NORTH COUNTRY HOSPITAL
FISCAL YEAR 2025 - BUDGET NARRATIVE

A. Executive Summary

North Country Hospital is a critical access hospital located in Newport Vermont, part of what we refer to as the Northeast Kingdom. Based on current and historical requirements we are the only critical access hospital in Vermont that meets all federal requirements to be considered critical access. The two requirements that set us apart from other Vermont Critical access hospitals are distance to the next closest hospital and total distance to the nearest tertiary facility. In both cases we exceed those requirements, 45 miles to Northeastern Vermont Regional Hospital in St. Johnsbury which is the next closest hospital and 2+ hours to either The University of Vermont Medical Center in Burlington or Dartmouth Hitchcock in New Hampshire. The distance to UVM or Dartmouth makes it far more difficult along with EMS constraints and weather challenges to be able to transfer patients. Distance and other factors, such as being the oldest county in Vermont and the most economically challenged area in the state, transportation out of the area can be almost impossible for residents, many of whom do not own their own vehicles. Recent data supplied to us by the Green Mountain Care Board confirms those challenges exist by calling out that **92%** of our patient discharges are people from our community, a far higher percentage of serving our own than any other hospital in the state. North Country is the life blood of our community with a catchment area that includes a population of approximately 30,000 people, and a population that has a payer mix that is 70% Medicare or Medicaid. In addition to the outstanding medical care we provide to our patient base, it is estimated that North Country contributes $61m dollars to the local economy annually. We cannot even fathom what the Northeast Kingdom would become without a vibrant and fully functioning North Country Hospital.

B. Background

FY24 has been a year of turnaround for North Country. I have been in place now as CEO for just over a year. On arrival we developed a set of pillars that we as an organization have chosen to focus on short term. **I. Morale, Culture and Reputation**, tremendous efforts have been made to reset culture and improve morale internally and reestablish our reputation within our community. **II. Quality**, we've completely revamped our quality department bringing back experts who had previously left the organization under the last administration, reviewed and revamped many policies and promoted quality throughout the organization. We recently received the "**Pediatric Readiness Assessment Award**" presented to us by Dr. Nelson of UVM. North Country achieved the highest score of any other hospital in the state. **III. Employer of Choice**, eliminating the Vice President of HR position and replacing with a director level position that's provided more boots on the ground and brought a fresh customer service focus to the organization we are again seeing multiple applicants for many positions where over the last few years that had not been the case. **IV. Access to Care**, as discussed during our budget presentation last year we are a primary care focused organization. We employ 99% of the primary care providers in our community, and additionally we provide as much specialty care as we can feasibly afford. With the help of the consultant firm *Kaufmann Hall,* we are in the midst of a $1.5m primary care turnaround which includes expanding

provider schedules to accommodate more patients seen and expense reduction in areas to not impact patient care. **V. Financial Discipline**, many difficult decisions have needed to be made this year including scaling back our Orthopedics department, creating a vastly different care model for Urology, a soft freeze on all new or replacement positions, all positions needing to be approved by the senior team. Bringing back to the organization the position benchmarking service *Premier*, limiting staff increases to 2% given at the halfway point of the fiscal year for a realized increase of only 1%. The elimination of two Vice President positions and holding open the CFO position for a year. **VI. Cerner Inoperability**, the very poor implementation of the Cerner Community Works EMR and the limitation of the product itself is the main reason for our negative financial performance over the last two years. After trying for months to work with Cerner/Oracle leadership on all issues Cerner we unfortunately needed to make the very difficult and expensive decision to retain the law firm *Quinn Emanual* to work with us to provide a legal remedy to the situation. Much more to come. **VII. Infrastructure Expansion**, we currently have an approved $28m CON as part of that CON was a revamping of our Emergency Department that includes four private rooms for improved patient care for all, but we made the decision to construct all rooms with appropriate ligature precautions for us to be able to utilize them when necessary for the many Mental Health holds, we encounter in our community.

With our focus continuing the theme of being a Primary Care oriented organization we have been able to recruit two new Family Practice physicians, both will be working at our southernmost clinic in Barton. One physician begins in August the other comes on board in September. Both are experienced and will serve our community well. In addition, we have a third candidate coming to interview on site later in July. In addition to the new primary care physicians, we are now employing a fulltime psychiatric Nurse Practitioner to work in our primary care clinics.

