accompanying financial statements.

Donor restricted endowment gifts are reported as assets limited as to use.

Promises to Give

Unconditional promises to give that are expected to be collected in future years are recorded at the present value of their estimated future cash flows. The discounts on those amounts are computed using risk-free interest rates applicable to the years in which the promises are received. Amortization of the discounts is included in contribution revenue. Conditional promises to give are not included as support until the conditions are substantially met.

Excess (Deficit) of Revenue over Expenses

The statement of operations includes excess of revenue over expenses. Changes in unrestricted net assets, which are excluded from excess of revenue over expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, permanent transfers of assets to and from affiliates for other than goods and services, and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets).

NOTE 2 INVESTMENTS

Investments are stated at fair value and consist of the following at June 30, 2014 and 2013:

	<u>2014</u>	<u>2013</u>
Cash and cash equivalents	\$1,335,680	\$ 1,425,174
Fixed Income		
Mutual Funds - Income	3,152,615	2,336,148
- Bond market	3,035,399	2,981,924
Marketable equity securities		
Auto/ Auto parts	236,420	112,931
Alternative energy	63,281	67,664
Banks	582,153	-
Business Services	153,986	-
Communications	178,085	502,390
Consumer staples	131,245	436,252
Data processing	-	97,299
Energy	-	66,226
Financial	-	838,975
Food	103,767	174,672
Diversified industry	333,371	-
Medical	-	77,782
Medical equipment and supplies	431,734	287,617
Pharmaceuticals	383,956	405,862
Retail	374,371	190,984
Software	557,269	245,376
Technology	682,853	833,654
Utilities	409,084	452,949
Mutual funds		
International equity	1,036,491	779,553
Publicly traded equity investment trust	509,585	435,203
Total stock market exchange traded funds	<u>2,502,321</u>	<u>1,661,006</u>
Total Investments	<u>\$ 16,193,666</u>	<u>\$ 14,409,641</u>
Board designated for long term growth	\$ 5,651,769	\$ 4,886,215
Investments in charitable gift annuity (Note 3)	1,166,826	1,012,323
Donor restricted	<u>9,375,071</u>	<u>8,511,103</u>
Total	<u>\$ 16,193,666</u>	<u>\$ 14,409,641</u>

NOTE 2 INVESTMENTS (CONTINUED)

Cash and cash equivalents included in investments and assets limited as to use are not included in cash and cash equivalents for cash flow purposes.

Financial accounting standards established a valuation hierarchy for disclosure of the inputs to valuation used to measure fair value. This hierarchy prioritizes the inputs into three broad levels as follows:

- Level 1 inputs - quoted prices traded daily in active markets.
- Level 2 inputs - other than quoted prices for active markets that are traded less frequently than daily.
- Level 3 inputs - unobservable inputs.

An investment's classification within the hierarchy is determined based on the lowest level input that is significant to the fair value measurement.

The fair market value of the Association's investments are based on level 1 inputs

Investment income and change in fair value of investments, for the years ended June 30, 2014 and 2013 consists of the following:

	<u>2014</u>	<u>2013</u>
Unrestricted Net Assets		
Investment income	\$ 139,447	\$ 151,581
Change in fair value of investments	<u>641,749</u>	<u>348,355</u>
Total	<u>781,196</u>	<u>499,936</u>
Restricted Net Assets		
Investment income, net of fees	199,846	165,876
Change in fair value of investments	<u>1,168,448</u>	<u>627,303</u>
Total	<u>1,368,294</u>	<u>793,179</u>
Total Investment Income	<u>\$ 2,149,490</u>	<u>\$ 1,293,115</u>

NOTE 3 SPLIT INTEREST AGREEMENT

The Association has a charitable gift annuity program whereby donors may transfer assets to the Association in exchange for the right to receive an annuity during the donors' lifetime and/or the lifetime of a specified beneficiary. The split interest agreement with the donor consists primarily of an irrevocable charitable remainder trust for which the Association serves as trustee. Assets are invested and payments are made to donors and/or other beneficiaries in accordance with the respective agreements.

When a donor contributes assets for a split interest agreement, the difference between the amount contributed and the present value of future annuity payments is recognized as temporarily restricted income at the date of the agreement. The present value is recognized as a liability for future annuity payments. The present value is determined based on the current yield of U.S. 20-year AAA corporate bonds.

The annuity liability is revalued annually based upon the recalculated present value that uses the current age of the annuitants and the original discount rate for each annuity contract. Distributions paid and income earned on annuity investments are recorded as changes in the liability and increases or decreases in temporarily restricted net assets. The annuity liability was \$691,420 and \$739,653 at June 30, 2014 and 2013, respectively. Distributions are paid at the beginning of the calendar year. There were distributions paid in the amounts of \$28,923 and -0- during 2014 and 2013, respectively.

