Northwestern Medical Center Fiscal Year 2025 Budget Narrative

A. Executive Summary:

In Fiscal Year 2021, Northwestern Medical Center (NMC) embarked on a journey to get back to our roots, a journey to be an acute care community hospital providing safe, high-quality services. Some of the milestones on our journey thus far include:

- High reliability training began for senior leaders, cascaded to all medical staff and NMC team members – April 2021
- Launched hand hygiene compliance initiative – May 2021
- Developed a 3-year strategic plan with quality & safety at the forefront – Fall 2021
- Transitioned pediatric primary care services back to private practice – January 2022
- Launched sepsis bundle compliance initiative – January 2022
- Implemented aspects of Lean Daily Management with daily Gemba rounding and multi-disciplinary daily safety briefing (7 days per week) – March 2022
- Transitioned adult primary care services to the local Federally Qualified Health Center, Northern Tier Center for Health (NOTCH) – May 2022
- Developed a Patient & Family Advisory Council of engaged community members that meets monthly to provide feedback and input on improvement opportunities – September 2022
- Implemented Joint Commission daily checklists in clinical units for patient safety – Early 2023
- Created a physician-led Patient Experience Taskforce that meets monthly – February 2023
- Conducted Engagement and Culture of Safety Survey for all medical staff and NMC team members – 2022 and again in February 2024
- Co-founded New England Collaborative Health Network, LLC – May 2024
- Refreshed 3-year strategic plan with quality & safety at the forefront – Spring 2024

The current Fiscal Year (FY2024) has been a year of meaningful improvement. Performance data shows that we are on "the right track" and we are excited to continue this work. We achieved 90% of all NMC team members completing high reliability training, our year-to-date overall hand hygiene compliance for 2024 is currently 89% (goal of 90% which would place us among the top performing hospitals in the country, most recent month was 91%, and starting point in 2021 was approximately 67%), our overall sepsis bundle compliance for 2024 is currently 63% (starting point in 2022 was approximately 48% and national average is approximately 50%), we have significantly

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improved our CMS reimbursement penalties related to quality (projecting less than $30,000 in penalties in 2024 compared to over $200,000 in penalties in 2021), our 2024 engagement and culture of safety survey showed statistically significant improvement compared to our 2022 survey, and our operating margin for FY2024 is projected to be -0.78%, which represents meaningful improvement from our Fiscal Year 2023 (FY2023) operating margin of -6.68%.
Our journey is far from over. We still have room to improve and move the needle on our strategic goals of:

- Zero preventable harm
- A culture that engages and inspires
- Financial sustainability

We will build upon our momentum in Fiscal Year 2025 (FY2025). We will focus on patient centered process improvement and removing non-value-added steps from our work. Our FY2025 budget supports the continuation of our journey, to become a highly reliable organization focusing on safety, quality, and engagement, while maintaining NMC's place as an efficient and low-cost provider.
Our FY2025 budget exceeds the Net Patient Service Revenue (NPR) Growth benchmark of 3.5% over the FY2024 approved budget amount. Justification, including credible and sufficient supporting evidence that the excessive growth reflects an improvement in access or quality of care, is provided below (see response to C.b.). Our FY2025 budget exceeds the Commercial Rate Growth benchmark of 3.4%. Justification, including credible and sufficient supporting evidence of hospital efficiency and maximized productivity of resources is provided below (see response to C.b.). Our FY2025 budget meets the positive operating margin benchmark. NMC is budgeting for a positive 0.99% operating margin in FY2025.
Thank you in advance for your careful review and consideration of our budget submission.

B. Background:

a. Explain any changes that occurred to your corporate structure within the last year.

NMC has had no changes to our corporate structure within the last year.

b. Explain your approach to considering and participating in any corporate affiliations in which you or the other organization may have a financial stake.

NMC's Board of Directors and Leadership have yet to see the value add of a corporate affiliation, and as such, are committed to being an independent hospital. NMC would approach participating in any corporate affiliations with an extensive due diligence process involving community members, community partners, medical staff, and more. It would be crucial to understand any clinical care and patient experience advantages or disadvantages, the operational and day-to-day impacts to our community and to our team members, and any estimated financial impacts to the system and to each organization involved.

c. *Describe and quantify the impact of any participation in regional collaborations with other service organizations or providers.*

In May 2024, NMC co-founded the New England Collaborative Health Network, LLC ("the Collaborative"). The Collaborative's purpose is to provide independent hospitals (and their community partners) the structure, resources (including advocacy) and technical expertise to remain independent by creating an interdependence framework that achieves scale and efficiency. NMC, Copley Hospital, and Brattleboro Memorial Hospital are the founding members of the Collaborative. Although new, the Collaborative currently involves 4 organizations and is actively working on several initiatives, including improving buying power within our group purchasing organization for both capital and non-capital items, seeking out grant opportunities for Collaborative members, and sharing Providers to meet community needs. Extending savings opportunities to our local primary care and other strategic healthcare partners is good for the overall system. To date, this has resulted in approximately $1.4 million in savings to those organizations.

d. *Explain and quantify any service-line closures, transfers, or additions since the prior year budget review, please explain.*

The FY2025 budget does not include any service-line closures, transfers, or additions. Existing service-lines may include volume/utilization changes based on current experience and trends, and/or on Providers joining or leaving NMC. These changes are discussed in detail throughout this document.

C. Budget Questions:

a. *Concisely describe substantive variations from current year approved budget to current year projected, and to the proposed budget, in terms of service line changes (differentiate between new or divested services, and volume changes that necessitate changes in staffing), physician transfers, accounting adjustments etc.*

FY2024 results have tracked closely with the budget, with two notable exceptions: Traveler expense and Employee Benefits.
Traveler expense is projected to end the year at $5.3 million against a budget of $3.9 million. Hiring remains difficult for Nursing, Imaging Technologists and Laboratory Technologists. Traveler utilization has stabilized and is budgeted to remain at $5.3 million in FY2025. The budget targets for reduced traveler utilization in FY2024 have proven to be too aggressive.
Employee health insurance claims net of premiums is driving the expense variance in Employee Benefits. Claims are projected to end the year $1.4 million (35%) over budget. This expense is subject to large variations over short periods of time. The budget for FY2025 was developed using multi-year trended data with the guidance of our third-party benefits advisor.

