A. NARRATIVE

The budget narrative provides an opportunity to provide context for proposed budgets and highlight areas of interest and/or concern. The GMCB asks hospitals to answer each question. succinctly and to strictly follow the format below by responding in sequence to every question.

I. EXECUTIVE SUMMARY

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

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

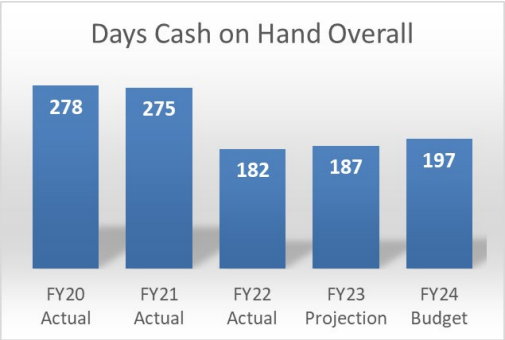
Rutland Regional Medical Center's budget complies with the net revenue parameters as established in the FY 2024 Hospital Budget Guidance and Reporting Requirements. The growth in net revenue from Actual 2022 to Budget 2024 is 8%, while guidance allowed for a growth rate of 8.6%. In addition to complying with the net revenue threshold, we have based our budget on reasonable assumptions as outlined within the guidance and where our assumptions differ, we have provided justification. We have also complied with all filing requirements, ensuring that we submitted our budget on time and complete.

As highlighted within the narrative below, RRMC's 2024 Budget is based on current utilization assumptions and most of the new revenue is activity that is included in Projection 2023. In response to patient access wait times, we have expanded CT and MRI imaging services by extending hours of operations and opening Saturday appointments. Currently 32% of our CT and 46% of our MRI appointments have wait times greater than one month which challenge care by delaying treatment. We have also expanded our infusion therapy program, again directly related to clinical need and patient access. Infusion therapy drives our pharmaceutical revenue where we also have significant revenue increases.

Net revenue is based on our most current payor mix, which includes a migration of patients from commercial insurances to State and Federal programs. This payer mix change is represented in Schedule 10 and demonstrates a negative impact to reimbursement of more than $7.7 million from actual 2022 to Budget 2024. We have included Medicare and Medicaid reimbursement updates based on information included in the most recently proposed Federal Registers. We assume full participation in OneCare risk programs and have assumed a small loss on the Medicaid program based on utilization and increased healthcare costs. The most significant impact in our budget relates to the fact that some patients will no longer be covered by the Medicaid program due to the reinstatement of eligibility review. As a result, we assume bad debt will be impacted by about 10% and have therefore increased our reserve for uncollectible to 2%.

Last year RRMC's operating loss of $12.5 million coupled with an investment loss of $28.7 million resulted in a significant decline in days cash on hand and a breach in our debt covenants, specifically the Debt Service Coverage requirement. RRMC had to enter into a Covenant Suspension Agreement with TD Bank and the

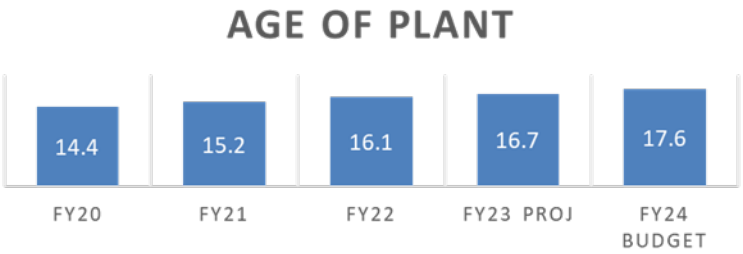
USDA to mitigate the impact of non-compliance and risk having the debt called. As a result, TD Bank required that our Days Cash on Hand requirement increase to 120 Days.



To mitigate the impact of additional increases in our commercial rate RRMC implemented a cost reduction plan in the Spring of 2023. This plan led to a reduction of more than $5 million and eliminated 45 FTEs from our budget. The impact of the cost reduction plan was significant; without the plan RRMC's rate request would have been increased by an additional 3.5%. The efficiency savings were achieved without limiting access to patient care and were balanced between clinical and administrative functions.

While operating performance ended with a significant loss in 2022, RRMC has been challenged to generate income from operations for several years. Over the past 5 years, RRMC's margin was $1.6 million. For the same period, RRMC's principal debt service requirement was $17.5 million, forcing us to use cash reserves to pay debt obligations.

As a result of weakened operating performance, we have also delayed investments in capital, this is evidenced by the continual aging of our plant, as shown below.



It is important that RRMC generate an operating margin to allow for reinvestment back into our organization and the services that we offer. The impacts of diminished liquidity and limited debt capacity coupled with the aging plant are challenges that will impact RRMC and the State of Vermont for years to come. Without continual investment in operations both quality and access to care will be jeopardized.

This year's targeted operating margin was thoughtfully approached to ensure that income from operations was sufficient to cover capital investments and principal payments. Our targeted operating margin generates $21 million in cash flow to cover $20.5 million in cash requirements, as shown below.

Operating Sources	
Sources:	
Operating Margin	$ 7,892,352
Depreciation	$ 13,089,033
	$ 20,981,385
Uses:	
Capital Investment	$ (15,144,790)
Principal Payments	$ (3,527,947)
Changes in Working Capital	$ (1,786,191)
	$ (20,458,928)
Beginning Cash - 2023 Projection	$ 9,241,549
Net Increase/(Decrease) in Cash	$ 522,457
Ending Cash - 2024 Budget	$ 9,764,006

While we have budgeted investment earnings, the market is too volatile to count on those funds to cover operations. Should the investment market perform, the resulting increases in cash reserves due to investment earnings will accumulate in 2024 to provide funding for increased capital expenditures as projected in our 4-Year Capital Plan. Due to the delay in capital investments, in the next four years RRMC projects that capital funding requirements could be as much as $71 million. This funding would support both the replacement of routine capital, upkeep and maintenance of our buildings, investments in efficiency initiatives, and the continued advancement of our medical equipment, information technology services and security posture.

To summarize, we believe that our budget balances the need to maintain access to care with the need to be to be responsible in controlling the cost of health care, all while complying with the required NPSR growth target. Workforce issues continue to be prevalent in both staff and physicians and therefore require that we acknowledge the cost in our budget. We must also acknowledge the cost of providing care for patients that do not require acute medical care but do not have any other safe housing or living options, and therefore remain within our facility. To mitigate the impact of these additional costs on our community we have responsibly completed a cost reduction program that realized more than $5 million of savings. This cost reduction program was critical in limiting our commercial rate increase, while at the same time ensuring an operating margin that supports reinvestment back into our hospital and our community. We have delayed capital spending for a several years and 2024 is the first year in our four-year plan that will allow us to address our unmet capital funding needs.