Upon the death of the annuitant, funds are transferred directly to the Association under the restrictions specified by the donor.

NOTE 4 ENDOWMENTS

The Association has interpreted the Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the Association classifies as a donor restricted endowment (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent donor restricted endowment gifts and (c) accumulations to the donor restricted endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the organization in a manner consistent with the standard of prudence prescribed by UPMIFA.

NOTE 4 ENDOWMENTS (CONTINUED)

In accordance with UPMIFA, the organization considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

- (1) The duration and preservation of the fund
- (2) The purposes of the organization and the donor-restricted endowment fund
- (3) General economic conditions
- (4) The possible effect of inflation and deflation
- (5) The expected total return from income and the appreciation of investments
- (6) Other resources of the Association
- (7) The investment policies of the Association

From time to time, the fair value of assets associated with donor-restricted endowment funds may fall below the level that the donor or UPMIFA requires the Association to retain as a fund of perpetual duration.

The Association has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. The endowment assets consist of a balanced portfolio of cash, debt, and equity securities.

In an effort to balance the current and future needs of the VNA with relatively stable year-to-year spending the following formula has been adopted to calculate annual spending limits. The Association will distribute funds to support the current operations in an amount not to exceed 4.5% of the 36 month average market value of the endowment assets, adjusted for recent new contributions to the fund.

There are no board designated endowments. Donor restricted endowments consisted of an investment portfolio managed by contracted investment managers with oversight by the Association's investment committee. As required by generally accepted accounting principles in the United State of America, net assets associated with endowment funds are classified and reported based on the existence or absence of donor imposed restrictions.

NOTE 4 ENDOWMENTS (CONTINUED)

The following summarizes changes in endowment assets for the years ended June 30, 2014 and 2013:

	<u>Unrestricted</u>	<u>Temporarily Restricted</u>	<u>Permanently Restricted</u>
Endowments, June 30, 2012	-	\$ 1,370,228	\$ 6,740,887
Contributions		-	9,318
Change in fair value of investments	-	627,303	-
Investment income, net of fees	-	165,876	-
Spending policy expense	<u>-</u>	<u>(349,888)</u>	<u>-</u>
Endowments, June 30, 2013	\$ -	\$ 1,813,519	\$ 6,750,205
Contributions		-	25,743
Change in fair value of investments	-	1,030,642	-
Investment income, net of fees	-	168,236	-
Spending policy expense	<u>-</u>	<u>(360,652)</u>	<u>-</u>
Endowments, June 30, 2014	<u>\$ -</u>	<u>\$ 2,651,745</u>	<u>\$ 6,775,948</u>

Restricted net assets consist of investments and are donor restricted for the following:

	<u>2014</u>	<u>2013</u>
Temporarily restricted -		
Available for release based on the		
Association's spending policy	\$ 2,651,745	\$ 1,813,519
Charitable remainder trust	<u>475,406</u>	<u>272,670</u>
	3,127,151	2,086,189
Permanently restricted		
Donor restricted, permanently restricted for		
endowment	<u>6,775,948</u>	<u>6,750,205</u>
Total restricted net assets	<u>\$ 9,903,099</u>	<u>\$ 8,836,394</u>

NOTE 5 PROPERTY AND EQUIPMENT

	<u>2014</u>	<u>2013</u>
Land	\$ 502,656	\$ 502,656
Building and building improvements	4,078,286	3,954,841
Furniture and equipment	<u>5,201,106</u>	<u>4,968,088</u>
Total Cost	9,782,048	9,425,585
Less, accumulated depreciation	<u>6,731,260</u>	<u>6,353,896</u>
Property and Equipment, Net	<u>\$ 3,050,788</u>	<u>\$ 3,071,689</u>

NOTE 6 LINE OF CREDIT

The Association has a \$1,500,000 line of credit payable on demand with a local bank secured by a first security interest in the Association's personal property (accounts receivable, machinery, equipment, furniture and fixtures) with a variable interest rate equal to the prime rate with a 4% floor through September 2014. There was no outstanding balance at June 30, 2014.

NOTE 7 PATIENT SERVICE REVENUE

Patient service revenue provided for the years ended June 30, 2014 and 2013 follows:

	<u>2014</u>	<u>2013</u>
Medicare	\$ 10,041,325	\$ 9,813,691
Medicaid	12,132,602	9,593,386
Other third-party payers	<u>4,699,666</u>	<u>5,039,332</u>
Patient service revenue	<u>\$ 26,873,593</u>	<u>\$ 24,446,409</u>

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. The Association believes that it is in substantial compliance with all applicable laws and regulations. However, there is at least a reasonable possibility that recorded estimates could change by a material amount in the near term. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in net patient service revenues in the year that such amounts become known.

