STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD
CERTIFICATE OF NEED APPLICATION

by

WINDSOR HOSPITAL CORPORATION d/b/a
MT. ASCUTNEY HOSPITAL AND HEALTH CENTER

for

Docket No. GMCB-006-24CON
MT. ASCUTNEY HOSPITAL AND HEALTH CENTER
ELECTRONIC HEALTH RECORD REPLACEMENT
PROJECT COST: $9,100,524

DATED: March 25, 2024

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SECTION I

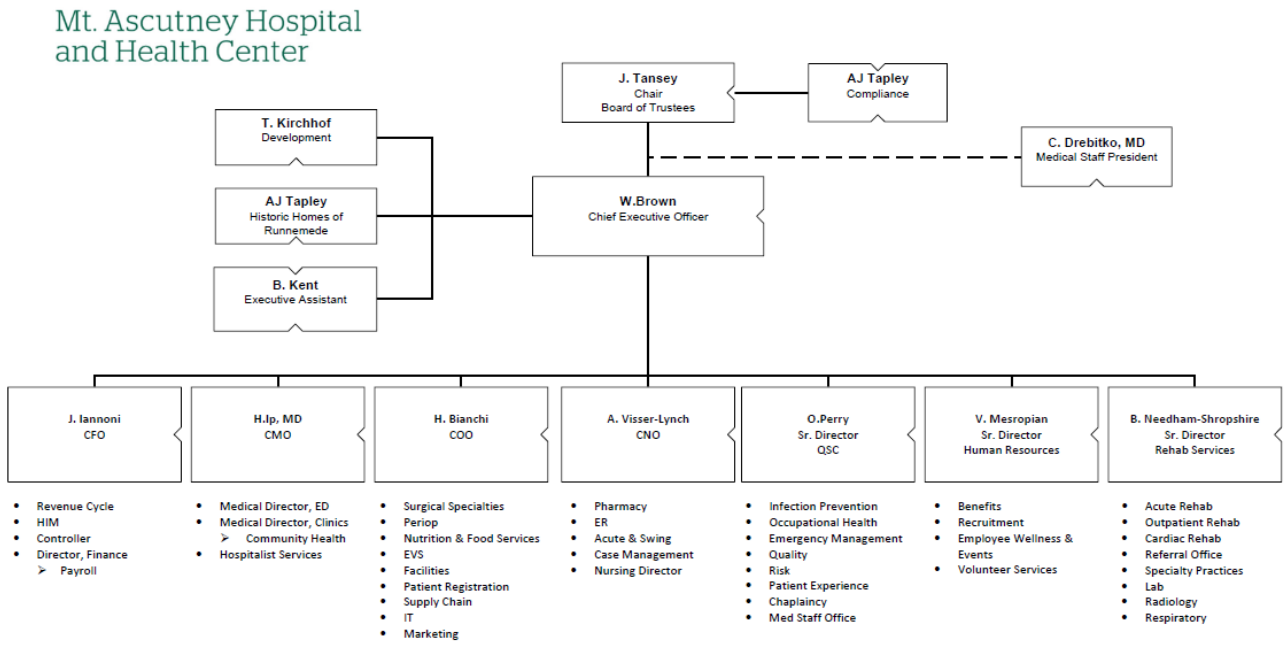
DESCRIPTION OF THE PROJECT

A. OVERVIEW

Mt. Ascutney Hospital and Health Center (MAHHC and the Applicant), a community hospital in Windsor County, submits this Certificate of Need Application (the Application) to the Green Mountain Care Board (GMCB) in accordance with 18 V.S.A. Section 9434(b)(1). The Application requests a Certificate of Need ("CON") approval for a project to replace the current electronic health record and related information technology systems (EHR) at MAHHC to achieve a unified health information system with Dartmouth Health.

MAHHC became an affiliate of Dartmouth Health (DH) system in 2014. It is a designated Critical Access Hospital located in Windsor, VT. MAHHC has provider clinics located in Woodstock, VT and Hanover, NH. It also has a subsidiary, Historic Homes of Runnemede, a residential and independent living facility, located in Windsor, VT. MAHHC focuses on community-based care, support for the region in post-acute and inpatient acute rehabilitation, and provides the base of primary care for our service area. The primary service area is on both sides of the Connecticut River. Approximately 30% of patients come from New Hampshire. The Inpatient Rehabilitative service is regional and accepts patients from throughout Vermont and other New England states.

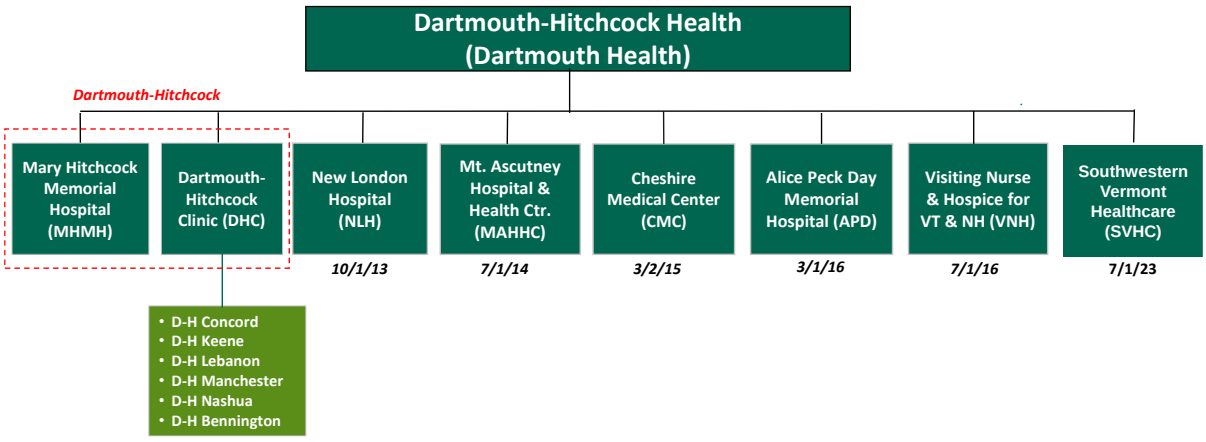
Our internal organizational chart is below:



DH is a system of community hospitals, clinics, and healthcare services across New Hampshire and Vermont. The DH system includes:

- Locally focused community hospitals and clinics in New Hampshire and Vermont.
- An academic medical center with deep ties to Geisel School of Medicine at Dartmouth.
- Dartmouth Cancer Center, one of only 56 NCI-designated Comprehensive Cancer Centers in the nation.
- Dartmouth Health Children's, the state's only children's hospital; and member hospitals and clinics across the state and in Vermont.
- A broad community of nursing, rehabilitation, hospice, and personal healthcare services.

The Dartmouth Health System organizational chart is as follows:



DH is an integrated delivery system that provides high quality care, timely access to services, and an optimal patient experience. Aside from the human capital required for this ongoing effort, technology integration is the backbone of this endeavor. In order to successfully function as a truly integrated delivery system, DH has developed an Enterprise Information Systems Strategy that has as its goal, the replacement of the disparate, poorly-connected systems currently in place at system member sites. DH has developed a cutting edge, digital infrastructure and tightly integrated information system which has been implemented with most of its affiliates. Originally, the MAHHC implementation was scheduled a couple years ago, but due to pandemic and the financial uncertainty during that period, the project was postponed.

As an affiliated member of the system, it is incumbent on MAHHC to replace its current technology platform in order to advance and enhance patient care and patient access in the hospital's service. This project will be similar in nature to the approved UVMMC project that integrated UVMMC with Central Vermont Medical Center, Porter Medical Center, and its New York affiliates. It is also similar to the DH – VNA/VNH project approved a few years ago by the GMCB. DH has already converted all of its locations and affiliates onto its suite of technologies, with the exception of MAHHC and newly affiliated Southwestern Vermont Medical Center.

MAHHC has been on its current clinical and financial systems for twelve years and access to and communication with DH, relative to patient information and business functions, is limited by the lack of full integration. Moving onto the DH platform will not only replace end-of-life technologies, but will more effectively connect MAHHC and its patients to a best-in-class, unified electronic medical record, more efficient human resource applications, and more effective business support functions. Nearly every service line and business function will be replaced.

Full clinical integration will advance the health of the region's communities by supporting numerous population health initiatives, by reducing the risks associated with transitions in care and by improving communication for providers, other clinicians and patients. The goal is to improve system-wide outcomes by improving care coordination, reducing digital barriers to the timely sharing of patient information, and by reducing system redundancies.

Adopting standardized systems will also enhance staff sharing opportunities, human resource management, business/group purchasing functions, and provide leverage for the adoption of new technologies as best practices change over time. It will strengthen the region's ability to meet local and system missions.

If approved, the project will kick-off during this fiscal year. The project will begin with a discovery period where opportunity and gap analysis will occur. Demonstrations of the applications and understanding of the inter-connectivity will be reviewed during this process. The financial and human resource platforms will tentatively go live in the second quarter of MAHHC's fiscal year 2025 (January 2025) and the clinical applications will tentatively go live in the first quarter of fiscal year 2026 (November 2025).

The DH Enterprise Information Systems Division uses an enterprise-wide system governance model that provides technology solutions to all members, in a cost effective, standardized

manner, with common policies, procedures, tools and workflows. The unified EHR integrates health, clinical, registration, billing, scheduling, patient portal and insurance information into one system that will improve patients' experience of care while giving them, their families, and their providers access to consistent, timely, and accurate information regardless of where care is delivered in the health system.

The project is essential to provide MAHHC with the tools necessary to provide the most effective, efficient, and highest quality care.

B. PROJECT NEED AND RATIONALE

As noted above, replacing the EHR and related information technology systems currently utilized by the MAHHC is the focus of this project which, will enable MAHHC to provide the most effective, efficient, and highest quality care to the communities that it serves. MAHHC provides community-based services in four (4) locations in New Hampshire and Vermont. The service covers towns on both sides of the Connecticut River and throughout the Upper Valley region of NH and VT. Approximately 30% of patients are from New Hampshire. A flagship service, Acute Rehabilitative Services, cares for patients from all over Vermont, New Hampshire, and occasionally out-of-state. It is one of two CARF accredited units in the state and is the largest recipient of transfers from DH for Acute to Acute, Acute to Acute Rehabilitation, and Acute to sub-Acute services. MAHHC is a regional oncology and medical infusion site (collaborating with DH Hematology/Oncology), we are the only affiliate with outpatient physiatry, and offers other sub-specialties that receive referrals from other system members. Our units and practices routinely refer and request consultation from other system members, most notably DH. MAHHC employs 520 FTE's and care for nearly 300 patients per day on an inpatient and outpatient basis.

It is far less than ideal and inefficient to refer people to these other facilities and providers from a stand-alone information technology platform. Sending and receiving providers should have timely, complete, and easy access to the same information in order to facilitate safer and more efficient transfers of care. MAHHC currently uses a set of systems for clinical, human resource, business, and ancillary functions that are not integrated with the DH system. With the ongoing migration to value-based care initiatives, population health management, OneCare Vermont participation, and DH affiliation, it is incumbent on MAHHC to replace its current technology platform in order to advance and enhance patient care and patient access.

This project will be similar in nature to the approved UVMMC project that integrated UVMMC with CVMC, Porter Medical Center, and their New York affiliates. It is also similar to the DH - VNA/VNH project approved a few years ago by the GMCB. Other regional systems like Mayo, MaineHealth, Yale, Mass General Brigham, etc. have all developed IT platforms for their respective systems. DH has already converted all of its locations and affiliates onto their suite of technologies, with the exception of MAHHC and newly affiliated Southwestern Vermont Medical Center. While there are many models of system roll-out to affiliates and subsidiaries, DH has adopted a model of affiliate ownership as opposed to a subscription model.

MAHHC has been on its current clinical and financial systems for twelve years and access to, and communication with DH, relative to patient information, is limited by the lack of full integration. Moving onto the DH platform will not only replace end-of-life technologies, but will more effectively connect MAHHC and patients to a best-in-class, unified electronic medical record, more efficient human resource applications, and business support functions. Nearly every service line and business function will be replaced.

Full clinical integration will advance the health of communities by supporting numerous population health initiatives, by reducing the risks associated with transitions in care and by improving communication for providers, other clinicians, and patients. The goal is to improve system-wide outcomes by improving care coordination, increasing the number of timely handoffs, reducing barriers to sharing patient information, and by streamlining system redundancies.

Adopting standardized systems will also enhance staff sharing opportunities, human resource management, business/group purchasing functions, and leverage for new technologies as best practices change. It will strengthen the region's ability to meet local and system missions more effectively.

The way forward can only be one of the following three possibilities:

1. ***Stay the course with our current technologies***. Seemingly, this is the least expensive solution, at least for the short term. However, MAHHC will continue to have all of the issues, previously described, that are inherent in stand-alone systems. Additionally, MAHHC's human resource application is sunsetting in thirteen months and needs to be replaced. Ultimately, clinical and financial systems will likely follow suit and will receive none of the efficiencies and new technology opportunity enjoyed by the other DH system members.

2. ***Invest in another set of technologies with the same lack of integration***. When MAHHC replaced its IT systems nearly twelve years ago, the entire suite of systems cost more than $3m. The market is that a similar project today would be upwards of $6m and would still have all of the clinical and business limitations of a stand-alone system described previously. This would require a more significant outlay of cash than is contemplated with this project and possibly having to finance or lease the project in order to maintain appropriate liquidation levels. Ongoing operating costs would likely rival the operating costs of this proposed project.

3. ***Integrate with the DH IT system***. While the depreciation value of the project is estimated at just over $9m, the actual cash outlay is only $2.3m which is less than what was spent for the project twelve years ago. It also provides the best-in-class solution(s) and it solves the issues described previously relative to operating stand-alone systems. Ongoing costs will be the same or less than option 2 (above), but not significantly more than current expenses.
   The cost of replacing aging systems with another stand-alone solution will not accomplish any of the aforementioned goals or realize any of the benefits of DH

integration. Continuing with aging systems will also not address these concerns. Essentially, by migrating to the DH platform, MAHHC will have best of class systems for less cash than what it paid to get its current systems, more than a decade ago.

As MAHHC considered how best to proceed given the current needs of the organization for replacements of, or upgrades to existing systems, leadership concluded that implementing a unified EHR that fully integrates with the DH system and provides better access to clinical information, would provide significant benefits to patients and referring Providers, while being the most prudent approach financially.

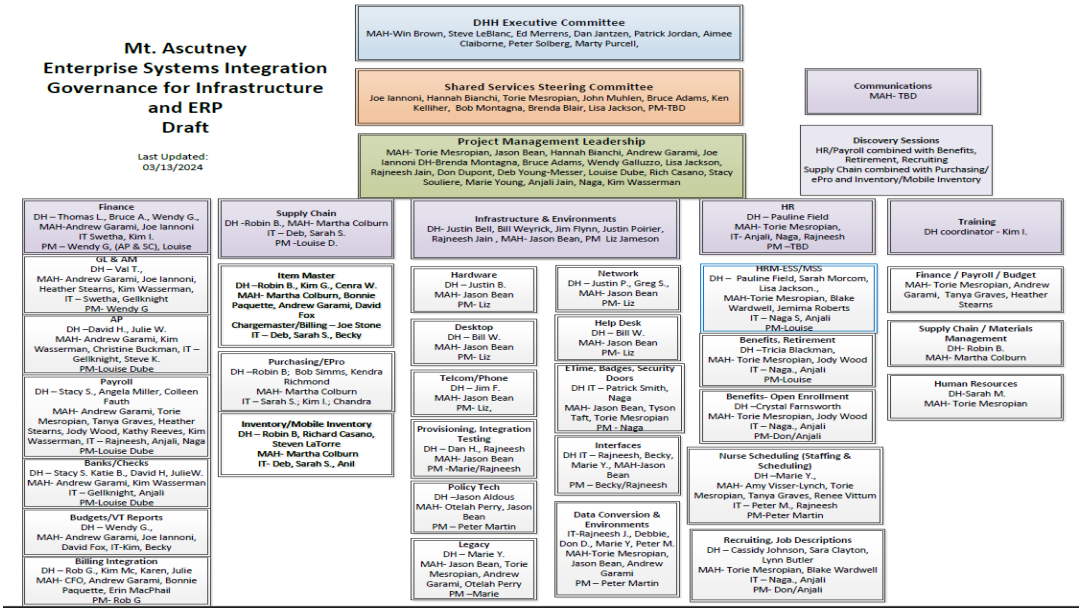
C. PLANNING PROCESS

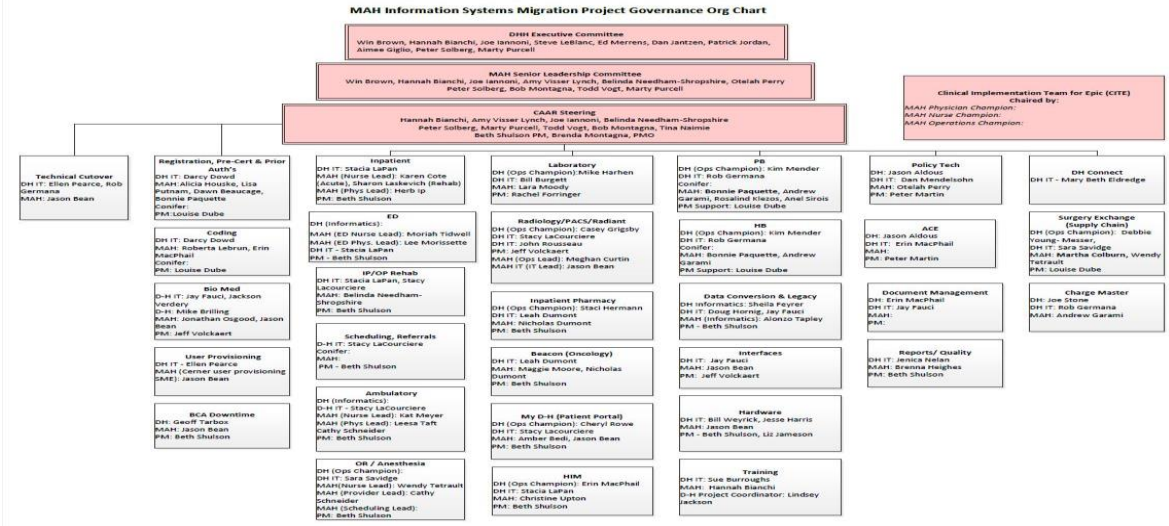
The planning process for MAHHC integration began with the affiliation process and in parallel with the development of the Dartmouth-Hitchcock Health Enterprise IT Strategy in 2016. The foundation of the Enterprise IT Strategy rests on the earlier decision to implement Epic as the EHR and revenue cycle system solution for Dartmouth-Hitchcock Medical Center in 2008. With the expansion of the health system, DH Executive and IT leadership engaged external consultants to develop a plan for updating or replacing affiliate EHRs and related technology systems to achieve the vision of a fully integrated delivery system that provides high value care, timely access to services, and an optimal patient experience to system patients. A phased and sequential approach to member integration was approved by the DH Board of Trustees in June 2016. The timeline for member integration was driven by the impact on clinical care, the condition of legacy systems, current level of system function, and system and member financial position. DH has successfully implemented four member organizations, Cheshire Medical Center, Alice Peck Day Memorial Hospital, New London Hospital and the VNA/VNH. Each project was implemented on budget and as scheduled, with the exception of New London Hospital where an intentional delay was instituted due to the COVID19 pandemic. The model adopted by DH is an established and proven model used throughout the country by other academic and non-academic health systems.

In accordance with the DH Enterprise IT Strategy, planning specific to the MAHHC project has been underway since 2019. To ensure project success, project management resources are assigned by both DH and MAHHC to oversee the project plans for the various phases of work; this includes a DH project manager for the Enterprise Resource Planning systems (IT infrastructure, finance, budget, human resources, supply chain, etc.), DH project manager for Epic (clinical and revenue cycle), and a MAHHC project manager to facilitate the work needed to accomplish the goals of the various subgroups. Based on the criteria listed above, as well as MAHHC's financial condition, it was determined that DH and MAHHC were well positioned to begin IT integration in the latter part of FY24 with full integration achieved in FY26. Archiving and termination of the legacy systems would occur in FY26 or FY27.

With full system integration in FY26, the project work concludes and shifts to normal operations for maintenance and optimization. The ongoing operational work will be overseen and governed

by DH IT leadership and IT Governance. The following draft charts illustrate the groups and oversight involved in the planning process for the two major implementation date timelines (ERP: infrastructure/business/operations and CAAR: clinical) described above. Because the project has not officially (pending CON review and approval) kicked off, there may be adjustments to the names and areas of responsibility once discovery and planning is completed:

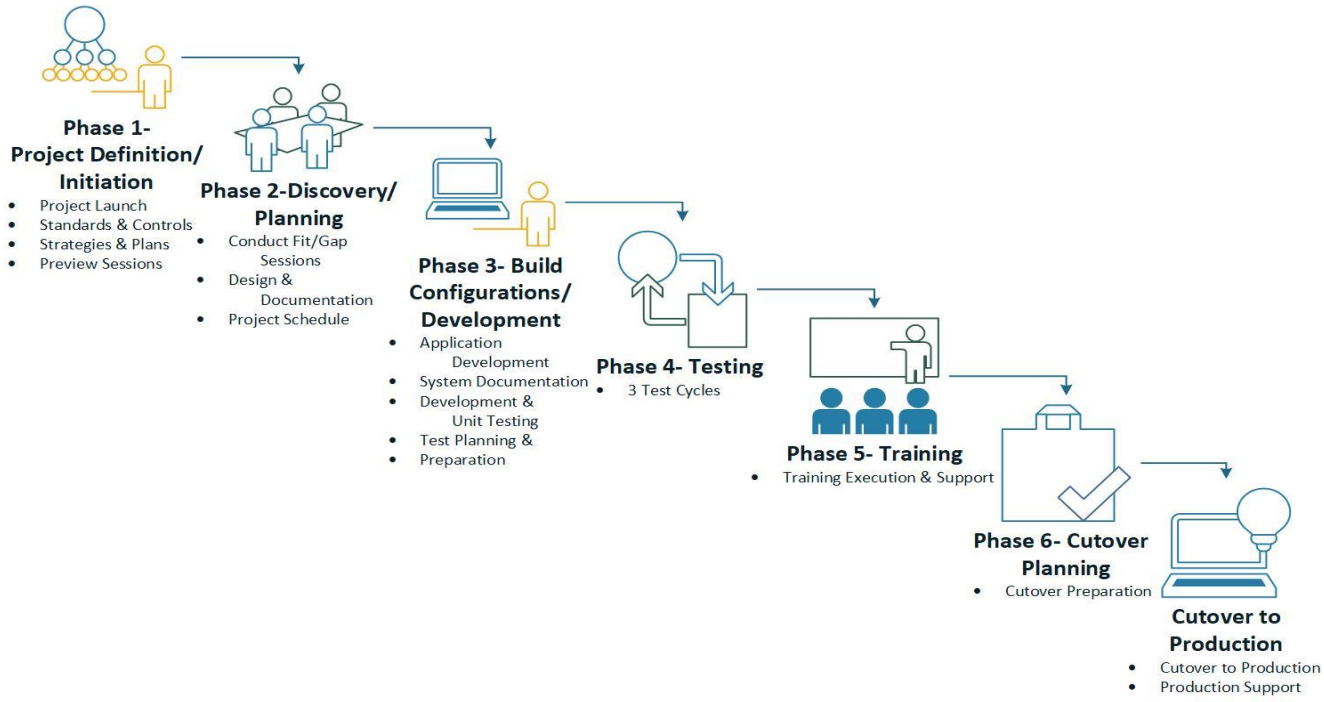




Larger versions of these sample charts are included in the appendices of this application.

Regular meetings will be held at all levels of the governance structure to assure that the integration plan is executed effectively and efficiently. Ultimately, this governance structure will function to protect the MAHHC and DH missions and to implement the systems for the benefit of patients, their families and providers.

The following chart illustrates the process and steps utilized to bring a suite of applications from definition and discovery to "live status":



MAHHC will receive the benefit of DH's efforts and experience of bringing four other affiliates onto its systems. Additionally, Epic is also involved with innumerable IT system implementations and extensive experience. The uniqueness of MAHHC, its service lines, and the nuance of Vermont will be incorporated into the implementation plan. These aspects will be identified during the discovery phase and will be incorporated into the implementation plan.

From a system/regional planning perspective, DH routinely surveys and interprets service lines, provider/specialty complements, availability of services, and system-wide business planning processes to ensure that major capital investments are planned on a system-wide basis and to take into account regional needs, unnecessary duplication of services, and patient trends. The process includes representatives from the system's operations leaders, the affiliates, and the systems planning/finance teams. This is necessary from not only a perspective of patient-centric delivery of care, but also from a business perspective. Healthcare entities are increasingly required to provide more and better services for the same or less money from payers (patients, employers, commercial insurers and governmental insurers).

D. PROJECT DESCRIPTION

1. Project Description and Objectives

The objective of this project is to improve care delivery, as well as, the patient experience, by replacing the existing disparate and outdated IT systems at MAHHC with a single-platform, unified EHR system from Epic Systems, the nation's leading vendor and the same company that provided the Dartmouth-Hitchcock Medical Center with its clinical information system in 2010. If the project is approved, the unified Epic-based EHR platform and related information technology systems would be extended from DH, as the licensee, to MAHHC as an affiliated member of the health system.