II. QUESTIONS

a. Concisely describe necessary adjustments to your FY22 actuals or other considerations required for the proposed budget. Examples may include physician transfers, accounting adjustments, or changes to service offerings, staffing, or infrastructure.

RRMC does not request any adjustments to our FY22 actuals. Our Fiscal Year 2022 Budget aligns with our Budget for 2024, as utilization is similar and our cost structure continues to be challenged by many of the same workforce issues.

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

i. Labor expenses

Wage adjustments for all non-union employees are determined using market data. RRMC uses annual benchmark data of other hospitals similar in size (staffing and bed count) or those who we are collocated in a geographic region. RRMC's strategy is to set salaries at the market median. In addition, a Compensation Committee of the Board was created in 2019 and serves to evaluate CEO performance and set the CEO salary as well as to ensure that the compensation philosophy across the organization is equitable and complies with State and Federal law.

RRMC is in the process of completing a market analysis and will not have results until late summer. For budgetary purposes, our base wage assumption is an average base wage increase of 3% with an additional 1% for hard to fill positions that require market adjustments. Together our planned rate increases are within the U.S. Bureau of Labor Statistics' Employment Cost Index that identified inflation related to civilian workforce at 4.8%. RRMC's planned wage increases are supported by the Employment Cost Index.

We continue to face significant wage pressures and have had several potential employees decline offers or current employees leave our organization due to our pay scales being out of line with competitors. The most recent examples of hard to fill positions include pharmacists, social workers, registrars.

Our market often requires alignment with regional and national markets, as well as tertiary care centers. It is critical that RRMC compare with these competitive markets otherwise we are at risk in the recruitment of new staff and the retainment of current employees. The workforce shortage continues to be a significant challenge. Currently we have 186 open positions, with the following vacancies:

Registered Nurses – 83 positions
Other Clinical - 72 positions
Administrative and Support – 31 positions

It is also important to note that wages for registered nurses are negotiated through a collective bargaining agreement, which represents nearly one-quarter of our workforce. Our current collective bargaining agreement is in effect until September 2024. Our 2024 labor assumptions are based on obligated compensation adjustments within the contract.

ii. Utilization

We are basing our 2024 utilization on current utilization demands and have included minimal growth. Overall RRMC's ability to increase utilization is limited due to capacity issues with both beds and diagnostic testing equipment and as a result of permanent provider availability.

We have included increases in two programs: infusion services and advanced imaging. We have created additional capacity in both programs to respond to patient access challenges as has been demonstrated through wait time reports and physician concerns.

Wait times for both CT and MRI services are longer than they should be to respond timely to physician referrals and treatment plans. Currently, 32% of our CT and 46% of our MRI appointments have wait times greater than one month. Our 2024 operational budget includes assumptions to increase hours of operation to respond to the delay in care, as a result we have included $7.5 million of increased gross revenue. In addition, our 2024 Capital Budget includes $1.4 million to fund a second CT scanner.

iii. Pharmaceutical expenses

We buy most of our pharmaceuticals from a group purchasing vendor, Vizient. Through Vizient we can match inflationary projections with our exact drug formulary and utilization. Matching inflationary projections to RRMC specific spend is important as we provide oncology care that requires expensive, long-term pharmacy treatment protocols. We have budgeted inflation based on information provided by Vizient, which estimates our pharmaceutical inflation to be $1.3 million based on our drug spend; this is equivalent to an inflation rate of 4.0%.

While the 12-month inflation for pharmaceuticals as established by the Producer Price Index for prescription drugs is estimated to be 2.9%, we do not believe that this reflects the categories of drugs used at RRMC. As outlined above, we have considered our own drug spend through Vizient to predict inflation for pharmaceuticals.

iv. Cost inflation

RRMC used the Producer Price Index for general and medical and surgical supplies for hospitals as a starting point. We have included $1.2 million of inflation in the 2024 Budget. As published in the U.S. Bureau of Labor Statistics Producer Price Index, inflation is expected to be 2.3% from year to year. Based on our current group purchasing contracts we have established a range of inflation, depending on supply or commodity, overall our inflation falls within the inflationary published target.

v. Commercial price changes

The overall commercial price change for RRMC is 5.62%. This price change allows for a modest operating margin of 2.4% to support capital investment and debt service requirements. There are many impacts to our requested rate increase, including:

Negative Impacts:

- The ***340B program*** continues to face challenges as hospitals' ability to participate in the program is being significantly limited due to manufacturer restrictions that are imposed on contract pharmacies. Included in our 2024 Budget is a reduction of 340B pharmacy revenue of $3.5 million. This reduction impacts (raises) commercial rates by approximately 2.3%. We have already begun to see this reduction in 340b revenue.

  This program limitation presents a significant risk across the State of Vermont as most hospitals rely heavily on 340B revenue to subsidize losses from State and Federal programs. 340B revenue limits the need for commercial rate increases. While hospitals have a responsibility to respond, our response will require a coordinated effort with State agencies and State and Federal legislative delegates.

- ***Providing care that is not reimbursable*** due to the inability to transfer patients to post-acute care or other more appropriate care settings varies by payer. In Exhibit 10 of the 2024 budget filing, the impact of the Medicare long length of stay patients is seen in the utilization section with an Actual FY 22 to Budget 24 gross patient service revenue increase of $10.9 million but a correlated net patient service revenue decline of $1.6 million. This is the result of providing care for a projected 3,150 days while patients awaited placement in a long-term care facility or appropriate home care setting. Together these unreimbursed days resulted in an operational loss of $7.8 million, which is equivalent to a 5.2% rate increase.

- ***Workforce challenges*** continue in 2024 and as a result RRMC will continue to be reliant on travelers. We expect to have contracts with 52 travelers in 2024. The difference in cost to provide care with travelers is approximately $8.5 million. Without travelers in the budget RRMC would not need a rate increase.

Positive Impacts

- RRMC committed to a cost savings program in the Spring of 2023. This program generated $5.6 million in cost savings which included the elimination of 45 FTEs. The cost savings were carefully planned to ensure that access to care would not be impacted. More than half of the savings relates to administrative, support and overhead functions. If RRMC had not

committed to the cost savings program our commercial rate request would have been as much as 3.5% higher.

vi. Financial indicators

The three most important financial indicators to RRMC relate to our obligations with TD Bank and the USDA to support our debt. Based on loan agreements, RRMC is required to meet the following debt covenant requirements:

- Days of Cash on Hand: 90 Days / After Breach of Covenant: 120 Days
- Debt Service Coverage Ratio: 1.4 times
- Debt to Capitalization: 60%

RRMC's budget ensures that we meet each of the covenants. The ability to generate an operating margin serves as an important foundation to our performance. Meeting debt covenants remains important as RRMC breached the Debt Service Coverage Ratio for fiscal year 2022. We were required to enter into a suspension agreement that was costly and could challenge RRMC from additional debt capacity should we breach covenants again.