This current year we lost one of our Orthopedic physicians as well as our Urologist. We've made the decision to not do hip or knee replacements in our community, we do reserve the right to reevaluate on providing that service if we see our patients are having difficulty or long delays seeking that care elsewhere. We are working on a plan with NVRH in more of a shared model with Ortho. We have also made the very tough decision not to recruit a replacement for Urology. Our care plan is here again to partner with NVRH and employ a Nurse Practitioner with direct connections to the already employed Urologist in St. Johnsbury.

With our turnaround strategies to continue in budget year 25 and the recognition that health care is a very expensive recourse for our patients we are adapting to that new normal and have created a budget that includes a 2% margin for reinvestment in our organization, a net revenue growth of only 1.00% budget 24 to budget 25 and only a 2.94% NPR growth from projection 24 to budget 25. On the expense side our budget 24 to Budget 25 growth is .4% and our expenses are flat, 0% increase projection 24 to budget 25. We are requesting a 4.5% fee increase for commercial revenue. Our organization continues to do the very hard work on becoming as efficient as possible to generate that positive margin. Within our budget we have set aside a 2% increase for physician salaries and a 4% mid-year increase for our staff. We continue to not pass on increasing health care expenses to staff. The new day care tax which begins in July will cost North Country approximately $250k in fiscal year 25. Our budget allows us to

attain our financial goals while continuing to provide the best care possible to the citizens of the Northeast Kingdom.

C. Budget Questions

a) Changes to service lines

Projected 24 to Budget 24

- Orthopedics – see below, the decrease of the Orthopedic surgeon was effective June 2024
- Urology – see below, the decrease of the Urologist was effective in March 2024

Budget 24 to Budget 25

- Orthopedics – we decreased Orthopedics by 1 Orthopedic surgeon. No other staff was reduced since the remaining Orthopedic surgeon is planning on handling the volume remaining except for total knee and hip replacements. Revenue was adjusted accordingly.
- Urology – we no longer employ a Urologist. The budget for 2025 consists of a two day a week Urology nurse practitioner that will be done in collaboration with Northeastern Vermont Regional Hospital. Revenue was adjusted accordingly. We have decreased the support staff to match the part time provider.
- Pediatrics – we have added a full-time nurse practitioner to the Pediatrics practice due to patient need. We have historically employed a nurse practitioner in this practice but did not have one in last year's budget because no one was hired. This Nurse Practitioner is scheduled to start in September of 2024. There was no increase in support staffing and revenue was adjusted.

b) Section 1: Benchmarks

Net Patient service revenue growth – met – Budget 24 to Budget 25 the net patient service revenue growth is 1%.

Commercial Rate Growth – the requested commercial rate growth is 4%. This is only .60% over the PCE price index plus 1%. Total expenses from Budget 24 to Budget 25 are down by .40% or $437,564. This decrease includes the expected inflation cost increase. This commercial rate growth is needed for the hospital to obtain an operating margin. The payer mix of the hospital of 67% Medicaid and Medicare, which includes Medicare advantage and necessitates a higher commercial increase.

Operating Margin – North Country Hospital has budgeted in 2025 an operating margin of $2,209,679 or 2%.

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c) Assumptions

a. Labor expenses

STAFFING COSTS	BUDGET 24	PROJ. 24	BASE BUDGET 25	WITH RAISES BUDGET 25	VARIANCE PROJ 24 / BUD 24	VARIANCE BASE BUD 25/ BUD 24	VARIANCE BUD 25 WITH RAISES 25/ BUD 24
SALARIES	49,363,120	48,032,140	47,766,440	48,763,155	(1,330,979)	(1,596,680)	(599,965)
LOCUMS	2,264,724	3,650,421	1,910,426	1,910,426	1,385,697	(354,298)	(354,298)
CONTRACT-STAFFING	711,360	498,271	221,728	221,728	(213,089)	(489,632)	(489,632)
TOTAL STAFFING COSTS	52,339,204	52,180,833	49,898,594	50,895,309	(158,371)	(2,440,610)	(1,443,895)

LOCUMS	BUDGET 24	PROJ. 24	BUDGET 25
NURSING	1,126,651	2,297,809	931,826
OTHER CLINICAL	522,393	351,752	72,146
ADMINISTRATIVE	0	7,500	372,000
PROVIDER	615,680	993,360	534,454
TOTAL	2,264,724	3,650,421	1,910,426

b. Utilization

GROSS REVENUE	BUDGET 24	YEAR TO DATE MAY ANLZD	PROJ. 24	BASE BUDGET 25 - NO CHARGE INCREASE	VARIANCE BUD 25/BUD 24	VARIANCE BUD 25/PROJ 24
Inpatient	41,767,636	37,574,066	37,119,602	37,719,790	-4,047,846	600,188
Outpatient	202,530,513	222,678,822	221,160,215	220,748,177	18,217,664	-412,038
Medical Group	26,706,070	26,745,053	26,023,063	27,019,365	313,295	996,302
Total Gross revenue	**271,004,219**	**286,997,940**	**284,302,880**	**285,487,332**	**14,483,113**	**1,184,452**