The DH system comprises seven member hospitals and one home health organization medical center: Dartmouth-Hitchcock Medical Center (Lebanon, NH), Cheshire Medical Center (Keene, NH), Southwestern Vermont Medical Center (Bennington, VT), New London Hospital (New London, NH) Alice Peck Day Memorial Hospital (Lebanon, NH), Mt. Ascutney Hospital and Health Center (Windsor, VT) and Visiting Nurse and Hospice for Vermont and New Hampshire (White River Junction, VT). Upon affiliation, DH member organizations, including MAHHC, utilized many different systems to care for patients and to perform the necessary business operations. Some of these systems were no longer fully supported by their vendors and did not support best practice. The existing systems could not guarantee that all necessary information is available when and where it is needed, and communication between them can be inconsistent and untimely, which can disrupt or adversely impact patient care. It also creates difficulties for patients trying to navigate the care delivery system.

Continued investment in MAHHC's existing systems would be both expensive and wasteful. There is no guarantee that the vendors of these systems will be able to keep up with the ever-changing regulations, best practices, and advances in care. Instead, MAHHC seeks to replace the existing EHR with a single-platform unified EHR from Epic that integrates with the DH system and shares costs between the member organizations in the system.

The benefits of a unified EHR are many and reflect the DH system goals of improving patients' experience, the patients' care, the health of populations, and the cost of health care:

- Patients and their families will have accurate, timely and up-to-date information available 24/7.
- One patient portal across the System will allow patients, and family members to access health, billing, scheduling and insurance information at their fingertips.
- All System providers will have access to the most current information about a patient, their history, and current needs eliminating the need, or reliance upon, patient and

families to remember and communicate important aspects of their care. Missing and incomplete information can result in medical errors, delays, and unnecessary services.

- The unified EHR will enhance communication and collaboration between referring providers, facilities, and home health and hospice facilitating coordination and timeliness of care.
- Ultimately, such a system will improve the ability to coordinate patients' care both locally and across and beyond DH's primary and secondary service areas.
- A unified EHR will advance data analytic capabilities, allowing for evaluation of patient populations across the continuum of care and enhancing the ability to improve patient outcomes.
- A unified EHR will also enhance information security and patient privacy by reducing the risks inherent with moving information across multiple IT systems.
- Integration with DH provides much-needed expertise and oversight by the System security and privacy governance structure.

The project proposes to convert all clinical, revenue cycle, business and administrative systems to the enterprise system. Epic is the core system for clinical care and MAHHC will implement the core system, to include clinical and billing functions. As a DH member, MAHHC will benefit from additional core Epic modules that would have added significant cost to MAHHC if it purchased similar applications as a stand-alone provider. MAHHC has already had to put off beneficial application purchases knowing that it would be migrating to Epic (care management modules, clinical equipment interfaces for EEG/EMG, etc.).

The Epic modules include the patient portal, provider portal, enterprise master patient index (EMPI), medical records/release of information, and Care Everywhere. Additionally, the project includes add-on applications that enhance or supplement the core Epic modules, including patient education, document management, and provider-to-provider communications, and a clinical outcome module called Cosmos. This database provides best practice diagnostic and treatment protocols for common and rare patient conditions. There are more than a billion veiled patients records that assist a provider to determine what works best to diagnose and treat a patient with certain conditions. This information can be made available to a provider at the point of care or outside of a patient encounter for care planning. This reduces unnecessary testing and treatment and limits diagnosis and treatment options to the most effective and efficient.

The DH core system for business and administrative systems is PeopleSoft Enterprise Resource Planning (ERP), which includes financials, human capital management, and supply chain. There are multiple modules within PeopleSoft that will expand MAHHC's capabilities well beyond the current systems, which would cost substantially more if MAHHC were to purchase independent of the system solution. The project also aligns IT infrastructure and security to ensure protection of patient data. All of these applications and infrastructure are included in the total project scope and cost.

The project has five phases which will be tracked separately and will be placed in service in two major implementations and one minor implementation:

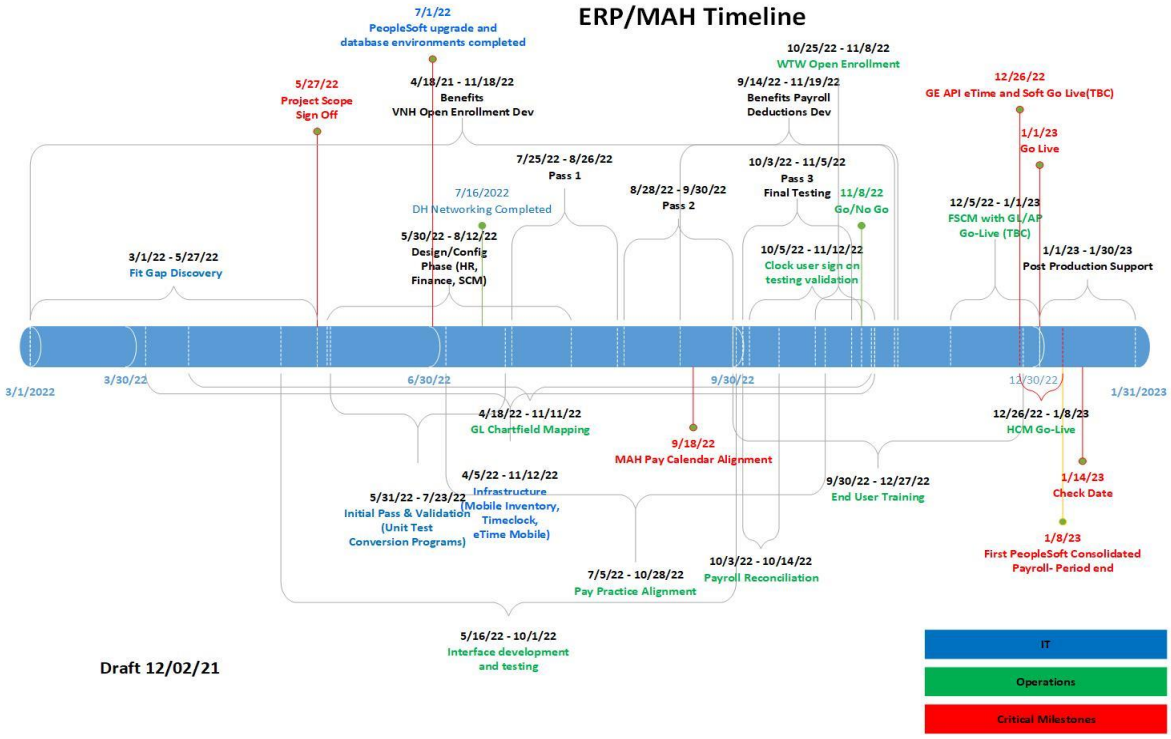
- **ERP** (infrastructure, business/financial/human resources):
    1. ***Infrastructure***: This is the required infrastructure (access points, servers, routers, etc.) necessary for the system to operate throughout MAHHC and its satellite locations. It also facilitates functional integration with the rest of the system and enhances data/cyber security.
    2. ***Business***: This phase of applications is associated with implementing the human resource and business operations portion of the project. These are housed within PeopleSoft and also include other best in class applications for specific areas within the human resource and business operation arena (recruitment, grant management, financial data warehousing, etc.).
- ***CAAR***: Refers to the clinical and medical (traditional EMR/EHR) applications from Epic as well as some related specialty applications:
    3. ***Epic Inpatient and Outpatient clinical systems***: Nursing, providers, clinicians, ancillary departments, etc. This also includes other best in class applications for specific areas in the clinical arena (blood bank, cardiac applications, PACS, etc.).
        a. ***EPIC Revenue Cycle***: This includes patient registration, patient billing, coding, medical records, etc.
    4. ***Epic Rehabilitation Module***: This is the portion of the integrated EHR that encompasses acute rehabilitative inpatient services, as well as outpatient rehabilitative services.
- ***Archive Legacy Systems***:
    5. Once live, this item relates to archiving clinical and financial data from current legacy systems for future access as needed.

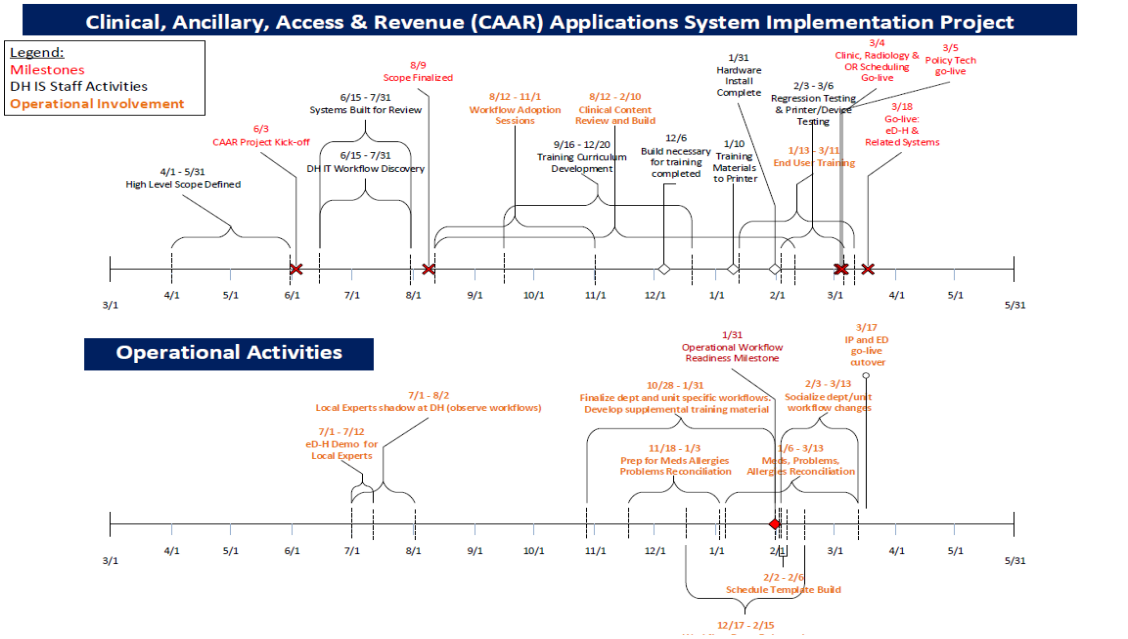
2. Timetable (pending CON approval)

With the Letter of Intent and the Application submitted, MAHHC and DH will be refreshing the discovery process which was terminated a few years ago during the pandemic. The findings from this process will be incorporated into the implementation planning process. Workflows, gap analysis, unique requirements, unique service lines, and efficiencies will be identified and added to the implementation plan in addition to the standard rollout. The go-live will be unique in the sense that MAHHC will be the first Vermont hospital entity to go live on the DH suite of applications. This uniqueness will also be incorporated into the planning and will be reviewed during the discovery process.

Assuming that Application is approved, the project implementation plan will be developed and finalized. If approved, the implementation project will kick-off later this fiscal year. The infrastructure, financial and human resource platforms (Phases 1 and 2 above) will tentatively go live in the second quarter of our fiscal year 2025 (January 2025). The clinical applications (Phases 3 and 4 above) will tentatively go live in the first quarter of fiscal year 2026 (November 2025). Phase 5 will likely be placed into service at the end of FY26 or early FY2027. Accordingly, the project will span four (4) fiscal years.

The following draft charts illustrate the typical timelines involved in the project based on prior implementation experience for DH and MAHHC's postponed project during the pandemic. Because the project has not officially (pending CON review and approval) kicked-off, actual dates will be assigned upon CON approval and the completion of discovery. More readable versions are in the appendices.





E. PROJECT FINANCES

1. Project Costs

The total capital and operating costs associated with this project, subject to CON review under 18 V.S.A. §9434(b)(1), are $9.1 million. For the purposes of this Application, contingency will be apportioned to the ratio of known capital and operating expense. Of this $9.1m total, capital expenditures are expected to be approximately $7.3m, operational expenditures are expected to be approximately $949k, and an estimated $827k in potential contingency for capital and operating expenses.

	Total Project Costs	FY 2024	FY 2025	FY 2026	FY 2027
Capital Expenditures (Labor)	**$ 4,563,152**	**$ -**	**$ 1,476,091**	**$ 3,024,054**	**$ 63,008**
1. Epic Rehab Module Initial Implementation	$ 394,325	$ -	$ -	$ 394,325	$ -
2. Infrastructure - Extend DH Systems	$ 584,939	$ -	$ 565,527	$ 19,412	$ -
3. ERP - Extend DH Systems	$ 782,045	$ -	$ 782,045	$ -	$ -
4. CAAR - Extend DH Systems	$ 2,515,804	$ -		$ 2,515,804	$ -
5. Archive Legacy Systems for Decommission	$ 286,039	$ -	$ 128,519	$ 94,512	$ 63,008
Operating Expenditures (Labor)	**$ 901,756**	**$ 91,673**	**$ 594,501**	**$ 215,582**	**$ -**
1. Epic Rehab Module Initial Implementation	$ 44,262	$ 16,454	$ 27,808	$ -	$ -
2. Infrastructure - Extend DH Systems	$ 89,323	$ 18,805	$ 56,414	$ 14,104	$ -
3. ERP - Extend DH Systems	$ 312,829	$ 56,414	$ 256,414	$ -	$ -
4. CAAR - Extend DH Systems	$ 455,343	$ -	$ 253,865	$ 201,478	$ -
Total	**$ 5,464,909**	**$ 91,673**	**$ 2,070,592**	**$ 3,451,136**	**$ 63,008**

	Total Project Costs	FY 2024	FY 2025	FY 2026	FY 2027
Capital Expenditures (Non-Labor)	**$ 2,761,295**	**$ -**	**$ 606,000**	**$ 2,115,295**	**$ 40,000**
1. Epic Rehab Module Initial Implementation	$ 57,650	$ -	$ -	$ 57,650	$ -
2. Infrastructure - Extend DH Systems	$ 356,000	$ -	$ 356,000	$ -	$ -
3. ERP - Extend DH Systems	$ 200,000	$ -	$ 200,000	$ -	$ -
4. CAAR - Extend DH Systems	$ 1,997,645	$ -	$ -	$ 1,997,645	$ -
5. Archive Legacy Systems for Decommission	$ 150,000	$ -	$ 50,000	$ 60,000	$ 40,000
Operating Expenditures (Non-Labor)	**$ 47,000**	**$ 18,000**	**$ -**	**$ 29,000**	**$ -**
2. Infrastructure - Extend DH Systems	$ 18,000	$ 18,000	$ -	$ -	$ -
4. CAAR - Extend DH Systems	$ 29,000	$ -	$ -	$ 29,000	$ -
Total	**$ 2,808,295**	**$ 18,000**	**$ 606,000**	**$ 2,144,295**	**$ 40,000**

Total Project Expenditures (Capital vs. Operating)	Total Project Costs	FY 2024	FY 2025	FY 2026	FY 2027
Capital Expenditures Total:	$ 7,324,447	$ -	$ 2,082,091	$ 5,139,348	$ 103,008
Operating Expenditures Total:	$ 948,756	$ 109,673	$ 594,501	$ 244,582	$ -
Contingency of 10%:	$ 827,320	$ 10,967	$ 267,659	$ 538,393	$ 10,301
Grand Total:	**$ 9,100,524**	**$ 120,641**	**$ 2,944,251**	**$ 5,922,323**	**$ 113,309**

The table above reflects timing of the expenses that will be recognized for each phase (labor or non-labor, capital or operating expense, etc.). It does not reflect the period of the cash outlay. Operating expenses will be recognized in the profit and loss statement in the period that they are incurred. Capital expenditures for each of the phases will be funded on an ongoing basis with periodic reconciliation between MAHHC and DH for the funding of the capital. The "assets" will reside in Construction in Progress (CIP) until a phase is completed and put into service. At the point of being placed in service, the phase will then begin to be depreciated with straight line methodology and then recognized in the profit and loss statement.

Relative to capital expense, MAHHC is responsible to fund 25% of the capital expense and all of the operating expense. Relative to MAHHC's share of capital, this will amount to an amount somewhere between $1.95m (without contingency) and $2.15m (with contingency). DH will fund 75% of the capital expenditures. Operating expense funding for MAHHC will run between $950k without contingency to $1.15m with contingency. DH will not share in the funding of these expenses. These expenses will hit profit and loss in the period that they are incurred. They are expenses that cannot be capitalized under the current accounting definition and are not ongoing.

DH will not be seeking to recover their 75% funding (sunk costs) over time in the form of subscription fees or other mechanisms. Ongoing costs, after implementation will be in the form of a shared service allocation (MAHHC's percentage of system costs based on size/licensure) and will be comparable to ongoing costs with the legacy system or even lower than MAHHC moving to a new, stand-alone system. DH's 75% contribution to capital costs will be recognized as a net asset transfer, below the line on our profit and loss statement and will be recognized as the project cash outlays are made and related reconciliations are performed.

Regarding ongoing operating expenses resulting from this project, there will not be any interest expense since MAHHC will be funding this from cash/investments. Depreciation will be recognized on a straight-line basis, based on the period that the capital is placed in service. In addition to this expense, MAHHC's share of system IT cost allocations to support and maintain the ongoing system IT operations will increase, but there will also be a decrease in service contract fees for MAHHC's legacy systems (detailed in the financial tables) as they are taken offline and archived. There will be some nominal service contract fees to manage the archived legacy data.

Assuming timely approval for this project, the project will likely cross four fiscal years. The table above reflects the five phases of the project:

- **ERP** (infrastructure, business/financial/human resources):
    1. ***Infrastructure***: This is the required infrastructure (access points, servers, routers, etc.) necessary for the system to operate throughout MAHHC and its satellite locations. It also facilitates functional integration with the rest of the system and enhances data/cyber security.
    2. ***Business***: This phase of applications is associated with implementing the human resource and business operations portion of the project. These are housed within PeopleSoft and also include other best in class applications for specific areas within the human resource and business operation arena (recruitment, grant management, financial data warehousing, etc.).
- ***CAAR***: Refers to the clinical and medical (traditional EMR/EHR) applications from Epic as well as related specialty applications:

3. ***Epic Inpatient and Outpatient clinical systems***: Nursing, providers, clinicians, ancillary departments, etc. This also includes other best in class applications for specific areas in the clinical arena (blood bank, cardiac applications, PACS, etc.).
    a. ***EPIC Revenue Cycle***: This includes patient registration, patient billing, coding, medical records, etc.
4. ***Epic Rehabilitation Module***: This is the portion of the integrated EHR that encompasses MAHHC's acute rehabilitative inpatient services, as well as outpatient rehabilitative services.

- ***Archive Legacy Systems***:
    5. Once live, this item relates to archiving clinical and financial data from current legacy systems for future access as needed.

MAHHC will own 100% of the project's capital assets and the total of the capital expenditures will be fully depreciated by MAHHC on a ten (10) year depreciation schedule (consistent with other affiliates and their Medicare Cost Report filings). This methodology is based on appropriate accounting practices and is consistent with what the Medicare Fiscal Intermediary has seen and approved of with the other DH affiliates.

Contingency has been estimated based on recent inflationary trends for IT-related supply chain and contracted labor. Additionally, MAHHC presents some unique aspects (Inpatient Acute Rehabilitation, Vermont entity, Vermont regulations/reporting, etc.) and is the first entity to be going live post-pandemic (as it relates to inflation and supply chain concerns).

This project will be funded from cash and short-term investments and nothing will be financed. This will amount to approximately 15 days' cash. At January 31, 2024, MAHHC has approximately 188 days cash. This project will not put the organization at risk relative to cash reserves and it will not incur financing or interest costs. There will, obviously, be a loss of opportunity relative to potential investment earnings. On the off chance that expenditures exceed current estimates, MAHHC and DH will be able to cover the difference without creating financial concerns.

As mentioned previously, DH will not be seeking to recover its 75% funding (sunk costs) over time in the form of subscription fees or other mechanisms. Ongoing costs, after implementation will be in the form of a shared service allocation (percentage of system costs based on size/licensure) and will be comparable to ongoing costs with legacy systems or even lower than MAHHC moving to a new, stand-alone system. DH's 75% contribution to capital costs will be recognized as a net asset transfer, below the line on MAHHC's profit and loss statement and will be recognized as the project cash outlays are made and related reconciliations are performed.

2. Financial Feasibility

We estimate, based on MAHHC's budgeting model that the project will it likely be required to have an extra 0.5% rate increase request for pricing in FY2025 and 1.0% increase in FY2026 This will cover the additional depreciation and operating expenses for this project while maintaining a positive margin. While cost reimbursement will cover a portion of the capital and operating expense, it will only cover Medicare's percentage or share of the expense. Even with this federal draw-down and the price increases, it will be a challenge to keep MAHHC at a 1% operating margin. The impact of this project is reflected in the attached financial tables, as requested.

SECTION II - CONSISTENCY WITH THE HRAP CON STANDARDS

Statutory Criteria and HRAP Standards

1. **Proposed project aligns with statewide health care reform goals and principles because the project:**
   - **A. takes into consideration health care payment and delivery system reform initiatives;**

     Vermont's Health Resource Allocation Plan statutes, specifically section 9405, speaks to number of goals relating to quality, access, and cost containment for Vermonters. With regard to health care payment and delivery system reform, MAHHC has been participating in OneCare Vermont, Vermont's Accountable Care Organization (ACO) for several years. This step into payment reform has been largely successful. That said, as a hospital representing the DH system within the Vermont ACO, and being on a stand-alone IT platform, MAHHC has had to staff up in order to meet the administrative and care management responsibilities associated with participation. While MAHHC has performed reasonably well in the quality and access measures, the cost containment effectiveness has been unclear with the risk mitigation during the pandemic. Our CHT, Blueprint, and Spoke efforts have been reasonably effective. However, the management of databases, reporting, organizing appropriate responses to the data, etc. has been labor intensive and expensive to support. Our legacy system is limited in its database and reporting structures.

     Moving to Epic will provide us with state-of-the-art databases and staffing to assist with the responsibilities of managing patients more effectively. Currently, DH collects, tracks and manages data submissions to public health departments in two states, the Care Quality national database, OneCare Vermont, innumerable payers for quality payment reform initiatives, and Cosmos (mentioned previously). This enhanced data collection, reporting support, and response analysis will improve MAHHC's ability to get data to providers and community health teams in a more timely manner. The databases will also assist practitioners in identifying patients who are not following their plan of care and those patients whose plan of care isn't working. This database management will help MAHHC pivot quickly to improve quality measures, protocols, and better prioritize patients. All of this works well in the payment and healthcare

reform environment. As MAHHC and DH look to expand a collective footprint in healthcare reform (AHEAD, NextGen, and other ACO initiatives), these tools and the feedback that they provide will improve the ability to better manage the care and associated cost for all patients.

Access should also be improved relative to the timeliness of referrals in and out of MAHHC for patients within the DH system. Handoffs for patients should be more effective, reducing risk and improving quality and safety.

B. addresses current and future community needs in a manner that balances statewide need (if applicable); and

Epic currently provides tools to assist with case management, care management, care planning, and outcome management. An integrated MAHHC solution will assist with timely surgical, medical, and mental/behavioral health inpatient referrals to DH. Currently, as a non-integrated affiliate, MAHHC has a very limited view into the schedules and census (bed management) at DH. Likewise, DH has a limited view into MAHHC's schedules and census. Direct access will speed up the referral process, eliminating unnecessary patient days and delays of care. Additionally, MAHHC will also have enhanced views into the other affiliate's schedules and census. DH runs a regional care management software package which will help with non-system referrals for Brattleboro Retreat, nursing homes, home health, and other community partners. Coordination of care the region will be greatly improved.

Timely consultations, outpatient referrals, and telehealth encounters will also be improved with this transition.

Additionally, the data will be automatically included in the DH strategy/resource allocation data. This data is used by the system for system/regional planning perspective. DH routinely surveys and interprets service lines, provider/specialty compliments, availability of services, and system-wide business planning processes to ensure that system resources are planned on a system-wide/regional basis and to take into account regional needs, unnecessary duplication of services, and patient trends.

As mentioned earlier, moving to Epic will provide MAHHC with state-of-the-art databases and staffing to assist with the responsibilities of managing patient more effectively. Currently, DH collects, tracks, and manages data submissions to public health departments in two states, the Care Quality national database, OneCare Vermont, innumerable payers for quality payment reform initiatives, and Cosmos (mentioned previously). This enhanced data collection, reporting support, and response analysis will improve ability to get data to providers and community health teams in a more timely manner. The databases will also assist practitioners in identifying patients who are not following their plan of care and those patients whose plan of care isn't working. This database management will help pivot quickly to improve quality measures, protocols, and better prioritize patients. All of this works well in the payment and healthcare reform environment.

C. is consistent with appropriate allocation of health care resources, including appropriate utilization of services, as identified in the HRAP pursuant to section 9405 of this title.

In regard to the allocation of health care resources, including appropriate utilization of resources, the IT system change itself will not change the service lines, available providers and clinicians, or materially change access for patients at MAHHC. However, it will likely improve staffing and maintaining current providers, which will have a positive effect on the ability to staff small clinical departments. Staff and providers, with appropriate licensure, can now function at MAHHC, from other system affiliates with minimal training and orientation. This should help reduce traveler staffing and have options for per diem help for leaves, vacation, sickness, etc. MAHHC will be better able to maintain consistent staffing and patient schedule for patients.

Access should also be improved for timeliness of referrals in and out of MAHHC for patients within the DH system. Handoffs for patients should be more effective, reducing risk and improving quality and safety.