KaufmanHall published the following commentary on June 21, 2023, as part of their featured highlights. The guidance is relevant to RRMC and magnifies the need for hospitals to be diligent in the management of liquidity and financial strength measures.

"The importance of cash cannot be overstated. Reserves are needed to fund the unexpected, like a mandated shutdown of elective services or a government shutdown when Congress can't agree on a budget package. Reserves are needed to fund capital when debt capacity is limited, or the cost of debt is unaffordable. Reserves are needed to fund strategies that may not qualify for tax-exempt financing or be large enough to justify a borrowing. Reserves are needed to fund programs that are core to mission and that payers do not reimburse for, such as teaching costs, research, and community health programs. Reserves are an important metric for assessing credit, which informs the cost to borrow."
(Blog: Lisa Goldstein, June 21, 2023: The Sky Is Orange and the Bottom Line Is Red)

vii. Known pricing changes for Medicare and Medicaid

- We have only included reimbursement increases for the Medicare program, as shown below.
  - Medicare Impatient – 3%
  - Medicare Outpatient – 1%
- We have not included any change in reimbursement for the following:
  - Medicare Professional Services
  - Medicaid Inpatient
  - Medicaid Outpatient
  - Medicaid Professional Services
- We assume full participation in OneCare risk programs. We have included a Medicaid payment fixed payment shortfall of $600,000.

viii. Uncompensated care

The end of the public health emergency will impact Medicaid beneficiaries as the State will resume eligibility verification to continue Medicaid coverage. Not only is this an issue for RRMC, but it is also an issue for Vermont and across the Nation. Estimates have been made that projects that 33,000 Vermonters could be impacted and removed from the plan. RRMC estimates that we could have between 2,500 and 4,000 patients who will have benefits terminated. Due to this we have increased our uncompensated care from 1.8% to 2.0% of gross revenue, this equates to approximately $2.5 million in additional reserve.

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

In reference to Exhibit 10 it is important to note the impact of the commercial rate increase on Commercial payers. The two-year FY22 to FY24 column is the most relevant to refer to. For Rutland, our 2-year rate adjustment for commercial payers is $47,111,252 and the net impact is $22,237,358. This equates to a net revenue impact of 47%; said more simply, for each $1 dollar that we raise rates, on average commercial insures only participate in about 47 cents.

There has been a significant amount of emphasis on the commercial rate, but what has not been emphasized are the continual changes in payment rules that commercial payers are leveraging on hospitals. In the past two years commercial payment rule changes that materially reduce reimbursement include:

- Loss of reimbursement for some services in clinics that used to be paid as provider based
- Bundling of services to disallow certain charges to be reimbursed
- Rules that set limits on reimbursement for supplies, pharmaceuticals and select services
- Price transparency rules for out of network services

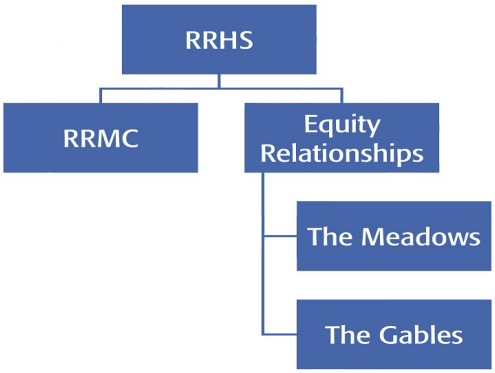
These changes permit commercial insurers to reduce reimbursement without the need to renegotiate contracts. There is continued risk that these payment rule changes would not be known in advance of budget preparation as they are often enacted mid-year. This is highlighted as a risk below.

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

Risk	Mitigation/Impact
Unpredictable change in volume	Decrease in variable cost structure
Unanticipated loss of physician/provider	Commit to locum/per diem staffing (costs double the cost of our own clinician) There is an opportunity to expand telehealth provider services.
Continued payment rule changes from commercial payors	The impact of commercial payment rule changes in the last two years has resulted in a loss of net revenue of more than $4 million.
Medicaid Eligibility – loss of coverage differs from RRMC assumptions	Included $2.5 million in additional bad debt reserves Provide RRMC financial counselor and Health Exchange navigators
Continued deterioration in payer mix (migration from Commercial to State/Federal payors)	The impact in payer mix changes from 2022 to 2024 reduce net revenue by more than $7.7 million (refer to Exhibit 10 Total Payer Mix changes from FY22 to Budget 24)
340B Programs – continued increase in manufacturer exclusions.	Included manufacturers exclusions known to date. This is an impact of $3.5 million in other operating revenue. Working with State and Federal agencies to educate and communicate the benefit of the program, considering changes in program administration.
Continued workforce issues	Included 52 travelers in the budget, which adds over $8 million of costs to the Budget. RRMC continues to offer staff incentives to pick up additional shifts and we are engaging in “Grow Your Own Programs” Recruitment and retention efforts require strategies for housing and childcare initiatives

d. Provide an up-to-date chart or graphic outlining the corporate structure associated with the hospital.

Entity/Investment	Relationship	Business Purpose/Description
Rutland Regional Health Services, Inc.	Parent company	Planning, development, and coordination of healthcare activities for Rutland County.
The Gables	50% Ownership *(recognized as investment)*	40 Unit senior housing complex
The Meadows	50% Ownership *(recognized as investment)*	Assisted living residence - generates positive cash flows.



It is important to note that within our operating structure RRMC does not have an employment relationship with primary care providers. Most of Rutland County's primary care is delivered within a Federally Qualified Health Center, an entity that is not part of RRMC's organizational structure. This delineation is important to understand as it impacts RRMC payments with OneCare. OneCare provides funding to primary care for quality incentives and care management functions, known as "per member per month" or PMPM payments. RRMC does not receive any PMPM payments from OneCare.

