FY24 Hospital Budget Narrative

I. EXECUTIVE SUMMARY

Provide a high-level overview about key considerations for the proposed budget, highlighting any adjustments required to the budget reference year (FY22 actuals). Indicate areas where the proposed budget deviates from parameters specified in this Guidance.

For hospitals whose budget interacts with or includes other entities, explain any differences in what is happening at the hospital versus consolidated level.

Grace Cottage's FY24 budget submission is a carefully and thoroughly thought-out financial plan for the coming fiscal year. It was developed with a minimal price increase, and an eye on controlling expenditures as tightly as possible.

We are not aware of any adjustments required to the FY22 actuals as a reference year for the budget submission. As Exhibit 10 indicates in the Rate section, our increase from FY22 actuals to FY24 budget is essentially at the 8.6% (within $200k) based on the volumes in the FY22 actuals. The additional increase in Net Patient Revenue (NPR) is due to volume changes experience during the two-year period, taking care of those patients arriving at our facility for health care.

II. QUESTIONS

a. Concisely describe necessary adjustments to your FY22 actuals or other considerations required for the proposed budget. Examples may include physician transfers, accounting adjustments, or changes to service offerings, staffing, or infrastructure. There are no adjustments necessary to our FY22 actuals.

b. Clearly and succinctly explain the factors used in your proposed budget and how they compare with those outlined in Section I of the FY24 GMCB Hospital Budget Guidance, providing evidence to support your assumption(s). Each factor should be addressed:

i. Labor expenses Wages are evaluated regularly as they compare to annual compensation surveys conducted collaboratively with Vermont, New Hampshire, and Maine hospital associations. Periodic evaluations are also done of individual job classifications as to how they relate to local market rates, and adjustments made as appropriate, when positions are unable to be filled based on the wage scale offered.

ii. Utilization All utilization for the FY24 budget was based on current levels of volume for the first seven months of FY23. There are no changes predicted in levels of service offered in the coming year, or any reason to believe the current level of patient visits being experienced will not continue.

iii. Pharmaceutical expenses Pharmaceuticals were budgeted at costs currently being paid, with 5% inflation factored in.

iv. Cost inflation Costs of supplies were budgeted at costs currently being paid, with inflationary amounts of 2%-3% based on expected changes in pricing.

v. Commercial price changes A charge increase of 4% was budgeted across the board for all areas and payers. With the Commercial reimbursement being primarily Fee-Schedule based (with annual inflationary adjustments not yet known), with a small amount of Percent-Of-Charges, the resulting net received from Commercial insurers is budgeted at an average of 2%.

vi. Financial indicators While a positive Operating Margin would be ideal, the submitted budget reflects a minimal Operating Loss of 3.36%, comparable to the 3.73% loss submitted for FY23, and projected 2.29% loss for FY23. The overall positive Total Margin is attributed to contributions by our generous supporters, with larger amounts in FY23 raised for needed renovation/expansion of our Emergency Department, and in FY24 as the beginning phase of the new Clinic Building Project.

vii. Known pricing changes for Medicare and Medicaid As a Critical Access Hospital and Rural Health Clinic, Medicare reimbursement is ultimately based on just under actual cost of providing care to those patients. Medicaid reimbursement is all based on fee schedules set by the State of Vermont.

viii. Uncompensated care Uncompensated care is budgeted for FY24 at the levels experienced in the first seven months of FY23, which is consistent with what was budgeted for FY23.

Hospitals should include other factors material to the proposed budget along with supporting material.

c. Briefly summarize known risks in the budget as submitted and indicate how the risks are being addressed. Include the cost, any realized benefit, and descriptions of new or ongoing measures used to reduce or otherwise manage budgeted expenses. Understanding the dollars associated with efforts to decrease or slow the increase in specific categories of expenditures is most helpful in understanding implications for

the proposed budget. The largest potential risk would be for expenses that are out of our control to be more than budgeted, particularly in areas such as Travel Staff and Supply Chain. While the cost of Travel Staff has decreased greatly over levels experienced last year (and hopefully will remain stabilized), many Supply costs have not decreased back to reasonable levels, and in fact, continue to increase at greater-than-normal levels. We continually scrutinize all costs, looking for ways to reduce or eliminate wherever possible without affecting quality patient care.

d. Provide an up-to-date chart or graphic outlining the corporate structure associated with the hospital. See Organizational Chart included as a separate attachment.

e. For any referrals or appointments requested in the **first two weeks of May 2023**, report the following metrics separately for each hospital-owned primary and specialty care practice as well as the top five most frequent imaging procedures:

1. **Referral lag**, the percentage of appointments scheduled within 3 business days of referral (percentage of all referrals where the clinic or hospital has completed scheduling an appointment within 3 business days of receiving the referral, regardless of the date on which the appointment will take place), Grace Cottage Family Health is a Primary Care practice with Behavioral Health embedded within the practice. Behavioral Health appointments would be the only referrals that would be scheduled. During the first two weeks of May there were no referrals to Behavioral Health.