Further, MAHHC data will be automatically included in the DH strategy/resource allocation data. This data is used by the system for system/regional planning perspective, DH routinely surveys and interprets service lines, provider/specialty compliments, availability of services, and system-wide business planning processes to ensure that major investments (capital, providers, staff, service lines, etc.) are planned on a system-wide/regional basis and to take into account regional needs, unnecessary duplication of services, and patient trends. Over time, this should improve utilization, the rational allocation of services, etc.

SECTION III – CONSISTENCY WITH CON STANDARDS

1. CON STANDARD 3.4: Applicants subject to budget review shall demonstrate that a proposed project has been included in hospital budget submissions or explain why inclusion was not feasible.

In prior year budget presentations to the GMCB, MAHHC has advised the GMCB that this project was forthcoming. Most recently, the $9m project was presented to the GMCB at the FY2024 budget hearing, as tentatively scheduled for FY2025. However, because the DH system had not specifically committed to a date in advance of the budget hearing, MAHHC could only provide a "heads up" relative to this project. Because the first phases of the project will not be placed into service until FY2025, and the FY2025 budget cycle has not yet begun, nothing specific has been submitted to the GMCB relative to the project. The chart on page 15 indicates that MAHHC's maximum exposure on the FY2024 actual is $120k ($110k without contingency) in operating expense. Depending on the timing of the CON approval, it is possible that some additional minimal expense may trickle into FY2025.

2. The cost of project is reasonable because each of the following conditions is met:

A. The applicant's financial condition will sustain any financial burden likely to result from completion of the project;

At January 31, 2024, MAHHC has 188 Days Cash On Hand. MAHHC has been one of the more consistent and stable Vermont hospitals relative to financial and clinical performance for many years. Because of the funding mechanism associated with this project, MAHHC is well positioned to safely engage in this commitment. If this project exceeds the 10% budgeted contingency level, MAHHC and DH are adequately reserved to cover any additional overrun. It should be noted that DH's experience with prior installations has been "on time" and "on budget". The minimal rate increase requests, outlined previously, result in only a 0.5% (FY2025) and a 1.0% (FY2026) increase in net reimbursement.

It is anticipated that there will be a temporary decline in clinic volume during the first few weeks at go-live. The three hospital affiliates who have transitioned to this platform experienced far less volume reduction than forecasted. This reduction is noted in MAHHC's financial tables and is based on internal analysis and the experiences of the other DH affiliates that have converted. The expected slowdown is projected to be largely in the primary care practices. Slowdown in specialty clinics and hospital departments is not material or almost all of specialty providers have experience in Epic at DH or at other facilities prior to being employed at MAHHC. MAHHC has been in the process of adopting DH equipment, policies and protocols over the last few years in order to facilitate a less invasive and burdensome transition.

MAHHC has reasonably low accounts receivable and the transition from legacy A/R to the Epic billing system is not expected to be problematic from a cash flow standpoint.

This project has been carried in the MAHHC 5 Year Capital Plan for some time and finance staff have been planning for this project and its funding. Strategic capital planning is reviewed annually by DH and MAHHC Board of Trustees in budget process and planning, and MAHHC's strategic capital plan is incorporated into the DH system planning. Current projections and recent financial performance relative to margin and cash flow indicate that MAHHC and DH are in a position to move forward on this project. Additionally, the timing for this project works within the DH IT Strategy Plan with SVMC's recent entrance into the system and the strong possibility of Valley Regional Health entering the system soon. Borrowing for this project is not required for MAHHC and DH. All major projects and investments come with some level of risk. DH and MAHHC recognize that the project's size and scope are significant to MAHHC, DH, and to the Vermont healthcare system. MAHHC has the benefit of DH's experience with Alice Peck Day Hospital, New London Hospital, Cheshire Hospital, and the VNA/VNH to minimize the risk and to avoid problems during the course of implementation.

B. The project will not result in an undue increase in the costs of medical care or an undue impact on the affordability of medical care for consumers. In making a finding, the Board shall consider and weigh relevant factors, including:

(i) The financial implications of the project on hospitals and other clinical settings, including the impact on their services, expenditures and charges; and

MAHHC estimates, based on its budgeting model that the project will likely require an extra 0.5% increase in pricing in FY2025 and 1.0% increase in FY2026 above historical averages. The minimal rate increase requests, outlined previously, result in only a 0.25% (FY2025) and a 0.5% (FY2026) increase in net reimbursement. This will cover the additional depreciation and operating expenses for this project. While cost reimbursement will cover a portion of the capital and operating expense, it will only cover Medicare's percentage or share of the expense. Even with this federal draw down and the proposed price increases, it will be a challenge to keep MAHHC at a 1% operating margin. The operating expenses (cannot be capitalized under general accounting principles) related to the planning and implementation of this project will not be ongoing and are projected beyond FY26.The impact of this project is reflected in the attached financial tables, as requested. Our current service contract costs for MAHHC's current legacy systems will be replaced after FY26 with the system service contract costs (system shared service allocations).

(ii) Whether the impact on services, expenditures, and charges is outweighed by the benefit of the project to the public;

Regulators and healthcare industry leaders foresaw that EMR/EHR adoption would lead to significant savings in addition to reducing risk and increasing quality for many years. Incentives and grants were extended to facilitate this adoption. It was widely believed that the efficient access to information, reduction of duplicate testing, etc. would offset the cost of adoption. However, the adoption of EMR/EHR's has not achieved the savings expected. That said, there have been great strides made in the areas of quality improvement, patient safety, risk reduction, patient outcomes, best practice, etc. All of these benefits will be realized with MAHHC's adoption of the DH IT platform. MAHHC does, however, expect some incremental reduction of duplicate testing, incremental reduction of unnecessary testing, better outcome rates, lower re-admission rates, etc., as well as better staffing models resulting in less expense for travelers. While difficult to calculate, there are long term direct and indirect cost benefits to quality improvement, patient safety, risk reduction, and improved patient outcomes.

Like all equipment in healthcare, IT systems need to be replaced over time. MAHHC has maximized its use of the system it purchased more than a decade ago. Most small hospital systems diminish relative to effectiveness over time and it is time for MAHHC to replace it. Deciding to stick with the current solution will not likely improve quality, risk, and safety for patients and their providers. Ultimately, MAHHC will need to replace its systems very soon. MAHHC is unlikely to be able to obtain the quality system that our patients deserve for less than the cash outlay proposed for this project.

While the costs of the project are substantial, after rigorous review and analysis, MAHHC has concluded that maintaining the current patchwork of disparate IT systems is unacceptable and imprudent, and that this project is the best approach to addressing the challenges for patients, providers and healthcare reform efforts, including:

- Patients will find it easier to navigate the health care system.
- Providing a high quality and safe experience for our patients as they move throughout the healthcare continuum.
- Providers across the system and region will have easier access to patient records and clinical tools.
- It is expensive and wasteful to manage, update and maintain the disparate existing systems. MAHHC estimates that updating, revising, and maintaining existing systems and dictionaries/tables costs more than $250,000 per year. Further, replacing the existing EMR/EHR would be a substantial investment without any meaningful return for our patients and providers
- Elimination of the risk of staying on aging systems longer than is viable and putting the hospital, providers and patients into an untoward situation in the future.
- It is also becoming increasingly challenging to meet regulatory reporting standards, and quality reporting, while maintaining current cost structures. ACO participation, payer quality payments, and outcome measures place a heavy financial and staffing burden on an organization that is already running with thin margins and staffing. Centralization of data and reporting functions provide efficiency.

.

For these reasons, MAHHC believes that any alternative to this project for replacing existing systems would be more costly, wasteful and imprudent.

C. Less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate.

The way forward can only be one of the following three possibilities:

1. ***Stay the course with our current technologies***. Seemingly, this is the least expensive solution, at least for the short term. However, MAHHC will continue to have all of the issues, previously described, that are inherent in stand-alone systems. Additionally, MAHHC's human resource application is sunsetting in thirteen months and needs to be replaced. Ultimately, clinical and financial systems will likely follow suit and will receive none of the efficiencies and new technology opportunity enjoyed by the other DH system members.

2. ***Invest in another set of technologies with the same lack of integration***. When MAHHC replaced its IT systems nearly twelve years ago, the entire suite of systems cost us a bit more than $3m. The market is that a similar project today would be upwards of $6m and would still have all of the clinical and business limitations of a stand-alone system described previously. This would require a more significant outlay of cash than is contemplated with this project and possibly having to finance or lease

the project in order to maintain appropriate liquidation levels. Ongoing operating costs would likely rival the operating costs of this proposed project.

3. ***Integrate with the DH IT system***. While the depreciation value of the project is estimated at just over $9m, the actual cash outlay is only $2.3m which is less than what was spent for the project nearly twelve years ago. It also provides the best-in-class solution(s) and it solves the issues described previously relative to operating stand-alone systems. Ongoing costs will be the same or less than option 2 (above), but not significantly more than current expenses.

The cost of replacing aging systems with another stand-alone solution will not accomplish any of the aforementioned goals or realize any of the benefits of DH integration. Continuing with aging systems will also not address these concerns. Essentially, by migrating to the DH platform, MAHHC will have best of class systems for less cash than what it paid to get its current systems, nearly twelve (12) years ago.

As MAHHC considered how best to proceed given the current needs of the organization for replacements of, or upgrades to existing systems, leadership concluded that implementing a unified EHR that fully integrates with the DH system and provides better access to clinical information, would provide significant benefits to patients and referring Providers, while being the most prudent approach financially.

D. If applicable, the applicant has incorporated appropriate energy efficiency measures.

MAHHC earned the U.S. Environmental Protection Agency's (EPA) 2018 Energy Star certification for performing in the top 25 percent of all hospitals nationwide for energy efficiency and meeting strict energy efficiency performance levels set by the EPA. At the time, Mt. Ascutney Hospital was Vermont's highest-scoring hospital. MAHHC's major energy efficiency projects include an upgrade of interior and exterior lighting to more efficient LED technologies, a solar array on the property, and installation of a data analytics software tool that helps contractors and hospital staff implement controls optimization and achieve setback savings. Use of such tools uncovered an opportunity to improve efficiency through the implementation of a hospital-wide chilled water system. Community hospitals such as MAHHC have significant energy demands due to the advanced technology required to provide healthcare excellence. MAHHC has taken the necessary steps to become more a responsible steward of the environment while lowering costs, and ensuring that its spaces are all illuminated and climate-controlled for patient comfort according to industry best practices. Every project is reviewed with the consideration of energy efficiency. In this project, however, there will be little gain in this area.

3. There is an identifiable, existing, or reasonably anticipated need for the proposed project that is appropriate for the applicant to provide.

This has been addressed previously in the application narrative. In brief, MAHHC has been on its current clinical and financial systems for more than twelve years and access to, and communication with DH, relative to patient information, is limited by the lack of full integration. Moving onto the DH platform will not only replace end-of-life technologies, but will more effectively connect MAHHC and its patients to a best-in-class, unified electronic medical record, more efficient human resource applications, and business support functions. Nearly every service line and business function will be replaced.

Full clinical integration will advance the health of MAHHC's communities by: (1) supporting numerous population health initiatives; (2) reducing the risks associated with transitions in care; and (3) by improving communication for providers, other clinicians, and patients. The goal is to improve system wide outcomes by improving care coordination, reducing digital barriers to sharing patient information, and streamlining system redundancies.

Adopting standardized systems will also enhance staff sharing opportunities, human resource management, business/group purchasing functions, and leverage for new technologies as best practices change. It will strengthen the region's ability to meet local and system missions more effectively.

The cost of replacing our aging systems with another stand-alone solution will not accomplish any of the aforementioned goals and benefits of DH integration and continuing with aging systems will also not solve these concerns. By migrating to the DH platform, MAHHC will enjoy best of class systems for less than what it paid to get its current systems, twelve (12) years ago.

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.

The objective of this project is to improve both care delivery as well as the patient experience by replacing the existing disparate and outdated IT systems at MAHHC with a single-platform, unified EHR system from Epic Systems, the nation's leading vendor and the same company that provided the Dartmouth-Hitchcock Medical Center with its clinical information system in 2010.

MAHHC utilizes different systems to care for patients and to perform the necessary business operations. Some of these systems are, or soon will be, unsupported by vendors and may not support best practice or advances in patient care. The existing systems do not guarantee that all necessary information is available when and where it is needed, and the communication between them can be inconsistent and untimely, which can disrupt or adversely impact patient care and the transfer of care. It also creates difficulties for patients trying to navigate the care delivery system. Providers, patients, and patient families must navigate multiple portals, especially when the patient is transferred for care, consultation, or specialty services between facilities, most notably, DH. One of the riskiest areas of shared patient care is the patient handoff. Migration to the DH system will ensure that patient handoffs and co-

managed care will be timely and cohesive. A common set of patient records, results, and history will remove much of the risk.

Epic has an extensive set of quality "helps" for providers and clinicians. Standardized protocols, documentation standards, problem and medication lists, etc. will all provide consistency and clarity for all patient navigating the DH system.

The benefits of a unified EHR are many and reflect the DH system goals of improving patients' experience, the patients' care, the health of populations, and the cost of health care:

- Patients and their families will have accurate, timely, and up-to-date information available 24/7.
- One patient portal across the System will allow patients, and family members to access health, billing, scheduling and insurance information at their fingertips.
- All System providers will have access to the most current information about a patient, their history, and current needs eliminating the need, or reliance upon, patient and families to remember and communicate important aspects of their care. Missing and incomplete information can result in medical errors, delays, and unnecessary services.
- The unified EHR will enhance communication and collaboration between referring providers, facilities, and home health and hospice facilitating coordination and timeliness of care.
- Ultimately, such a system will improve our ability to coordinate patients' care both locally and across and beyond DH's primary and secondary service areas.
- A unified EHR will advance data analytic capabilities, allowing for evaluation of patient populations across the continuum of care and enhancing the ability to improve patient outcomes.
- A unified EHR will also enhance information security and patient privacy by reducing the risks inherent with moving information across multiple IT systems.
- Integration with DH provides much-needed expertise and oversight by the System security and privacy governance structure.

The project proposes to convert all clinical, revenue cycle, business and administrative systems to the enterprise systems. Epic is the core system for clinical care and MAHHC will implement the core home health and hospice modules, to include clinical and billing functions. As a DH member, MAHHC will benefit from additional core Epic modules. These modules include the patient portal, provider portal, enterprise master patient index (EMPI), medical records/release of information, and Care Everywhere. Additionally, the project includes add-on applications that enhance or supplement the core Epic modules, including patient education, document management, and provider-to-provider communications, and a module called Cosmos. This database provides best in practice diagnostic and treatment protocols for common and rare patient conditions. There are more than a billion veiled patients records that all a provider to determine what works best to diagnose and treat a patient. This information can be made available to a provider at the point of care or outside of

a patient encounter. This reduces unnecessary testing and treatment and focuses diagnosis and treatment to the most effective and efficient.

Epic, and its functionality, will better support MAHHC's Blueprint, Spoke, and CHT work and will help to measure, track, and improve the multitude of quality requirements in healthcare reform, accountable care participation, and contracted payer relationships.

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

Other than some reduced volume in the clinics at go-live for a few weeks, based on other DH implementation experience, there should be no negative impact any of the existing service line offerings at MAHHC. Additionally, it will not create new clinical service lines or grow existing market shares.

6. REPEALED

This section is not applicable.

7. The applicant has adequately considered the availability of affordable, accessible transportation services to the facility, if applicable.

This section is not applicable.

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.**

The DH-MAHHC project conforms to and advances the Vermont HIT Plan. The Epic suite of applications is the gold standard for regional and system integration. The products interact effectively with the national EHR vendors (Care Quality) and state public health databases. Patient records are easily shared between facilities and amongst providers. The DH firewall is best-in-class so despite an ability to efficiently share information, the patient data is well protected. The DH systems are more than adequate in complying with expectations for healthcare reform initiatives in Vermont like Blueprint, Spoke, Community Health Team, accountable care organizations, and quality measures.

9. The project will support equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care, as appropriate.

MAHHC's current suite of applications has allowed reasonable adaptation to the ever-changing environment and expectations of healthcare reform. MAHHC has met and improved against the Vermont system averages for quality, access and affordability as documented in its annual GMCB budget submissions and hearings. It has effectively participated in the OneCare Vermont Accountable Care pilot. MAHHC was able to recruit mental health providers over the last few years and has an effective partnership with HCRS (mandated provider in NH). The current systems have allowed maintaining a mental/behavioral health line of service within primary care clinics, to effectively engage in Community Health Team activities, Blueprint and Spoke initiatives, etc. However, the applications are limited.

Migrating to the DH IT platform will bring new opportunities for MAHHC to more effectively manage behavioral/mental health needs in the community. Tele-psych services will be more integrated for outpatient, inpatient and emergency room service lines, and their patients. Best-in-class tools to facilitate screening and intervention for behavioral/mental health patients at risk are integrated within the Epic platform and readily available to clinicians. Clinicians will have access to tools to assist with trauma informed care. Transfers from MAHHC providers to DH inpatient and outpatient behavioral/mental health services will be more seamless and timely. Specialists and subspecialists will have a line of sight for these patients as is appropriate. Integration will speed up handoffs to specialists and sub-specialists and will make patient follow-up more timely which will improve access for all populations. A clinical data warehouse will help with provider management of the social determinants of health, patient access, timely response to patient needs, and measurements of care plan effectiveness. Identification of care management/patient navigation functions will improve and speed up referrals and placements with mandated providers and non-DH inpatient mental health providers.

It is expected that there will be some measure of reduction in duplicate testing and indirect savings due to improved quality, safety, outcomes, and reduced risk. The funding assistance from DH and the cost-based reimbursement mentioned previously, will make this project affordable. This improves affordability for patients, insurers, employers, etc. From a cash and balance sheet perspective, MAHHC will have a best-in-class suite of applications for less than the cost of a new, nominal system that would still be disparate, unintegrated, and ineffective relative to DH's regional mission.

CONCLUSION

For the reasons set forth in MAHHC's Letter of Intent, our Expedited Review Request Letter and this Application, MAHHC respectfully requests that this Application be reviewed on an expedited basis in accordance with 18 V.S.A. § 9440b and following review, that the Application be approved.

APPLICANT: Windsor Hospital Corporation d/b/a Mt. Ascutney Hospital and Health Center

By: _____ _____

Winfield Brown,
Interim Chief Executive Officer

F. Joseph Iannoni
Interim Chief Financial Officer

Tables 1-3

Mt. Ascutney Hospital & Health Ctr

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

Table 1

* $9.1m considers all CAPEX and OPEX associated directly with the project
* $9.1m does not consider OPEX not directly associated with implementing the systems
* 10% contingency is prorated between expected CAPEX and OPEX
* All of capital, except 10% contingency, is listed as major moveable
  * Includes capitalized labor

Table 2

* No financing of any kind
* Table 2 does not delineate the sharing cost funding between DH and MAHHC
* DH is funding 75% of the CAPEX funding
* MAHHC is funding 25% of the CAPEX funding and 100% of OPEX funding
* Note additional table for break out of project if 10% contingency is needed

		Contribution	
	Total	DH	MAHHC
CAPEX	$8,056,892	$6,042,669	$2,014,223
OPEX	$1,043,632	$ -	$1,043,632
TOTAL	$9,100,523	$6,042,669	$3,057,855

	Proposed Yr 1	Proposed Yr 2	Proposed Yr 3
INCOME STATEMENT			
FY24:			
* No changes to volume, pricing, payer mix or other operating revenue			
* $45k improvement in Medicare cost report reimbursement on project OPEX	45,483		
* Contracted services of $120k, after for non-CAPEX work on the project, one time expense	(120,640)		
FY25:			
* No changes to volume			
* Increased rate request 0.5% on gross charges (net effect is ~ 0.25% pickup)		737,342	
* Improvement in Medicare cost report reimbursement (OPEX & Depreciation)		365,472	
* Salary and benefits of $27k for training costs (replace staff for training)...one time expenses		(20,616)	
		(6,597)	
* Purchased services/consulting for $642k for implementation		(642,144)	
* $533k in consulting, training, etc. from DH and Epic, one time expense			
* $109k in shared service allocation (DH Support/service costs), ongoing annual expense			
* Depreciation increase due to project is $171k		(171,772)	
* Net Assets Increase = DH CAPEX 75% share + Shared Service of $109K		1,825,725	
FY26:			
* 1.0% loss of volume in clinics			(250,000)
* .01% loss of volume in outpatient			(99,000)
* Increased rate request 1.0% on gross charges (net effect is ~ 0.50% pickup)			1,972,711
* Improvement in Medicare cost report reimbursement (OPEX & Depreciation), less increased deductions (B/D, F/C, C/A)			478,169
* Salary and benefits of $273k for training costs (replace staff for training)...one time expenses			(207,190)
			(66,301)
* Purchased services/consulting of $502K for implementation that cannot be capitalized...one time expenses for project			(502,663)
* Implementation specific work $276k (consulting, training, optimization, etc. from DH & Epic), one time expense			
* Shared service increase (DH support/service costs) $109k, ongoing expense			
* Transition of legacy A/R workout of $117k, one time expense			
* Depreciation increase due to project is $747k			(747,247)
* Net Assets Increase = DH CAPEX 75% share + Shared Service of $109K			4,347,962

BALANCE SHEET

Balance Sheet Changes are based on:

* Cash reduction based on CAPEX funding period
* All other componants of cash changes based on earned/incurred period (OPEX, margin, Investment Income, etc.)
* CAPEX @ 25% of CAPEX total relative to cash and 100% relative to Assets (Property & Equipment)
* No A/R or A/P changes contemplated beyond impact of rate increase and additional OPEX costs
* Capital funded but not placed in service (CIP) resides in Assets (Property & Equipment)

CASH FLOW

* Cash flow is based on CAPEX placed in service
* All other componants of Cash Flow is based on earned/incurred period (OPEX, margin, Investment Income, etc.)

REVENUE SOURCE-PAYER

* Because this project will not change service lines, market share, etc., no change in Payer mix is calculated, except:

* FY24 improvement in Medicare cost report reimbursement on project OPEX	See Above		
* FY25 Improvement in Medicare cost report reimbursement (OPEX & Depreciation), less increased deductions (B/D, F/C, C/A)		See Above	
* FY26 Improvement in Medicare cost report reimbursement (OPEX & Depreciation), less increased deductions (B/D, F/C, C/A)			See Above

UTILIZATION

* Because this project will not change service lines, market share, etc., no change in statistics is calculated, except:

FY26:

* Loss of 1.0% of clinic volume for impact of go-live
* Loss of 0.1% of outpatient volume for impact of go-live

STAFFING

FY25:

* Addition of < 0.5% of staff for training

FY26:

* Addition of < 1.0% of staff for training

STATISTICS

* Because this project will not change service lines, market share, etc., no change in statistics is calculated, except:

FY26:

* Loss of 1.0% of clinic volume
* Loss of 0.1% of outpatient volume

Notes to Support Assumptions: See above

Mt. Ascutney Hospital & Health Ctr
GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT
TABLE 1
PROJECT COSTS

Construction Costs		
1. New Construction	$	-
2. Renovation		-
3. Site Work		-
4. Fixed Equipment		-
5. Design/Bidding Contingency		-
6. Construction Contingency		-
7. Construction Manager Fee		-
8. Other (please specify)		-
Subtotal	$	-
Related Project Costs		
1. Major Moveable Equipment	$	7,324,447
2. Furnishings, Fixtures & Other Equip.		-
3. Architectural/Engineering Fees		-
4. Land Acquisition		-
5. Purchase of Buildings		-
6. Administrative Expenses & Permits		
7. Debt Financing Expenses (see below)		-
8. Debt Service Reserve Fund		-
9. Working Capital		-
10. Other (Capital Contingency)		732,445
11 Other (Non-capitalized OPEX for implementatio		1,043,632
		-
Subtotal	$	9,100,523
Total Project Costs	**$**	**9,100,523**

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

Assumptions used for this table:

* $9.1m considers all CAPEX and OPEX associated directly with the project
* $9.1m does not consider OPEX not directly associated with implementing the systems
* 10% contingency is prorated between expected CAPEX and OPEX
* All of capital, except 10% contingenc, is listed as major moveable
    * Includes capitalized labor

Mt. Ascutney Hospital & Health Ctr
GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT
TABLE 2
DEBT FINANCING ARRANGEMENT, SOURCES & USES OF FUNDS

Sources of Funds

1. Financing Instrument	Bond		
a. Interest Rate	0.0%		
b. Loan Period		To:	
c. Amount Financed			$ -
2. Equity Contribution			9,100,523
3. Other Sources			
a. Working Capital			-
b. Fundraising			-
c. Grants			-
d. Other			-
Total Required Funds			**$ 9,100,523**

	Contribution		
	Total	**DH**	**MAHHC**
CAPEX	$8,056,892	$6,042,669	$2,014,223
OPEX	$1,043,632	$ -	$1,043,632
TOTAL	$9,100,523	$6,042,669	$3,057,855

Uses of Funds

Project Costs (feeds from Table 1)		should be zero
1. New Construction	$ -	$0
2. Renovation	-	$0
3. Site Work	-	$0
4. Fixed Equipment	-	$0
5. Design/Bidding Contingency	-	$0
6. Construction Contingency	-	$0
7. Construction Manager Fee	-	$0
8. Major Moveable Equipment	7,324,447	$0
9. Furnishings, Fixtures & Other Equip.	-	$0
10. Architectural/Engineering Fees	-	$0
11. Land Acquisition	-	$0
12. Purchase of Buildings	-	$0
13. Administrative Expenses & Permits	-	$0
14. Debt Financing Expenses	-	$0
15. Debt Service Reserve Fund	-	$0
16. Working Capital	-	$0
17. Other (Operating Expenses)	1,776,076	$0
Total Uses of Funds	**$ 9,100,523**	$0

Total sources should equal total uses of funds.