Substantive changes from budget FY2024 to budget FY2025 are discussed in section C.c.

b. For each of the Section I benchmarks not met in the budget submission, explain and justify the deviation using credible and sufficient evidence.

- NPR Growth Benchmark – NMC's FY2025 budget does not meet the NRP growth benchmark of 3.5% or less. Patients in our community are waiting too long for access to key services as shown in the table below:

Visit lag data for February through March 2024

Specialty Practices

	Within Category					
Specialty	Within 2 Weeks	Within 1 Month	Within 3 Month	Within 6 Month	Greater Than 6 Months	Appointments
General Surgery	25%	16%	18%	12%	28%	528
Cardiology	19%	5%	14%	31%	31%	798
Endocrinology	11%	9%	27%	38%	14%	592
ENT	9%	9%	34%	35%	13%	1654
Obstetrics	28%	33%	31%	2%	7%	1488
Orthopedics	33%	21%	39%	4%	3%	3164
Pulmonology	30%	5%	16%	18%	32%	818
Urology	25%	17%	32%	10%	16%	477
Ophthalmology	17%	8%	16%	22%	37%	1020

Another metric to consider is third next available appointment days. Management Group Medical Association (MGMA) median data is as follows:

- General Surgery – 6 days
- Obstetrics – 7 days
- Orthopedics – 10 days
- All other non-surgical specialties – 15 days
- All other surgical specialties – 10 days

We are not hitting these standards. To improve visit lag and third next available appointment, NMC has increased provider resources in nearly every specialty as follows:

- Cardiology – Dr. Steve Anisman (full-time) joined in June 2024. Beth Paquin, Nurse Practitioner (full-time) joined in April 2024. Dr. Adam Kunin joined NMC in January of 2023. Dr. Kunin is a full-time employee of Copley Hospital and splits his time between Copley Hospital and NMC. NMC also continues to partner with the University of Vermont Medical Center for Cardiology Physicians.
  FY2024 Budget to FY2025 Budget Increase in Access – 30%
- ENT – Kristie Oliver, Physician Assistant increased from part-time to full-time in April 2024.
  FY2024 Budget to FY2025 Budget Increase in Access – 21%
- Orthopedics – Dr. Carter Lindborg (full-time) joining in September 2024. Dr. Allicia Imada (full-time) joining in September 2024.

FY2024 Budget to FY2025 Budget Increase in Access – 37%
- Pulmonology – Dr. Ben Chaucer (full-time) joining in August 2024.
  FY2024 Projection to FY2025 Budget Increase in Access – 56%
- Urology – Dr. Kevan Sternberg (full-time) joining in July 2024.
  FY2024 Budget to FY2025 Budget Increase in Access – 42%
- Ophthalmology – Signed letter of intent from a full-time Pediatric Ophthalmologist to join in October 2024.
  FY2024 Budget to FY2025 Budget Increase in Access – 16%

The volume and associated revenues have been budgeted in FY2025 for all of the providers above with the exception of the full-time Pediatric Ophthalmologist who signed a letter of intent just one week ago.

NMC's rate decomposition schedule shows that without utilization increases, the NPR growth over the FY2024 approved budgeted amount is -1.8%.

- Commercial Rate Growth Benchmark – NMC's FY2025 budget does not meet the commercial rate growth benchmark of 3.4% or less. NMC is an efficient organization that maximizes its resources. Hospital efficiency and productivity are carefully monitored in a variety of ways.

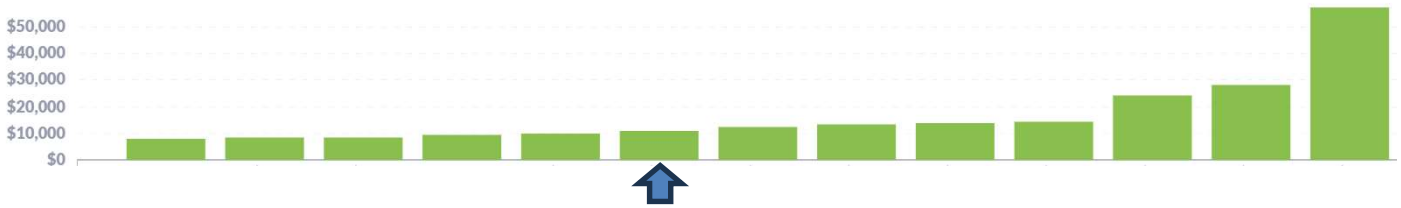
  Most notably, each leader receives a "productivity report" after the end of each pay period showing the actual worked hours per unit of service for their department(s) compared to a national benchmark. This is very similar to a worked RVUs per clinical FTE metric. Benchmarks are provided by Premier, an industry leader specializing in group purchasing, quality improvement, cost management and workforce productivity, data and analytics. NMC has access to these benchmarks through our contract with Ovation Healthcare (formerly, Quorum Health). Benchmarks are updated annually; benchmarks provided include a 50th percentile benchmark, a 75th percentile benchmark, and a 90th percentile benchmark.

  Key pieces of information specific to our productivity reports include:
  - 57 unique department productivity reports are being generated biweekly.
  - 79 total benchmarks are included (most departments have one benchmark, but some have two or more benchmarks being measured).
  - 67 of the 79 benchmarks are set to the 75th percentile target (85%).
  - 12 of the 79 benchmarks are set to the 50th percentile target (15%).
  - 37 of the 57 departments are meeting or exceeding their target – defined as a fiscal year-to-date score of 90% or better.
  - 20 of the 57 departments are not meeting their target – defined as a fiscal year-to-date score of less than 90%.
  - NMC's total overall fiscal year-to-date score is 98%.

Although NMC has an opportunity for improvement, it is important to note that for most benchmarks, we are holding ourselves to a top quartile standard. NMC ended FY2023 with an overall score of 97%. As a small community hospital, volume fluctuations make achieving 100% extremely difficult.

While salaries are any hospital's single largest expense, operational efficiency should also be measured inclusive of all expenses. Per the National Academy for State Health Policy (NASHP), the hospital operating costs per adjusted patient discharge were as follows in 2022 for all Vermont hospitals (the most recent data available):

Hospital operating costs per adjusted patient discharge for each selected hospital



Median hospital operating costs per adjusted patient discharge for each selected state and nationally

State	Health System	Bed Size	Hospital Ownership	Median	Number of Hospitals Included
National	All	All	All	$11,987	4,478
Vermont	All	All	All	$12,430	14

NMC is outperforming the National Median of $11,987 and the Vermont Median of $12,430.