2. **Visit lag**, the percentage of new patient appointments scheduled for the patient to be seen within 2 weeks, 1 month, 3 months, and 6 months of their scheduling date. (The scheduling date is the date the hospital or practice schedules the appointment, not the date the referral was received or the date the patient will be seen.)
   52% < 2 weeks
   78% < 1 month
   100% < 3 months
   100% < 6 months

If you are unable to report these metrics, explain what is preventing the calculation and when you will be able to report them. In their place, provide the third next available appointment for practices and imaging procedures identified above along with those for comparable hospitals or other industry benchmarks.

f. Provide a summary of planned capital expenditures for FY24, including a description of their funding source(s). If relevant, indicate how the pandemic relates to these expenditures, such as deferred projects or new associated needs. Planned capital expenditures for FY24 are relatively small, totaling $570k. Projects include an upgraded Laboratory Analyzer, interfaces for the Electronic Health Record (EHR) to communicate directly with patient care equipment to enhance clinical documentation, and continued refresh of Information Technology equipment. These

projects will be funded with a combination of contributions, grant, and operational funds.

g. Describe planned expenditures related to cybersecurity. FY2024 will require $87,550 for cyber security including $8100 for our internal vulnerability scanner; $5,450 for external penetration testing; $36,000 for outsourced security auditing and risk assessment; $38,000 for cyber liability insurance. We also have a $2,582 monthly lease that in part includes our firewall and antivirus/end point protection licensing.

h. Indicate the estimated annual expenditures associated with providing care that cannot be reimbursed due to the inability to transfer patients to post-acute or other more appropriate care settings. Examples include stays that exceed length of stay requirements for reimbursement or other care that would not generally be provided in a hospital setting. Provide these estimates for as many fiscal years as possible, including the estimates for FYs 23 and 24. Indicate how the values are derived or otherwise estimated. How are these unreimbursed expenses captured in the proposed budget? Include an estimate of how many boarding episodes occurred in your Emergency Department for that period, the associated total patient days and charges, and the proportion of each associated with a primary diagnosis related to mental health. It is difficult to place a dollar amount on expenditures associated with delays in transfers to appropriate setting from the inpatient setting. However, these delays do have an impact that has affected our ability to admit new patients; particularly when patients waiting for long-term Medicaid are occupying needed beds. One example is a patient with dementia who waited for more than 60 days for a payer source that would allow transfer. A bed was secured at a long-term care (LTC) facility, but the facility would not accept transfer until Medicaid was approved. The behavioral management required a 1:1 for the duration of stay to ensure the patient did not wander outside in rural Vermont during the winter months. This patient occupied a room at a billable rate far less than a Swing or Acute patient had we been able to accept into that space. The shortage of LTC beds in the state also impacts the ability to transition patients in a timely manner. We are not licensed for LTC and therefore we have needed to be much more careful about accepting Swing patients who may not be able to return to a prior level of functioning. The Emergency Department has experienced delays in the ability to transfer those in need of mental health beds or for a higher level of care over the last year, but again this is not easily translated into dollar amounts.

i. How much revenue did the hospital net for reimbursements above cost for pharmaceuticals in FY22 actuals, FY23 projections, and in estimates used for the proposed budget? Include estimates for rebates associated with the 340B program. How does the hospital spend or otherwise account for the net revenue? Our billing system is unable to breakout net reimbursements above cost for pharmaceuticals as reimbursements are paid on a bundled payment per claim/encounter, not line-item detail. The Contract Pharmacy segment of the 340B program is a critical part of Grace Cottage's overall reimbursement. In FY22, the program added $791k in net

proceeds, FY23 projection is $932k, and FY24 budget is $1m. This net revenue goes directly to helping both fund uncompensated care, and to assure that we are able to continue providing the outstanding patient care we are known for as other reimbursements continue to lag behind inflationary costs.