Assumptions used for this table:
* No financing of any kind
* Table 2 does not provide for the sharing cost funding between DH and MAHHC
* DH is funding 75% of the CAPEX funding
* MAHHC is funding 25% of the CAPEX funding and 100% of OPEX funding
* Note additional table for break out of project if 10% contingency is needed

MT. ASCUTNEY HOSPITAL & HEALTH CTR

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

INCOME STATEMENT

Table 3A

WITHOUT PROJECT

Proposed Years Must change from Current Budget

	FY2022	FY2023		FY2024		Proposed Yr 1 Proj 2024		Proposed Yr 2 FY2025		Proposed Yr 3 FY2026	
	Actual	Actual/Projection	% change	Budget 2024 App	% change		% change		% change		% change
REVENUES											
INPATIENT CARE REVENUE	6,953,737	5,976,545	-36.8%	7,358,046	23.1%	7,071,983	-3.9%	7,725,948	9.2%	8,112,246	5.0%
OUTPATIENT CARE REVENUE	72,634,656	76,126,763	-2.7%	85,392,363	12.2%	83,255,990	-2.5%	89,661,981	7.7%	94,145,080	5.0%
OUTPATIENT CARE REVENUE - PHYSICIAN	22,026,595	22,013,765	-7.9%	27,629,174	25.5%	26,534,060	-4.0%	28,458,049	7.3%	29,311,791	3.0%
CHRONIC/SNF PT CARE REVENUE	14,330,837	15,292,716	0.8%	16,597,787	8.5%	16,964,792	2.2%	17,427,676	2.7%	18,299,060	5.0%
SWING BEDS PT CARE REVENUE	9,818,435	10,392,638	6.5%	10,490,902	0.9%	11,018,420	5.0%	11,015,447	0.0%	11,566,219	5.0%
GROSS PATIENT CARE REVENUE	125,764,260	129,802,427	-4.9%	147,468,272	13.6%	144,845,245	-1.8%	154,289,101	6.5%	161,434,396	4.6%
DISPROPORTIONATE SHARE PAYMENTS	1,265,351	424,300	-21.4%	450,000	6.1%	424,300	-5.7%	437,029	3.0%	450,140	3.0%
TOTAL BAD DEBT FREE CARE	(2,631,871)	(3,203,027)	-14.7%	(4,055,378)	26.6%	(4,180,563)	3.1%	(4,453,134)	6.5%	(4,659,363)	4.6%
DEDUCTIONS FROM REVENUE	(64,564,162)	(64,847,591)	-7.1%	(75,278,660)	16.1%	(73,011,717)	-3.0%	(79,510,486)	8.9%	(83,185,574)	4.6%
NET PATIENT CARE REVENUE	59,833,579	62,176,109	-2.1%	68,584,234	10.3%	68,077,265	-0.7%	70,762,510	3.9%	74,039,599	4.6%
TOTAL FIXED PROSPECTIVE PAYMENTS AND RESERVES	2,748,808	3,176,715	33.0%	1,749,116	-44.9%	1,749,116	0.0%	1,827,826	4.5%	1,910,078	4.5%
NET PATIENT CARE REV & FIXED PAYMENTS & RESERVES	62,582,387	65,352,824	-0.8%	70,333,350	7.6%	69,826,381	-0.7%	72,590,336	4.0%	75,949,677	4.6%
OTHER OPERATING REVENUE	3,501,283	4,491,139	25.2%	3,556,643	-20.8%	4,506,642	26.7%	4,490,490	-0.4%	4,471,421	-0.4%
TOTAL OPERATING REVENUE	66,083,669	69,843,963	0.6%	73,889,993	5.8%	74,333,023	0.6%	77,080,826	3.7%	80,421,098	4.3%
OPERATING EXPENSE											
SALARIES NON MD	24,204,016	22,437,139	-12.3%	26,427,912	17.8%	25,899,354	-2.0%	27,194,321	5.0%	28,554,038	5.0%
FRINGE BENEFITS NON MD	7,655,433	8,208,075	-7.4%	9,260,264	12.8%	9,940,563	7.3%	9,983,535	0.4%	10,482,712	5.0%
PHYSICIAN FEES & SALARIES	6,977,655	8,742,154	8.5%	9,878,911	13.0%	9,878,911	0.0%	10,372,857	5.0%	10,891,499	5.0%
FRINGE BENEFITS MD	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
HEALTH CARE PROVIDER TAX	2,393,940	2,254,166	-0.9%	2,500,424	10.9%	2,500,424	0.0%	2,575,437	3.0%	2,652,700	3.0%
TOTAL DEPRECIATION AMORTIZATION	2,316,501	2,326,851	-9.6%	2,654,002	14.1%	2,654,002	0.0%	2,508,971	-5.5%	2,573,264	2.6%
INTEREST - LONG/SHORT TERM	484,634	479,332	-3.3%	472,751	-1.4%	475,461	0.6%	486,934	2.4%	501,542	3.0%
TOTAL OTHER OPERATING EXPENSE	20,932,421	23,994,106	17.4%	21,585,813	-10.0%	21,962,017	1.7%	22,613,505	3.0%	23,387,468	3.4%
TOTAL OPERATING EXPENSE	64,964,600	68,441,823	0.2%	72,780,077	6.3%	73,310,732	0.7%	75,735,560	3.3%	79,043,223	4.4%
NET OPERATING INCOME (LOSS)	1,119,070	1,402,140	19.5%	1,109,916	-20.8%	1,022,291	-7.9%	1,345,266	31.6%	1,377,875	2.4%
NON-OPERATING REVENUE	-	-	#DIV/0!	-	#DIV/0!	2,630,121	#DIV/0!	2,678,835	1.9%	2,785,989	4.0%
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE	1,119,070	1,402,140	19.5%	1,109,916	-20.8%	3,652,412	229.1%	4,024,101	10.2%	4,163,864	3.5%
Operating Margin %	1.7%	2.0%		1.5%		1.4%		1.7%		1.7%	
Bad Debt & Free Care%	2.1%	2.5%		2.8%		2.9%		2.9%		2.9%	
Compensation Ratio	59.8%	57.5%		62.6%		62.4%		62.8%		63.2%	
Capital Cost % of Total Expenses	4.3%	4.1%		4.3%		4.3%		4.0%		3.9%	

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

INCOME STATEMENT

Table 3B

PROJECT ONLY

Proposed Years Must change from Current Budget

	FY2022	FY2023	FY2024		Proposed Yr 1		Proposed Yr 2		Proposed Yr 3	
	Actual	Actual/Projection	% change Budget 2024 App	% change	Proj 2024	% change	FY2025	% change	FY2026	% change
REVENUES										
INPATIENT CARE REVENUE			#DIV/0!	#DIV/0!	-	#DIV/0!	36,790	#DIV/0!	116,257	216.0%
OUTPATIENT CARE REVENUE			#DIV/0!	#DIV/0!	-	#DIV/0!	426,962	#DIV/0!	1,250,199	192.8%
OUTPATIENT CARE REVENUE - PHYSICIAN			#DIV/0!	#DIV/0!	-	#DIV/0!	138,146	#DIV/0!	178,252	29.0%
CHRONIC/SNF PT CARE REVENUE			#DIV/0!	#DIV/0!	-	#DIV/0!	82,989	#DIV/0!	262,245	216.0%
SWING BEDS PT CARE REVENUE			#DIV/0!	#DIV/0!	-	#DIV/0!	52,455	#DIV/0!	165,756	216.0%
GROSS PATIENT CARE REVENUE	-	-	#DIV/0!	- #DIV/0!	-	#DIV/0!	737,341	#DIV/0!	1,972,710	167.5%
DISPROPORTIONATE SHARE PAYMENTS			#DIV/0!	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
BAD DEBT FREE CARE			#DIV/0!	#DIV/0!	-	#DIV/0!	(21,281)	#DIV/0!	(56,937)	167.5%
DEDUCTIONS FROM REVENUE			#DIV/0!	#DIV/0!	45,483	#DIV/0!	(12,417)	-127.3%	(532,848)	4191.4%
			#DIV/0!	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
NET PATIENT CARE REVENUE	-	-	#DIV/0!	- #DIV/0!	45,483	#DIV/0!	703,643	1447.0%	1,382,925	96.5%
FIXED PROSPECTIVE PAYMENTS AND RESERVES			#DIV/0!	#DIV/0!	0	#DIV/0!	-	-100.0%	-	#DIV/0!
NET PATIENT CARE REV & FIXED PAYMENTS & RESERVES			#DIV/0!	#DIV/0!	45,483	#DIV/0!	703,643	1447.0%	1,382,925	96.5%
OTHER OPERATING REVENUE			#DIV/0!	#DIV/0!	(0)	#DIV/0!	(0)	-91.2%	-	-100.0%
TOTAL OPERATING REVENUE	-	-	#DIV/0!	- #DIV/0!	45,483	#DIV/0!	703,643	1447.0%	1,382,925	96.5%
OPERATING EXPENSE										
SALARIES NON MD			#DIV/0!	#DIV/0!	0	#DIV/0!	20,616	8589713.3%	207,190	905.0%
FRINGE BENEFITS NON MD			#DIV/0!	#DIV/0!	-	#DIV/0!	6,597	#DIV/0!	66,301	905.0%
FRINGE BENEFITS MD			#DIV/0!	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
PHYSICIAN FEES & SALARIES			#DIV/0!	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
HEALTH CARE PROVIDER TAX			#DIV/0!	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
DEPRECIATION AMORTIZATION			#DIV/0!	#DIV/0!	-	#DIV/0!	171,772	#DIV/0!	747,247	335.0%
INTEREST - LONG/SHORT TERM			#DIV/0!	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
OTHER OPERATING EXPENSE			#DIV/0!	#DIV/0!	120,640	#DIV/0!	642,144	432.3%	502,663	-21.7%
TOTAL OPERATING EXPENSE	-	-	#DIV/0!	- #DIV/0!	120,640	#DIV/0!	841,128	597.2%	1,523,401	81.1%
NET OPERATING INCOME (LOSS)	-	-	#DIV/0!	- #DIV/0!	(75,157)	#DIV/0!	(137,485)	82.9%	(140,476)	2.2%
NON-OPERATING REVENUE			#DIV/0!	#DIV/0!	-	#DIV/0!	1,826,725	#DIV/0!	4,347,962	138.0%
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE	-	-	#DIV/0!	- #DIV/0!	(75,157)	#DIV/0!	1,689,240	-2347.6%	4,207,486	149.1%

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

Note: This table requires no "fill-in" as it is populated automatically

INCOME STATEMENT

Table 3C

WITH PROJECT

Proposed Years Must change from Current Budget

	FY2022	FY2023		FY2024		Proposed Yr 2		Proposed Yr 2		Proposed Yr 3	
	Actual	Actual/Projection	% change	Budget 2024 App	% change	Proj 2024	% change	FY2025	% change	FY2026	% change
REVENUES											
INPATIENT CARE REVENUE	6,953,737	5,976,545	-36.8%	7,358,046	23.1%	7,071,983	-3.9%	7,762,738	9.8%	8,228,503	6.0%
OUTPATIENT CARE REVENUE	72,634,656	76,126,763	-2.7%	85,392,363	12.2%	83,255,990	-2.5%	90,088,943	8.2%	95,395,279	5.9%
OUTPATIENT CARE REVENUE - PHYSICIAN	22,026,595	22,013,765	-7.9%	27,629,174	25.5%	26,534,060	-4.0%	28,596,195	7.8%	29,490,043	3.1%
CHRONIC/SNF PT CARE REVENUE	14,330,837	15,292,716	0.8%	16,597,787	8.5%	16,964,792	2.2%	17,510,665	3.2%	18,561,305	6.0%
SWING BEDS PT CARE REVENUE	9,818,435	10,392,638	6.5%	10,490,902	0.9%	11,018,420	5.0%	11,067,902	0.4%	11,731,975	6.0%
GROSS PATIENT CARE REVENUE	125,764,260	129,802,427	-4.9%	147,468,272	13.6%	144,845,245	-1.8%	155,026,442	7.0%	163,407,106	5.4%
DISPROPORTIONATE SHARE PAYMENTS	1,265,351	424,300	-21.4%	450,000	6.1%	424,300	-5.7%	437,029	3.0%	450,140	3.0%
BAD DEBT FREE CARE	(2,631,871)	(3,203,027)	-14.7%	(4,055,378)	26.6%	(4,180,563)	3.1%	(4,474,415)	7.0%	(4,716,300)	5.4%
DEDUCTIONS FROM REVENUE	(64,564,162)	(64,847,591)	-7.1%	(75,278,660)	16.1%	(72,966,234)	-3.1%	(79,522,903)	9.0%	(83,718,422)	5.3%
	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
NET PATIENT CARE REVENUE	59,833,579	62,176,109	-2.1%	68,584,234	10.3%	68,122,748	-0.7%	71,466,153	4.9%	75,422,524	5.5%
FIXED PROSPECTIVE PAYMENTS AND RESERVES	2,748,808	3,176,715	33.0%	1,749,116	-44.9%	1,749,116	0.0%	1,827,826	4.5%	1,910,078	4.5%
NET PATIENT CARE REV & FIXED PAYMENTS & RESERVES	62,582,387	65,352,824	-0.8%	70,333,350	7.6%	69,871,864	-0.7%	73,293,979	4.9%	77,332,602	5.5%
OTHER OPERATING REVENUE	3,501,283	4,491,139	25.2%	3,556,643	-20.8%	4,506,642	26.7%	4,490,490	-0.4%	4,471,421	-0.4%
TOTAL OPERATING REVENUE	66,083,669	69,843,963	0.6%	73,889,993	5.8%	74,378,506	0.7%	77,784,469	4.6%	81,804,023	5.2%
OPERATING EXPENSE											
SALARIES NON MD	24,204,016	22,437,139	-12.3%	26,427,912	17.8%	25,899,354	-2.0%	27,214,937	5.1%	28,761,228	5.7%
FRINGE BENEFITS NON MD	7,655,433	8,208,075	-7.4%	9,260,264	12.8%	9,940,563	7.3%	9,990,132	0.5%	10,549,013	5.6%
FRINGE BENEFITS MD	6,977,655	8,742,154	8.5%	9,878,911	13.0%	9,878,911	0.0%	10,372,857	5.0%	10,891,499	5.0%
PHYSICIAN FEES & SALARIES	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
HEALTH CARE PROVIDER TAX	2,393,940	2,254,166	-0.9%	2,500,424	10.9%	2,500,424	0.0%	2,575,437	3.0%	2,652,700	3.0%
DEPRECIATION AMORTIZATION	2,316,501	2,326,851	-9.6%	2,654,002	14.1%	2,654,002	0.0%	2,680,743	1.0%	3,320,511	23.9%
INTEREST - LONG/SHORT TERM	484,634	479,332	-3.3%	472,751	-1.4%	475,461	0.6%	486,934	2.4%	501,542	3.0%
OTHER OPERATING EXPENSE	20,932,421	23,994,106	17.4%	21,585,813	-10.0%	22,082,657	2.3%	23,255,649	5.3%	23,890,131	2.7%
TOTAL OPERATING EXPENSE	64,964,600	68,441,823	0.2%	72,780,077	6.3%	73,431,372	0.9%	76,576,688	4.3%	80,566,624	5.2%
NET OPERATING INCOME (LOSS)	1,119,070	1,402,140	19.5%	1,109,916	-20.8%	947,134	-14.7%	1,207,781	27.5%	1,237,399	2.5%
NON-OPERATING REVENUE	-	-	#DIV/0!	-	#DIV/0!	2,630,121	#DIV/0!	4,505,560	71.3%	7,133,951	58.3%
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE	1,119,070	1,402,140	19.5%	1,109,916	-20.8%	3,577,255	222.3%	5,713,341	59.7%	8,371,350	46.5%
Operating Margin %	1.7%	2.0%		1.5%		1.3%		1.6%		1.5%	
Bad Debt & Free Care%	2.1%	2.5%		2.8%		2.9%		2.9%		2.9%	
Compensation Ratio	59.8%	57.5%		62.6%		62.3%		62.1%		62.3%	
Capital Cost % of Total Expenses	4.3%	4.1%		4.3%		4.3%		4.1%		4.7%	

Tables 4A - 4C

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT
BALANCE SHEET PROJECTIONS--TABLE 4

	Proposed Yr 1 **Proj FY2024**	Proposed Yr 2 **Proj FY2025**	Proposed Yr 3 **Proj FY2025**
ASSETS			
CURRENT ASSETS			
CASH & INVESTMENTS	(75,157)	1,613,082	5,820,568
* FY24 reduction of cash due to OPEX expenses for project, net of Medicare reimbursement			
* FY25 and FY26, cash flow impact			
PATIENT ACCOUNTS RECEIVABLE, GROSS		764	2,334
* FY25 and FY25 increased A/R due to increased rate increase			
of 0.5%, and 1.0%, respectively, and increased payables for project			
LESS: ALLOWANCE FOR UNCOLLECTIBLE ACCTS		(480)	(1,466)
* Impact of rate increase			
DUE FROM THIRD PARTIES			
OTHER CURRENT ASSETS			
TOTAL CURRENT ASSETS			
BOARD DESIGNATED ASSETS			
FUNDED DEPRECIATION			
ESCROWED BOND FUNDS			
OTHER			
TOTAL BOARD DESIGNATED ASSETS			
* No transfers to BDF during these years due to project costs, paying from cash/short term investments			
PROPERTY, PLANT, AND EQUIPMENT			
LAND, BUILDINGS & IMPROVEMENTS			
CONSTRUCTION IN PROGRESS			
MAJOR MOVABLE EQUIPMENT		2,290,300	5,653,283
* FY25 and FY26 increase are project phases coming on line			
FIXED EQUIPMENT			
TOTAL PROPERTY, PLANT AND EQUIPMENT			
LESS: ACCUMULATED DEPRECIATION			
LAND, BUILDINGS & IMPROVEMENTS		52,790	297,742
* Decreases largely a function of ratios used for estimates			
EQUIPMENT - FIXED			
EQUIPMENT - MAJOR MOVEABLE		(224,562)	(1,216,761)
* Increases due to bringing the project online and the ratios method			
and the full year depreciation of FY25 phase			
TOTAL ACCUMULATED DEPRECIATION		(171,772)	(919,019)
TOTAL PROPERTY, PLANT AND EQUIPMENT, NET		2,118,528	7,024,564
* Increases largely a function of ratios used for estimates			
OTHER LONG-TERM ASSETS			
TOTAL ASSETS			
LIABILITIES AND FUND BALANCE			
CURRENT LIABILITIES			
ACCOUNTS PAYABLE			
SALARIES, WAGES AND PAYROLL TAXES PAYABLE			
ESTIMATED THIRD-PARTY SETTLEMENTS			
OTHER CURRENT LIABILITIES			
CURRENT PORTION OF LONG-TERM DEBT			
TOTAL CURRENT LIABILITIES			
LONG-TERM DEBT			
BONDS & MORTGAGES PAYABLE			
CAPITAL LEASE OBLIGATIONS			
OTHER LONG-TERM DEBT			
TOTAL LONG-TERM DEBT			
OTHER NONCURRENT LIABILITIES			
TOTAL LIABILITIES			
FUND BALANCE		2,118,528	4,734,264
TOTAL LIABILITIES AND FUND BALANCE			

NOTES: See above. All changes in the balance sheet for the project are resultant upon the profit and loss results and a cash flow analysis.

MT. ASCUTNEY HOSPITAL & HEALTH CTR

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

Balance Sheet

WITHOUT PROJECT

Proposed Years Must change from Current Budget

	FY2022	FY2023		FY2023		FY2024		Proj FY2024		Proj FY2025		Proj FY2026	
	Actual	Budget	% change		% change	Budget	% change	Proposed Year 1	% change	Proposed Year 2	% change	Proposed Year 3	% change
ASSETS													
CURRENT ASSETS													
CASH & INVESTMENTS	10,661,829	10,168,645	-4.6%	14,346,061	41.1%	13,588,834	-5.3%	16,630,834	22.4%	19,232,592	15.6%	21,917,218	14.0%
PATIENT ACCOUNTS RECEIVABLE, GROSS	14,605,996	15,823,179	8.3%	16,439,913	3.9%	16,068,474	-2.3%	16,592,716	3.3%	16,749,339	0.9%	16,909,877	1.0%
LESS: ALLOWANCE FOR UNCOLLECTIBLE ACCT	(9,618,590)	(10,279,396)	6.9%	(10,327,810)	0.5%	(10,093,982)	-2.3%	(10,423,803)	3.3%	(10,522,196)	0.9%	(10,623,049)	1.0%
DUE FROM THIRD PARTIES	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
ACO RISK RESERVE/SETTLEMENT RECEIVABLE	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
OTHER CURRENT ASSETS	1,859,415	1,552,807	-16.5%	1,055,157	-32.0%	1,265,669	20.0%	1,055,157	-16.6%	1,055,157	0.0%	1,055,157	0.0%
TOTAL CURRENT ASSETS	17,508,650	17,265,235	-1.4%	21,513,321	24.6%	20,828,995	-3.2%	23,854,904	14.5%	26,514,892	11.2%	29,259,203	10.4%
BOARD DESIGNATED ASSETS					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL FUNDED DEPRECIATION	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
ESCROWED BOND FUNDS	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL OTHER	32,924,084	37,993,913	15.4%	34,190,956	-10.0%	36,475,292	6.7%	35,558,594	-2.5%	36,980,938	4.0%	38,460,176	4.0%
TOTAL BOARD DESIGNATED ASSETS	32,924,084	37,993,913	15.4%	34,190,956	-10.0%	36,475,292	6.7%	35,558,594	-2.5%	36,980,938	4.0%	38,460,176	4.0%
PROPERTY, PLANT, AND EQUIPMENT													
LAND, BUILDINGS & IMPROVEMENTS	32,110,181	35,965,666	12.0%	34,517,662	-4.0%	36,617,501	6.1%	35,467,662	-3.1%	36,517,662	3.0%	37,717,662	3.3%
CONSTRUCTION IN PROGRESS	769,293	250,000	-67.5%	1,177,720	371.1%	250,000	-78.8%	-	-100.0%	-	#DIV/0!	-	#DIV/0!
MAJOR MOVABLE EQUIPMENT	13,852,555	16,012,387	15.6%	14,220,564	-11.2%	14,469,697	1.8%	16,520,564	14.2%	18,095,064	9.5%	18,907,564	4.5%
FIXED EQUIPMENT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL PROPERTY, PLANT AND EQUIPMENT	46,732,029	52,228,053	11.8%	49,915,946	-4.4%	51,337,198	2.8%	51,988,226	1.3%	54,612,726	5.0%	56,625,226	3.7%
LESS: ACCUMULATED DEPRECIATION													
LAND, BUILDINGS & IMPROVEMENTS	(21,140,309)	(22,546,712)	6.7%	(22,174,535)	-1.7%	(23,354,809)	5.3%	(23,961,277)	2.6%	(25,699,174)	7.3%	(27,481,606)	6.9%
EQUIPMENT - FIXED	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
EQUIPMENT - MAJOR MOVEABLE	(8,823,343)	(11,069,787)	25.5%	(9,763,930)	-11.8%	(11,336,097)	16.1%	(10,631,190)	-6.2%	(11,402,264)	7.3%	(12,193,096)	6.9%
TOTAL ACCUMULATED DEPRECIATION	(29,963,652)	(33,616,499)	12.2%	(31,938,465)	-5.0%	(34,690,906)	8.6%	(34,592,467)	-0.3%	(37,101,438)	7.3%	(39,674,702)	6.9%
TOTAL PROPERTY, PLANT AND EQUIPMENT, NET	16,768,377	18,611,554	11.0%	17,977,481	-3.4%	16,646,292	-7.4%	17,395,759	4.5%	17,511,288	0.7%	16,950,524	-3.2%
OTHER LONG-TERM ASSETS	8,198,757	8,226,195	0.3%	8,169,483	-0.7%	7,519,592	-8.0%	9,806,508	30.4%	11,476,273	17.0%	13,179,434	14.8%
TOTAL ASSETS	**75,399,868**	**82,096,897**	8.9%	**81,851,241**	-0.3%	**81,470,171**	-0.5%	**86,615,765**	6.3%	**92,483,391**	6.8%	**97,849,337**	5.8%
LIABILITIES AND FUND BALANCE													
CURRENT LIABILITIES													
ACCOUNTS PAYABLE	3,186,063	3,593,473	12.8%	4,853,417	35.1%	2,990,680	-38.4%	4,942,497	1.8%	5,034,249	1.9%	5,128,754	1.9%
CURRENT LIABILITIES COVID-19	4,239,658	4,239,658	0.0%	2,969,334	-30.0%	4,239,658	42.8%	2,969,334	0.0%	2,969,334	0.0%	2,969,334	0.0%
SALARIES, WAGES AND PAYROLL TAXES PAYAB	5,109,381	5,803,763	13.6%	5,041,044	-13.1%	5,504,057	9.2%	5,041,044	0.0%	5,041,044	0.0%	5,041,044	0.0%
TOTAL ESTIMATED THIRD-PARTY SETTLEMENTS	(13,713)	1,300,000	-9580.2%	676,651	-47.9%	(250,000)	-136.9%	676,651	0.0%	676,651	0.0%	676,651	0.0%
OTHER CURRENT LIABILITIES	652,801	950,000	45.5%	550,883	-42.0%	366,221	-33.5%	550,883	0.0%	550,883	0.0%	550,883	0.0%
CURRENT PORTION OF LONG-TERM DEBT	472,589	542,543	14.8%	448,207	-17.4%	472,589	5.4%	448,207	0.0%	448,207	0.0%	448,207	0.0%
TOTAL CURRENT LIABILITIES	13,646,780	16,429,437	20.4%	14,539,536	-11.5%	13,323,205	-8.4%	14,628,616	0.6%	14,720,368	0.6%	14,814,873	0.6%
LONG-TERM DEBT													
LONG TERM LIABILITIES COVID-19	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
BONDS & MORTGAGES PAYABLE	22,216,289	16,917,022	-23.9%	22,266,463	31.6%	17,464,149	-21.6%	21,698,951	-2.5%	21,151,539	-2.5%	20,628,027	-2.5%
CAPITAL LEASE OBLIGATIONS	-	4,421,502	#DIV/0!	-	-100.0%	4,259,834	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
OTHER LONG-TERM DEBT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL LONG-TERM DEBT	22,216,289	21,338,524	-4.0%	22,266,463	4.3%	21,723,983	-2.4%	21,698,951	-2.5%	21,151,539	-2.5%	20,628,027	-2.5%
OTHER NONCURRENT LIABILITIES	650,238	800,000	23.0%	546,774	-31.7%	650,238	18.9%	546,774	0.0%	546,774	0.0%	546,774	0.0%
TOTAL LIABILITIES	**36,513,307**	**38,567,961**	5.6%	**37,352,773**	-3.2%	**35,697,426**	-4.4%	**36,874,341**	-1.3%	**36,418,681**	-1.2%	**35,989,674**	-1.2%
TOTAL FUND BALANCE	38,886,561	43,528,936	11.9%	44,498,468	2.2%	45,772,745	2.9%	49,741,424	11.8%	56,064,710	12.7%	61,859,662	10.3%
TOTAL LIABILITIES AND FUND BALANCE	**75,399,868**	**82,096,897**	8.9%	**81,851,241**	-0.3%	**81,470,171**	-0.5%	**86,615,765**	5.8%	**92,483,391**	6.8%	**97,849,336**	5.8%