- Positive Operating Margin Benchmark – NMC's FY2025 budget meets the positive operating margin benchmark. NMC is budgeting for a positive 0.99% operating margin.

c. *Explain the assumptions embedded in your proposed budget for the following, providing evidence to support your assumption(s), as well as any substantive variations from FY24 (budget & projected). Please list any other factors not included below that may be material to your budget along with supporting material. This includes any assumptions that are uncertain but could have a potential budgetary impact. For such assumptions that are not reflected in your budget, please quantify the range of potential impact.*
    a. *Labor expenses. Differentiate between the use of employed versus contracted labor, separating nursing from other clinical, and non-clinical staff. Please highlight any trends that are specific to particular clinical domains.*

Total FTEs are budgeted to increase by 21.5 compared to the FY2024 budget. The increase is focused in areas of clinical support (inpatient LNAs) and in supporting enhanced access in the outpatient physician practices and associated surgical demand.

	FY2024 (May YTD)	FY2024 Budget	FY2025
Employed FTEs	565.11	602.36	608.30
Traveler FTEs			
Nursing	23.40	12.60	23.40
Imaging	2.34		3.00
Laboratory	0.27		0.90
Respiratory	0.64		0.90
Total Traveler FTEs	26.65	12.60	28.20
Total FTEs	591.76	614.96	636.50

Position	**New FTEs**
Inpatient LNA	6.6
Surgical Services Tech	3.2
Surgical Services RN	4.5
Physicians	5.5
Direct Physician Support	3
All Else	-1.3
Total	21.5

There is no additional non-clinical contracted labor included in the FY2025 budget and the breakdown of Traveler staffing by specialty shown in the table above is representative of the need by clinical domain.
The budget includes wage increases of 2.5% for all staff, with additional increases to certain differential pay codes to keep up with the market ($180,000), and a pool for as yet unidentified market increases that may arise throughout the year ($200,000).

b. *Utilization. Explain and quantify any anticipated changes in utilization across care settings (e.g. inpatient/outpatient), or any other expected deviations from historical trends. Indicate the method(s) used to derive utilization changes in proposed budgets. If utilization assumptions include increases associated with hiring additional staff or other capacity changes, provide evidence to support estimated impact on utilization.*

Utilization is expected to increase with the additional capacity and access afforded by new providers in the outpatient practices, along with strategically identified areas where increased volumes promote the goals of access and affordability.

- New physicians include: two orthopedic surgeons, one pulmonologist, and one cardiologist. Other changes due to retirement and/or the elimination of contract services to lower cost include: general surgery, urology, pathology.
- Operating room hours are budgeted to increase by 40% over the FY2024 budget and 20% increase over the FY2024 actual projection. The nurse staffing model and anesthesia contract have been updated to allow for additional operating room availability, which will accommodate the new surgeons and provide additional time for current surgeons who have unmet demand.
- Urgent care visit volumes in both locations are behind expectations. We have set a target of 2.0 visits per provider hour. Work is ongoing with the staff and providers in both locations to increase our performance against this measure. The budget assumes that we will meet it. Increasing the efficiency of this service allows for more patients to choose urgent care instead of the emergency room.
- Rehab services and outpatient diagnostic imaging are two areas that generate a positive margin and help subsidize many of the other services provided at NMC. New orthopedic providers at NMC and direct outreach to community providers will be used to increase volumes in these services. Rehab services are projecting volumes 19% over budget in FY2024 and the budget includes an additional 2.5% growth. Diagnostic imaging volumes are projected to be 6.5% over budget in FY2024 and an additional growth of 8.5% has been budgeted for FY2025.

c. *Pharmaceutical expenses. Differentiate assumptions regarding growth due to price from volume, or product mix. Please estimate reimbursements received in excess of the cost of pharmaceuticals (FY23 actuals, FY24 budget, projection, & proposed budget) noting how you arrived at those estimates? Include estimates for rebates associated with the 340B program.*

Pharmaceutical volumes and revenue is not a primary service line used when creating our budget. Pharmacy volume and revenue budgets are affected by volume assumptions in other primary service lines that generate ancillary revenue from the pharmacy. Since the majority of pharmaceutical revenue is ancillary, a large portion of the gross charges are not reimbursed as separately identifiable payments. Approximately 40% of pharmaceutical revenue is generated by inpatient cases and 15% comes from outpatient surgical cases. These case types are most often paid at

a fixed amount for the visit regardless of pharmaceutical utilization and charge amounts.

The 340(b) program helps offset the purchasing cost of drugs through the rebate program and generates some Other Operating Revenue as part of the outpatient pharmacy program. The FY2025 budget includes an increase of $1.25 million to hospital-based rebates (a reduction to the cost of drugs sold) from implementation of bedside scanning in the Emergency and Surgical Services departments. Below is a summary of the program as incorporated into the FY2025 budget.

Gross Cost of Drugs Sold	3,653,325
Hospital Based Rebates	(1,983,061)
Net Cost of Drugs Sold	1,670,264
Outpatient Pharmacy Payments	803,171
Net Benefit of 340(b) Program	2,786,232
Effect on Commercial Rates	-5.0%

d. Cost inflation. Please explain any substantive changes and break out by medical and non-medical supplies and isolate the price effect separately from the utilization effect.

Supply cost inflation is estimated using market data by supply category. The FY2025 budget includes inflation factors ranging from 2.5% (general patient supplies) to 7% (cost of blood). As discussed above, pharmaceutical expenses are impacted by increased utilization of 340(b) price reductions. Minor Equipment is a zero-based budget line where managers identify needs durable, non-capital, equipment and supply needs within each department. These expenses have been deferred in recent years and the increased need is reflected in the FY2025 budget.

Supply Category	FY2024 Budget	Utilization	Price	Other	Total
General	195,633	63,025	-	-	258,658
Clinical	13,452,258	1,317,879	412,876	-	15,183,013
Raw Food	627,900	11,100	19,170	-	658,170
Minor Equipment	168,883	-	-	171,664	340,547
Cost of Drugs	2,359,644	455,379	114,601	(1,250,000)	1,679,624
Total	16,804,318	1,847,383	546,647	(1,078,336)	18,120,012

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.