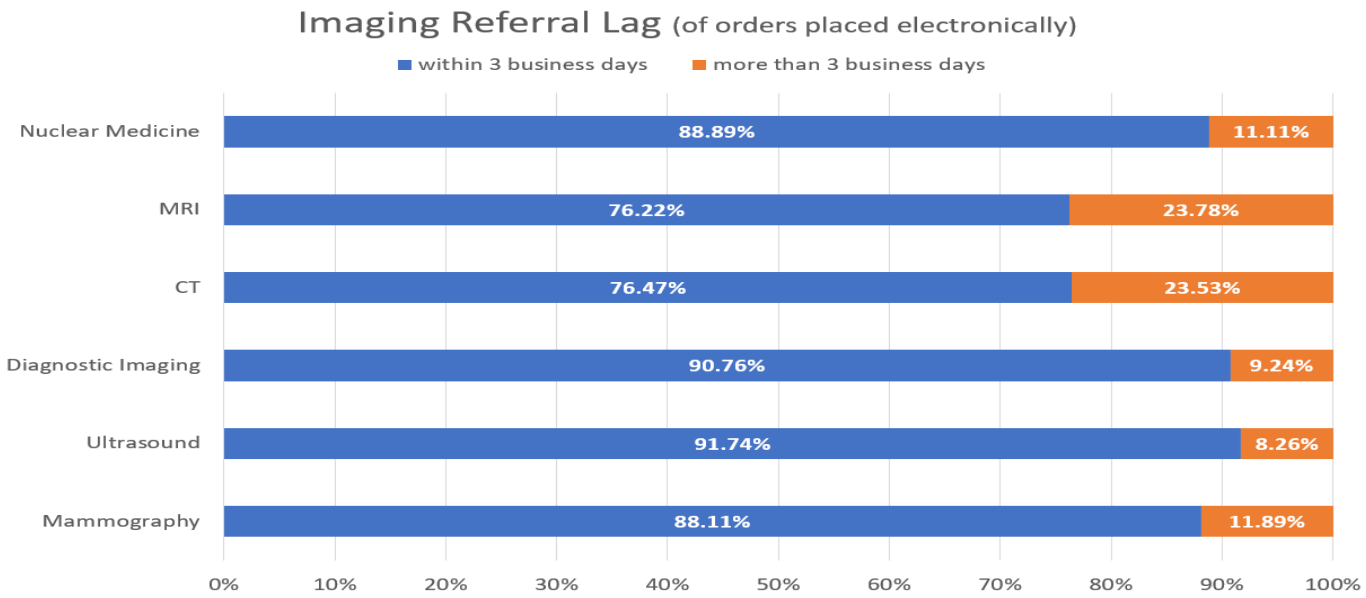
e. For any referrals or appointments requested in the first two weeks of May 2023, report the following metrics separately for each hospital-owned primary and specialty care practice as well as the top five most frequent imaging procedures:

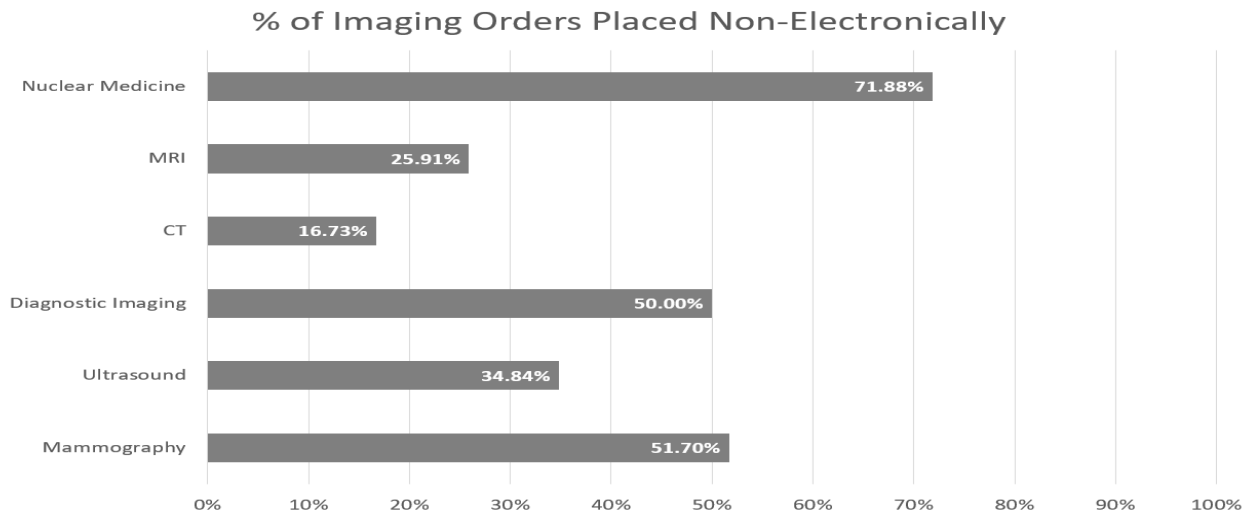
1. Referral lag, the percentage of appointments scheduled within 3 business days of

referral (percentage of all referrals where the clinic or hospital has completed scheduling an appointment within 3 business days of receiving the referral, regardless of the date on which the appointment will take place), and

Referrals are reportable for imaging if they are electronically ordered; the missing data represents volume that was ordered via paper or fax. Of note, orders are often placed in advance for imaging, with scheduling occurring closer to the appointment date, which extends the referral lag time. Longer CT and MRI referral rates are due to prior authorization approval required before scheduling can be completed.

Referral data is unavailable for our practices because the date of referral is not captured as a reportable field in our medical record. We do not have an estimated time frame for the availability of that field.