The above chart reflects the utilization changes that we are experiencing this fiscal year and have been carried forward into Projected 2024 and Budget 2025. These changes reflect historical trends of continuing decrease of inpatient and increase of outpatient. Increase in the Medical group revenue is due to increased patient access in our primary care clinics. No additional staff have been hired to accomplish this. We have replaced locum physicians with staff physicians in primary care.

c. Pharmaceutical expenses: Pharmaceutical expenses for Budget 25 were based on actuals for FY 24 with no substantial expected volume increase. Inflationary increase accounts for $170,557 additional expense.

PHARMACY	BUDGET 24	YEAR TO DATE MAY ANLZD	PROJ. 24	BUDGET 25	VARIANCE BUD 25/BUD 24	VARIANCE BUD 25/PROJ 24
GROSS REVENUE	7,420,050	6,932,279	6,698,368	7,014,490	-405,560	316,122
NET REVENUE	3,710,025	2,370,839	2,290,842	2,398,956	-1,311,069	108,114
340B PROGRAM REVENUE	2,423,909	1,909,548	1,796,086	1,796,086	-627,823	0
TOTAL PHARMACY EXPENSES	6,437,485	5,525,364	4,771,426	5,652,992	-784,493	881,566
TOTAL NET	-303,551	-1,244,977	-684,498	-1,457,950	-1,154,399	-773,452

d. Cost Inflation: Please see the chart below detailing the percentage of inflation and the cost of that percent increase. No substantial adjustments above projected were made for volume except for staffing changes outlined above for providers.

BUDGET 2025 INFLATION	%	AMOUNT
SALARIES	2.00%	$997,000
MEDICAL SUPPLIES	5.00%	$225,752
PHARMACEUTICALS	5.00%	$170,577
NON-MEDICAL SUPPLIES	5.00%	$102,155
UTLILITIES	5.00%	$70,000
GENERAL INSURANCE	13.50%	$205,000
COST OF DAY CARE TAX		$300,000
TOTAL INFLATION		$2,070,484

e. Case Mix Index (CMI): No change

f. Rate Changes by Payer: The 4% rate increase was applied to all hospital changes for all payers in inpatient and outpatient. No rate increase was applied to the Medical Group.

g. Capital Expenditures: Please see the chart below summarizing the capital expenditures anticipated for Budget 25. North Country Hospital has been on a capital freeze for the last three years until last month. This capital budget reflects an increase in items due to the freeze.

BUDGET 20225 CAPITAL ITEMS SUMMARY	AMOUNT
MEDICAL	$2,888,653
FACILITIES	$1,524,072
INFORMATION SYSTEMS	$440,175
OTHER	$19,614
TOTAL	$4,872,514

North Country is also actively pursuing grants to fund additional information system technology in the amount of $900,000. These capital purchases will be financed with the cash generated from the requested 2% margin.

h. Financial indicators

FINANCIAL INDICATORS	BUDGET 24	PROJECTED 24	BUDGET 2025
OPERATING MARGIN	0	-0.37%	2.00%
DAYS CASH ON HAND	200	200	212
DEBT SERVICE COVERAGE RATIO	0.50	0.97	1.00

The above financial indicators are trending in a positive direction from Budget 24 and improving or remaining stable from projected 24. The generation of an operating margin has a favorable effect on both the days cash on hand and the debt service coverage ratio.

i. Uncompensated Care: There have not been any changes related to bad debt and free care. The bad debt to free care ratio for Budget 25 is 1 to .50. Bad debt has increased over the last two years due to billing issues we have experienced. Bad debt and free care are calculated as a percent of gross revenue based on year-to-date percentages.

Collection Processes:

Pure Self-Pay (no insurance)

- Patient Access staff will collect all information during stay/discharge process, provide an estimate, and attempt to collect initial payment(s).
- Financial Navigators offer financial assistance applications, as well as investigating/determining if patient is eligible for other coverage (i.e. qualifying health plans, Medicaid, or other state programs).
- Payment options and discount programs are explored.
- After all efforts by NCH staff or contact attempts from the extended business office have been exhausted (120 days), the patient will receive one final contact attempt from the Navigator team.
- The Navigator team will send out a financial assistance application.
- If no response to the above after 14 days, the account is removed from the extended business office and sent to a collection agency.
- The collection agency works the account for 120 days (4 months).
- If no successful account resolution occurs, the account is then returned to NCH and no further collection efforts are pursued.
- If the patient has hired an attorney for a motor vehicle accident or a workers compensation claim, the account is forwarded to the NCH collection attorney.

