# FY25 BUDGET NARRATIVE

## Executive Summary

Grace Cottage's FY25 budget submission is a carefully and thoroughly thought-out financial plan for the coming fiscal year. It was developed with a minimal price increase of 4%, and a continued eye on controlling expenditures as tightly as possible.

The FY25 budget continues the same service lines as the approved FY24 budget. All patient volumes are budgeted at the level of service experienced throughout the first seven months of FY24, with two minor exceptions: Outpatient Physical Therapy includes one additional FTE and additional footprint to accommodate the continued increased demand for services, and Rural Health Clinic encounters are increased slightly based on projected growth and demand for Primary Care.

## Background

There have been no changes to Grace Cottage's corporate structure within the last year, nor are any changes expected in the coming year.

We regularly assess ways to maintain the high quality of care we provide to our patients through the most cost effective ways. While we have used TeleRadiology and TelePharmacy for several years to avoid unnecessary staffing FTEs, we have recently implemented three services in our Emergency Department: TelePsych, TeleNeurology, and TeleEmergency – all aimed at providing an excellent level of care to all patients that walk through the door at the most efficient cost possible.

## Budget Questions

a. **Labor expenses.**

Grace Cottage's goal is to return to having all employed staff, rather than contracted labor. Throughout FY24 we have relied on the use of contracted labor in Nursing, Diagnostic Imaging, and Physical Therapy. The FY25 budget includes continued use of contracted labor in those three areas, however at a

lower number in Nursing (the area with the highest number of contracted labor) due to successes in filling open positions with employed staff.

b. Utilization.

As discussed in the Executive Summary, there are no expected deviations in historical utilization trends across service lines, with the exception the two minor changes in Outpatient Physical Therapy and the Rural Health Clinic, both areas of which have waiting lists. One additional FTE is needed in the Physical Therapy department, and improved efficiencies in the Rural Health Clinic will allow the additional patient encounters with no additional staff.

c. Pharmaceutical expenses.

Pharmaceuticals were budgeted at costs currently being paid, with a 3.8% inflation factored in (based on projections from our group purchasing affiliation).

d. Cost inflation.

Costs of supplies were budgeted at current costs, with inflationary amounts of 2%-3% based on expected changes in pricing.

e. Case Mix Index (CMI). Explain any substantive changes in CMI by Payer, providing evidence to justify anticipated changes. Quantify any impacts on your budget by payer.

There are no substantive changes in CMI expected or budgeted.

f. Rate Changes by Payer.

Medicare: 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 of which Grace Cottage has no control over.

Commercial: 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 approximately 2%.

g. Capital Expenses.

FY25 Capital Expenditures are primarily IT related, and are renewals/refreshes of existing capital leases to keep our IT infrastructure both current and as safe as possible for cyber attacks.

Also included is the projected is the start of construction of our new Rural Health Clinic Building.

h. Financial indicators.

While a positive Operating Margin would be ideal, the submitted budget reflects a minimal Operating Loss slightly better than the loss submitted for FY24. The overall positive Total Margin is attributed to contributions by our generous supporters, with larger amounts in FY25 as the beginning phase of the new Clinic Building Project.

i. Uncompensated care

Uncompensated care, both bad debt and free care, is budgeted for FY25 at the levels experienced in the first seven months of FY24.

j. Community Benefit.

Grace Cottage is essential to our Community, as evidenced by the overwhelming generosity of our donors, by countless testimonials, and virtue of us being one of the largest employers in Windham County (not only do our employees have a place to work, they also support local businesses and the economy by living and spending here).
We are awarded several workplace awards.

Briefly summarize known risks in the budget as submitted, including the potential impact of and any known timelines associated with the risk, as well as any risk mitigation efforts, and their cost or potential benefit.

There are no known risks in the budget as submitted, though as in any budget there are unknowns:
China tariffs and resulting cost increases.

Will the budgeted volumes continue the trend they are based on? Will expenses remain within the inflationary factors budgeted? Will employed positions be able to remain filled without use of additional contracted labor?