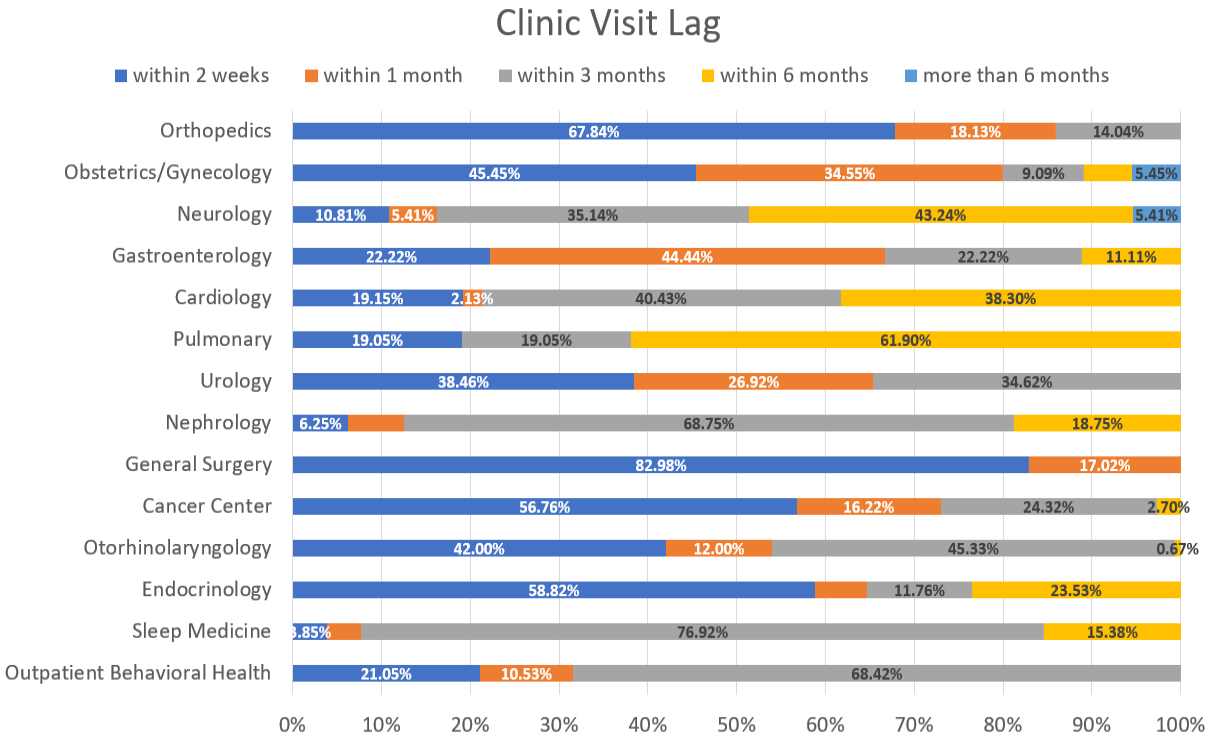




2. Visit lag, the percentage of new patient appointments scheduled for the patient to be seen within 2 weeks, 1 month, 3 months, and 6 months of their scheduling date. (The scheduling date is the date the hospital or practice schedules the appointment, not the date the referral was received or the date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

Visit Lag

a. Practices



We can't mitigate the full impact of physician vacancies, but RRMC has worked to keep access to all services open despite physician and advanced provider vacancies. Many of the clinics with higher wait times are the result of provider vacancies, for which we are actively recruiting. In some areas we can offset the vacancy of a physician by recruiting, hiring and training an advanced practice provider. In some specialties where we had difficulty in recruiting a physician, and an advanced practice provider is not an option, we are able to engage locum firms to provide coverage. Unfortunately, in several specialty areas, it is cost prohibitive to utilize locum physicians or locum physicians are not available. Our staff triage patients to accommodate appointment needs as clinically necessary.

Of the twelve most recent physician vacancies, there are ten vacant physician positions that remain open, some of which have been vacant for more than two years. As stated above, when possible RRMC utilizes locum and per diem provider staff to ensure access to care is not limited. Budget 2024 includes

$4.1 million in contract physician expenses and supports new telehealth services, all of which serve to keep access to care available for our community.

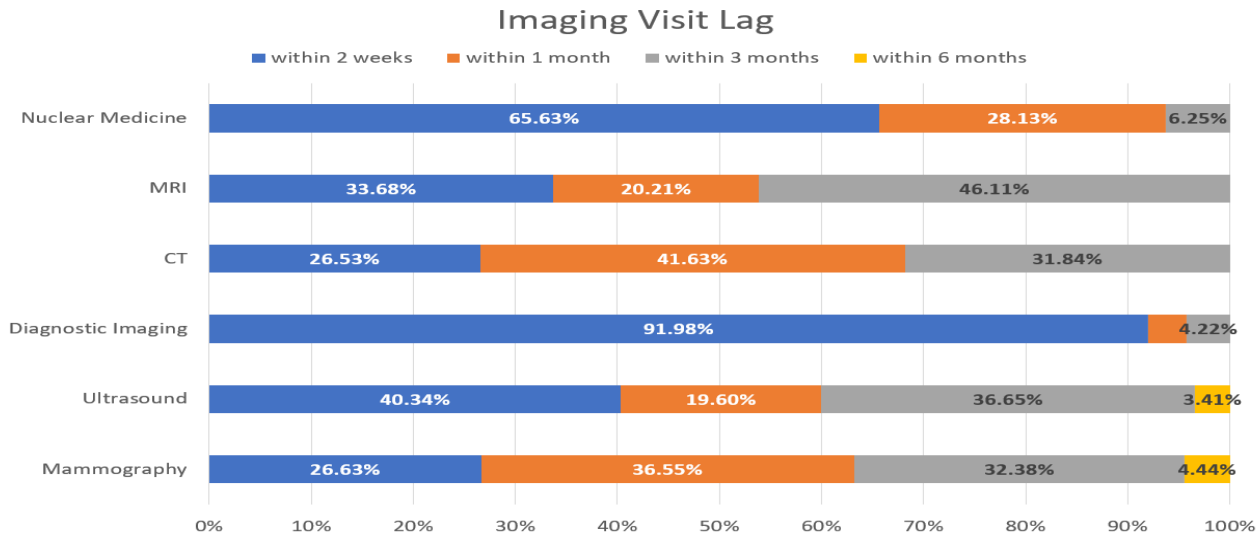
The following depicts how difficult physician recruitment has become.

Open Positions	# of MDs needed	Days open	# of candidates presented	# of candidates interviewed	# of candidates who received offers	Still open
Anesthesia	2	344	17	7	5	1
Cardiology	1	433	7	1	0	1
Critical Care	2	320	12	3	3	1
Emergency	1	90	12	6	3	1
Endocrinologist	1	433	5	0	0	1
Hospitalist (Day)	2	433	13	5	2	2
OB/GYN Med Dir	1	310	5	1	0	1
OB/GYN	1	310	8	2	0	1
Psychiatrist	1	433	3	1	1	1

Competitive Environment
Currently recruiting 10 physicians
Of theses vacancies:

82 Candidates
26 Interviewed
14 Offered Contract
2 Accepted

b. Imaging



Source: RRMC Medical Record data, May 1 – May 12, 2023

Benchmarking:

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

Our organization does not use a national or regional benchmark to evaluate this measure. However, we have set an organizational targeted benchmark based on our previous year's annual performance for the Clinic Visit Lag measure provided in this request. We track our progress quarterly.

f. Provide a summary of planned capital expenditures for FY24, including a description of their funding source(s). If relevant, indicate how the pandemic relates to these expenditures, such as deferred projects or new associated needs.

Our past capital investments have been largely building and facility projects. Going forward, we aim to balance facility needs with medical equipment upgrades and advancements. Our 2024 Capital Plan will be funded with internal cash flow generated from our operating margin. The listing of planned 2024 Capital projects is provided below. Based on 18 V.S.A. § 9434 RRMC does not anticipate submitting a request for a Certificate of Need. The projected costs of any single piece of diagnostic and therapeutic equipment included in the budget is below $1,800,000 (18 V.S.A. § 9434(b)(2)) and all costs related to construction and renovations are below $3,600,000 (18 V.S.A. § 9434(b)(1)).