NOTE 7 PATIENT SERVICE (CONTINUED)

The Association provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Association does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Association estimates the costs associated with providing charity care by calculating the ratio of cost to gross charges for care to private pay patients, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for free care. The estimated cost of providing services to patients under the Association's charity care policy amounted to \$262,616 and \$326,646 for the years ended June 30, 2014 and 2013, respectively.

The Association provided services in other health-related activities, primarily to indigent patients, at rates substantially below cost. For certain activities, services were provided without charge. The Association estimates the costs associated with providing the other health-related activities by applying Medicare cost report methodology to determine program costs less any net patient revenue generated by the program. The estimated costs incurred in these activities amounted to \$1,003,103 and \$1,002,950 for the years June 30, 2014 and 2013, respectively.

The Association provides medically necessary services to Medicaid patients at costs exceeding Medicaid reimbursement, which the Association considers to be partial charity care. The Association estimates the loss from providing services to Medicaid patients by applying Medicare cost report methodology to determine program costs less any net patient revenue generated by the program. The estimated costs incurred in these activities amounted to \$1,441,858 and \$1,299,402 for the years June 30, 2014 and 2013, respectively.

The Association is able to provide these services with a component of funds received through local community support and state grants. Local community support consists of contributions and United Way and municipal appropriations.

NOTE 8 FUNCTIONAL EXPENSES

The Association provides various services to residents within its geographic location. Expenses related to providing these services were as follows:

	<u>2014</u>	<u>2013</u>
Program services	\$ 25,788,934	\$ 23,079,147
Administrative and general	<u>3,915,766</u>	<u>3,942,343</u>
Total	<u>\$ 29,704,700</u>	<u>\$ 27,021,490</u>

NOTE 9 COMMITMENTS

Leases that do not meet the criteria for capitalization are classified as operating leases with related rental charged to operations as incurred.

The following is a schedule by year of future minimum lease payments under operating lease for office facilities as of June 30, 2014, that have initial or remaining lease term in excess of one year:

<u>Year Ending</u> <u>June 30,</u>	<u>Minimum Lease</u> <u>Payments</u>
2015	\$ 73,992
2016	<u>4,468</u>
Total	<u>\$ 78,460</u>

NOTE 10 RETIREMENT PLAN

The Association has adopted a defined contribution retirement plan and a tax deferred annuity plan. Retirement plan expense amounted to \$868,176 and \$701,158 for June 30, 2014 and 2013, respectively.

NOTE 11 CONCENTRATIONS OF RISK

The Association routinely has cash deposits in excess of \$250,000, which exceeds federal depository insurance limits in a major financial institution. The financial institution has a strong credit rating and management believes the credit risk related to these deposits is minimal.

The Association grants credit without collateral to its patients, most of who are local residents and are insured under third-party payer agreements. At June 30, 2014, Medicare and Medicaid represented 48% and 22% of gross accounts receivable, respectively. No other individual payer source exceeded 10% of the gross accounts receivable balance.

NOTE 12 MALPRACTICE INSURANCE

The Association insures its medical malpractice risks on a claims made basis. As of June 30, 2014, there were no known malpractice claims outstanding, which in the opinion of management, will be settled for amounts in excess of insurance coverage; nor are there any unasserted claims or incidents which require loss accrual. The Association intends to renew coverage on a claims made basis and anticipates that such coverage will be available.

NOTE 13 VERMONT MEDICAID DEFINED CORE NET PATIENT SERVICE REVENUE

Vermont Medicaid defines "core net patient service revenue" as the net revenue generated by the Association from all intermittent skilled nursing, physical therapy, speech therapy, occupational therapy, medical social work, home health aide and related billable supply service revenue, excluding all Medicare revenue, plus revenue generated from all adult waiver services regardless of funding source. The Association's core net patient service revenue amounted to \$5,986,596 and \$6,152,938 for the years ended June 30, 2014 and 2013, respectively

Medicaid defined core net patient service revenue is the basis for the annual assessment of the Medicaid enhancement tax by the State of Vermont.

NOTE 14 BOARD OF DIRECTORS COMPOSITION

A majority of the members of the board of directors or their family members have or are currently receiving home health services from the Association.

NOTE 15 SUBSEQUENT EVENTS

For financial reporting purposes, subsequent events have been evaluated by management through November 5, 2014, which is the date the financial statements were available to be issued.