Case mix index has remained steady over the past four years. No changes are anticipated in FY2025.

f. Rate Changes by Payer. Explain any assumptions related to rate changes for Medicare, Medicaid (e.g. In State/Out of State), and Commercial Payers overall and by setting of care (inpatient, outpatient, professional services).

Medicaid market basket increase is expected to be 0%. Initial guidance for Medicare rates indicates a maximum market basket increase of 2.26% subject to penalty reductions. The budget assumes that NMC will realize a 1.7% increase. Inpatient and Outpatient Commercial rates are determined as a percentage of the eligible gross charges, so price increases for these services result in the same percentage increase to Inpatient and Outpatient Commercial net revenue. Physician professional fees are paid on a fee schedule that is independently and rarely renegotiated. The budget assumes 0% change to outpatient physician professional fee reimbursement for all payers. Because increases in gross charges on physician fees result in very little additional net revenue which comes only from uninsured patients, these have historically been exempted from increases in gross charges. However, to ensure compliance with the anticipated budget order language, gross charges for physician professional fees will be increased in FY2025 by the same rate as all other hospital charges.

g. Capital Expenses. Explain any anticipated capital expenditures in the proposed budget, including a description of funding sources.

All capital expenditures are funded through operations and cash on hand. Capital expenditures anticipated for FY2025 include routine replacements and upgrades of clinical equipment, IT related equipment and infrastructure and facility maintenance projects. The total capital budget for FY2025 is $7.28 million, or 1.026 times, depreciation expense. Capital expenditures have lagged depreciation expense in recent years, signaling that equipment and infrastructure replacements are not keeping up with the need for those replacements.

Fiscal Year	Routine (Non-CON) Capital	Depreciation Expense
FY2021	4,473,896	6,098,075
FY2022	4,251,577	6,351,177
FY2023	4,355,992	6,196,138
FY2024 Projected	5,674,126	6,439,376
FY2025 Budget	7,282,021	7,097,650

The largest items in the FY2025 capital budget are air handling units that total approximately $2 million, a nuclear medicine imaging and processor to update an aged piece of equipment ($900,000), and operating room camera and boom replacements ($840,000).

h. *Financial indicators. Explain any changes (key drivers) to your Operating Margin, Days Cash on Hand, and Debt Service Coverage Ratio relative to your FY24 projections, as well as any other key financial indicators that are important to consider in relation to your budget request.*

NMC is projecting a loss in FY2024 resulting in a -0.78% operating margin. The FY2025 budget results in a positive operating margin of 0.99%. Days cash on hand remains stable and debt service coverage ratio is and will remain in compliance with our bond covenant with an operating margin of 0.99%.

i. *Uncompensated care. Differentiate any assumptions/changes as they relate to exogenous trends (e.g. patient needs) or internal practices (e.g. changes in accounting or business processes) related to bad debt and free care. Please include a description of collection processes. Report your budgeted bad debt to free care ratio and how you derived your estimates for bad debt and free care.*

Our collection process adheres to the requirements of the Financial Assistance Policy as provided.

Over the past three years, there is a consistent rate of bad debt write-offs as a percentage of patient responsibility. This includes 72% of uninsured (self-pay) balances (after the standard self-pay discount).

Historically, the self-pay discount has been reported as either bad debt or a commercial discount. Based on the Cost Report worksheet S-10 inclusion of self-pay discounts with Charity Care, and advice of our auditors, we are reporting self-pay discount as charity care in the FY2024 projection and FY2025 budget. The values shown below include that classification for all years.

The share of revenue associated with self-pay patients has increased over the past few years and is projected to continue to increase. A 1% change equals approximately $3.5 million.

Fiscal Year	Uninsured Payor Mix
FY2022	2.26%
FY2023	2.03%
FY2024	2.72%
FY2025 Budget	3.08%

Bad debt and free care budgets are calculated using a multi-year lookback of write-offs as a percentage of gross revenue. The rate of charity as a percentage of bad debt has fluctuated from year to year. The FY2025 budget is set with a rate that is within the historical range.

Fiscal Year	Charity (incl Self-Pay Discount)	Bad Debt	Charity as % of Bad Debt
FY2018	1,729,722	6,470,848	26.7%
FY2019	1,231,699	6,899,923	17.9%
FY2020	1,317,726	8,153,915	16.2%
FY2021	2,685,279	7,261,575	37.0%
FY2022	2,797,291	7,320,294	38.2%
FY2023	2,772,606	10,089,990	27.5%
FY2024 Projected	2,818,464	16,416,969	17.2%
FY2025 Budget	5,599,308	16,899,590	33.1%

j. Community Benefit. Differentiate between the various drivers of community benefit.

As reported in the most recently filed 990 Schedule H, community benefits by category include:

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense
a Financial Assistance at cost (from Worksheet 1)			799,035.		799,035.
b Medicaid (from Worksheet 3, column a)			31956414.	16361298.	15595116.
c Costs of other means-tested government programs (from Worksheet 3, column b)					
d **Total.** Financial Assistance and Means-Tested Government Programs			32755449.	16361298.	16394151.
Other Benefits					
e Community health improvement services and community benefit operations (from Worksheet 4)					
f Health professions education (from Worksheet 5)					
g Subsidized health services (from Worksheet 6)			2235634.	1694340.	541,294.
h Research (from Worksheet 7)					
i Cash and in-kind contributions for community benefit (from Worksheet 8)			62,169.		62,169.
j **Total.** Other Benefits			2297803.	1694340.	603,463.
k **Total.** Add lines 7d and 7j			35053252.	18055638.	16997614.