Self-Pay after Insurance

- After all efforts by NCH staff or contact attempts from the extended business office have been exhausted (120 days), the patient will receive one final contact attempt from the Navigator team.
- The Navigator team will send out a financial assistance application.
- If no response to the above after 14 days, the account is removed from the extended business office and sent to a collection agency.
- The collection agency works the account for 120 days (4 months).
- If no successful account resolution occurs, the account is then returned to NCH and no further collection efforts are pursued.
- If the patient has hired an attorney for a motor vehicle accident or a workers compensation claim, the account is forwarded to the NCH collection attorney.

j. Community Benefits: NCH's 2021 Community Health Needs Assessment identified several Priority Health Concerns, including employment, affordable housing, access to regular medical care, mental health, and substance use. Addressing and improving these Priority Health Concerns are the drivers of NCH's Community Benefit to ensure we are responsive to our community needs. Examples include resources for Medication Assistance Programs, health professional workforce development, donations to multiple community

agencies that address social determinants of health risks and full support of our Healthcare Shares program, providing healthy food to at-risk families.

d) Risk

Every finance person will say that once a budget is complete it's wrong due to unknown changes that can occur in the health care world. The biggest risks we see with our budget are around nurse travelers and physician locums. Any change in these two areas can change the expense structure tremendously. This past year we had two physicians go out on medical leave for an extended period of time, and if that happens again in FY25 it's a risk. Cerner/Oracle legal outcome and the possible need to change to another EMR is a risk. ACT 167, what does that truly look like? Our aging infrastructure. Inflation, always the unknown.

e) Administrative vs Clinical Expense

COST REPORT DEFINITION	BUDGET 2025
Administrative & General	$41,801,304
Clinical	$66,350,345
Total	$108,151,649

A large amount of the administrative expenses include facilities, food and nutrition, environmental services, laundry, revenue cycle services, and provider tax. These expenses can fluctuate greatly between hospitals. For one example, the age of the facility will greatly impact the facility and housekeeping costs to maintain it. The size of the facility would also be a factor. Volumes of services have an effect. Depending on whether the laundry services are contracted or in house and the same with revenue cycle services and other services will affect the percentages. Also, the Provider tax should be removed for all hospitals. This is an expense that the hospitals are required to pay and cannot affect. If the percentages are compared from hospital to hospital, it is important that there is an understanding of the potential differences in operations that could affect the numbers.

f) Facility fees have been long standing fees. No new fees have been established. Facility fees are only in our Emergency Room. The facility fees projected for FY 2024 projected are $26.7 million and Budget 25 are $28 million.

g) Consumer affordability is always a consideration as we prepare our budget. By only requesting a 4.5% fee increase and by holding our expenses flat year after year even with increased inflation we take affordability very seriously.

h) If we were to have to reduce our NPR request it would require draconian solutions with staffing, services etc. I do believe our ask for FY25 is very fair and reasonable, and any reduction in the ask would set us back tremendously.

i) (i) Lobbying costs: The dollars paid for lobbying were $16,782.27 as provided for the 990 of this $11,540.13 was VAHHS and $5,242.14 was AHA. The total owed VAHHS was

$123,293 and the total owed AHA was $19,209. These expenses are used to create awareness of very important issues impacting the healthcare industry. (ii) Costs associated with marketing, advertising, and branding: North Country Hospital does not currently utilize consultants that cover these public relations costs. One FTE Marketing Manager does much of this work in-house, to include planning marketing strategies for brochure materials and service lines, recognition events, and community initiatives. The employee is responsible for graphic design and production of materials, serves as Webmaster, and is responsible for all aspects of NCH social media accounts.