Total Sources (annual depreciation x 1.2)	**$ 15,164,588**	
Uses:		
General Facilities (Less than $500,000)	$ 1,454,676	
Major Facilities		50%
Food Service Hoods and HVAC Replacement	$ 1,950,000	
Operating Rooms Renovation	$ 1,910,000	
Major Air Handler Replacement (S-6)	$ 2,250,000	
Minor Equipment (Less than $250,000)	$ 1,738,262	
Major Equipment		
Omnicell Anesthesia Workstation	$ 483,909	
Chemistry Analyzers	$ 770,000	39%
Second CT Scanner	$ 1,400,000	
Surgery - Stryker System 9 Power Tools	$ 646,943	
Medical/Surgical Bed Replacement	$ 616,000	
Nursing Communication System Replacement/Upgrade	$ 275,000	
Other		
Planning and Concept Design	$ 200,000	
IT Roadmap	$ 100,000	11%
Contingency	$ 1,350,000	
Total Uses	**$ 15,144,790**	

It is important to note that we are projected to increase capital expenditure requirements in the years 2025-2027 which will require a mix of operationally generated cash flow, cash reserves and likely new debt. Our need to increase capital spending is a result of the multiple years of deferred capital spending. The larger capital items are outlined below. None of the projects have been formally committed to and each will be evaluated for community need, financial and clinical merit.

Based on preliminary estimates, we anticipate filing a Certificate of Need to acquire a PET (Positron Emission Tomography) Scanner. This equipment is expected to exceed the cost threshold included in (18 V.S.A. §

9434(b)(2)). Currently, we do not expect to file a Certificate of Need for any facility construction or renovation projects.

RRMC	FOUR-YEAR CAPITAL PLAN (CONSOLIDATED)			Version 6.9.23 rev2-6.29
	Budget Year	Year 2	Year 3	Year 4
	FY24	FY25	FY26	FY27
Food Service Hoods and HVAC Replacement	$ 1,950,000			
Operating Rooms Renovation	$ 1,910,000			
Major Air Handler Replacements (6)	$ 2,250,000	$ 1,970,000	$ 4,180,000	$ 3,700,000
Birthing and Pediatric Suite Consolidation		$ 2,000,000		
Minor Facilties Projects Summary	$ 1,454,676	$ 2,000,000	$ 2,000,000	$ 2,000,000
Master Plan Projects		$ 3,000,000	$ 3,000,000	$ 3,000,000
FACILITIES PROJECTS TOTAL	**$ 7,564,676**	**$ 8,970,000**	**$ 9,180,000**	**$ 8,700,000**
Equipment Projects				
GENERAL MEDICAL/SURGICAL				
Medium Equipment Summary	$ 2,791,852			$ 1,358,000
DaVinci Robot		$ 1,000,000		
DIAGNOSTIC IMAGING				
Second CT Scanner	$ 1,400,000			
PET Scanner		$ 2,000,000		
Interventional Radiology Room Equipment Replacement		$ 1,400,000		
Medium Equipment Summary		$ 1,919,000		
Trubeam Linear Accelerator			$ 3,200,000	
CT Replacement			$ 1,900,000	
Digital X-Ray Replacement (3)			$ 950,000	
Nuclear Medicine CT Replacement				$ 950,000
INFORMATION TECHNOLOGY				
Migrate the GE RIS-IC Radiology Information System to Cerner		$ 1,382,000		
Tonic Mobile Patient Interface		$ 2,510,000		
MINOR EQUIPMENT SUMMARY	$ 1,738,262	$ 2,674,246	$ 1,412,505	$ 779,000
EQUIPMENT PROJECTS TOTAL	**$ 5,930,114**	**$ 12,885,246**	**$ 7,462,505**	**$ 3,087,000**
Total Uses	**$ 15,144,790**	**$ 23,655,246**	**$ 18,442,505**	**$ 13,587,000**
Balance - Capital Sources and Uses	$ 19,798	$ (8,035,720)	$ (2,354,394)	$ 2,983,755

g. Describe planned expenditures related to cybersecurity.

RRMC is contracted for various cybersecurity and network security support services and software that protect our organization and costs approximately $850,000 annually. These include an off-site Security Operations Center (SOC) that monitors our Security Information and Event Management (SIEM) system which scans our network for potential risks in addition to a full-time cybersecurity analyst. In recent years we have invested in new endpoint protection which adds another layer of protection on end-user devices from cybersecurity threats as well as expanded scanning for potential security vulnerabilities on our medical devices. This year we have implemented privileged access management (PAM) to provide greater protection for our user accounts that have the most sensitive access to our network as well as enhanced protection against possible threats introduced by third parties connected to our network. For next year we have budgeted to implement email archiving. We complete regular penetration tests, risk and Payment Card Industry (PCI) assessments of our network that inform how we continue to prioritize and invest in cybersecurity.

h. Indicate the estimated annual expenditures associated with providing care that cannot be

reimbursed due to the inability to transfer patients to post-acute or other more appropriate care settings. Examples include stays that exceed length of stay requirements for reimbursement or other care that would not generally be provided in a hospital setting. Provide these estimates for as many fiscal years as possible, including the estimates for FYs 23 and 24. Indicate how the values are derived or otherwise estimated. How are these unreimbursed expenses captured in the proposed budget? Include an estimate of how many boarding episodes occurred in your Emergency Department for that period, the associated total patient days and charges, and the proportion of each associated with a primary diagnosis related to mental health.

The annual expenditures associated with providing care that is not reimbursable due to the inability to transfer patients to post-acute care or other more appropriate care setting varies by payer. In Exhibit 10 of the 2024 budget filing the impact of the Medicare long length of stay patients is seen in the utilization section with a FY 22 to Budget 24 gross patient service revenue increase of $10.9M resulting in a net patient service revenue decline of $1.6M.

The patient population creating the most negative reimbursement impact to RRMC is custodial care patients. Custodial care patients no longer require physical therapies or any advanced nursing care and therefore are not eligible for a Medicare skilled nursing facility. This patient population most often has primary insurance for acute care and has full personal financial responsibility for the custodial level of care.

A custodial care patient discharge is delayed for the reasons below:

- Long term Medicaid application process is lengthy and complicated for patient and family
- Lack of a legal Medical Decision maker
- Patient has a behavioral health history in medical record and/or is exhibiting difficult to manage behaviors
- Care needs are extraordinary such as a special bed or mobility transfer challenges
- Family is unable or refuses to assume care of the patient
- Patient is homeless

The estimated room and bed cost per day of $2,500 is based on the Medicare Cost Report fully allocated cost per day. The direct patient care costs for the unreimbursed care are included in salaries and expenses of the department caring for patients. Other costs for managing this patient population are in the ancillary service departments, Dietary, Housekeeping, Social Work, Utilization Management, and other administrative areas.

In FY 2023 through May, RRMC has incurred approximately 1,500 patient days for care that could have been provided outside of the hospital acute care setting. The FY 2023 annualized patient days are 2,250. Based on cost per day, this financial impact is a loss of $5.6 million for care provided without reimbursement.