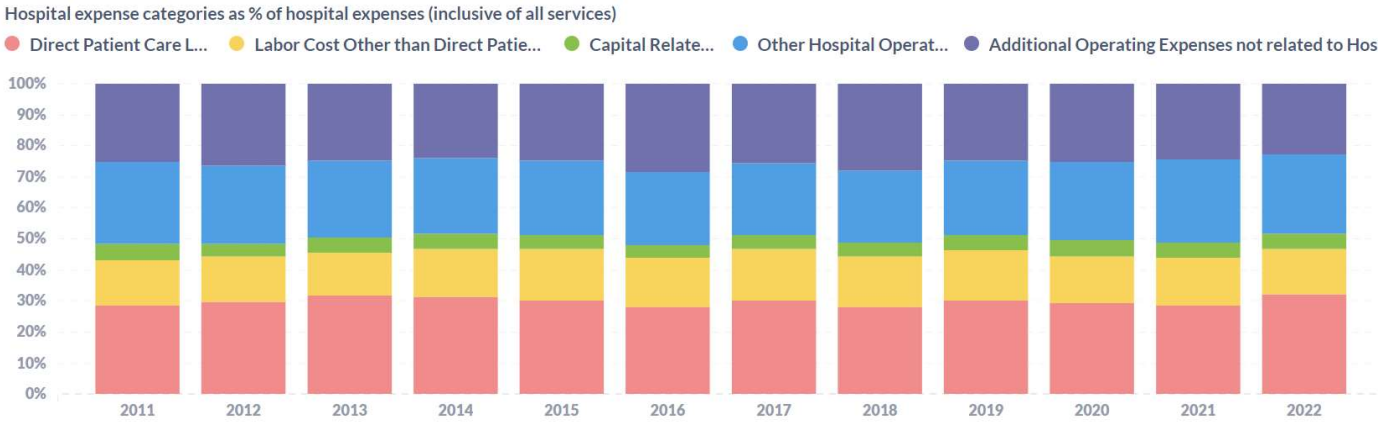
k. Briefly summarize known risks in the budget as submitted, including the potential impact of and any known timelines associated with the risk, as well as any risk mitigation efforts, and their cost or potential benefit.

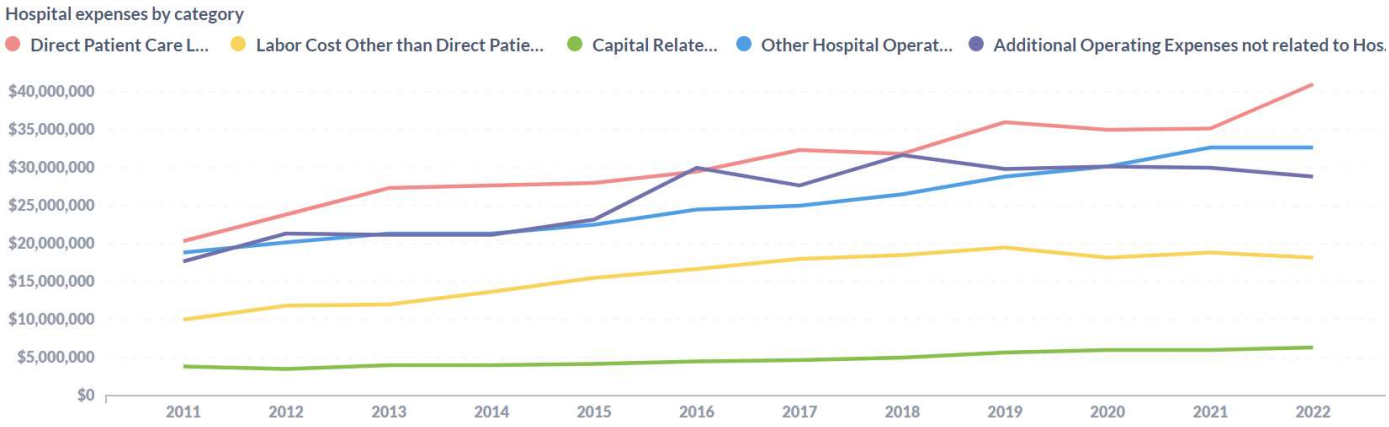
NMC is assuming a large amount of risk within the FY2025 budget. The most significant areas of risk include:

- Volume increases will only be realized if adequate staffing is in place.
- 340b rebates increasing by $1.25 million.
- 2.5% wage rate increases may not be adequate to recruit and retain clinical staff if there is a significant shift in the local market.
- Payer mix shifts toward low reimbursement Medicare Advantage plans has been significant in recent years.
- Employee health insurance claim amounts within the self-insured plan is a risk each year.

l. *Administrative vs. Clinical Expenses: using the Medicare Cost Report definition of administrative clinical, and mixed expenses in Wang & Bai (2023)2, also defined in the Uniform Reporting Manual, please comment on the relative trends in each of these expense categories over time. If you believe the Medicare Cost Report definition does not accurately reflect your organization, please articulate how you would adjust the calculation and why and provide an alternative estimate with sufficient detail that it can be cross walked to the standard definition. Further, to the extent you make modifications specific to your hospital, indicate which of your peers require such modification and the impact of such modification on each such hospital.*

The National Academy for State Health Policy (NASHP) provides meaningful and accurate information of NMC's Administrative vs. Clinical Expenses over time and is displayed below:





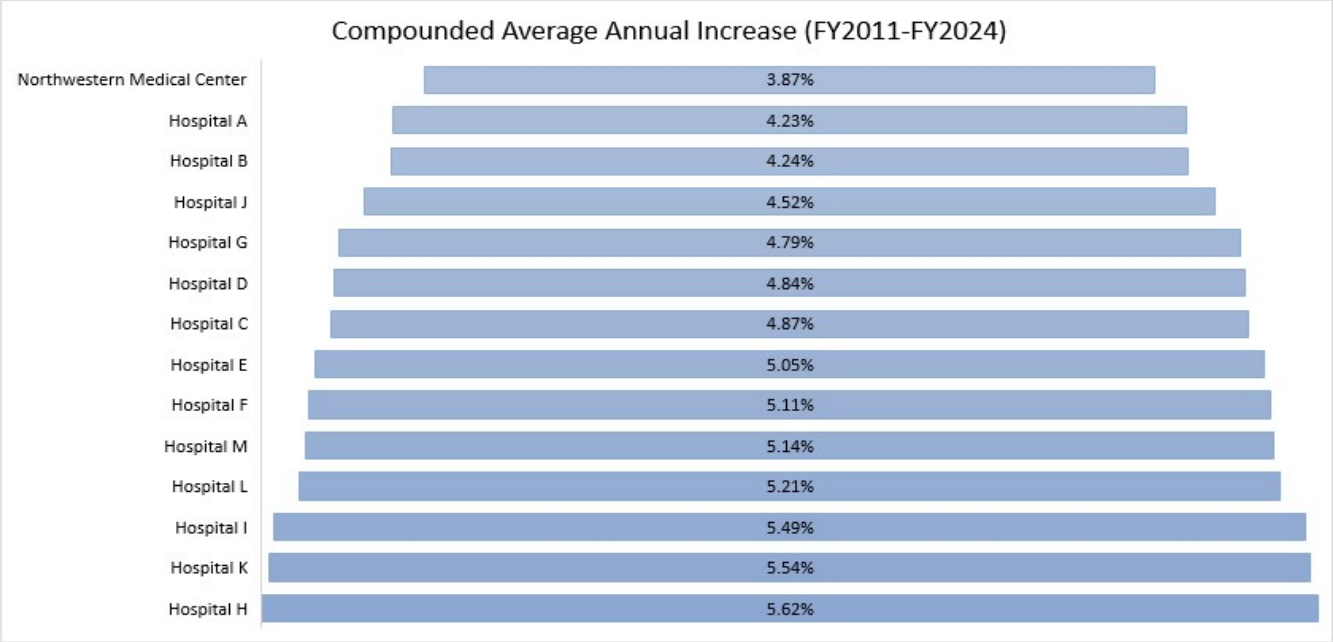
NMC is proud that we have made significant investments in direct patient care labor over the 12 years reported above and has curbed or reduced growth in all other categories.