Administrative vs. Clinical Expenses:

The relative trend of Clinical Expenses at Grace Cottage considerably outpaces the rate of increase in Administrative Expenses. Market rates for clinical staff are increasing at a much higher rate than non-clinical staff, and the need for additional FTEs in recent years is all in clinical areas, both Hospital and Physician, as patients in general require more care, more paperwork and hoops to jump through to provide them the care they need, and the increasing volume of patients seeking care.

Facility Fees: Please describe the methodology your hospital uses to establish any facility fees and how much they totaled in FY24 and are expected to total in FY25.

Grace Cottage charges 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 nursing care, registration, billing, housekeeping, medical records, and other support staff). The total fees projected in FY24 are $5.3m and budgeted in FY25 are $5.5m.

Does your budget increase request consider consumer affordability, and if so, how?

Grace Cottage's budget increase request always considers consumer affordability by virtue of the fact we ask for as little as we possibly can to meet the goal of a break-even bottom line. The loss we absorb for Medicaid patients, a good citizen test.

If your proposed rate and/or NPR increase request were to be reduced, provide a high-level description of your hospital's contingency plan for maintaining access to essential services and generating a positive margin.

Should Grace Cottage's minimal increase request not be approved, access to essential services would be affected. As we do not provide any specialty services, access to the provision of Emergency Care and Primary Care would be affected.

Provide all costs associated with (i) lobbying and (ii) marketing, advertising, and branding, and identify the amount paid to each entity that performed such services on your behalf.

i. Lobbying: A percentage of the dues Grace Cottage pays to VAHHS and AHA are considered lobbing. That portion of the annual VAHHS dues is $2,591 and the annual AHA dues is $702.
ii. Marketing, Advertising, and Branding: the FY25 budget includes $80,000 for public awareness of Grace Cottage and the services available to them in their community.

Describe planned fundraising efforts and anticipated donations for FY25.

During FY25, we plan to raise approximately $2,000,000 to help cover operating expenses and to purchase equipment, as we have done annually for the past few years. We plan to do this by meeting with individual donors who support the hospital annually, and by hosting our annual fundraising events (Cabin Fever Auction, approximately $30,000; Tee It Up for Health, approximately $50,000; Hospital Fair Day, approximately $60,000; and Giving Tuesday, approximately $20,000).

In addition, we receive annual distributions from two bank-managed Funds (we are the beneficiaries of both) that total approximately $340,000.
During FY25, we will be continuing to work to raise the $20M needed for our clinic construction project. With pledges and gifts in hand, we are at 45% of that goal, to date.

Describe projected investment income and, if projected to be zero, please provide a 3-year summary of annual investment income.

The investment income included in the FY25 budget is $265,268.

Has your hospital experienced a reduction in payment from any payer based on quality performance in the last two years? If so, please explain the nature of the penalty, the revenue impact, and steps taken to remediate the situation.

Grace Cottage has not experienced any such reductions in payment.

Describe the hospital's investments in workforce development initiatives, including nursing workforce pipeline collaborations with nursing schools and compensation and other support for nurse preceptors, residency programs, and any other workforce development initiatives in which you are participating. Include a description of the program and where the accounting entries show up in your proposed budget (income statement and balance sheet). Please describe the hospital's investments in workforce retention such as housing, day care, and other employee benefits. Include a description of the program and where the associated accounting entries show up in your proposed budget (income statement and balance sheet).

We collaborate with Greenfield Community College for their nursing student rotations, we participate in the Nursing Needs Assessment for the VT Talent Pipeline, we host UVM students along with other local educational institutions.
We have an Employee Appreciation BBQ, we offer several Pride Month events, we provide Nurses' week festivities. We were awarded the Vermont Best Place to Work in Windham County award from Brattleboro Reformer, Best Places to Work in Vermont

from Vermont Biz magazine, the Governor's Excellence in Worksite Wellness Award-Gold Level, and we are one of 3 Top Performers in VT, with a score of 85, on the LGBTQ+ Healthcare Equality Index (HEI) 2024 from the Human Rights Campaign Foundation.

For what drivers of expense growth do you feel hospitals should be "held harmless" and why?