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

Balance Sheet

PROJECT ONLY

Proposed Years Must change from Current Budget

	FY2022	FY2023		FY2023		FY2024		Proj FY2024		Proj FY2025		Proj FY2026	
	Actual	Budget	% change		% change	Budget	% change	Proposed Year 1	% change	Proposed Year 2	% change	Proposed Year 3	% change
ASSETS													
CURRENT ASSETS													
CASH & INVESTMENTS			#DIV/0!		#DIV/0!		#DIV/0!	(75,157)	#DIV/0!	(212,643)	182.9%	1,472,606	-792.5%
PATIENT ACCOUNTS RECEIVABLE, GROSS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	764	#DIV/0!	2,334	205.5%
LESS: ALLOWANCE FOR UNCOLLECTIBLE ACCTS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	(480)	#DIV/0!	(1,466)	205.5%
DUE FROM THIRD PARTIES			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
ACO RISK RESERVE/SETTLEMENT RECEIVABLE			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
OTHER CURRENT ASSETS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL CURRENT ASSETS	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	(75,157)	#DIV/0!	(212,359)	182.6%	1,473,474	-793.9%
BOARD DESIGNATED ASSETS					#DIV/0!		#DIV/0!		#DIV/0!				
FUNDED DEPRECIATION			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
ESCROWED BOND FUNDS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
OTHER			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL BOARD DESIGNATED ASSETS	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
PROPERTY, PLANT, AND EQUIPMENT													
LAND, BUILDINGS & IMPROVEMENTS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
CONSTRUCTION IN PROGRESS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
MAJOR MOVABLE EQUIPMENT			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	2,290,300	#DIV/0!	5,653,283	146.8%
FIXED EQUIPMENT			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL PROPERTY, PLANT AND EQUIPMENT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	2,290,300	#DIV/0!	5,653,283	146.8%
LESS: ACCUMULATED DEPRECIATION													
LAND, BUILDINGS & IMPROVEMENTS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	52,790	#DIV/0!	297,742	464.0%
EQUIPMENT - FIXED			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
EQUIPMENT - MAJOR MOVEABLE			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	(224,562)	#DIV/0!	(1,216,761)	441.8%
TOTAL ACCUMULATED DEPRECIATION	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	(171,772)	#DIV/0!	(919,019)	435.0%
TOTAL PROPERTY, PLANT AND EQUIPMENT, NET	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	2,118,528	#DIV/0!	4,734,264	123.5%
OTHER LONG-TERM ASSETS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL ASSETS	**-**	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**(75,157)**	#DIV/0!	**1,906,169**	-2636.2%	**6,207,738**	225.7%
LIABILITIES AND FUND BALANCE													
CURRENT LIABILITIES													
ACCOUNTS PAYABLE			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
CURRENT LIABILITIES COVID-19			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
SALARIES, WAGES AND PAYROLL TAXES PAYABLE			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
ESTIMATED THIRD-PARTY SETTLEMENTS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
OTHER CURRENT LIABILITIES			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
CURRENT PORTION OF LONG-TERM DEBT			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL CURRENT LIABILITIES	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
LONG-TERM DEBT													
LONG TERM LIABILITIES COVID-19			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
BONDS & MORTGAGES PAYABLE			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
CAPITAL LEASE OBLIGATIONS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
OTHER LONG-TERM DEBT			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL LONG-TERM DEBT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
OTHER NONCURRENT LIABILITIES			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL LIABILITIES	**-**	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!
FUND BALANCE			#DIV/0!		#DIV/0!		#DIV/0!	(75,157)	#DIV/0!	1,906,169	-2636.2%	6,207,738	225.7%
TOTAL LIABILITIES AND FUND BALANCE	**-**	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**(75,157)**	#DIV/0!	**1,906,169**	-2636.2%	**6,207,738**	225.7%

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

Note: This table requires no "fill-in" as it is populated automatically

Balance Sheet

WITH PROJECT

Proposed Years Must change from Current Budget

	FY2022 Actual	FY2023 Budget	% change	FY2023	% change	FY2024 Budget	% change	Proj FY2024 Proposed Year 1	% change	Proj FY2025 Proposed Year 2	% change	Proj FY2026 Proposed Year 3	% change
ASSETS													
CURRENT ASSETS													
CASH & INVESTMENTS	10,661,829	10,168,645	-4.6%	14,346,061	41.1%	13,588,834	-5.3%	16,555,677	21.8%	19,019,949	14.9%	23,389,824	23.0%
PATIENT ACCOUNTS RECEIVABLE, GROSS	14,605,996	15,823,179	8.3%	16,439,913	3.9%	16,068,474	-2.3%	16,592,716	3.3%	16,750,103	0.9%	16,912,211	1.0%
LESS: ALLOWANCE FOR UNCOLLECTIBLE ACCT:	(9,618,590)	(10,279,396)	6.9%	(10,327,810)	0.5%	(10,093,982)	-2.3%	(10,423,803)	3.3%	(10,522,676)	0.9%	(10,624,515)	1.0%
DUE FROM THIRD PARTIES	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
ACO RISK RESERVE/SETTLEMENT RECEIVABLE	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
OTHER CURRENT ASSETS	1,859,415	1,552,807	-16.5%	1,055,157	-32.0%	1,265,669	20.0%	1,055,157	-16.6%	1,055,157	0.0%	1,055,157	0.0%
TOTAL CURRENT ASSETS	17,508,650	17,265,235	-1.4%	21,513,321	24.6%	20,828,995	-3.2%	23,779,747	14.2%	26,302,533	10.6%	30,732,677	16.8%
BOARD DESIGNATED ASSETS					#DIV/0!		#DIV/0!		#DIV/0!				
FUNDED DEPRECIATION	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
ESCROWED BOND FUNDS	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
OTHER	32,924,084	37,993,913	15.4%	34,190,956	-10.0%	36,475,292	6.7%	35,558,594	-2.5%	36,980,938	4.0%	38,460,176	4.0%
TOTAL BOARD DESIGNATED ASSETS	32,924,084	37,993,913	15.4%	34,190,956	-10.0%	36,475,292	6.7%	35,558,594	-2.5%	36,980,938	4.0%	38,460,176	4.0%
PROPERTY, PLANT, AND EQUIPMENT													
LAND, BUILDINGS & IMPROVEMENTS	32,110,181	35,965,666	12.0%	34,517,662	-4.0%	36,617,501	6.1%	35,467,662	-3.1%	36,517,662	3.0%	37,717,662	3.3%
CONSTRUCTION IN PROGRESS	769,293	250,000	-67.5%	1,177,720	371.1%	250,000	-78.8%	-	-100.0%	-	#DIV/0!	-	#DIV/0!
MAJOR MOVABLE EQUIPMENT	13,852,555	16,012,387	15.6%	14,220,564	-11.2%	14,469,697	1.8%	16,520,564	14.2%	20,385,364	23.4%	24,560,847	20.5%
FIXED EQUIPMENT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
TOTAL PROPERTY, PLANT AND EQUIPMENT	46,732,029	52,228,053	11.8%	49,915,946	-4.4%	51,337,198	2.8%	51,988,226	1.3%	56,903,026	9.5%	62,278,509	9.4%
LESS: ACCUMULATED DEPRECIATION													
LAND, BUILDINGS & IMPROVEMENTS	(21,140,309)	(22,546,712)	6.7%	(22,174,535)	-1.7%	(23,354,809)	5.3%	(23,961,277)	2.6%	(25,646,384)	7.0%	(27,183,864)	6.0%
EQUIPMENT - FIXED	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
EQUIPMENT - MAJOR MOVEABLE	(8,823,343)	(11,069,787)	25.5%	(9,763,930)	-11.8%	(11,336,097)	16.1%	(10,631,190)	-6.2%	(11,626,826)	9.4%	(13,409,857)	15.3%
TOTAL ACCUMULATED DEPRECIATION	(29,963,652)	(33,616,499)	12.2%	(31,938,465)	-5.0%	(34,690,906)	8.6%	(34,592,467)	-0.3%	(37,273,210)	7.7%	(40,593,721)	8.9%
TOTAL PROPERTY, PLANT AND EQUIPMENT, NET	16,768,377	18,611,554	11.0%	17,977,481	-3.4%	16,646,292	-7.4%	17,395,759	4.5%	19,629,816	12.8%	21,684,788	10.5%
OTHER LONG-TERM ASSETS	8,198,757	8,226,195	0.3%	8,169,483	-0.7%	7,519,592	-8.0%	9,806,508	30.4%	11,476,273	17.0%	13,179,434	14.8%
TOTAL ASSETS	**75,399,868**	**82,096,897**	8.9%	**81,851,241**	-0.3%	**81,470,171**	-0.5%	**86,540,608**	6.2%	**94,389,560**	9.1%	**104,057,075**	10.2%
LIABILITIES AND FUND BALANCE													
CURRENT LIABILITIES													
ACCOUNTS PAYABLE	3,186,063	3,593,473	12.8%	4,853,417	35.1%	2,990,680	-38.4%	4,942,497	1.8%	5,034,249	1.9%	5,128,754	1.9%
CURRENT LIABILITIES COVID-19	4,239,658	4,239,658	0.0%	2,969,334	-30.0%	4,239,658	42.8%	2,969,334	0.0%	2,969,334	0.0%	2,969,334	0.0%
SALARIES, WAGES AND PAYROLL TAXES PAYAB	5,109,381	5,803,763	13.6%	5,041,044	-13.1%	5,504,057	9.2%	5,041,044	0.0%	5,041,044	0.0%	5,041,044	0.0%
ESTIMATED THIRD-PARTY SETTLEMENTS	(13,713)	1,300,000	-9580.2%	676,651	-47.9%	(250,000)	-136.9%	676,651	0.0%	676,651	0.0%	676,651	0.0%
OTHER CURRENT LIABILITIES	652,801	950,000	45.5%	550,883	-42.0%	366,221	-33.5%	550,883	0.0%	550,883	0.0%	550,883	0.0%
CURRENT PORTION OF LONG-TERM DEBT	472,589	542,543	14.8%	448,207	-17.4%	472,589	5.4%	448,207	0.0%	448,207	0.0%	448,207	0.0%
TOTAL CURRENT LIABILITIES	13,646,780	16,429,437	20.4%	14,539,536	-11.5%	13,323,205	-8.4%	14,628,616	0.6%	14,720,368	0.6%	14,814,873	0.6%
LONG-TERM DEBT													
LONG TERM LIABILITIES COVID-19	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
BONDS & MORTGAGES PAYABLE	22,216,289	16,917,022	-23.9%	22,266,463	31.6%	17,464,149	-21.6%	21,698,951	-2.5%	21,151,539	-2.5%	20,628,027	-2.5%
CAPITAL LEASE OBLIGATIONS	-	4,421,502	#DIV/0!	-	-100.0%	4,259,834	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
OTHER LONG-TERM DEBT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
TOTAL LONG-TERM DEBT	22,216,289	21,338,524	-4.0%	22,266,463	4.3%	21,723,983	-2.4%	21,698,951	-2.5%	21,151,539	-2.5%	20,628,027	-2.5%
OTHER NONCURRENT LIABILITIES	650,238	800,000	23.0%	546,774	-31.7%	650,238	18.9%	546,774	0.0%	546,774	0.0%	546,774	0.0%
TOTAL LIABILITIES	**36,513,307**	**38,567,961**	5.6%	**37,352,773**	-3.2%	**35,697,426**	-4.4%	**36,874,341**	-1.3%	**36,418,681**	-1.2%	**35,989,674**	-1.2%
FUND BALANCE	38,886,561	43,528,936	11.9%	44,498,468	2.2%	45,772,745	2.9%	49,666,267	11.6%	57,970,879	16.7%	68,067,400	17.4%
TOTAL LIABILITIES AND FUND BALANCE	**75,399,868**	**82,096,897**	8.9%	**81,851,241**	-0.3%	**81,470,171**	-0.5%	**86,540,608**	5.7%	**94,389,560**	9.1%	**104,057,074**	10.2%

Tables 6A - 6C

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT
PAYER PROJECTIONS--TABLE 6

	Proposed Yr 1 **Proj FY2024**	Proposed Yr 2 **Proj FY2025**	Proposed Yr 3 **Proj FY2025**	
Commercial				
Hospital	-	181,609	540,721	Price Increase
Physician	-	47,942	61,860	Price Increase
Total Revenue	-	229,551	602,581	Total price increase
Allowances - Hospital	-	214,582	453,585	Effect of price increase & revenue model ratios
Allowances - Physicians	-	(84,680)	(94,472)	Effect of price increase & revenue model ratios
Free Care	-	(7,507)	(20,085)	Price Increase
Bad Debt	-	(13,775)	(36,852)	Price Increase
Net Payer Revenue	-	338,171	904,757	Effect of price increase & revenue model ratios
Medicaid				
Hospital	-	65,666	196,332	Price Increase
Physician	-	21,535	27,787	Price Increase
Total Revenue	-	87,201	224,119	Total Price Increase
Allowances - Hospital	-	(65,666)	(196,331)	Effect of price increase
Allowances - Physicians	-	(21,535)	(27,788)	Effect of price increase
Free Care				
Bad Debt				
Net Payer Revenue	-	-	-	Medicaid reimbursement doesn't change with price increase
Medicare				
Hospital	-	351,920	1,057,405	Effect of price increase
Physician	-	68,670	88,606	Effect of price increase
Total Revenue	-	420,590	1,146,011	Total price increase
Allowances - Hospital	45,483	(153,763)	(758,102)	Add'l Medicare Reimbursement
Allowances - Physicians	-	98,645	90,260	Add'l Medicare Reimbursement
Free Care				
Bad Debt				
Net Payer Revenue	45,483	365,472	478,169	Cost Reimbursement gain
Disproportionate Share Payments				
Total Payer Revenue				
Hospital	-	599,195	1,794,458	Effect of price increase
Physician	-	138,147	178,253	Effect of price increase
Total Revenue	-	737,342	1,972,711	Total price increase
Allowances - Hospital	45,484	(4,847)	(500,848)	Effect of price increase
Allowances - Physicians	-	(7,569)	(31,998)	Effect of price increase
Free Care	-	(7,507)	(20,085)	Effect of price increase
Bad Debt	-	(13,775)	(36,852)	Effect of price increase
Disproportionate Share Payments	-	-	-	
Net Payer Revenue	45,483	703,643	1,382,925	Reimbursement gain for price increase

NOTES:
* Other than a reduction of volumes in FY26 in some clinics and outpatient departments for go-live adjustment, there will be no foreseeable change in volume or service lines resulting from this implementation.
* Due to this project, we would be increasing our rate request by 0.5% in FY25 and 1.0% in FY26.
  * Medicare will still be based on cost and but will recognize the increases in contracted services and depreciation in FY24, FY25, and FY26 ($45k, $365k, and $478k, respectively)
  * Medicaid will not share in any of this rate increase since their reimbursement is not based on cost and their reimbursement rates are fixed
  * Commercial will pay most of this increase
* Bad Debt and Free Care will be largely unaffected, slight increases due to the price increase.
* There is no direct correlation between ACO payments and DSH to the project itself. Inflationary changes year to year.
* Reimbursement estimates do not consider contractual term changes with commercial insurers.
* Net Revenue projections are estimates based on our historical reimbursement and our most recent revenue modeling.

MT. ASCUTNEY HOSPITAL & HEALTH CTR

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

PAYER REVENUE REPORT

WITHOUT PROJECT

Proposed Years Must change from Current Budget

	FY2022 Actual	FY2023 Budget	% change	FY2023	% change	FY2024 Budget	% change	Proj. FY24 Proposed Year 1	% change	Proj. FY25 Proposed Year 2	% change	Proj. FY26 Proposed Year 3	% change
Commercial													
Hospital	30,646,868	36,014,597	17.5%	31,545,312	-12.4%	36,321,913	15.1%	35,710,518	-1.7%	38,138,009	6.8%	40,044,909	5.0%
Physician	7,758,525	8,683,887	11.9%	7,911,247	-8.9%	9,588,247	21.2%	9,208,205	-4.0%	9,875,893	7.3%	10,172,170	3.0%
Total Revenue	38,405,393	44,698,484	16.4%	39,456,559	-11.7%	45,910,160	16.4%	44,918,723	-2.2%	48,013,902	6.9%	50,217,079	4.6%
Allowances - Hospital	-10,130,611	-10,947,947	8.1%	-7,528,952	-31.2%	-12,448,122	65.3%	(12,177,393)	-2.2%	(13,071,943)	7.3%	(13,725,541)	5.0%
Allowances - Physicians	-2,642,281	-4,964,830	87.9%	-2,459,799	-50.5%	-5,516,571	124.3%	(5,297,915)	-4.0%	(5,682,068)	7.3%	(5,852,530)	3.0%
Free Care	-562,795	-1,365,357	142.6%	-389,555	-71.5%	-1,474,683	278.6%	(1,474,683)	0.0%	(1,570,831)	6.5%	(1,643,578)	4.6%
Bad Debt	-2,069,077	-2,389,375	15.5%	-2,813,471	17.7%	-2,949,366	4.8%	(2,705,880)	-8.3%	(2,882,302)	6.5%	(3,015,785)	4.6%
Net Payer Revenue	23,000,629	25,030,975	8.8%	26,264,782	4.9%	23,521,418	-10.4%	23,262,852	-1.1%	24,806,758	6.6%	25,979,645	4.7%
Fixed Prospective Payment & Reserves	87,689	100,000	14.0%	27,460	-72.5%	100,000	264.2%		-100.0%		#DIV/0!		#DIV/0!
Total Net Payer Revenue & Fixed Prospective Payment	23,088,318	25,130,975	8.8%	26,292,241	4.6%	23,621,418	-10.2%	23,262,852	-1.5%	24,806,758	6.6%	25,979,645	4.7%
Reimbursement Rate - Commercial	60%	56%		67%		51%		52%		52%		52%	
Payer Mix - Commercial	37%	38%		40%		33%		33%		34%		34%	
Medicaid													
Hospital	12,523,514	12,804,876	2.2%	11,046,828	-13.7%	13,133,286	18.9%	12,923,960	-1.6%	13,789,950	6.7%	14,479,447	5.0%
Physician	3,511,395	3,807,132	8.4%	3,262,149	-14.3%	4,306,944	32.0%	4,136,234	-4.0%	4,436,153	7.3%	4,569,237	3.0%
Total Revenue	16,034,909	16,612,008	3.6%	14,308,977	-13.9%	17,440,230	21.9%	17,060,194	-2.2%	18,226,103	6.8%	19,048,684	4.5%
Allowances - Hospital	-12,647,505	-9,706,669	-23.3%	-12,483,402	28.6%	-9,908,142	-20.6%	(11,488,715)	16.0%	(12,282,324)	6.9%	(12,896,440)	5.0%
Allowances - Physicians	-1,851,036	-3,509,000	89.6%	-1,902,574	-45.8%	-2,855,207	50.1%	(2,742,038)	-4.0%	(2,940,864)	7.3%	(3,029,090)	3.0%
Free Care	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Bad Debt	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Graduate Medical Education Payments-Phys.	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Graduate Medical Education Payments-Hosp	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Net Payer Revenue	1,536,367	3,396,339	121.1%	-76,999	-102.3%	4,676,881	-6174.0%	2,829,441	-39.5%	3,002,915	6.1%	3,123,154	4.0%
Fixed Prospective Payment & Reserves	0	0	#DIV/0!	0	#DIV/0!	2,188,076	#DIV/0!	1,749,116	-20.1%	1,827,826	4.5%	1,910,078	4.5%
Total Net Payer Revenue & Fixed Prospective Payment	4,071,653	5,960,754	46.4%	2,758,923	-53.7%	6,864,957	148.8%	4,578,557	-33.3%	4,830,741	5.5%	5,033,232	4.2%
Reimbursement Rate - Medicaid	25%	36%		19%		39%		27%		27%		26%	
Payer Mix - Medicaid	7%	9%		4%		10%		7%		7%		7%	
Medicare													
Hospital	60,567,283	63,814,695	5.4%	65,196,522	2.2%	70,383,899	8.0%	69,676,707	-1.0%	73,903,094	6.1%	77,598,249	5.0%
Physician	10,756,675	11,410,527	6.1%	10,840,369	-5.0%	13,733,983	26.7%	13,189,621	-4.0%	14,146,003	7.3%	14,570,383	3.0%
Total Revenue	71,323,958	75,225,222	5.5%	76,036,891	1.1%	84,117,882	10.6%	82,866,328	-1.5%	88,049,097	6.3%	92,168,632	4.7%
Allowances - Hospital	-34,779,883	-34,226,345	-1.6%	-37,729,218	10.2%	-35,597,329	-5.7%	(33,017,344)	-7.2%	(36,412,866)	10.3%	(38,287,938)	5.1%
Allowances - Physicians	-2,512,844	-6,485,779	158.1%	-2,743,647	-57.7%	-9,084,620	231.1%	(8,288,314)	-8.8%	(9,120,423)	10.0%	(9,394,036)	3.0%
Free Care	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Bad Debt	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Net Payer Revenue	34,031,231	34,513,098	1.4%	35,564,026	3.0%	39,435,933	10.9%	41,560,670	5.4%	42,515,808	2.3%	44,486,658	4.6%
Fixed Prospective Payment & Reserves	125,833	-275,357	-318.8%	313,333	-213.8%	300,000	-4.3%		-100.0%		#DIV/0!		
Total Net Payer Revenue & Fixed Prospective Payment	34,157,064	34,237,741	0.2%	35,877,360	4.8%	39,735,933	10.8%	41,560,670	4.6%	42,515,808	2.3%	44,486,658	
Reimbursement Rate - Medicare	48%	46%		47%		47%		50%		48%		48%	
Payer Mix - Medicare	55%	52%		55%		56%		60%		59%		59%	
Disproportionate Share Payments	1,265,351	540,000	-57.3%	424,300	-21.4%	450,000	6.1%	424,301	-5.7%	437,029	3.0%	450,142	3.0%
Total Payer Revenue													
Hospital	103,737,665	112,634,168	8.6%	107,788,662	-4.3%	119,839,098	11.2%	118,311,185	-1.3%	125,831,053	6.4%	132,122,605	5.0%
Physician	22,026,595	23,901,546	8.5%	22,013,765	-7.9%	27,629,174	25.5%	26,534,060	-4.0%	28,458,049	7.3%	29,311,790	3.0%
Total Revenue	125,764,260	136,535,714	8.6%	129,802,427	-4.9%	147,468,272	13.6%	144,845,245	-1.8%	154,289,102	6.5%	161,434,395	4.6%
Allowances - Hospital	-57,558,000	-54,880,961	-4.7%	-57,741,572	5.2%	-57,953,593	0.4%	-56,683,452	-2.2%	-61,767,133	9.0%	-64,909,919	5.1%
Allowances - Physicians	-7,006,162	-14,959,609	113.5%	-7,106,020	-52.5%	-17,456,398	145.7%	-16,328,267	-6.5%	-17,743,355	8.7%	-18,275,656	3.0%
Free Care	-562,795	-1,365,357	142.6%	-389,555	-71.5%	-1,474,683	278.6%	-1,474,683	0.0%	-1,570,831	6.5%	-1,643,578	4.6%
Bad Debt	-2,069,077	-2,389,375	15.5%	-2,813,471	17.7%	-2,949,366	4.8%	-2,705,880	-8.3%	-2,882,302	6.5%	-3,015,785	4.6%
Disproportionate Share Payments	1,265,351	540,000	-57.3%	424,300	-21.4%	450,000	6.1%	424,301	-5.7%	437,029	3.0%	450,142	3.0%
Graduate Medical Education Payments_Phys.	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Graduate Medical Education Payments-Hosp	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Net Payer Revenue	59,833,578	63,480,412	6.1%	62,176,109	-2.1%	68,084,232	9.5%	68,077,264	0.0%	70,762,510	3.9%	74,039,599	4.6%
Fixed Prospective Payment & Reserves	2,206,024	2,314,058		2,088,076		2,588,076		1,749,116		1,827,826		1,910,078	
Total Net Payer Revenue & Fixed Prospective Payment	62,582,387	65,869,470		65,352,824		70,672,308		69,826,380		72,590,336		75,949,677	
Reimbursement Rate - All Payers	50%	48%		50%		48%		48%		47%		47%	