m. 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.

NMC bills and collects facility fees for provider-based, hospital-owned, outpatient clinics. These facility fees are also known as "provider-based billing fees" and are regulated by 42 CFR § 413.65. NMC bills this way because our provider-based, hospital-owned, outpatient clinics comply will the CMS requirements and carry the same regulatory responsibilities as the main hospital. It is important to note that the total gross charge for a visit to a NMC provider-based, hospital-owned, outpatient clinic is exactly the same as the total gross charge for a visit to a NMC non-provider-based, hospital owned, outpatient clinic. The difference is simply how the visit is billed and adjudicated. The provider-based billing fee is not an additional charge. In FY2023, NMC billed $2,622,868 in provider-based billing fees.

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

Affordability means something different to each consumer. Since the inception of the Green Mountain Care Board in 2011, NMC has implemented the lowest price increases of all Vermont hospitals.



The effect of seemingly small differences compounded over a long period of time have a sizable effect. NMC would need to implement a one-time 14.4% increase to reach Hospital C, and a 26.4% increase to reach Hospital H.

o. *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.*

Depending on the size of the reduction, NMC would need to implement some or all of the following:

- Respectful and careful consideration of service lines with a negative margin. Collaborative and inclusive discussions with community members, community partners, NMC's Board of Directors, and more to define what essential services are, grounded in our most recent community health needs assessment and with the goal of the least negative impacts possible.
- Reduce 0.99% positive operating margin (maintaining some amount of positive operating margin less than 0.99%).
- Reduce or eliminate raises for staff – budgeted at only 2.5%.

p. *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.*

Lobbying expenses are incurred as a percentage of annual dues paid to Vermont Association of Hospitals and Health Systems (VAHHS) and the American Hospital Association (AHS). Of the total dues paid to VAHHS, roughly 7.8% is reported to the State of Vermont as going toward lobbying. Those expenses are used to create awareness of very important issues impacting the healthcare industry. Lobbying

expenses are reported annually on the Medicare Cost Report and on Form 990. Total lobbying expenses for the most recent fiscal year end (FY2023) was $14,937 and no significant changes are anticipated for FY2024 and FY2025.

Marketing costs are kept to a minimum and primarily focus on increasing awareness of new providers, and on services that have additional capacity (urgent care). This helps promote system-wide improvements in access. Marketing costs are discretionary and have been reduced in recent years due to financial constraints. The FY2025 budget includes additional costs compared to the past two years as new providers join NMC.

Fiscal Year	Marketing Costs
FY2017	377,737
FY2018	262,507
FY2019	191,140
FY2020	129,753
FY2021	146,794
FY2022	45,924
FY2023	22,810
FY2024 Projected	14,616
FY2025 Budget	152,100

q. *Describe planned fundraising efforts and anticipated donations for FY25.*

NMC plans to maintain traditional and local fundraising efforts in FY2025. For example, NMC co-hosts and annual golf tournament each year to raise money for our local United Way, Northwestern Counseling & Support Services, and NMC. NMC also participates in fundraising efforts for the Martin H. Wennar, MD Health Professions Scholarship, the Jim Bashaw Fund to help those with catastrophic illness, and other small fundraising efforts. NMC also plans to maintain donations to local community partners, the amount included in the FY2025 budget is $25,000.

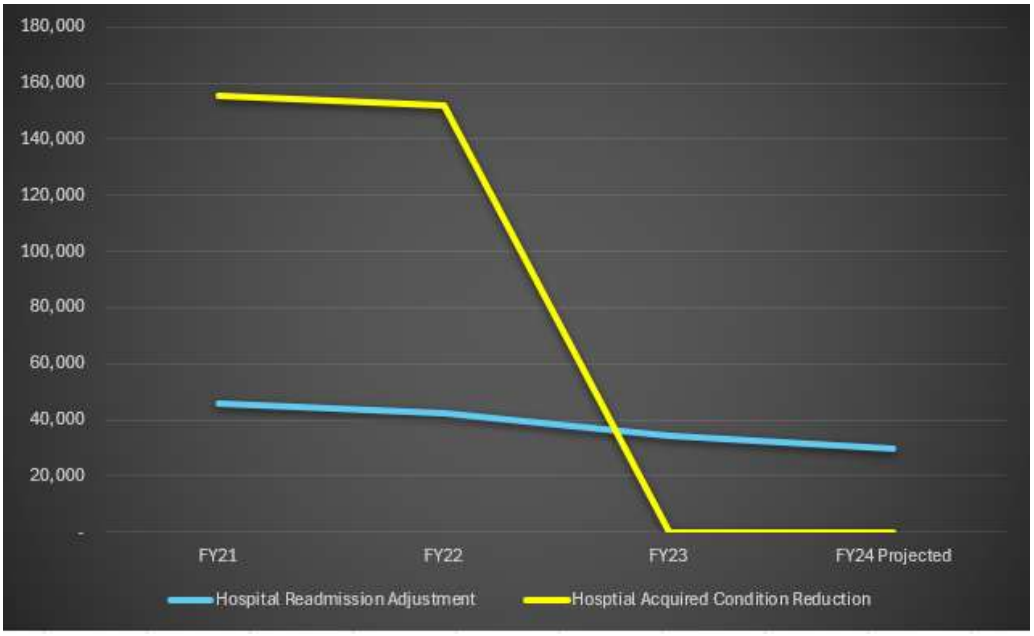
r. Describe projected investment income and, if projected to be zero, please provide a 3-year summary of annual investment income.