Grace Cottage works tirelessly to keep expense growth to a minimum, and while there are no specific ones that should necessarily be "held harmless", there are certainly many that are out of our control and none that would be incurred if not necessary for the provision of quality patient care.
Equipment/med cost increases and tariffs causing price increases.

Hospital & Health System Improvement

a) Given the access challenges related to Mental Health, Substance Use Disorder, Long Term Care, and Primary Care, please share any investments you are making and/or the steps you are taking to improve access in each of those areas, with specific ties to your budget, where appropriate.

Mental Health - We partner with HCRS for evaluation of all mental health patients who have any degree of danger to self or others. We have partnered with a state-wide suicidal ideation improvement project.

We are partnering with Turning Point Recovery Center for SUD. We have a Business Associates Agreement.

We have access to both Mental Health and Substance Use Disorder treatment in the clinic at this time. We have an open position for a LADC; however, we have not had any applicants. With access not being impacted and our space constraints, we have not pushed this opening.

We have implemented IHI's (Institute for Healthcare Improvement) program in the hospital side using their lauded "Age-Friendly Health Systems" movement. This focuses on the 4Ms (what Matters, Medication, Mentation, and Mobility) This improves care of the elderly by organizing their care in a highly relevant way. We plan to implement this in the clinic.

We are investigating an intensive outpatient geriatric psych program in partnership with Senior Life Solutions - they provide counselors and providers, and we partner for patient recruitment and provide space and offices. There is good data for effectiveness of this approach for those with mental health issues, social isolation etc. We have partnered

with the state quality team on suicidal patients in the ED working group to improve our processes and order sets, practices etc for this patient population.
Equity Initiative: We have had a very successful Equity program for the past 4+ years that has enabled us to be one of the highest scoring hospitals in the nation (none with higher score in VT) in terms of LGBTQ+ friendliness. We also are very active in improving care for many other categories of historically marginalized people: elderly, BIPOC community, those who are economically challenged, those with disabilities, the hearing challenged, those with substance use disorders, those who speak languages other than English.

We have invested in providing easy access to telemedicine consultative services for the ED and hospital: teleED, teleNeurology, telePsychiatry, telePharmacy, teleRadiology and teleOPAT (outpatient antibiotic services at DH for our swing patients). This helps us in a variety of ways:

- Patient safety:
- We have expert help for critically ill patients who present to our remote setting
- We can use teleED nurses and providers to help during surges, reducing our needed rosters of staff
- Improved Quality of care: world-class consultations that are immediately available.
- Cost savings to GCH and the larger health care system:
- We can keep more acute admissions rather than sending to more expensive care at tertiary care settings.
- We have less need for expensive transfers to outpatient consultations of our swing patients
- We can staff our ED with APPs who are less expensive to recruit and retain than physicians, all the while maintaining quality and safety
- Reduce the number of in-house pharmacists for after-hour and surge coverage.
- Decrease length of stay
- Improved physician life balance, retention, and recruitment
- Reduced professional isolation in rural settings
- During the depth of the Covid emergency, we temporarily contracted with a quasi-governmental agency to provider teleICU services. This capacity is currently being improved at the federal level that we can redeploy should the need arise again.

Long term care- We continue to work collaboratively with other hospitals to determine which patients could benefit from rehab services vs long term care- we work diligently to offload appropriate patients from our busy colleagues. We offer respite services to community and end of life care.

Primary care- We just hired two new practitioners. One will be replacing pediatrics FNP Cynthia Howes who will be retiring in October and the other will assume a FNP role with

the clinic and will be taking on new patients and assisting with patient care as Dr. Tim Shafer cuts back towards his retirement plans. We currently have 6 providers taking on new patients. We just updated our new patient packets and are streamlining the process of new patient appointments.

We are almost 50% of the way to completion in our fundraising for our new primary care location. We are beginning workflow optimization for our primary care group to ensure top of license practice, reduce administrative burden and increase productivity.

b) Describe how you work with other providers in your community, including the FQHC, designated agencies, other community-based services etc., being sure to include opportunities and obstacles to ensuring smooth transitions of care along the care continuum.