NCH utilizes mass marketing/mail houses for direct mail advertising and fundraising solicitation packages (development). These include:
Mail New England – 4 mailings per year total $18,000 (PR, includes postage)
Spencer Group – 2 mailings total $16,000 (Development, includes postage)

NCH Public Relations outsources 75% of its printing needs to include brochures, sandwich board sized posters, invitations, and annual report.
Memphremagog Press - $8,000
Vista Print - $3,800
Website host Greenlight - $2,000 per year

j) Planned Fundraising Efforts:
- 11th Annual Moonlight Ball to benefit the FY25 purchase of Mammography equipment – projected net $70,000. The hospital Foundation will purchase the new equipment ($425,000) in FY25, relieving the hospital's capital equipment list of this item.
- Continued collection of multi-year pledges to ED Renovation - $40,000 and move forward into capital campaign in FY25 for Phase II of hospital renovation. Projecting $200,000 in revenue + multi-year pledges.
- 37th Annual Scholarship Golf Classic – Summer of FY25 – projected net $30,000
- Annual giving – projected $60,000

k) Investment Income: Due to the volatility of the market we do budget investment income. Please see the below summary of the last three years of investment income and the projection for FY 2024.

FY2021	FY2022	FY2023	FY2024 Projected
$4,035,970	$4,737,268	-$1,829,192	$4,667,358

l) Reduction in Payment: No, the hospital has not experienced a reduction in payment from any payer based on quality performance.

m) Workforce Development: Recruitment to the NEK is a challenge. We have a longstanding partnership with Vermont State University's School of Nursing. There is a designated instructor who is shared between the hospital and university. Students rotate through the emergency department, surgery, maternal child health and our progressive care unit.

Each year we host up to nine RN and nine LPN students to provide a meaningful clinical rotation and experience. We recently re-established our relationship with North Country Union High School, their career center and adult learning program. We have staff who volunteer to speak to allied health students and leaders who attend events showcasing the students' projects throughout the school year. We are a clinical site for licensed nursing assistant classes for high school students and we've recently added day and evening options for adult students pursuing a career in healthcare. In January of this year, we held our first annual Nursing Expo. Invitations were sent to nursing schools around the state. The event featured tours of the hospital, leader interviews, and an overview of our benefits. We had twenty nursing students and one experienced nurse attend.

Each year we offer a nurse residency program for new graduate students. The program is a combination of classroom and hands-on learning. Each resident has an assigned preceptor or two. The length of the orientation is dependent on the clinical area. After spending two weeks with our educators for the didactic portion of the program, nursing residents begin their unit specific orientation. For the Progressive Care Unit (PCU), orientation is twelve weeks with dedicated preceptors. Maternal Child Health (MCH), Surgery and the Emergency Department's (ED) orientation is six months long. The residency program is nine months total. Each new grad selects a project related to their unit. Past projects have included a handoff process from surgery to PCU, birthing positions for laboring moms on MCH and developing a mock code process for the ED. At the end of their residency, each nurse presents their completed project to nursing leadership. They receive a certificate and new grad bonus.

Once orientation is completed each novice nurse is assigned a mentor. The mentorship program is comprised of nurses across the organization who volunteer their time to meet one on one monthly. The mentor is carefully chosen after an interview with the selection team. We are intentional to choose mentors outside the nurse's clinical area. This provides another layer of support to assure we are doing all we can to set our new grads up for success.

We offer preceptor pay and ongoing preceptor education. Being a preceptor is a huge commitment and investment for the organization, especially for the clinical areas that require six months orientation. The preceptor hours count toward clinical ladder points. The clinical ladder program developed for experienced nurses and LPNs is a yearlong process of completing projects, volunteering in the community and on teams within the hospital. There are four levels or "rungs" of the ladder. Each level is associated with compensation paid annually.

n) Hospital Investment in Workforce Retention: As an organization we work hard to be competitive in all standard benefits including the offering of three platinum healthcare plans with no increased premiums for employees for several consecutive years. We offer a strong 403b plan that includes both a standard match as well as discretionary employer contributions up to 5% based on tenure. As with most local hospitals - we offer sign on bonuses, relocation, tuition reimbursement and loan repayment. NCH works to address our housing challenges by owning properties that we can offer as temporary housing solutions. In addition, we also carry

several relationships with local property owners, making NCH the first place property owners go to when needing new tenants. The majority of these offerings are reflected on the income statement in Adaptive under Fringe Benefits MD or Non MD based on the position. The properties owned by North Country are on the balance sheet as an asset and the depreciation on the income statement as a depreciation expense. The properties we rent for employees would be under rental expense which is under Other purchased services – miscellaneous on the Adaptive reports.

o) Hospitals should be held harmless for any government created expenses that are beyond the control of the hospital and expenses associated with possible transformation to global budgets or Act 167.