Investment returns are budgeted and appear in the non-operating portion of the income statement.

Fiscal Year	Interest & Dividends
FY2021	$988,652
FY2022	$1,479,216
FY2023	$1,587,974
FY2025 Budget	$1,742,851

s. *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.*

For the current fiscal year period from 10/1/23 to 6/17/24, NMC has incurred a Medicare hospital readmission penalty of $21,135. This amount projected for the entire current fiscal year is $29,557. In FY2023, NMC incurred a Medicare readmission penalty of $34,133. NMC is proud of the meaningful improvements we have made to quality and safety and our Medicare readmission and hospital acquired condition penalties are excellent proof of that improvement. Below is a graph showing NMC's penalties from FY2021 through FY2024 Projected.



t. *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, residence 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).*

Workforce development is a priority for NMC with multiple programs in place, both independently and through community partnerships.

- Vermont State University School of Nursing utilizes NMC space located on Main Street in St. Albans at no cost, for their LPN and ADN programs. This has allowed them to increase capacity from 18 students to 54. In addition,

NMC supports the salary of a Clinical Associate to teach the LPN clinical rotations. This partnership has been in place since 2019.

- NMC (along with two other hospitals) were leaders in developing a Nursing Apprenticeship and Pipeline program with the Vermont Agency of Human Services. This program allows current NMC employees the opportunity to go to nursing school while maintaining full-time employment and benefits. Over three years, participants are allowed a mix of employment and paid work release time to complete the LPN (year 2) and their RN (year 3). We are receiving grant funds to help cover the cost of this program and results this far are very good.
- NMC awards up to 5 full tuition scholarships for RN programs per year. To receive the full award, recipients must work at NMC for three years following graduation.
- The LPN bridge program allows LPNs the opportunity to maintain full-time employment status while they attend school to obtain their Registered Nursing license.
- Those wishing to become an LNA are employed full-time and use that time to take classes and receive clinical training. They work their remaining hours in support departments until they receive their LNA license and are moved to a clinical role.
- ASPIRE Nurse Residency program for new graduate nurses or nurses who have not worked in a hospital setting.

Paid time for participants of these programs, whether it is orientation, work-release or regular hours, is recorded as a salary expense. Offsetting grant revenue is recorded as Grant Revenue and is shown on the income statement as part of Other Operating Revenue.

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 associate accounting entries show up in your proposed budget (income statement and balance sheet).

NMC's FY2025 budget includes nearly $15 million of employee benefits (24% of salaries and wages). While we have intentionally focused on increasing base wages over the past few years to align with the market, we dream of doing more and are laying the groundwork for future initiatives. Recruiting and retaining highly qualified team members is extremely competitive in the current environment and we recognize that being able to offer housing and/or day care is a competitive advantage. NMC owns and maintains a single-family home across the street from the hospital that we rent out to new team members in need of housing, but the need is much greater than that. Lack of affordable housing options does impact our

ability to recruit and retain qualified team members. It is not unusual for travelers to communicate that they would be open to exploring a permanent position at NMC if affordable housing was more widely available. Our approach is to leverage partnerships to develop solutions. We are working with the Franklin County Development Corporation to explore daycare options and we are working with housing developers to understand how we can best utilize our property to create housing for staff.

Employee benefits appear as a separate item on the income statement. Revenue and expenses related to NMC owned housing is part of non-operating revenue.

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

NMC has an obligation to spend money and resources wisely. We must be good stewards in order to truly serve our community and provide exceptional care. Examples of stewardship at NMC include:

- Every FTE request is reviewed by Senior Leadership with the department leader providing information about budget to actual performance, volumes, and efficiency and productivity compared to benchmarks.
- A traveler reduction workgroup that meets bi-weekly to review each current traveler assignment with projections of future months with team members joining and leaving and discussion of recruitment ideas and strategies.
- Monthly monitoring of group purchasing contract compliance for capital and non-capital expenditures to obtain the most favorable pricing.
- A value analysis committee that meets monthly to evaluate new product requests and to trial products that offer cost savings.
- A robust contract negotiation process where leaders are required to push back on vendors including annual price increases above consumer price index.
- Routinely bidding purchased services (linen, security services, snow removal, etc.), employee benefits, and insurance.

Drivers of expense growth that we feel hospitals should be "held harmless" include:

- Inflation and other cost increases incurred only after the completion of our exhaustive process described above.
- Medicaid provider tax increases.
- Expense increases that are grant funded.

D. 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.

Investments focused on mental health include:

- Within the Emergency department, two safe rooms (with the ability to convert an additional two rooms) have been constructed as part of the CON project that was completed at the beginning of year. This is a significant improvement over the limited and suboptimal space that was available for patients experiencing acute mental health crisis prior to the project completion.
- Emergency department nurse leadership is actively implementing universal suicide screening for all patients 8 years of age and older. Patients can be screened to determine risk levels and the appropriate, evidence-based, interventions can be provided.
- The Accountable Communities for Health of Franklin and Grand Isle County partners with local schools, mental health agencies and the Vermont Department of Health to support initiatives and programs that improve access to mental health services for children.

Investments focused on substance use disorders include:

- Turning Point recovery coaches are available within the emergency department with dedicated space to allow recovery coaches to be integrated into the emergency department team to simplify the referral process.
- The Department of Population Health is working with NMC to invest in Quit Kits that provide resources, including NRT for individuals who want to quit tobacco. This is an important project, because lung cancer and chronic conditions related to tobacco products continues to be one of the leading causes of death in our region.
- NMC, through grants, is funding a part-time substance use disorder community health worker who serves both hub and spoke practices within our region.

Investments focused on long-term care include:

- Grant funded medical respite bed pilot program for patients awaiting a long-term care bed or other housing solution. NMC rents two apartments that patients can discharge to continue their recovery. Patients may be capable of living independently or may require services (home health, meals, etc.) that we are able to arrange within our Care Management team.

Investments focused on primary care include:

- Please see response to D.b. below.