We work with numerous community partners from brainstorming difficult cases to ensuring smooth transitions in and out of facilities and community-based services. When a patient receiving Home Based Services or home health enters our facility, communication on prior level of function, needs and supports is communicated from the beginning. Together we continue to give updates on their patients and include them in the discharge planning. Given the burden on Bayada Home Health in our area since VNH no longer services our area, we must get creative on piecing together transitional supports. For instance, someone needing wound care 3x/week, may need to go to the wound care clinic, or their PCPs office one of the days to offset what Bayada isn't able to provide. This then entails setting up transportation. Another example is when someone is requiring IV infusions 1x/ day but doesn't have the support of family nor are they able to manage the medication administration themselves. We will set up Home Health to do what they can and then sometimes outpatient at our facility. Given the restrictions on transportation support (limited to 4 rides/month for Medicare recipients), we are forced to create plans accordingly. We do our best to think outside the box to decrease inpatient rehab days and support patients to be in their home settings. Fortunately for us we have a strong Community Health Team Nurse who works collaboratively and has often times helped address unmet needs upon discharge that would have otherwise delayed the discharge or put the patient at a high risk of readmission.

With the Home-Based Waiver – We work with the CM from Senior Solutions, so they have time to set up the home-based services the patient had prior to admission. When residents from Valley Village (formerly Valley Cares) come to GCH for Acute or SWING bed care we communicate with the nursing team, encourage participation in care plan meetings and observation of their residents in PT/OT sessions to help decide the goals needed to return to Assisted Living.

Overall, the biggest obstacles to obtaining smooth transitions to home are limited home health support, transportation and availability of private caregivers.

Community Partners - We work with but not limited to, Home Health/Hospice, Area Agency on Aging (Senior Solutions); SASH; Valley Village ALF (formerly Valley Cares); Long Term Clinical Care Coordinator (LTCCC), DCF/LTC Medicaid, Chronic Care Case Managers; VPQHC Care Managers Group; Brattleboro Area Hospice; local Cares organizations; Meals on Wheels, local churches for volunteerism; The Moover Transportation Services; Vt Ethics Network, Housing supports -Groundworks Collaborative; Insurance company case managers, Durable Medical Equipment Suppliers – New England life Care, Adapt New England, Lincare, Option Care, KCl/3M; Hospitals, and SNF/LTC facilities, in VT and N.H.

c) If your hospital was asked to submit a Performance Improvement Plan, please provide an update on progress or challenges relative to that plan.

N/A

d) Hospital Networks: Explain your shared services strategy, any additional revenues associated with such investments and methodologies for allocating associated costs. Quantify any efficiencies to date, and when you expect to achieve any future efficiencies.

Grace Cottage is not part of a Hospital Network.

Other

a) Is this a zero-based budget? If not, when was the last time your organization developed a true zero-based budget (creating a budget from scratch and then justifying every expense rather than basing the budget on prior spending)?

While this is not a zero-based budget, it is far from a budget based solely on an across-the-board increase in prior spending. Every Department Director is met with one-on-one by the CFO and every line item of their expense areas, including both staffing and supplies/equipment, are reviewed and are budgeted up, down, or flat based on analysis.

b) Patient Financial Assistance

a. 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. (For period 10-1-2023 – 3-31-2024) $32,009 paid for self-pay collections. $22,469 received from bad debt recovery.

b. If you have a contract with a third party, please describe the return on investment for this decision compared to managing these activities internally

as a part of Patient Financial Assistance Programs? We would have to hire an additional staff member to bring collections back with the organization.

c. Please describe how patients are screened for Patient Financial Assistance at your hospital. A patient is referred by either self-referral, case worker, billing department or provider's office to our resource advocate. She will meet and assist the patient with the application.

d. When patients receive a bill – either paper or electronic – are they made aware of the hospital's patient financial assistance policy and how to apply? Yes, it is at the bottom of our paper statements with a phone number to call, it is also on our website and told to any patient who calls regarding a bill. Currently, we do not do electronic statements.