A second category of non-reimbursable patient care is the Medicare patient with a discharge delayed while awaiting a skilled nursing facility placement due to challenging care needs. Inpatient Medicare discharges are paid based on Diagnosis Related Group (DRG) which do not consider the patient length of stay, but rather are based on the medical diagnosis for the inpatient stay.

In FY 2023 through May, RRMC has incurred approximately 600 Medicare patient days for care that could have been delivered in a skilled nursing facility. FY 2023 annualized patient days are 900. Based on the cost per day, this financial impact is a loss of $2.2 million for care provided without reimbursement.

Our conservative budgetary estimates assume that this utilization will remain consistent for the remainder of fiscal year 2023 and budget 2024. There is risk in this assumption because of the increasing homeless population and changes in housing benefits.

In addition to inpatient care that is not reimbursable we also hold patients in our emergency room. As of May 2023, the Emergency Department has held 418 patients overnight in the ED while waiting for a bed in an inpatient location. The average ED length of stay for this patient population is 1.1 days.

Psychiatric patients are held in the ED while awaiting placement at another facility. DVHA has authorized a Medicaid per diem reimbursement for psychiatric stays > 24 hours in the ED while awaiting an inpatient psychiatric bed if there are no beds available for patient placement.

In FY 2023 through May, RRMC has boarded 80 pediatric and adult patients qualifying for this add on payment for a total of 158 days. The average length of stay in the ED was 2.8 days with a patient maximum stay of 7 days before transfer to an appropriate inpatient bed. There are additional staffing resources dedicated to this patient population. The estimated Medicaid reimbursement for this population is $31,600, far less than the cost of providing the care.

i. How much revenue did the hospital net for reimbursements above cost for pharmaceuticals in FY22 actuals, FY23 projections, and in estimates used for the proposed budget? Include estimates for rebates associated with the 340B program. How does the hospital spend or otherwise account for the net revenue?

The reimbursement for pharmaceuticals varies by payer. Medicare, Medicaid and Medicare Advantage bundle the cost of most pharmaceuticals into the related inpatient or outpatient service, there is no separate reimbursement. Pharmaceuticals provided in support of chemotherapy service at the Foley Cancer are separately reimbursed by Medicare, Medicaid and Medicare Advantage at industry standard average sales price plus 6%. Commercial payers pay on average 78% of the covered pharmaceutical charge.

As a result of the 340B program RRMC can purchase certain drugs at discounted prices. Based on our expected utilization our 340B discount savings is projected to be $9.9 million.

j. Facility Fees: Does your institution charge "facility fees" to patients who access your emergency department? Facility fees have been defined as "the cost of walking in the door" that are billed separately to cover overhead and other costs to provide care in addition to the charges for specific services received by the patient. If your institution charges facility fees, please provide an estimate of the total sum of facilities fees billed and collected in FY22.

RRMC charges facility fees for all patients receiving emergency room care. RRMC bills both department facility fees and professional fees for services provided in the Emergency Department. There are five healthcare common procedure codes (HCPC) associated to levels of emergency department facility fees. The hospital visit level of Emergency Department care is determined by hospital resources consumed and includes triage upon arrival, direct nursing and other staff care as well as care coordination, ongoing patient monitoring, non-billable supplies, limited non-billable testing, patient registration services and discharge planning. CMS requires hospitals to develop internal guidelines for reporting the appropriate visit level. (78 Fed. Reg. 74826, 75038). Medicare guidelines require the hospital's own coding guidelines must relate the intensity of hospital resources to the different levels of HCPCS codes assigned. There is no billing for Emergency Department services if a patient leaves before seeing a provider.

A statewide comparative financial report is required per 18 VSA §9405b. Included in the report is a Pricing by Service Type for common hospital services. Rutland Regional Medical Center patient charge amounts for Emergency department services are available at

https://www.healthvermont.gov/sites/default/files/document/HSI-stats-HRC-2023-CPT-Table-ED.pdf

Reimbursement rates for hospital services, including the Emergency Department facility services are posted on the RRMC.org website as Payer Negotiated Rates. The information can be reached at **https://www.rrmc.org/patient-visitors/billing-insurance/pricing-estimates**

Reimbursement for the emergency department facility fees varies by payer. Medicare, Medicaid and Medicare Advantage bundle services for inpatient and outpatient emergency care. For Medicare, Medicare Advantage and Medicaid outpatient insured patients, the ED visit facility fee, some diagnostic testing, pharmaceuticals and laboratory charges are bundled into a single reimbursement amount. For the most common outpatient emergency department episode of care visit, Medicare reimburses $386. and Medicaid reimburses $323. Medicare, Medicaid and Medicare Advantage do not reimburse for inpatient emergency room services, rather they are bundled into the inpatient episode of care DRG payment amount. Commercial payers perform some bundling of emergency services. For the most common inpatient and outpatient emergency department service, commercial payers reimburse an average rate of $945. per visit.

k. Patient Financial Assistance:

i. Are patients given a financial assistance plan or policy with the first attempt to collect a debt?

RRMC's billing statements explain how to apply for Financial Assistance. The billing statement provides the RRMC website link to the policy, application, and contact information for the Financial Counselors to support the patient with questions or concerns.

We also widely publicize the Financial Assistance program at each patient check-in area to offer assistance with medical bills. The Financial Counseling office is open from 8:00 to 5:00 Monday through Friday for walk-in assistance. This often engages patients to apply prior to services being rendered.

A copy of the statement with the financial assistance language is shown below:

Financial Assistance

Rutland Regional has developed a Financial Assistance Program (FAP) to assist eligible patients who have incurred expenses for services received due to illness or injury. Eligible hospital expenses must meet the following criteria:

1. You must be uninsured, underinsured, ineligible for any government healthcare insurance programs, or under financial hardship.
2. The services provided to you must be medically necessary.
3. All insurances must have been billed and benefits paid to Rutland Regional Medical Center, as well as, all insurance guidelines/plan provisions must have been followed.
4. Your eligibility must meet the financial assistance criteria based on household income and asset calculations.
5. Catastrophic assistance is applicable when expenses exceed 20% of the household income.

Assistance is provided on a sliding scale based on household income as compared to the Federal Poverty Guidelines. Once FAP approval is determined financial assistance adjustments will be made to any open account for services provided 240 days from 1st billing statement and services 1 year after the FAP approval date, at which time new proof of income will be required.

NO FAP eligible individual will be charged more for emergency or other medically necessary care than the amounts generally billed to insurance companies.

For an application, assistance in completing the application or general questions about your bill, you may contact:

- Patient Account Representatives at 802.747.1751 or 866.460.8277.
- Financial Counseling at 802.747.1648 or PatientAccounts@rrmc.org
- Or go to https://www.rrmc.org/patient-visitors/billing-insurance/financial-assistance/ for a Financial Assistance Summary Application or to view or policy and procedure.

ii. If a contract with a third party exists to collect payments from patients, please provide the contract and disclose the amount paid for such collection efforts and the revenue generated therefrom.