j. **Facility Fees:** Does your institution charge "facility fees" to patients who access your emergency department? Facility fees have been defined as "the cost of walking in the door" that are billed separately to cover overhead and other costs to provide care in addition to the charges for specific services received by the patient. If your institution charges facility fees, please provide an estimate of the total sum of facilities fees billed and collected in FY22. Grace Cottage does charge a "facility fee" to patients treated in the emergency department. This fee is to cover those costs associated with caring for that patient, aside from the fee for the actual Medical Provider, which is billed separately. These costs include building, equipment, supplies, staff (including patient care, registration, billing, housekeeping, medical records, and other support staff). The total fees billed in FY22 totaled $3.5m. Actual reimbursement is significantly less than that, as our overall net reimbursement for Outpatient services is approximately 35% of billed charges. Actual collected reimbursement is unable to be obtained from our billing system since as discussed in question "i" above, reimbursements are paid on a bundled payment per claim/encounter, not line-item detail.

k. **Patient Financial Assistance:**

i. Are patients given a financial assistance plan or policy with the first attempt to collect a debt? Yes, it is listed on our patient statements and a call placed prior to sending to the agency.

ii. If a contract with a third party exists to collect payments from patients, please provide this contract and disclose the amount paid for such collection efforts and the revenue generated therefrom. As the contract with the third party includes a confidentiality agreement, the contract cannot be provided, nor can the details of amounts paid.

iii. At what point of non-collection does the hospital write off the money owed as bad debt? When it is brought back from the collection agency and finalized.

iv. What happens if a debt is collected outside of the allowed payment window? Does it show up as revision of the FY in which the services were provided or does it show up in some revenue line in the FY it was collected? It would show up in the fiscal year it was collected.

v. What, if any, effort does the hospital undertake to evaluate whether a patient can pay money owed to the hospital? We encourage patients to apply for financial assistance and evaluate their ability to pay.

vi. What, if any, effort does the hospital undertake to proactively evaluate whether a patient, prospective, current, or past, is eligible for the hospital's free care program? We offer patients the chance to apply at any time before services have been rendered.

vii. Please provide the quantitative and/or qualitative evidence the hospital used to determine the appropriate Federal Poverty Limit ranges used for free care eligibility. See below.

Effective 3/23/2023-3/23/2024

	2023 Grace Cottage Hospital Sliding Fee Scale				
	Based on 2023 Poverty Guidelines for the 48 Contiguous States and the District of Columbia				
	Family Size	≤250% of Poverty Level I Earnings up to:	≤300% of Poverty Level II Earnings up to:	≤350% of Poverty Level III Earnings up to:	≥ 350% of Poverty Level Earnings at/above:
$ 14,580	1	$36,450	$43,740	$51,030	$51,031
$ 19,720	2	$49,300	$59,160	$69,020	$69,021
$ 24,860	3	$62,150	$74,580	$87,010	$87,011
$ 30,000	4	$75,750	$90,000	$105,000	$105,001
$ 35,140	5	$87,850	$105,420	$122,990	$122,991
$ 40,280	6	$100,700	$120,840	$140,980	$140,981
$ 45,420	7	$113,550	$136,260	$158,970	$158,971
$ 50,560	8	$126,400	$151,680	$176,960	$176,961
% of Financial Assistance		100%	75%	50%	0%
Add $5140 for each additional household member					

l. **Administrative Costs:**

i. Please provide a breakdown of administrative costs by activity type and title (billing and insurance, non-billing and insurance, Executive, VP, Director, etc). If no such disaggregation can be provided or a different breakdown more accurately reflects the specific structure of your hospital, please explain. Our financial system does not provide the level of detail to breakdown costs by activity type/title. The following summarizes administrative costs as a percentage of total costs:

Clinical	19,525,696	65.0%
General Support	7,645,954	25.4%
Administrative	2,884,404	9.6%
	30,056,054	100.0%

ii. Please provide the number of FTEs by type by average and median salary and total compensation (i.e., total cost of FTE to the organization) by clinical (physicians, PAs, NPs, nurses, etc.) and non-clinical (C-suite, managerial, other). Our system does not have the capability to allocate total compensation by position, thus using the same breakdown as above, our total salaries and FTEs are distributed as follows:

	Total Salaries	Physician	PA/NP	Other	Total FTEs
Clinical	11,531,274	8.28	11.26	91.63	111.17
General Support	3,699,278			50.69	50.69
Administrative	1,645,966	-	-	12.42	12.42
	16,876,518	8.28	11.26	154.74	174.28

B. FORM 990 (TAX YEAR 2022)

No later than June 30, 2023, file a complete copy of hospital's most recent Form 990 (for FY22), including the most current version of Schedule H that has been submitted to the Internal Revenue Service as part of the hospital organization's Form 990 reporting obligations under Section 501(c)(3) of the Internal Revenue Code.

C. COMMUNITY HEALTH NEEDS ASSESSMENT

No later than June 30, 2023, file a complete copy of hospital's most recent Community Health Needs Assessment (CHNA) and/or most recent Implementation Strategy, as required by the Patient Protection and Affordable Care Act.