D. Hospital & Health System Improvement

a) Regarding Mental Health, Substance Use Disorder, and long-term care we work with our area agencies/facilities on a regular basis and highlighted in other portions of this narrative. The leadership of our Primary Care practices meet regularly with the administration of Northeast Kingdom Human Services to discuss the care of mutual patients and how to maximize the services for the patient from both organizations. Also stated earlier in this narrative we have hired two more primary physicians to serve our patients in the Barton area and are actively working on hiring an additional primary care physician for the Newport office. We are also recruiting primary care physicians due to the need for this area.

b) Transportation post discharge is a huge challenge. Rural Community Transportation (RCT) is our only option if a patient does not have family or friends available. During the day we schedule RCT to take patients home or back to their facility. After hours if a patient cannot find transportation, they must stay in the emergency department or on PCU until RCT is available. This decreases our capacity to see acutely ill patients in the ED or admit patients to our inpatient unit. We do partner with our local Emergency Medical Services (EMS) providers to transport patients home or back to facilities. But the criteria for this service to be covered by the patient's insurance provider is becoming increasingly challenging. Often families are left with a large out of pocket expense if ambulance transportation isn't approved by their insurer. If the patient doesn't have a payor source, the hospital is responsible for paying. The fee for service is based on distance. The cost for transportation to our tertiary hospitals can be thousands of dollars per transfer because we are two hours away from DHMC and UVMMC. Time is also a challenge associated with transfers. Round trip transports to DHMC and UVMMC can take hours which leads to long wait times and holding patients in the ED or PCU when we have multiple transports. Our house supervisors and physicians spend hours calling to find appropriate placement for continued services for patients who are critically ill and need a higher level of care, while nursing staff provide one on one care until EMS arrives. Trauma and critically ill patients are very labor intensive for departments across the organization. In a critical access hospital, we frequently pull

resources from the laboratory, radiology, respiratory therapy, and other nursing units to provide the best care possible for our community.

NKHS is a community partnership we value for patients in mental health crisis. Patients presenting to the ED in crisis must receive medical clearance before they can be evaluated, and a plan of care created. NKHS makes every attempt to see the patient in person. When that is not possible, they will complete their evaluation by Zoom. Paperwork is then completed, and the plan of care is submitted to the hospital and referrals are made throughout the state for inpatient admission. In person evaluations are much more efficient and the preferred process. When NKHS is experiencing high volumes of referrals and cannot be on site, delays in the referral process occurs leading to hours, days or even weeks of holding patients for inpatient treatment.

Journey to Recovery, JTR, is another partnership we value. They provide one social detox bed for our community. This is a resource for a patient who is seeking help for drug or alcohol rehabilitation, and they need a short-term safe place to stay while they wait. After receiving medical clearance by an ED provider, JTR is called to see the patient. They are available 24/7 but if their care bed is occupied, they will see the patient, offer education, and follow up until the patient secures a bed at a rehab facility. The patient is discharged back into the community where they are vulnerable and at risk. To support JTR we provide bedding, linens, and meals.

Umbrella is a community resource that advocates for survivors of domestic and sexual violence. To support our community during this vulnerable time, we have developed a SANE (Sexual Assault Nurse Examiner) Program. Recently we sent two nurses to the SANE training provided by the state. We now have a total of four nurses who are certified SANE for adults. One of the four nurses is also a certified pediatric SANE. For adult victims, we call Umbrella for any patient who has experienced sexual or domestic violence. Umbrella sends an advocate to assess the need and provide support. They are also present during SANE examinations.

For pediatric victims we have partnered with Orleans County Child Advocacy Center. They offer ongoing training for our pediatric SANE, monthly case studies and meetings for providers across the county involved with pediatric sexual assault and human trafficking. Our SANE coordinator is working with Copley and NVRH to create a SANE network to share in call, supplies and best practice to improve the SANE process and support for our community.

c) Performance Improvement Plan: North Country Hospital was not asked to submit a performance improvement plan.

d) Hospital Networks: We continue to foster collaborations with other hospitals in Vermont. We employ a Pathologist from UVM, Nephrology, Dialysis from UVM and continue to foster our very strong connections to pediatrics and maternal child with UVM. Dartmouth works closely with us on Cardiology, they read our echoes and provide both tele neurology and

tele psychiatry services to our emergency department. As we look to the future, we've embarked on developing a "Northeast Kingdom health system" with NVRH. In April Shawn Tester and I hosted a mini retreat with our key operations and finance leaders to develop plans on what sharing services, both medical and administrative, would look like. We are already seeing this play out in Orthopedics, Urology and Interventional Radiology. We are sharing policies and providing educational opportunities to each other. We are planning a joint board retreat for late summer or early fall; our goal is to keep as many services as possible local in our community that we possibly can. Working together gives us the best opportunity to do that. It makes no sense to send Vermont patients to New Hampshire if we can provide the services locally. As health care reimbursement changes, we need to change as well. What worked five years ago may no longer work today. Both Mr. Tester and I understand that.