PAYER REVENUE REPORT

PROJECT ONLY

Proposed Years Must change from Current Budget

	FY2022 Actual	FY2023 Budget	% change	FY2023	% change	FY2024 Budget	% change	Proj. FY24 Proposed Year 1	% change	Proj. FY25 Proposed Year 2	% change	Proj. FY26 Proposed Year 3	% change
Commercial													
Hospital	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	181,609	#DIV/0!	540,721	197.7%
Physician	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	47,942	#DIV/0!	61,860	29.0%
Total Revenue	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	229,551	#DIV/0!	602,581	162.5%
Allowances - Hospital	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	214,582	433.4%	453,585	-24.7%
Allowances - Physicians	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	(84,680)	#DIV/0!	(94,472)	75.3%
Free Care							#DIV/0!	-	#DIV/0!	(7,507)		(20,085)	
Bad Debt							#DIV/0!	-	#DIV/0!	(13,775)		(36,852)	
Net Payer Revenue	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	-	#DIV/0!	338,171		904,757	167.5%
Fixed Prospective Payment & Reserves													
Total Net Payer Revenue & Fixed Prospective Payment	0	0		0		0		-		338,171		904,757	
Reimbursement Rate - Commercial	0%	0%		0%		0%		0%		0%		1%	
Payer Mix - Commercial	0%	0%		0%		0%		0%		0%		1%	
Medicaid	0	0		0		0.0%		-		-		-	
Hospital	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	65,666	#DIV/0!	196,332	199.0%
Physician	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	21,535	#DIV/0!	27,787	29.0%
Total Revenue	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	87,201	#DIV/0!	224,119	157.0%
Allowances - Hospital	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	(65,666)	#DIV/0!	(196,331)	199.0%
Allowances - Physicians	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	(21,535)	#DIV/0!	(27,788)	29.0%
Free Care							#DIV/0!		#DIV/0!				
Bad Debt							#DIV/0!		#DIV/0!				
Graduate Medical Education Payments-Phys.	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Graduate Medical Education Payments-Hosp	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Net Payer Revenue	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Fixed Prospective Payment & Reserves													
Total Net Payer Revenue & Fixed Prospective Payment	0	0		0		0		-		-		-	
Reimbursement Rate - Medicaid	0%	0%		0%		0%		0%		0%		0%	
Payer Mix - Medicaid	0%	0%		0%		0%		0%		0%		0%	
Medicare													
Hospital	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	351,920	#DIV/0!	1,057,405	200.5%
Physician	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	68,670	#DIV/0!	88,606	29.0%
Total Revenue	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	420,590	#DIV/0!	1,146,011	172.5%
Allowances - Hospital	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	45,483	#DIV/0!	(153,763)	-168.9%	(758,102)	1918.1%
Allowances - Physicians	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	98,645	#DIV/0!	90,260	48.4%
Free Care							#DIV/0!		#DIV/0!				
Bad Debt							#DIV/0!		#DIV/0!				
Net Payer Revenue	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	45,483	#DIV/0!	365,472	703.5%	478,169	30.8%
Fixed Prospective Payment & Reserves													
Total Net Payer Revenue & Fixed Prospective Payment	0	0		0		0		45,483		365,472		478,169	
Reimbursement Rate - Medicare	0%	0%		0%		0%		0%		0%		0%	
Payer Mix - Medicare	0%	0%		0%		0%		0%		0%		0%	
Disproportionate Share Payments	0	0	#DIV/0!	0	#DIV/0!	#DIV/0!	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!
Total Payer Revenue	0	0		0		0.0%		-					
Hospital	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	599,195	#DIV/0!	1,794,458	199.5%
Physician	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	138,147	#DIV/0!	178,253	29.0%
Total Revenue	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	737,342	#DIV/0!	1,972,711	167.5%
Allowances - Hospital	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	45,484	#DIV/0!	(4,847)	-110.7%	(500,848)	10233.2%
Allowances - Physicians	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	(7,569)	#DIV/0!	(31,998)	322.8%
Free Care	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	(7,507)	#DIV/0!	(20,085)	167.6%
Bad Debt	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	(13,775)	#DIV/0!	(36,852)	167.5%
Disproportionate Share Payments	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	(1)	#DIV/0!	(1)	0.0%	(3)	200.0%
Graduate Medical Education Payments-Phys.	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Graduate Medical Education Payments-Hosp	0	0	#DIV/0!	0	#DIV/0!	0.0%	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Net Payer Revenue	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	45,483	#DIV/0!	703,643	1447.0%	1,382,925	96.5%
Fixed Prospective Payment & Reserves													
Total Net Payer Revenue & Fixed Prospective Payment	0	0		0		0		45,483		703,643		1,382,925	
Reimbursement Rate - All Payers	-2%	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		95.4%		70.1%	

PAYER REVENUE REPORT

WITH PROJECT

Proposed Years Must change from Current Budget

	FY2022 Actual	FY2023 Budget	% change	FY2023	% change	FY2024 Budget	% change	Proj. FY24 Proposed Year 1	% change	Proj. FY25 Proposed Year 2	% change	Proj. FY26 Proposed Year 3	% change
Commercial													
Hospital	30,646,868	36,014,597	17.5%	31,545,312	-12.4%	36,321,913	15.1%	35,710,518	-1.7%	38,319,618	7.3%	40,585,630	5.9%
Physician	7,758,525	8,683,887	11.9%	7,911,247	-8.9%	9,588,247	21.2%	9,208,205	-4.0%	9,923,835	7.8%	10,234,030	3.1%
Total Revenue	38,405,393	44,698,484	16.4%	39,456,559	-11.7%	45,910,160	16.4%	44,918,723	-2.2%	48,243,453	7.4%	50,819,660	5.3%
Allowances - Hospital	-10,130,611	-10,947,947	8.1%	-7,528,952	-31.2%	-12,448,122	65.3%	-12,177,393	-2.2%	-12,857,361	5.6%	-13,271,956	3.2%
Allowances - Physicians	-2,642,281	-4,964,830	87.9%	-2,459,799	-50.5%	-5,516,571	124.3%	-5,297,915	-4.0%	-5,766,748	8.8%	-5,947,002	3.1%
Free Care	-562,795	-1,365,357	142.6%	-389,555	-71.5%	-1,474,683	278.6%	-1,474,683	0.0%	-1,578,338	7.0%	-1,663,663	5.4%
Bad Debt	-2,069,077	-2,389,375	15.5%	-2,813,471	17.7%	-2,949,366	4.8%	-2,705,880	-8.3%	-2,896,077	7.0%	-3,052,637	5.4%
Net Payer Revenue	23,000,629	25,030,975	8.8%	26,264,782	4.9%	23,521,418	-10.4%	23,262,852	-1.1%	25,144,929	8.1%	26,884,402	6.9%
Fixed Prospective Payment & Reserves	87,689	100,000	14.0%	27,460	-72.5%	100,000	264.2%	0	-100.0%	0	#DIV/0!	0	#DIV/0!
Total Net Payer Revenue & Fixed Prospective Payment	23,088,318	25,130,975	8.8%	26,292,241	4.6%	23,621,418	-10.2%	23,262,852	-1.5%	25,144,929	8.1%	26,884,402	0
Reimbursement Rate - Commercial	60%	56%		67%		51%		52%		52%		53%	
Payer Mix - Commercial	37%	38%		40%		33%		33%		34%		35%	
Medicaid													
Hospital	12,523,514	12,804,876	2.2%	11,046,828	-13.7%	13,133,286	18.9%	12,923,960	-1.6%	13,855,616	7.2%	14,675,779	5.9%
Physician	3,511,395	3,807,132	8.4%	3,262,149	-14.3%	4,306,944	32.0%	4,136,234	-4.0%	4,457,688	7.8%	4,597,024	3.1%
Total Revenue	16,034,909	16,612,008	3.6%	14,308,977	-13.9%	17,440,230	21.9%	17,060,194	-2.2%	18,313,304	7.3%	19,272,803	5.2%
Allowances - Hospital	-12,647,505	-9,706,669	-23.3%	-12,483,402	28.6%	-9,908,142	-20.6%	-11,488,715	16.0%	-12,347,990	7.5%	-13,092,771	6.0%
Allowances - Physicians	-1,851,036	-3,509,000	89.6%	-1,902,574	-45.8%	-2,855,207	50.1%	-2,742,038	-4.0%	-2,962,399	8.0%	-3,056,878	3.2%
Free Care	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Bad Debt	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Graduate Medical Education Payments-Phys.	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Graduate Medical Education Payments-Hosp	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Net Payer Revenue	1,536,367	3,396,339	121.1%	-76,999	-102.3%	4,676,881	-6174.0%	2,829,441	-39.5%	3,002,915	6.1%	3,123,154	4.0%
Fixed Prospective Payment & Reserves	0	0		0		2,188,076		1,749,116		1,827,826		1,910,078	
Total Net Payer Revenue & Fixed Prospective Payment	4,071,653	5,960,754		2,758,923		6,864,957		4,578,557		4,830,741		5,033,232	
Reimbursement Rate - Medicaid	25%	36%		19%		39%		27%		26%		26%	
Payer Mix - Medicaid	7%	9%		4%		10%		7%		7%		7%	
Medicare													
Hospital	60,567,283	63,814,695	5.4%	65,196,522	2.2%	70,383,899	8.0%	69,676,707	-1.0%	74,255,014	6.6%	78,655,654	5.9%
Physician	10,756,675	11,410,527	6.1%	10,840,369	-5.0%	13,733,983	26.7%	13,189,621	-4.0%	14,214,673	7.8%	14,658,989	3.1%
Total Revenue	71,323,958	75,225,222	5.5%	76,036,891	1.1%	84,117,882	10.6%	82,866,328	-1.5%	88,469,687	6.8%	93,314,643	5.5%
Allowances - Hospital	-34,779,883	-34,226,345	-1.6%	-37,729,218	10.2%	-35,597,329	-5.7%	-32,971,861	-7.4%	-36,566,629	10.9%	-39,046,040	6.8%
Allowances - Physicians	-2,512,844	-6,485,779	158.1%	-2,743,647	-57.7%	-9,084,620	231.1%	-8,288,314	-8.8%	-9,021,778	8.8%	-9,303,776	3.1%
Free Care	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Bad Debt	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Net Payer Revenue	34,031,231	34,513,098	1.4%	35,564,026	3.0%	39,435,933	10.9%	41,606,153	5.5%	42,881,280	3.1%	44,964,827	4.9%
Fixed Prospective Payment & Reserves	125,833	-275,357		313,333		300,000		0		0		0	
Total Net Payer Revenue & Fixed Prospective Payment	34,157,064	34,237,741		35,877,360		39,735,933		41,606,153		42,881,280		44,964,827	
Reimbursement Rate - Medicare	48%	46%		47%		47%		50%		48%		48%	
Payer Mix - Medicare	55%	52%		55%		56%		60%		59%		58%	
Disproportionate Share Payments	1,265,351	540,000	-57.3%	424,300	-21.4%	#DIV/0!	#DIV/0!	424,301	#DIV/0!	437,029	3.0%	450,142	3.0%
Total Payer Revenue													
Hospital	103,737,665	112,634,168	8.6%	107,788,662	-4.3%	119,839,098	11.2%	118,311,185	-1.3%	126,430,248	6.9%	133,917,063	5.9%
Physician	22,026,595	23,901,546	8.5%	22,013,765	-7.9%	27,629,174	25.5%	26,534,060	-4.0%	28,596,196	7.8%	29,490,043	3.1%
Total Revenue	125,764,260	136,535,714	8.6%	129,802,427	-4.9%	147,468,272	13.6%	144,845,245	-1.8%	155,026,444	7.0%	163,407,106	5.4%
Allowances - Hospital	-57,558,000	-54,880,961	-4.7%	-57,741,572	5.2%	-57,953,593	0.4%	-56,637,968	-2.3%	-61,771,980	9.1%	-65,410,767	5.9%
Allowances - Physicians	-7,006,162	-14,959,609	113.5%	-7,106,020	-52.5%	-17,456,398	145.7%	-16,328,267	-6.5%	-17,750,924	8.7%	-18,307,654	3.1%
Free Care	-562,795	-1,365,357	142.6%	-389,555	-71.5%	-1,474,683	278.6%	-1,474,683	0.0%	-1,578,338	7.0%	-1,663,663	5.4%
Bad Debt	-2,069,077	-2,389,375	15.5%	-2,813,471	17.7%	-2,949,366	4.8%	-2,705,880	-8.3%	-2,896,077	7.0%	-3,052,637	5.4%
Disproportionate Share Payments	1,265,351	540,000	-57.3%	424,300	-21.4%	450,000	6.1%	424,300	-5.7%	437,028	3.0%	450,139	3.0%
Graduate Medical Education Payments-Phys.	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Graduate Medical Education Payments-Hosp	0	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Net Payer Revenue	59,833,578	63,480,412	6.1%	62,176,109	-2.1%	68,084,232	9.5%	68,122,747	0.1%	71,466,153	4.9%	75,422,524	5.5%
Fixed Prospective Payment & Reserves	2,206,024	2,314,058		2,088,076		2,588,076		1,749,116		1,827,826		1,910,078	
Total Net Payer Revenue & Fixed Prospective Payment	62,582,387	65,869,470		65,352,824		70,672,308		69,871,863		73,293,979		77,332,602	
Reimbursement Rate - All Payers	48%	46%		48%		46%		48%		47%		47%	

Table 7A - 7C

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT
UTILIZATION PROJECTIONS--TABLE 7

	Proposed Yr 1 2024	Proposed Yr 2 2025	Proposed Yr 3 2026
Inpatient Utilization			
Acute Beds (Staffed)			-
Acute Admissions			-
Acute Patient Days			-
Acute Average Length Of Stay			-
Outpatient			
All Outpatient Visits			-
Operating Room Procedure			(12)
Operating Room Cases			(12)
Physician Office Visits			(547)
Ancillary			
All Operating Room Procedure			-
Emergency Room Visits			-
Cat Scan Procedures			-
Magnetic Resonance Image Exams			-
Nuclear Medicine Procedures			-
Radiology - Diagnostic Procedures			(74)
Laboratory Tests			(332)
Adjusted Statistics			-
Adjusted Admissions			(73)
Adjusted Days			(254)

NOTES:

* As stated elsewhere, this project will have no effect or change on existing service lines and will not create new service lines. The only material changes in volumes will occur in FY26 when there is a slow down in certain service lines as staff acclimate to the new systems and work processes. Most notably, we expect a reduction in clinic/provider office visits. This will have a small effect on ancillary services. We expect to be up to speed within 2-3 months in the clinic setting. We do not expect medically necessary, urgent and emergent services to be affected by the implementation.

Mt. Ascutney Hospital & Health Ctr

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

UTILIZATION PROJECTIONS--TABLE 7

WITHOUT PROJECT — Proposed Years Must change from Current Budget

	FY2022 Actual	FY2023 Budget	% change	FY2023	% change	FY2024 Budget	% change	Proposed Yr 1 Proj. FY24	% change	Proposed Yr 2 Proj. FY25	% change	Proposed Yr 3 Proj. FY26	% change
Inpatient Utilization													
Acute Beds (Staffed)	15	15	0.0%	15	0.0%	15	0.0%	15	0.0%	15	0.0%	15	0.0%
Acute Admissions	349	460	31.8%	333	-27.6%	361	8.4%	347	-3.9%	364	4.8%	367	1.0%
Acute Patient Days	1,442	1,780	23.4%	1,162	-34.7%	1,400	20.5%	1,346	-3.9%	1,410	4.8%	1,424	1.0%
Acute Average Length Of Stay	4.13	3.87	-6.3%	3.49	-9.8%	3.88	11.1%	3.88	0.0%	3.88	0.0%	3.88	0.0%
Outpatient													
All Outpatient Visits	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Physician Office Visits	45,513	48,367	6.3%	44,014	-9.0%	54,364	23.5%	52,209	-4.0%	54,700	4.8%	54,769	0.1%
Ancillary													
All Operating Room Procedure	1,640	1,739	6.0%	1,628	-6.4%	2,319	42.4%	2,261	-2.5%	2,333	3.2%	2,354	0.9%
All Operating Room Cases	1,635	3,599	120.1%	1,625	-54.8%	2,319	42.7%	2,261	-2.5%	2,333	3.2%	2,354	0.9%
Emergency Room Visits	5,934	5,217	-12.1%	6,191	18.7%	5,600	-9.5%	5,460	-2.5%	5,635	3.2%	5,685	0.9%
Cat Scan Procedures	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Magnetic Resonance Image Exams	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Nuclear Medicine Procedures	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Radiology - Diagnostic Procedures	14,848	14,387	-3.1%	14,580	1.3%	14,654	0.5%	14,287	-2.5%	14,746	3.2%	14,877	0.9%
Laboratory Tests	70,517	67,271	-4.6%	66,622	-1.0%	65,950	-1.0%	64,300	-2.5%	66,362	3.2%	66,953	0.9%
			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Adjusted Statistics													
Adjusted Admissions	6,312	6,640	5.2%	7,232	8.9%	7,877	8.9%	7,104	-9.8%	7,269	2.3%	7,320	0.7%
Adjusted Days	26,080	25,693	-1.5%	25,237	-1.8%	27,486	8.9%	24,788	-9.8%	25,365	2.3%	25,545	0.7%

PROJECT ONLY — Proposed Years Must change from Current Budget

	FY2022 Actual	FY2023 Budget	% change	FY2023	% change	FY2024 Budget	% change	Proposed Yr 1 Proj. FY24	% change	Proposed Yr 2 Proj. FY25	% change	Proposed Yr 3 Proj. FY26	% change
Inpatient Utilization													
Acute Beds (Staffed)			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
Acute Admissions			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
Acute Patient Days			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
Acute Average Length Of Stay			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
Outpatient													
All Outpatient Visits			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
Physician Office Visits			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	(547)	#DIV/0!
Ancillary													
All Operating Room Procedure			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	(12)	#DIV/0!
All Operating Room Cases			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	(12)	#DIV/0!
Emergency Room Visits			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
Cat Scan Procedures			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
Magnetic Resonance Image Exams			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
Nuclear Medicine Procedures			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!
Radiology - Diagnostic Procedures			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	(74)	#DIV/0!
Laboratory Tests			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	(332)	#DIV/0!
			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Adjusted Statistics													
Adjusted Admissions			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	(73)	#DIV/0!
Adjusted Days			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	(254)	#DIV/0!

Note: This table requires no "fill-in" as it is populated automatically

WITH PROJECT — Proposed Years Must change from Current Budget

	FY2022 Actual	FY2023 Budget	% change	FY2023	% change	FY2024 Budget	% change	Proposed Yr 1 Proj. FY24	% change	Proposed Yr 2 Proj. FY25	% change	Proposed Yr 3 Proj. FY26	% change
Inpatient Utilization													
Acute Beds (Staffed)	15	15	0.0%	15	0.0%	15	0.0%	15	0.0%	15	0.0%	15	0.0%
Acute Admissions	349	460	31.8%	333	-27.6%	361	8.4%	347	-3.9%	364	4.8%	367	1.0%
Acute Patient Days	1,442	1,780	23.4%	1,162	-34.7%	1,400	20.5%	1,346	-3.9%	1,410	4.8%	1,424	1.0%
Acute Average Length Of Stay	4	4	-6.3%	3	-9.8%	4	11.1%	4	0.0%	4	0.0%	4	0.0%
Outpatient													
All Outpatient Visits	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Physician Office Visits	45,513	48,367	6.3%	44,014	-9.0%	54,364	23.5%	52,209	-4.0%	54,700	4.8%	54,222	-0.9%
Ancillary													
All Operating Room Procedure	1,640	1,739	6.0%	1,628	-6.4%	2,319	42.4%	2,261	-2.5%	2,333	3.2%	2,343	0.4%
All Operating Room Cases	1,635	3,599	120.1%	1,625	-54.8%	2,319	42.7%	2,261	-2.5%	2,333	3.2%	2,343	0.4%
Emergency Room Visits	5,934	5,217	-12.1%	6,191	18.7%	5,600	-9.5%	5,460	-2.5%	5,635	3.2%	5,685	0.9%
Cat Scan Procedures	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Magnetic Resonance Image Exams	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Nuclear Medicine Procedures	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Radiology - Diagnostic Procedures	14,848	14,387	-3.1%	14,580	1.3%	14,654	0.5%	14,287	-2.5%	14,746	3.2%	14,803	0.4%
Laboratory Tests	70,517	67,271	-4.6%	66,622	-1.0%	65,950	-1.0%	64,300	-2.5%	66,362	3.2%	66,621	0.4%
	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Adjusted Statistics													
Adjusted Admissions	6,312	6,640	5.2%	7,232	8.9%	7,877	8.9%	7,104	-9.8%	7,269	2.3%	7,248	-0.3%
Adjusted Days	26,080	25,693	-1.5%	25,237	-1.8%	27,486	8.9%	24,788	-9.8%	25,365	2.3%	25,291	-0.3%

Table 8A - 8C

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

STAFFING REPORT--TABLE 8

	Proposed Yr 1 Proj. 2024	Proposed Yr 2 Proj 2025	Proposed Yr 3 Proj 2026
PHYSICIAN FTEs			
TRAVELERS			
Residents & Fellows			
MLPs		**0.2**	**1.6**
Non-MD FTEs			
TOTAL NON-MD FTEs			

NOTES:

* MAHHC does not budget for travelers. We always budget for the necessary staffing (employed), based on volumes and patient need. We are uncomfortable with institutionalizing an ongoing need for travelers post-pandemic and are striving to get back to 100% staffing without travelers. That said, we do look at the historical differential between the cost of a traveler and the cost of an employee with benefits. This differential is added to contracted services based on the historical use of travelers in a given department.
* Table 8 notes that proposed figures for FTE's should not be equal to budgeted figures presented. We could come up with no reason why that would necessarily be the case for MAHHC given the nature of this project.
* As mentioned in the CON narrative. This project will not be changing service lines, staffing needs, etc. therefore, there are no material changes to staffing levels (with the exception of the above noted FTE changes) due to this project. The FTE's above relate to the extra FTE required in specific departments to replace direct patient care staff to facilitate training on the new systems. The reduction in volumes for the first few months will not afect staffing. Any improvements in access (if any) down the road will be aborbed with in normal staffing levels.
* It should be noted that there will be an FTE hired at DH to oversee and support the inpatient and outpatient Physical Rehabilitation modules for MAHHC and other affiliates. This position will be a contracted service and the increase of an estimated $108k per year, is included in our shared services (contracted labor/constracted services) increase related to the project. We estimate that 38% of this new and additional cost will be captured in our Medicare cost reimbursement.
* There are loose plans to "re-badge" back-office (finance, HR, billing, IT, etc.) staffing at MAHHC to DH. These plans have not been determined in detail and as an affiliate, we are charged cost by DH for any staffing that that we received from them so the costs will essentially be flat (contracted vs. employed)

MT. ASCUTNEY HOSPITAL & HEALTH CTR

GMCB-006-24CON ELECTRONIC HEALTH RECORD REPLACEMENT

STAFFING REPORT - TABLE 8

WITHOUT PROJECT

Proposed Years Must change from Current Budget

	FY2022 Actual	FY2023 Budget	% change	FY2023 Actual	% change	FY2024 Budget	% change	Proposed Year 1 Proj 2024	% change	Proposed Year 2 Proj 2025	% change	Proposed Year 3 Proj 2026	% change
PHYSICIAN FTEs	**19.2**	**19.0**	-1.0%	**19.4**	2.2%	**18.2**	-6.3%	**17.3**	-4.8%	**17.7**	2.3%	**17.9**	1.1%
TRAVELERS	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Residents & Fellows	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
MLPs	9.3	8.8	-5.2%	8.8	-0.2%	12.3	40.1%	11.1	-9.8%	11.6	4.5%	11.9	2.6%
Non-MD FTEs	306.1	337.8	10.4%	311.8	-7.7%	342.9	10.0%	309.7	-9.7%	343.0	10.8%	343.5	0.1%
TOTAL NON-MD FTEs	**315.4**	**346.6**	9.9%	**320.6**	-7.5%	**355.2**	10.8%	**320.8**	-9.7%	**354.6**	10.5%	**355.4**	0.2%

Note: Mid-Level Providers and Residents are now included in Non-MD Employees, prior to 2013 Actual they were included in Physician FTEs