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.*

NMC is actively engaged in community partnerships, including:

- Through our Blueprint program, NMC supports the convening of multiple community partners, including the Long-Term Care facilities, Home Health Agencies, Primary Care Practices, and Social Justice Organizations. The St. Albans HSA Community Health Team is an inclusive group of organizations working together to address the needs of our friends, neighbors, and family members. We are currently working on a regional quality improvement project addressing Social Determinants of Health (SDoH) screenings and referrals with Vermont Program for Quality in Health Care and launching a Team Based Care initiatve with the Camden Institute.
- As the Blueprint Administrative Agency, NMC provides the Practice Facilitator for our community based primary care and pediatric practices, including the FQHC to ensure they are maintaining recognition with NCQA's Patient Centered Medical Home Model.
- Close partnership with our local FQHC on space and building needs on our campus and supporting their application for congressional direct funding.
- Working with the state Agency of Human Services on a hypertension grant that will support Primary Care in screening patients for SDoHs and who have hypertension and create a referral pathway to the MyHealthyVT Health Coaches for Hypertension program.
- Exploring a primary care residency program to better meet the primary care demands of our community.
- "Ask the Question" campaign that aims to improve access and quality of services for veterans and their families.

Key barriers and opportunities identified are:

- Lack of long-term care beds in our region.
- Lack of dementia care beds in our region.
- Lack of mental health beds in our region.
- Social determinants of health, including but not limited to poverty and housing insecurity, food insecurity, transportation, etc.
- Medication management continues to cause issues for our patients. Out of date medication information can lead to patients being prescribed medication that does not interact well with existing prescriptions.

- Discharge summaries to PCP offices are very long, and most relevant information is not top and center.
- One of our independent community practices does not have an RN Care Manager to facilitate smooth transitions of care.
- Patients with unknown or no primary care provider.
- Difficulty identifying a care companion for patients to ensure information is relayed accurately.
- Medicaid payment amounts.

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

NMC was not asked to submit a performance improvement plan.

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.*

NMC is not part of a hospital network.

E. 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)?*

Zero-based budgeting has both its advantages and disadvantages. One major benefit is that each individual expenditure must be actively considered and requested. There is increased visibility, and the result may be the reduction and/or elimination of expenditures that are not absolutely necessary. With that, the methodology carries disadvantages. One disadvantage is the increased resource level needed to research and construct the budget. Another is the risk that valid and necessary expenditures are inadvertently missed, resulting in a less accurate budget.

The approach that NMC takes is to assess the value of zero-based budgeting by budget component and weigh the relevant factors. Factors include, degree of improved accuracy, risk of expense omission, information availability, resource requirement, and the magnitude of the dollars that are part of that budget component.

The largest expense in the budget is clinical staffing. We take an organized approach to clinical staffing that would be considered zero-based budgeting. For outpatient practices and ancillary revenue departments, the budget starts with an assessment of hours of operation. Patient volumes are layered onto that so that the hourly and daily staffing model

can be created, and this ultimately becomes the budgeted staffing. Staffing on inpatient units is calculated in a similar fashion, looking at patient volumes in total and by hour and day. Industry staffing ratios (patients per nurse assignment, hours per patient day, etc.) are considered and the final budget is set using these as guides.

For all departments, we compare budgeted staffing to third party productivity benchmarks. Budgets are set with an understanding of the areas in which intentional investments beyond the industry top quartile are being made, and the areas in which they are not.

For certain significant contract services, a true zero-based budgeting approach is used. This includes traveler costs, Locum Tenen physicians, Information Systems contracted services and Facilities contracted services. In these areas, all contracts are individually identified and tracked.

Supply utilization presents a conflict between the ideals of zero-based budgeting and the ideals of a data driven model. It is also an area where a zero-based approach would be highly labor intensive and somewhat self-defeating. To go through the exercise of zero-based budgeting for most supplies, would require some data point to use as a foundation. The most reasonable and accurate data point available to any organization would be its own prior year supply utilization. For patient supplies, we utilize a methodology that tracks supply cost per department unit of service (could be a lab test, a patient day, an MRI procedure, etc.) and this rate is applied to the budgeted statistic. We can then add inflation or any other known changes.

Certain other discretionary accounts are created using the zero-based budgeting methodology every year, including Minor Equipment purchases (supplies between $500 and $4,999) and travel and seminar expenses.

We feel this hybrid approach most successfully achieves the goals of zero-based budgeting… visibility, accuracy and the promotion of thorough review.

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.

Contracts have been submitted. Total expense for contracted collection efforts, including statement preparation and mailing, was $830,000 in FY2023. During that fiscal year, the payments processed by these contractors and returned to NMC was $6.8 million.

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?

Third party collection agencies bring a level of expertise and scale that has proven difficult to replicate internally in the past. These positions tend to result in high rates of turnover and require additional management staff to monitor results and train new employees. The expertise required has been difficult to find and retain locally. Contracting with a third-party that has the scale and expertise has proven to be the most reliable approach. Existing management staff can monitor performance metrics and ensure that industry standards are met in terms of total cost and collection rates.

c. *Please describe how patients are screened for Patient Financial Assistance at your hospital.*

Patients are screened at registration with referrals made to the financial counselors as needed.

During the scheduling process, the patient financial services team is made aware of any uninsured patients and the financial counselors reach out to those patients.

The patient financial services teams runs reports routinely to identify accounts with significant patient balances and contacts those patients directly to ensure that they are aware of the financial assistance available, and all other payment options.

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, information about the financial assistance policy is included on all bills and statements.

c. *For reporting on boarding as required in Section VI, please explain how you derived your estimates and explain key drivers and trends over time.*

Reporting capabilities were limited for this section of the workbook. Avoidable days is manually tracked and lacks patient level detail for reporting. Furthermore, a system change limited historical data to March of 2023 as the earliest date. All available data was reported.

Costs were estimated assuming all avoidable days were spent in sub-acute status. The average daily rate of Variable Direct Costs for sub-acute patients was applied to the avoidable days reported to arrive at an estimated cost. Likewise for reimbursement, the average reimbursement per sub-acute day from FY2023 was applied to the avoidable days reported to estimate reimbursement.

Avoidable days are not specifically contemplated in the annual budget assumptions, implying that avoidable days are a function of total inpatient volumes and are affected by general inpatient volume assumptions.