F. Other

a) This is not a zero-based budget. We do not know the last time a zero-based budget was created.

b) Patient Financial Assistance

a. Please see the uploaded contracts named:
- BHR Collection Agreement
- EMA Extended Business Office Agreement
- EMA Invoicing Agreement
- Levy Collection Agreement
- The amount spent year to date May 2024 for the above services in total is $90,468.
- The amount collected in total is $2,004,710.

b. The decision to use third parties for collection efforts is made based on the internal resources available to North Country Hospital. We choose to have the billing staff so we can maintain focus on billing vs collections. The third parties we use are experts in the area of collections and are the best choice for this type of work.

c. Please see the uploaded Patient Financial Assistance policies named:
- Financial Aid Policy
- Financial Assistance Policy
- Patient Financial Counseling Policy

d. The financial statements do contain information on where and how to apply for free care.

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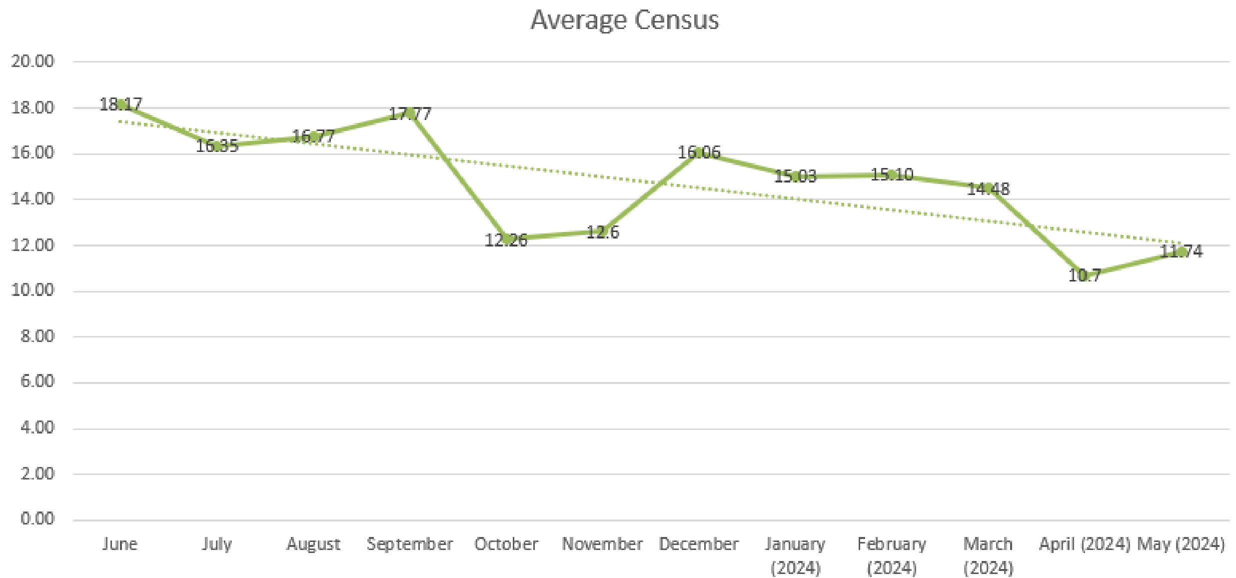
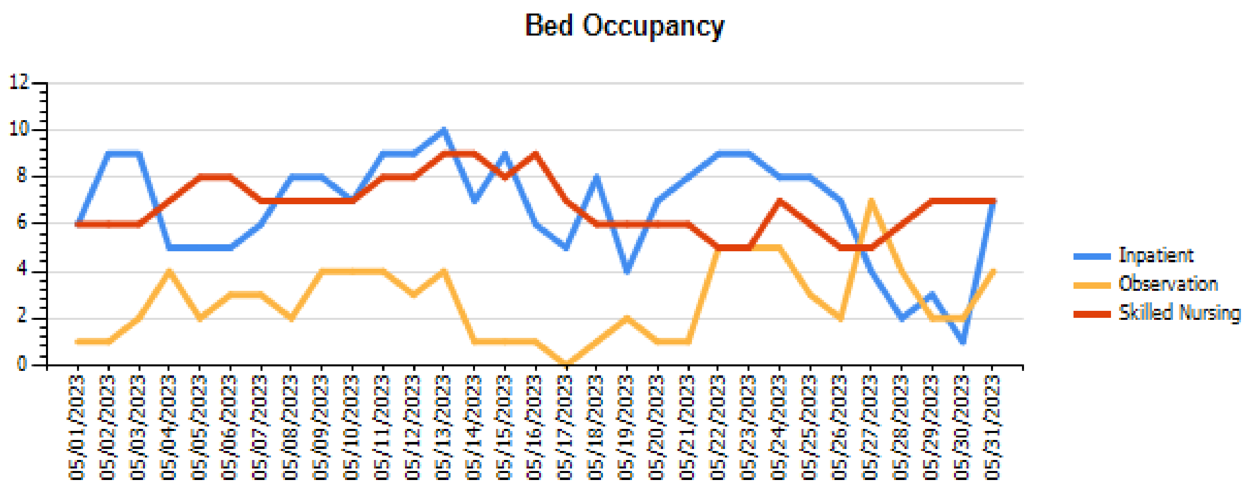
c) Boarding