STAFFING REPORT - TABLE 8

PROJECT ONLY

Proposed Years Must change from Current Budget

	FY2022 Actual	FY2023 Budget	% change	FY2023 Actual	% change	FY2024 Budget	% change	Proposed Year 1 Proj 2024	% change	Proposed Year 2 Proj 2025	% change	Proposed Year 3 Proj 2026	% change
PHYSICIAN FTEs			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TRAVELERS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Residents & Fellows			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
MLPs			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Non-MD FTEs			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!	0.2	#DIV/0!	1.6	657.7%
TOTAL NON-MD FTEs	**-**	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**0.2**	#DIV/0!	**1.6**	657.7%

Note: Mid-Level Providers and Residents are now included in Non-MD Employees, prior to 2013 Actual they were included in Physician FTEs

Note: This table requires no "fill-in" as it is populated automatically

STAFFING REPORT - TABLE 8

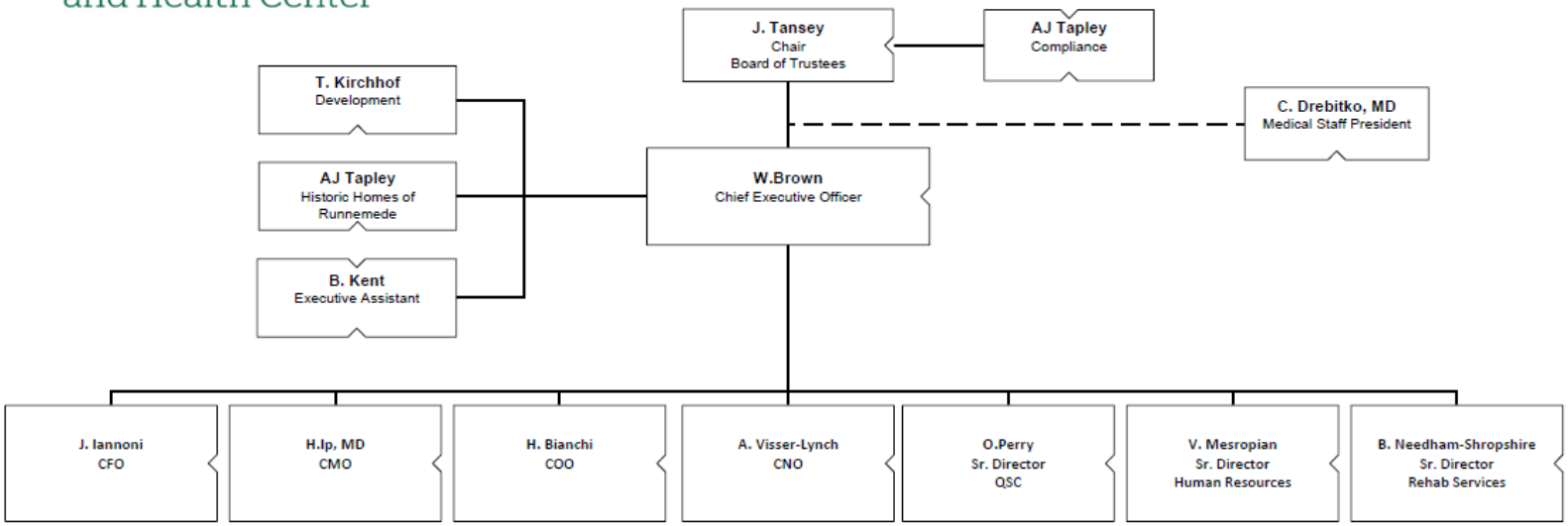
WITH PROJECT

Proposed Years Must change from Current Budget

	FY2022 Actual	FY2023 Budget	% change	FY2023 Actual	% change	FY2024 Budget	% change	Proposed Year 1 Proj 2024	% change	Proposed Year 2 Proj 2025	% change	Proposed Year 3 Proj 2026	% change
PHYSICIAN FTEs	**19.2**	**19.0**	-1.0%	**19.4**	2.2%	**18.2**	-6.3%	**17.3**	-4.8%	**17.7**	2.3%	**17.9**	1.1%
TRAVELERS	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Residents & Fellows	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
MLPs	9.3	8.8	-5.2%	8.8	-0.2%	12.3	40.1%	11.1	-9.8%	11.6	4.5%	11.9	2.6%
Non-MD FTEs	306.1	337.8	10.4%	311.8	-7.7%	342.9	10.0%	309.7	-9.7%	343.2	10.8%	345.0	0.5%
TOTAL NON-MD FTEs	**315.4**	**346.6**	9.9%	**320.6**	-7.5%	**355.2**	10.8%	**320.8**	-9.7%	**354.8**	10.6%	**356.9**	0.6%

Note: Mid-Level Providers and Residents are now included in Non-MD Employees, prior to 2013 Actual they were included in Physician FTEs

Mt. Ascutney Hospital and Health Center



- Revenue Cycle
- HIM
- Controller
- Director, Finance
  - Payroll

- Medical Director, ED
- Medical Director, Clinics
  - Community Health
- Hospitalist Services

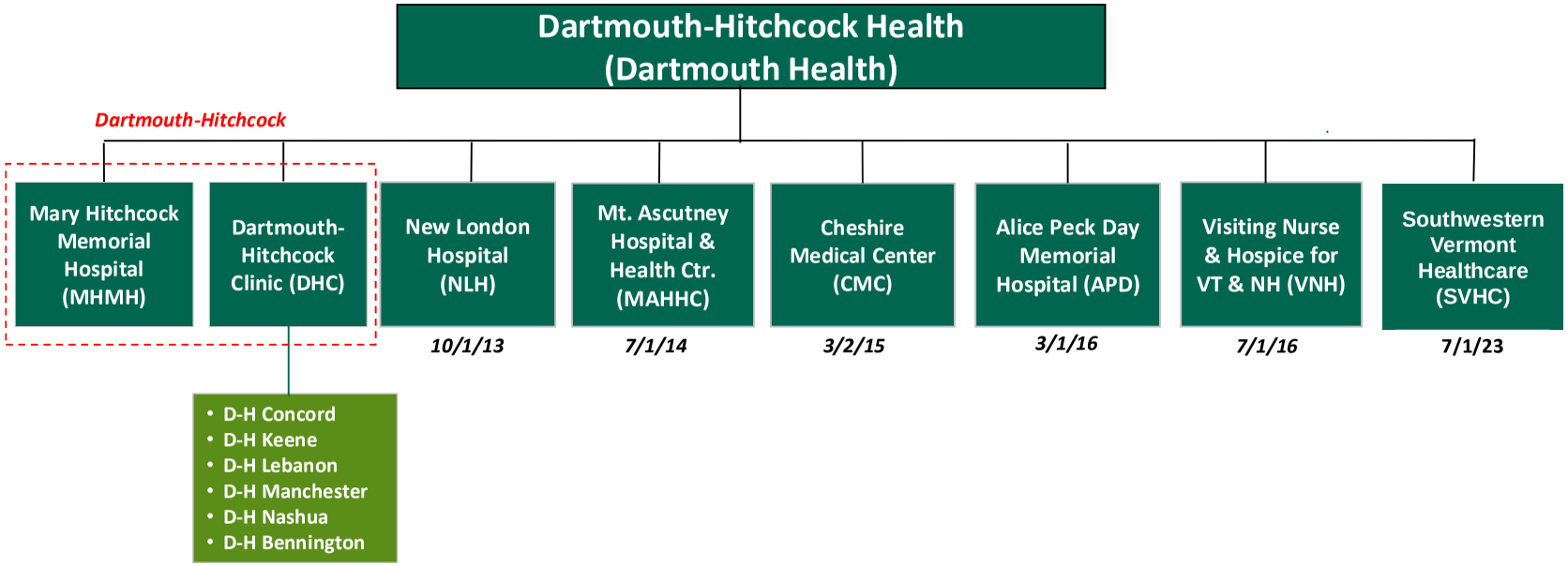
- Surgical Specialties
- Periop
- Nutrition & Food Services
- EVS
- Facilities
- Patient Registration
- Supply Chain
- IT
- Marketing

- Pharmacy
- ER
- Acute & Swing
- Case Management
- Nursing Director

- Infection Prevention
- Occupational Health
- Emergency Management
- Quality
- Risk
- Patient Experience
- Chaplaincy
- Med Staff Office

- Benefits
- Recruitment
- Employee Wellness & Events
- Volunteer Services

- Acute Rehab
- Outpatient Rehab
- Cardiac Rehab
- Referral Office
- Specialty Practices
- Lab
- Radiology
- Respiratory


Dartmouth-Hitchcock Health
(Dartmouth Health)
Dartmouth-Hitchcock
Mary Hitchcock Memorial Hospital (MHMH)
Dartmouth-Hitchcock Clinic (DHC)
New London Hospital (NLH)
10/1/13
Mt. Ascutney Hospital & Health Ctr. (MAHHC)
7/1/14
Cheshire Medical Center (CMC)
3/2/15
Alice Peck Day Memorial Hospital (APD)
3/1/16
Visiting Nurse & Hospice for VT & NH (VNH)
7/1/16
Southwestern Vermont Healthcare (SVHC)
7/1/23
• D-H Concord
• D-H Keene
• D-H Lebanon
• D-H Manchester
• D-H Nashua
• D-H Bennington

Mt. Ascutney Enterprise Systems Integration Governance for Infrastructure and ERP Draft

Last Updated: 03/13/2024

DHH Executive Committee
MAH-Win Brown, Steve LeBlanc, Ed Merrens, Dan Jantzen, Patrick Jordan, Aimee Claiborne, Peter Solberg, Marty Purcell,

Shared Services Steering Committee
Joe Iannoni, Hannah Bianchi, Torie Mesropian, John Muhlen, Bruce Adams, Ken Kelliher, Bob Montagna, Brenda Blair, Lisa Jackson, PM-TBD

Communications
MAH- TBD

Project Management Leadership
MAH- Torie Mesropian, Jason Bean, Hannah Bianchi, Andrew Garami, Joe Iannoni DH-Brenda Montagna, Bruce Adams, Wendy Galluzzo, Lisa Jackson, Rajneesh Jain, Don Dupont, Deb Young-Messer, Louise Dube, Rich Casano, Stacy Souliere, Marie Young, Anjali Jain, Naga, Kim Wasserman

Discovery Sessions
HR/Payroll combined with Benefits, Retirement, Recruiting
Supply Chain combined with Purchasing/ ePro and Inventory/Mobile Inventory

Finance
DH – Thomas L., Bruce A., Wendy G., MAH-Andrew Garami, Joe Iannoni
IT Swetha, Kim I.
PM – Wendy G, (AP & SC), Louise

GL & AM
DH – Val T.,
MAH- Andrew Garami, Joe Iannoni, Heather Stearns, Kim Wasserman,
IT – Swetha, Gellknight
PM- Wendy G

AP
DH –David H., Julie W.
MAH- Andrew Garami, Kim Wasserman, Christine Buckman, IT – Gellknight, Steve K.
PM-Louise Dube

Payroll
DH – Stacy S., Angela Miller, Colleen Fauth
MAH- Andrew Garami, Torie Mesropian, Tanya Graves, Heather Stearns, Jody Wood, Kathy Reeves, Kim Wasserman, IT – Rajneesh, Anjali, Naga
PM-Louise Dube

Banks/Checks
DH – Stacy S. Katie B., David H, JulieW.
MAH- Andrew Garami, Kim Wasserman
IT – Gellknight, Anjali
PM-Louise Dube

Budgets/VT Reports
DH – Wendy G.,
MAH- Andrew Garami, Joe Iannoni, David Fox, IT-Kim, Becky

Billing Integration
DH – Rob G., Kim Mc, Karen, Julie
MAH- CFO, Andrew Garami, Bonnie Paquette, Erin MacPhail
PM- Rob G

Supply Chain
DH -Robin B., MAH- Martha Colburn
IT – Deb, Sarah S.
PM -Louise D.

Item Master
DH –Robin B., Kim G., Cenra W.
MAH- Martha Colburn, Bonnie Paquette, Andrew Garami, David Fox
Chargemaster/Billing – Joe Stone
IT – Deb, Sarah S., Becky

Purchasing/EPro
DH –Robin B; Bob Simms, Kendra Richmond
MAH- Martha Colburn
IT – Sarah S.; Kim I.; Chandra

Inventory/Mobile Inventory
DH – Robin B, Richard Casano, Steven LaTorre
MAH- Martha Colburn
IT- Deb, Sarah S., Anil

Infrastructure & Environments
DH- Justin Bell, Bill Weyrick, Jim Flynn, Justin Poirier, Rajneesh Jain , MAH- Jason Bean, PM Liz Jameson

Hardware
DH – Justin B.
MAH- Jason Bean
PM- Liz

Desktop
DH – Bill W.
MAH- Jason Bean
PM- Liz

Telcom/Phone
DH – Jim F.
MAH- Jason Bean
PM- Liz,

Provisioning, Integration Testing
DH – Dan H., Rajneesh
MAH- Jason Bean
PM -Marie/Rajneesh

Policy Tech
DH –Jason Aldous
MAH- Otelah Perry, Jason Bean
PM – Peter Martin

Legacy
DH – Marie Y.
MAH- Jason Bean, Torie Mesropian, Andrew Garami, Otelah Perry
PM –Marie

Network
DH – Justin P., Greg S.,
MAH- Jason Bean
PM- Liz

Help Desk
DH – Bill W.
MAH- Jason Bean
PM- Liz

ETime, Badges, Security Doors
DH IT – Patrick Smith, Naga
MAH- Jason Bean, Tyson Taft, Torie Mesropian
PM - Naga

Interfaces
DH IT – Rajneesh, Becky, Marie Y., MAH-Jason Bean
PM – Becky/Rajneesh

Data Conversion & Environments
IT-Rajneesh J., Debbie, Don D., Marie Y, Peter M.
MAH-Torie Mesropian, Jason Bean, Andrew Garami
PM – Peter Martin

HR
DH – Pauline Field
MAH- Torie Mesropian,
IT- Anjali, Naga, Rajneesh
PM –TBD

HRM-ESS/MSS
DH – Pauline Field, Sarah Morcom, Lisa Jackson.,
MAH-Torie Mesropian, Blake Wardwell, Jemima Roberts
IT – Naga S, Anjali
PM-Louise

Benefits, Retirement
DH –Tricia Blackman,
MAH- Torie Mesropian, Jody Wood
IT – Naga., Anjali
PM-Louise

Benefits- Open Enrollment
DH –Crystal Farnsworth
MAH- Torie Mesropian, Jody Wood
IT – Naga., Anjali
PM-Don/Anjali

Nurse Scheduling (Staffing & Scheduling)
DH –Marie Y.,
MAH- Amy Visser-Lynch, Torie Mesropian, Tanya Graves, Renee Vittum
IT – Peter M., Rajneesh
PM-Peter Martin

Recruiting, Job Descriptions
DH – Cassidy Johnson, Sara Clayton, Lynn Butler
MAH- Torie Mesropian, Blake Wardwell
IT – Naga., Anjali
PM- Don/Anjali

Training
DH coordinator - Kim I.

Finance / Payroll / Budget
MAH- Torie Mesropian, Andrew Garami, Tanya Graves, Heather Stearns

Supply Chain / Materials Management
DH- Robin B.
MAH- Martha Colburn

Human Resources
DH-Sarah M.
MAH- Torie Mesropian

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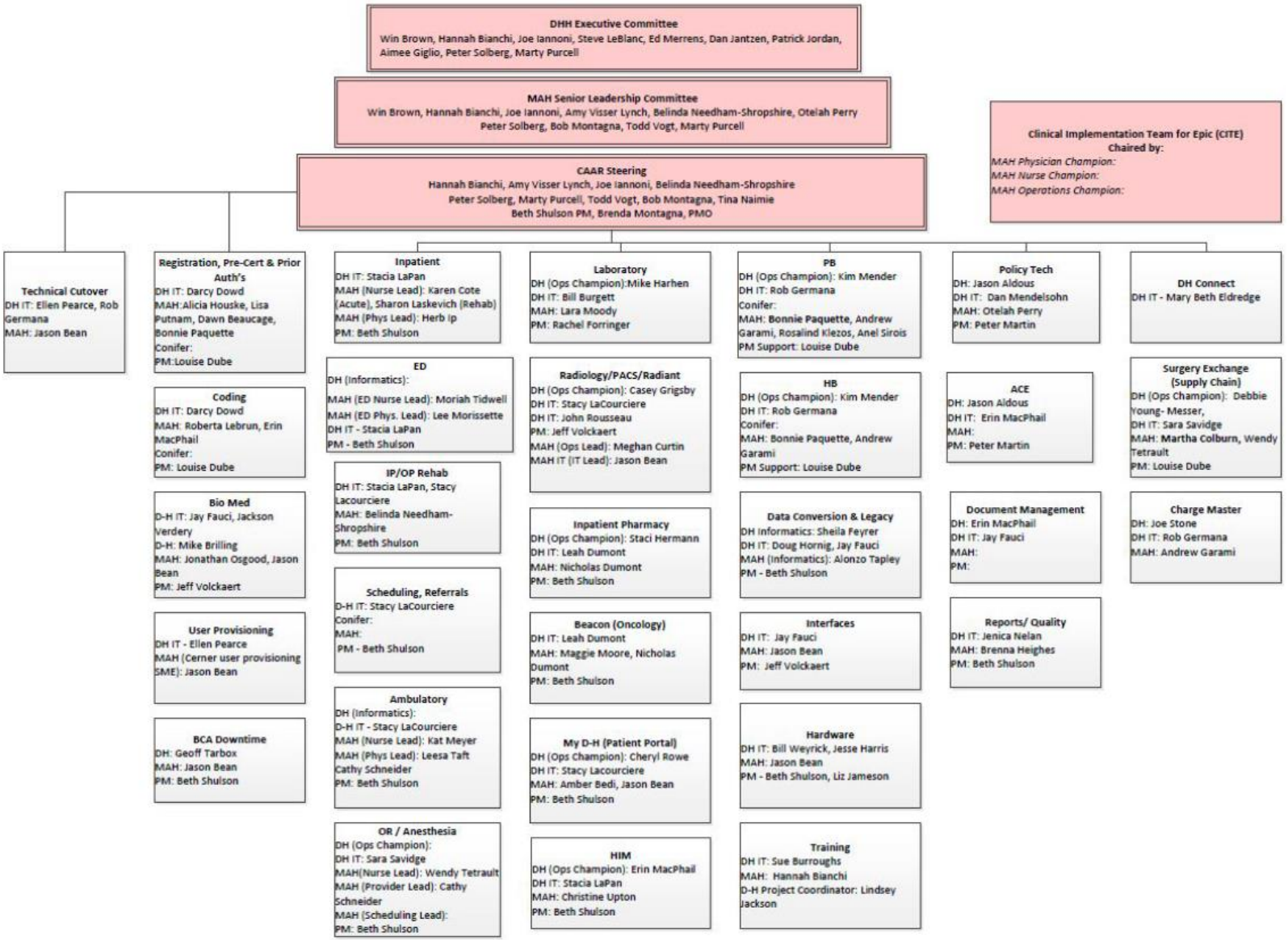
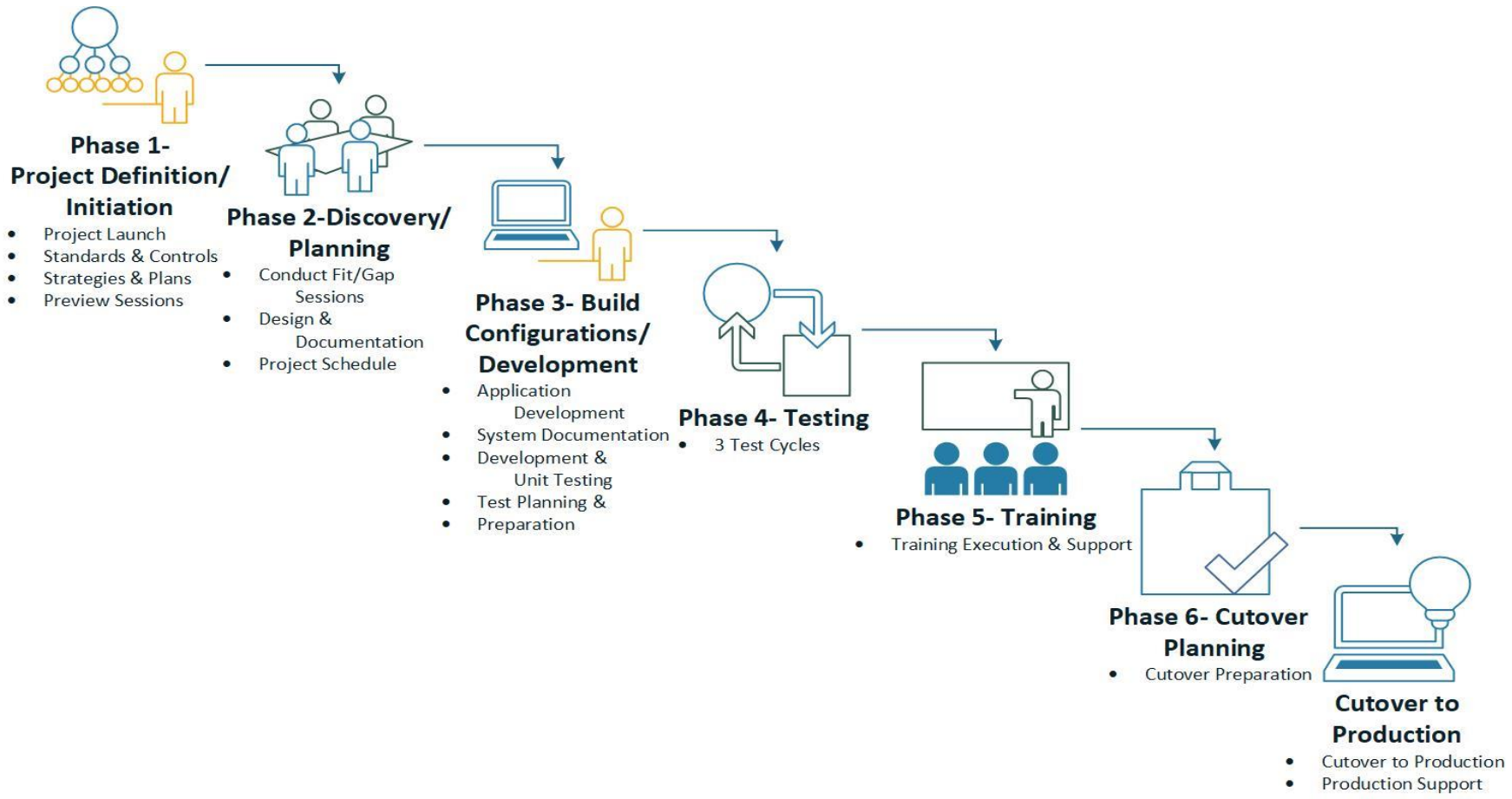
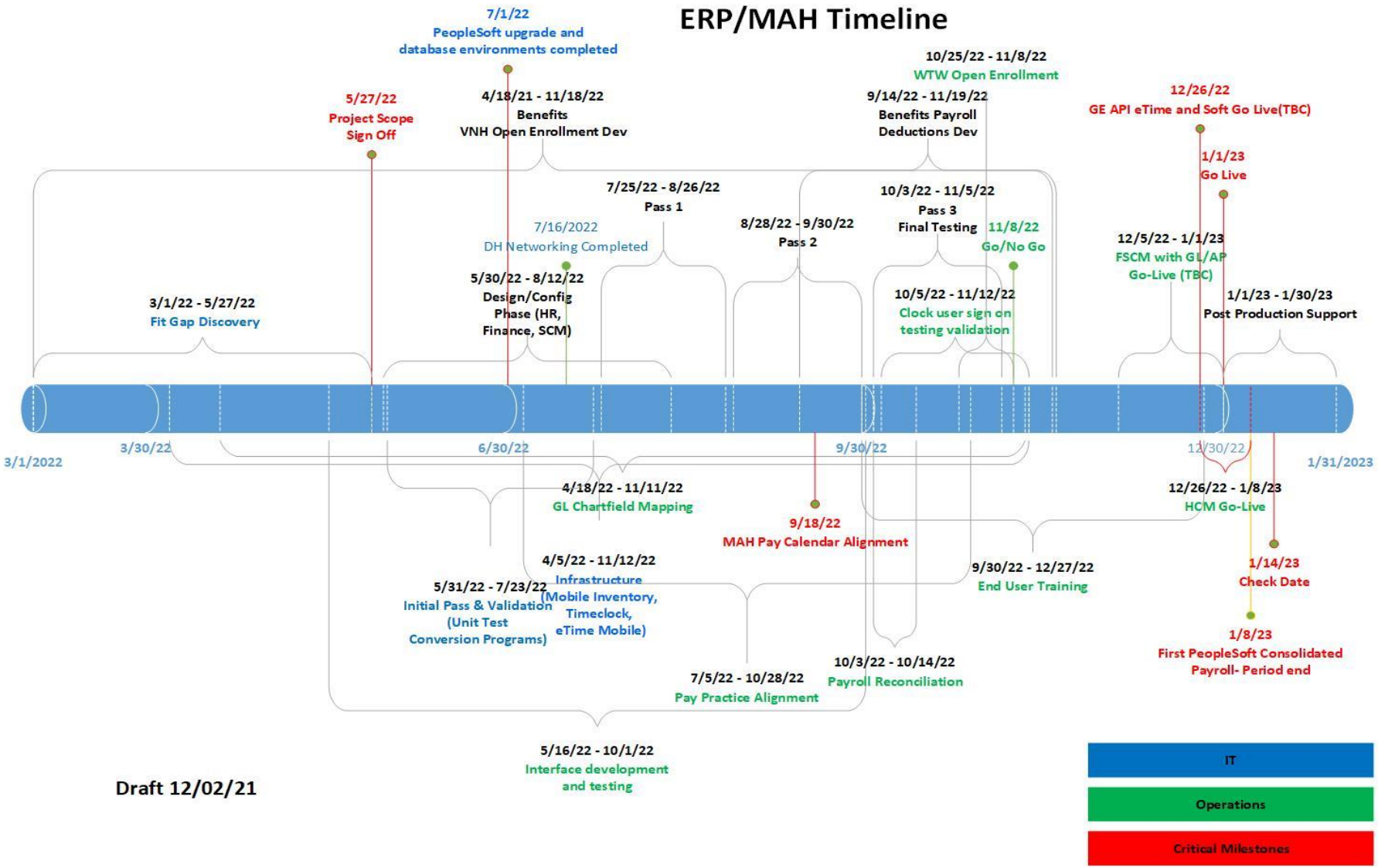
MAH Information Systems Migration Project Governance Org Chart