We are seeing a downward trend in our monthly census for the inpatient progressive care unit.

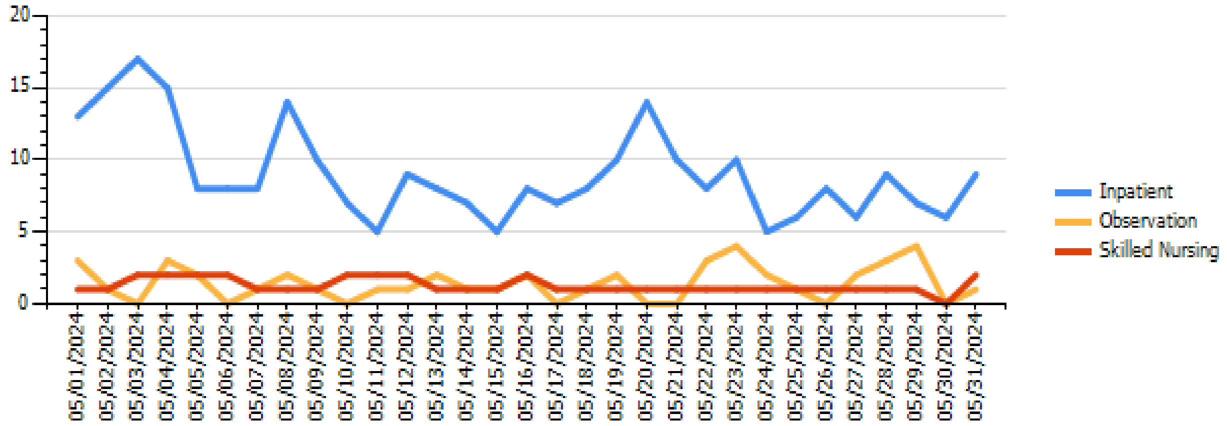


Average monthly census has decreased, and the skill mix has changed when comparing May 2023 to the same month in 2024.



During this timeframe for 15 of 31 days the number of Transitional Care patients were equal to or greater than the number of acute inpatients. The length of stay for TCU patients is higher in 2023 compared to 2024. When Newport Health Care Center closed in March of 2023, we saw an increase in the number of families bringing their loved ones to the hospital due to caregiver burnout/fatigue. It was a challenge to get patients admitted through the Emergency Department to an inpatient bed due to the higher utilization for TCU patients. We had patients without a payor source making it a challenge to find an accepting facility. Staff on our inpatient units were forced to get creative in providing care to our TCU patients whose hospital stay lasted weeks or even months

before finding a bed or the family making the decision to make their loved one comfortable during their final days of life.



Facilities	*FY 2022	FY 2023	FY 2024 YTD
Catholic Medical Center		1	1
Chesire Medical Center		2	3
Cottage Hospital		1	
Dartmouth Hitchcock Medical Center	11	52	40
Massachusetts General Hospital			1
Northeastern Vermont Regional Hospital		2	
Portsmouth Regional Hospital		1	
Ray of Hope			1
Rutland Regional Medical Center			1
Tufts Medical Center		1	
University of Vermont Medicl Center	8	19	22
Totals	19	79	69
LOS prior to transfer	59:15:29 hrs:min:sec	49:15:02 hrs:min:sec	46:57:12 hrs:min:sec
*Incomplete data due to transition from Athena to Cerner			

Please note, the decreased bed availability at DHMC and UVMMC, the two hospitals we typically transfer to has resulted in an expanded search well beyond Vermont and New Hampshire into New York for higher levels of care. This challenge increased the time it takes providers to coordinate transfers even though our length of stay has decreased.