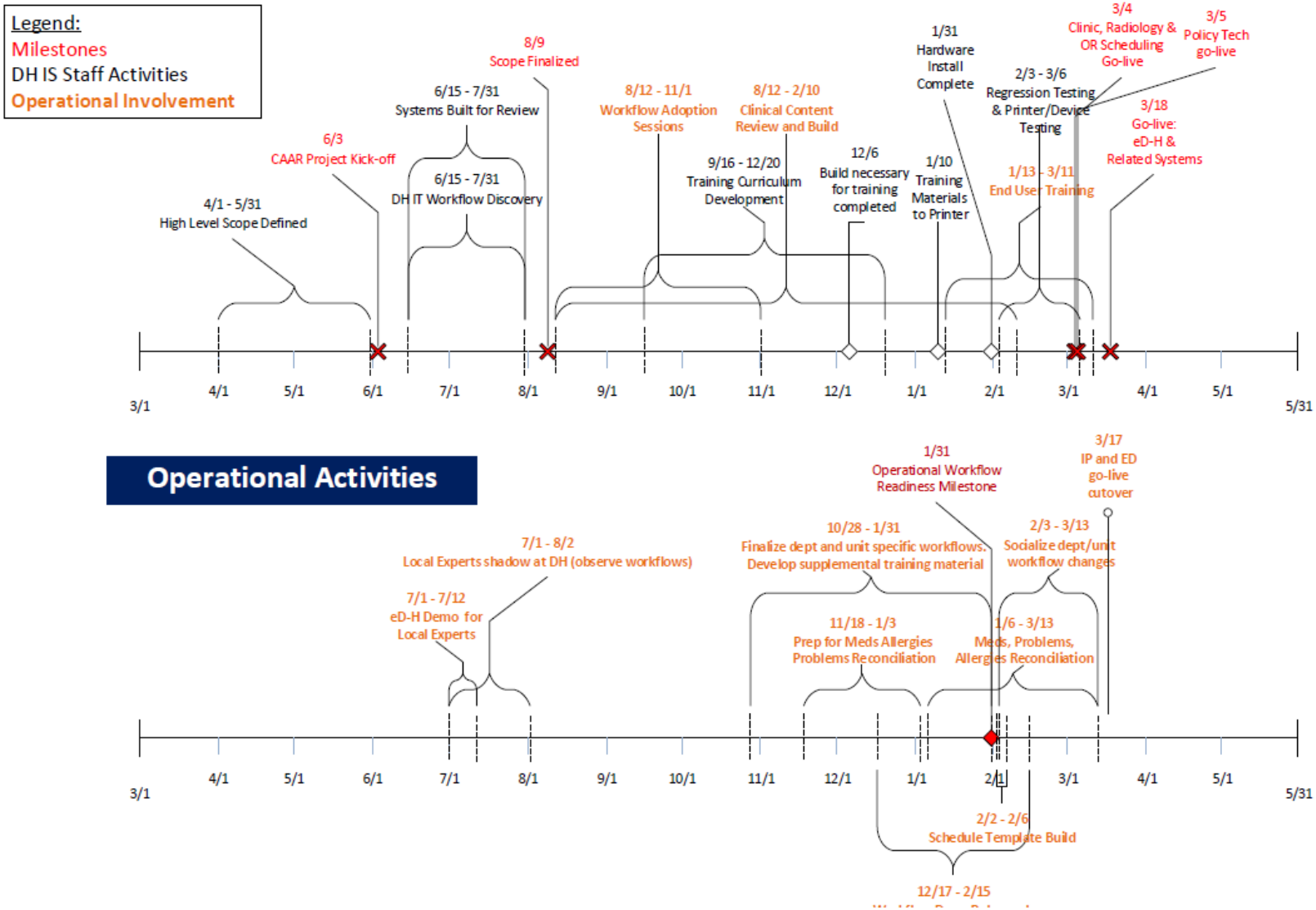

Phase 1- Project Definition/ Initiation
Project Launch
Standards & Controls
Strategies & Plans
Preview Sessions
Phase 2-Discovery/ Planning
Conduct Fit/Gap Sessions
Design & Documentation
Project Schedule
Phase 3- Build Configurations/ Development
Application Development
System Documentation
Development & Unit Testing
Test Planning & Preparation
Phase 4- Testing
3 Test Cycles
Phase 5- Training
Training Execution & Support
Phase 6- Cutover Planning
Cutover Preparation
Cutover to Production
Cutover to Production
Production Support

ERP/MAH Timeline



Draft 12/02/21

Clinical, Ancillary, Access & Revenue (CAAR) Applications System Implementation Project



Operational Activities

	Total Project Costs	FY 2024	FY 2025	FY 2026	FY 2027
Capital Expenditures (Labor)	**$ 4,563,152**	**$ -**	**$ 1,476,091**	**$ 3,024,054**	**$ 63,008**
1. Epic Rehab Module Initial Implementation	$ 394,325	$ -	$ -	$ 394,325	$ -
2. Infrastructure - Extend DH Systems	$ 584,939	$ -	$ 565,527	$ 19,412	$ -
3. ERP - Extend DH Systems	$ 782,045	$ -	$ 782,045	$ -	$ -
4. CAAR - Extend DH Systems	$ 2,515,804	$ -		$ 2,515,804	$ -
5. Archive Legacy Systems for Decommission	$ 286,039	$ -	$ 128,519	$ 94,512	$ 63,008
Operating Expenditures (Labor)	**$ 901,756**	**$ 91,673**	**$ 594,501**	**$ 215,582**	**$ -**
1. Epic Rehab Module Initial Implementation	$ 44,262	$ 16,454	$ 27,808	$ -	$ -
2. Infrastructure - Extend DH Systems	$ 89,323	$ 18,805	$ 56,414	$ 14,104	$ -
3. ERP - Extend DH Systems	$ 312,829	$ 56,414	$ 256,414	$ -	$ -
4. CAAR - Extend DH Systems	$ 455,343	$ -	$ 253,865	$ 201,478	$ -
Total	**$ 5,464,909**	**$ 91,673**	**$ 2,070,592**	**$ 3,451,136**	**$ 63,008**

	Total Project Costs	FY 2024	FY 2025	FY 2026	FY 2027
Capital Expenditures (Non-Labor)	**$ 2,761,295**	**$ -**	**$ 606,000**	**$ 2,115,295**	**$ 40,000**
1. Epic Rehab Module Initial Implementation	$ 57,650	$ -	$ -	$ 57,650	$ -
2. Infrastructure - Extend DH Systems	$ 356,000	$ -	$ 356,000	$ -	$ -
3. ERP - Extend DH Systems	$ 200,000	$ -	$ 200,000	$ -	$ -
4. CAAR - Extend DH Systems	$ 1,997,645	$ -	$ -	$ 1,997,645	$ -
5. Archive Legacy Systems for Decommission	$ 150,000	$ -	$ 50,000	$ 60,000	$ 40,000
Operating Expenditures (Non-Labor)	**$ 47,000**	**$ 18,000**	**$ -**	**$ 29,000**	**$ -**
2. Infrastructure - Extend DH Systems	$ 18,000	$ 18,000	$ -	$ -	$ -
4. CAAR - Extend DH Systems	$ 29,000	$ -	$ -	$ 29,000	$ -
Total	**$ 2,808,295**	**$ 18,000**	**$ 606,000**	**$ 2,144,295**	**$ 40,000**

Total Project Expenditures (Capital vs. Operating)	Total Project Costs	FY 2024	FY 2025	FY 2026	FY 2027
Capital Expenditures Total:	$ 7,324,447	$ -	$ 2,082,091	$ 5,139,348	$ 103,008
Operating Expenditures Total:	$ 948,756	$ 109,673	$ 594,501	$ 244,582	$ -
Contingency of 10%:	$ 827,320	$ 10,967	$ 267,659	$ 538,393	$ 10,301
Grand Total:	**$ 9,100,524**	**$ 120,641**	**$ 2,944,251**	**$ 5,922,323**	**$ 113,309**

Verification Under Oath

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	)	
	)	Docket No. GMCB-006-24CON
	)	
	)	

Verification Under Oath to file with Certificate of Need Application, correspondence and additional information subsequent to filing an Application.

[Officer or other deponent], being duly sworn, states on oath as follows:

1. My name is Winfield Brown. I am the Interim Chief Executive Officer of Mt. Ascutney Hospital and Health Center. I have reviewed the Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524).

2. Based on my personal knowledge and after diligent inquiry, I attest that the information contained in Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact.

3. My personal knowledge of the truth, accuracy and completeness of the information contained in the Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) is based upon either my actual knowledge of the subject information or upon information reasonably believed by me to be true and reliable and provided to me by the individuals identified below in paragraph 4. Each of these individuals has also 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.

4. The following individuals have provided information or documents to me in connection with Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) and each individual has certified, based either upon his or her actual knowledge of the subject information or, where specifically identified in such certification, based on information reasonably believed by the individual to be reliable, that the information or documents 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:

David C. Sanville, former Chief Financial Officer
Andrew Garami, Director of Finance

5. In the event that the information contained in the Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) 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, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.

[signature]

On March 19, 2024 Winfield Brown, appeared before me and swore to the truth, accuracy and completeness of the foregoing.

Mary A. Boardman
Notary public
My commission expires [date] January 31, 2025
[seal]

Verification Under Oath

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	)	
	)	Docket No. GMCB-006-24CON
	)	
	)	

Verification Under Oath to file with Certificate of Need Application, correspondence and additional information subsequent to filing an Application.

[Officer or other deponent], being duly sworn, states on oath as follows:

1. My name is Francis Joseph Iannoni. I am the Interim Chief Financial Officer of Mt. Ascutney Hospital and Health Center. I have reviewed the Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524).

2. Based on my personal knowledge and after diligent inquiry, I attest that the information contained in Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact.

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4. The following individuals have provided information or documents to me in connection with Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) and each individual has certified, based either upon his or her actual knowledge of the subject information or, where specifically identified in such certification, based on information reasonably believed by the individual to be reliable, that the information or documents 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:

David C. Sanville, former Chief Financial Officer
Andrew Garami, Director of Finance

5. In the event that the information contained in the Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) 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, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.

Francis Joseph Iannoni
[signature]

On March 19, 2024 Francis Joseph Iannoni, appeared before me and swore to the truth, accuracy and completeness of the foregoing.

Mary A. Boardman
Notary public
My commission expires [date] January 31, 2025
[seal]

Verification Under Oath

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	)	
	)	Docket No. GMCB-006-24CON
	)	
	)	

Verification Under Oath to file with Certificate of Need Application, correspondence and additional information subsequent to filing an Application.

[Officer or other deponent], being duly sworn, states on oath as follows:

1. My name is Andrew Garami. I am Director of Finance of Mt. Ascutney Hospital and Health Center. I have reviewed the Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524).

2. Based on my personal knowledge and after diligent inquiry, I attest that the information contained in Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact.

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Andrew Garami, Director of Finance

5. In the event that the information contained in the Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) 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, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.

[signature]

On March 19, 2024 Andrew Garami, appeared before me and swore to the truth, accuracy and completeness of the foregoing.

Mary A. Boardman
Notary public
My commission expires [date] January 31, 2025
[seal]

Verification Under Oath

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re:	)	
	)	Docket No. GMCB-006-24CON
	)	
	)	

Verification Under Oath to file with Certificate of Need Application, correspondence and additional information subsequent to filing an Application.

[Officer or other deponent], being duly sworn, states on oath as follows:

1. My name is David Sanville. I am former Chief Financial Officer of Mt. Ascutney Hospital and Health Center. I have reviewed the Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524).

2. Based on my personal knowledge and after diligent inquiry, I attest that the information contained in Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact.

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Andrew Garami, Director of Finance

5. In the event that the information contained in the Certificate of Need application, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) 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, supporting documents, and workpapers (Docket No. GMCB-006-24CON, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524) as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.

David C. Sanville

[signature]

On March 14, 2024 David Sanville, appeared before me and swore to the truth, accuracy and completeness of the foregoing.

Mary A. Boardman

Notary public
My commission expires [date] January ~~25~~ 31, 2025
[seal]

Mary A. Boardman
Notary Public State of Vermont
Commission
* No. 157.0015011 *

Dartmouth Health

By email

February 9, 2024

Ms. Donna Jerry
Senior Health Policy Analyst
Green Mountain Care Board
144 State Street
Montpelier, VT 05620

RE: Letter of Intent for Mt. Ascutney Hospital and Health Center Certificate of Need
Project: Replace Electronic Health Record, Financial, and Related Technology Systems
Project Cost: $9,100,524

Dear Ms. Jerry,

This letter serves to notify the Green Mountain Care Board (GMCB) of Mt. Ascutney Hospital and Health Center's (MAHHC) intent to file a Certificate of Need (CON) application for the above referenced project. MAHHC concedes that this project requires CON review and approval according to Vermont regulatory standards. MAHHC advised GMCB of the likelihood of this request during our 2024 budget presentation.

MAHHC became an affiliate of Dartmouth Health (DH) system in 2014. We are a designated Critical Access Hospital and our main campus is located in Windsor, VT. MAHHC has provider clinics located in Woodstock, VT and Hanover, NH. We also have a subsidiary, Historic Homes of Runnemede, a residential and independent living facility, located in Windsor, VT.

DH is a system of community hospitals, clinics, and healthcare services across New Hampshire and Vermont. The DH system includes:

- Locally focused community hospitals and clinics in New Hampshire and Vermont.
- An academic medical center with deep ties to Geisel School of Medicine at Dartmouth.
- Dartmouth Cancer Center, one of only 56 NCI-designated Comprehensive Cancer Centers in the nation.
- Dartmouth Health Children's, the state's only children's hospital; and member hospitals and clinics across the state.
- A broad community of nursing, rehabilitation, hospice and personal healthcare services.

DH is building an integrated delivery system that provides high quality care, timely access to services, and an optimal patient experience. Aside from the human capital required for this ongoing effort, technology integration is the backbone of this endeavor. In order to successfully function as a truly integrated delivery system, DH has developed a cutting edge digital infrastructure and tightly integrated information system which has been implemented with most of their affiliates over the last several years.

Mt. Ascutney Hospital and Health Center
289 County Road | Windsor, VT | 05089

Dartmouth Health

As an affiliated member of the system, it is incumbent on MAHHC to replace our current technology platform in order to advance and enhance patient care and patient access in our service area and in the region. This project will be similar in nature to the approved UVMMC project that integrated UVMMC with CVMC, Porter Medical Center, and their New York affiliates. It is also similar to the DH - VNA/VNH project approved a few years ago by the GMCB. DH has already converted all of their locations and affiliates onto their suite of technologies, with the exception of MAHHC and newly affiliated Southwestern Vermont Medical Center.

MAHHC has been on our current clinical and financial systems for more than eleven years and our access to and communication with DH, relative to patient information, is limited by the lack of full integration. Moving onto the DH platform will not only replace our end of life technologies, but will more effectively connect MAHHC and our patients to a best-in-class, unified electronic medical record, more efficient human resource applications, and business support functions. Nearly every service line and business function will be replaced.

Full clinical integration will advance the health of our communities by supporting numerous population health initiatives, by reducing the risks associated with transitions in care and by improving communication for providers, other clinicians, and patients. The goal is to improve system wide outcomes by improving care coordination, reducing digital barriers to sharing patient information, and by streamlining system redundancies.

Adopting standardized systems will also enhance staff sharing opportunities, human resource management, business/group purchasing functions, and leverage for new technologies as best practices change. It will strengthen the region's ability to meet our local and system missions more effectively.

If approved, the project will kick-off during this fiscal year. The financial and human resource platforms will tentatively go live in the second quarter of our fiscal year 2025 (January 2025) and the clinical applications will tentatively go live in the first quarter of our fiscal year 2026 (November 2025).

Budget:

As reflected in the following table, the proposed project budget cuts across three fiscal periods. The budget below reflects the period that the expenditures will be recognized. Note that capital expenditures that are not placed in service (CIP: construction in progress) are not recognized until the deliverables associated with the expenditures are placed in service. Operating expenditures that cannot be capitalized will be recognized within the period that they are incurred. In total, the budget for the project is approximately $9.1 million capital and operating costs as outlined below. These costs cover labor (employed and contracted), non-labor (hardware, devices, material infrastructure, etc.), and a 10% contingency. MAHHC will depreciate the entire project cost over ten years and the funding of the project will be shared between DH and MAH, 75% and 25%, respectively. Ongoing labor and non-labor annual costs of approximately $1m will be comprised of $800k in annual depreciation and $200k in ongoing support and service costs. Funding is projected by fiscal year according to the period of expense and costs are incurred and not when the deliverables are placed in service. (See table below:)

Dartmouth Health

	Total Project Costs	FY 2024	FY 2025	FY 2026	FY 2027
Capital Expenditures (Labor)	**$ 4,563,152**	**$ -**	**$1,476,091**	**$3,024,054**	**$ 63,008**
1. Epic Rehab Module Initial Implementation	$ 394,325	$ -	$ -	$ 394,325	$ -
2. Infrastructure - Extend DH Systems	$ 584,939	$ -	$ 565,527	$ 19,412	$ -
3. ERP - Extend DH Systems	$ 782,045	$ -	$ 782,045	$ -	$ -
4. CAAR - Extend DH Systems	$ 2,515,804	$ -		$ 2,515,804	$ -
5. Archive Legacy Systems for Decommission	$ 286,039	$ -	$ 128,519	$ 94,512	$ 63,008
Operating Expenditures (Labor)	**$ 901,756**	**$ 91,673**	**$ 594,501**	**$ 215,582**	**$ -**
1. Epic Rehab Module Initial Implementation	$ 44,262	$ 16,454	$ 27,808	$ -	$ -
2. Infrastructure - Extend DH Systems	$ 89,323	$ 18,805	$ 56,414	$ 14,104	$ -
3. ERP - Extend DH Systems	$ 312,829	$ 56,414	$ 256,414	$ -	$ -
4. CAAR - Extend DH Systems	$ 455,343	$ -	$ 253,865	$ 201,478	$ -
Total	**$ 5,464,909**	**$ 91,673**	**$2,070,592**	**$3,451,136**	**$ 63,008**

	Total Project Costs	FY 2024	FY 2025	FY 2026	FY 2027
Capital Expenditures (Non-Labor)	**$ 2,761,295**	**$ -**	**$ 606,000**	**$2,115,295**	**$ 40,000**
1. Epic Rehab Module Initial Implementation	$ 57,650	$ -	$ -	$ 57,650	$ -
2. Infrastructure - Extend DH Systems	$ 356,000	$ -	$ 356,000	$ -	$ -
3. ERP - Extend DH Systems	$ 200,000	$ -	$ 200,000	$ -	$ -
4. CAAR - Extend DH Systems	$ 1,997,645	$ -	$ -	$ 1,997,645	$ -
5. Archive Legacy Systems for Decommission	$ 150,000	$ -	$ 50,000	$ 60,000	$ 40,000
Operating Expenditures (Non-Labor)	**$ 47,000**	**$ 18,000**	**$ -**	**$ 29,000**	**$ -**
2. Infrastructure - Extend DH Systems	$ 18,000	$ 18,000	$ -	$ -	$ -
4. CAAR - Extend DH Systems	$ 29,000	$ -	$ -	$ 29,000	$ -
Total	**$ 2,808,295**	**$ 18,000**	**$ 606,000**	**$2,144,295**	**$ 40,000**

Total Project Expenditures (Capital vs. Operating)	Total Project Costs	FY 2024	FY 2025	FY 2026	FY 2027
Capital Expenditures Total:	$ 7,324,447	$ -	$ 2,082,091	$ 5,333,629	$ 103,008
Operating Expenditures Total:	$ 948,756	$ 109,673	$ 594,501	$ 244,582	$ -
Contingency of 10%:	$ 827,320	$ 10,967	$ 267,659	$ 557,821	$ 10,301
Grand Total:	**$ 9,100,524**	**$ 120,641**	**$2,944,251**	**$6,136,032**	**$ 113,309**

Funding*	Total	FY 2024	FY 2025	FY 2026	FY 2027
D-H Portion (75%)	$ 6,825,393	$ 90,481	$ 2,208,188	$ 4,602,024	$ 84,981
MAH Portion (25%)	$ 2,275,131	$ 30,160	$ 736,063	$ 1,534,008	$ 28,327
Grand Total:	**$ 9,100,524**	**$ 120,641**	**$2,944,251**	**$6,136,032**	**$ 113,309**

**** Based on timing of CIP expenditures***

Project Scope:

This project, led by DH Information Systems, DH leadership and MAH leadership, contemplates MAHHC replacing nearly all clinical and business applications with an integrated suite of DH applications, including:

- Integrated healthcare information systems suite which includes a single electronic medical record and required patient scheduling, registration and billing solutions.

Dartmouth Health

- Inpatient, outpatient, and clinic documentation systems
- Ancillary and clinical applications (laboratory, cardiology, radiology, etc.)
- Core business systems required to run the business enterprise (finance, accounting, budgeting, human resources, payroll, supply chain, etc.)
- Clinical and quality analytical tools
- Business analytical and intelligence tools
- Value based care and population health tools
- Required supporting technology, hardware and devices (laptops, tablets, servers, etc.)

Largely, our current applications will be replaced by a full suite of EPIC and PeopleSoft applications, as well as some other best-in-class specialized applications. Our current platforms currently reside within the state of the art DH network, firewall, and security monitoring which we have been implementing incrementally since our affiliation in 2014.

Currently, we are in the process of kicking off the project and will soon be engaged in discovery activities with DH IT. Implementation will begin upon GMCB approval of the CON.

Please contact me directly with any questions or concerns as well as the process to receive the proper application materials.

We thank you in advance for your consideration and efforts on behalf of our facility.

Sincerely,

David C. Sanville
C.F.O./V.P. Ancillary Services

cc: DH IT CON File

VERMONT
GREEN MOUNTAIN CARE BOARD

144 State Street
Montpelier, VT 05633-3601
802-828-2177

Owen Foster, Chair
Jessica Holmes, Ph.D.
Robin Lunge, J.D., MHCDS
David Murman, M.D.
Thom Walsh, Ph.D., MS, MSPT
Susan J. Barrett, J.D., Executive Director

DELIVERED ELECTRONICALLY

February 21, 2024

David C. Sanville, C.F.O./V.P. Ancillary Services
Mt. Ascutney Hospital and Health Center
289 County Road
Windsor, VT 05089

RE: Docket No. GMCB-006-24con, Mt. Ascutney Hospital and Health Center Electronic Health Record Replacement, Project Cost: $9,100,524.

Dear Mr. Sanville:

Thank you for your letter of intent received on February 9, 2024, regarding the above-referenced project. The project as described is subject to Certificate of Need (CON) review under 18 V.S.A. § 9434(b)(1).

The application must include a detailed description of the proposed project, the need for the proposed project and service area; an explanation of how the proposed project meets the applicable statutory criteria in 18 V.S.A. § 9437; a description of all program components, services, and staffing; a description of any demolition/renovation/construction/fit-up components and associated costs; a description of any temporary and permanent displacement of services or functions and associated costs; the cost of the individual project components and the total project cost; information on financing arrangements; a description of any health information technology components of the project and associated costs; an organizational chart and project timeline.

Note that the Board is currently working to update the Health Resource Allocation Plan (HRAP), which is referenced in one of the criteria, 18 V.S.A. § 9437(1)(C). Because the update is not yet completed the application should address the following applicable HRAP standards from the current HRAP: 3.4. Additionally, please address the statutory criteria set forth in 18 V.S.A. § 9437(1)-(5) and (7)-(9).

Detailed financial information must be provided for the project and an explanation of the impact of the project on: a) change in charges and b) future rate increases for commercial payers filed with the Green Mountain Care Board. The required financial tables can be downloaded from and uploaded to Workday Adaptive Planning (FKA Adaptive Insights) when completed. Please

contact Matthew Sutter at matthew.sutter@vermont.gov or Flora Pagan at flora.pagan@vermont.gov with any questions regarding the financial tables or Workday Adaptive Planning.

Once complete, please send your application to me electronically at donna.jerry@vermont.gov, and provide a three-hole punched hard copy with a Verification Under Oath to the Green Mountain Care Board, 1 National Life-Davis 3, Montpelier, Vermont 05633-3601, Attention: Donna Jerry.

If you have further questions, please do not hesitate to contact me at 802-760-8162.

Sincerely,

s/ *Donna Jerry*
Donna Jerry, Senior Health Policy Analyst
Green Mountain Care Board

cc: Laura Beliveau, Staff Attorney