FY 2022 Fees: $210,713

FY 2022 Collections: $543,195

RRMC has the following third-party companies that we pay for collection efforts:

Active Healthcare Receivables (AHR)*- Early out vendor that works current balances that are in good standing. They take inbound phone calls and make outbound phone calls to patients.

*As part of the administrative cost savings plan, RRMC has eliminated this contract beginning in September 2023. Rather than contract for this service RRMC will hire additional Financial Counselors. This is a savings of $505,000 and is included in the Budget FY 24.

Asset Recovery- A contracted collection agency for balances in bad debt. This was a Rutland based collection agency that as of 4/30/23 sold their business to CBM Services in Michigan. RRMC has decided that as of 05/01/23, CBM will work existing balances that Asset Recovery received, but new bad debt balances will not be assigned to them going forward.

CBCS-Revco Solutions- a contracted collection agency for balances in bad debt. As of 05/01/23, CBCS will have all patient balances for bad debt.

iii. At what point of non-collection does the hospital write off the money owed as bad debt?

A balance will go to bad debt at day 120 if no payments have been made or if the patient has not established an agreeable payment plan. We also monitor encounters where the patient is in the process of applying for Financial Assistance to prevent the encounter from going to bad debt during the application process; in this case the encounter is placed on hold.

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

When a debt is collected, it is treated as current year activity. Cash collection of the amount previously considered uncollectable is a recovery. Recovery amounts reduce the total bad debt expense amount in the current year.

v. What, if any, effort does the hospital undertake to evaluate whether a patient can pay money owed to the hospital?

The State of Vermont does not allow payment propensity credit checks. In lieu of this, our Financial Counselors engage with the patient or guarantor regarding the ability to pay their outstanding medical bills. We offer formal payment plans, financial assistance applications and patients are encouraged to apply for Medicaid/Vermont Health Connect plans, if applicable.

RRMC does not discriminate based on the patient's ability to pay. Staff are trained and educated to offer assistance at the time of scheduling, pre-registration, and registration. As required by law, we also provide a “Good Faith Estimate” for uninsured patients with scheduled visits. If a patient is admitted, the Financial Counseling team will visit uninsured/underinsured patients and offer Vermont Health Connect and Financial Assistance services. RRMC has three Certified Application Counselors (CAC) that assist individuals and families with enrolling for health insurance coverage.

vi. What, if any, effort does the hospital undertake to proactively evaluate whether a

patient, prospective, current, or past, is eligible for the hospital's free care program?

Financial Counseling monitors current approved patients for Financial Assistance and reaches out to the patient prior to the assistance ending to remind patients to reapply. We review open self-pay balances and reach out to patients letting them know about the Free Care program. This outreach is for all patients, not just self-pay.

If a patient is denied Financial Assistance and has a qualifying life event such as loss of job, birth, divorce etc., the patient can reapply and not have to wait for the one-year denial period.

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

We use the annual poverty guidelines published by the Federal Government. We base financial assistance eligibility on the table below.

2023 Federal Poverty Guidelines for FAP

Persons in Household	FPL	Up to 300% FPL	301-400% FPL	401-500% FPL
1	$14,580	$43,740	$58,320	$72,900
2	$19,720	$59,160	$78,880	$98,600
3	$24,860	$74,580	$99,440	$124,300
4	$30,000	$90,000	$120,000	$150,000
5	$35,140	$105,420	$140,560	$175,700
6	$40,280	$120,840	$161,120	$201,400
7	$45,420	$136,260	$181,680	$227,100
8	$50,560	$151,680	$202,240	$252,800
Allowed Discount		**100%**	**75%**	**50%**
Amount Owed		**0%**	**25%**	**50%**

Medicare applicants will be denied when liquid assets are more than the Medicare Low Income Beneficiary Limitation:

- **Single: $9,090**
- **Couple: $13,630**

l. Administrative Costs:

i. Please provide a breakdown of administrative costs by activity type and title (billing

and insurance, non-billing and insurance, Executive, VP, Director, etc.). If no such disaggregation can be provided or a different breakdown more accurately reflects the specific structure of your hospital, please explain.

RRMC's breakdown of salary costs is more accurately reflected in our Job Class codes. See below for a table outlining this breakdown for FY 21 Actual, FY 22 Actual and Budget 24.

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SALARIES BY RRMC JOB CLASS									
	FY 2021 Actual			FY 2022 Actual			FY 2024 Budget		
JOB CLASS & DESCRIPTION	Salaries/Fringes	FTEs	Salary/FTE	Salaries/Fringes	FTEs	Salary/FTE	Salaries/Fringes	FTEs	Salary/FTE
1 - AIDES, LNAs, COURIERS, PATIENT MONITORS	$ 4,941,609	98.52	$ 50,158	$ 5,852,986	96.23	$ 60,821	$ 4,804,810	75.41	$ 63,716
3 - FRONT OFFICE ASSIST, MED ASSIST, BILLING	$ 8,271,807	227.04	$ 36,434	$ 14,434,463	233.21	$ 61,895	$ 10,740,230	219.77	$ 48,870
4 - LPN	$ 719,402	11.69	$ 61,549	$ 568,648	7.78	$ 73,049	$ 351,661	6.14	$ 57,274
5 - CODERS, TECHNICIANS	$ 8,607,441	140.51	$ 61,259	$ 9,064,821	140.36	$ 64,584	$ 8,048,263	131.88	$ 61,027
6 - SECURITY, HOUSEKEEPING, FOOD SERVICE	$ 5,358,766	112.21	$ 47,757	$ 6,444,890	115.75	$ 55,677	$ 6,355,038	118.11	$ 53,806
7 - REGISTERED NURSES DIRECT CARE	$ 25,344,432	265.41	$ 95,493	$ 27,966,199	259.50	$ 107,770	$ 22,801,367	251.55	$ 90,643
8 - LEADERS	$ 15,124,821	119.35	$ 126,730	$ 16,821,297	117.65	$ 142,976	$ 15,133,863	116.13	$ 130,318
11 - PT, OT, ST, DIAGNOSTIC IMAGING TECHS	$ 17,252,987	191.58	$ 90,055	$ 17,996,880	187.47	$ 96,001	$ 16,391,002	179.86	$ 91,132
12 - ADVANCED PRACTICE PROVIDERS	$ 4,507,511	30.22	$ 149,172	$ 5,783,469	35.21	$ 164,247	$ 7,099,644	44.36	$ 160,046
13 - CASE MGRS, UTILIZATION REVIEW, QUALITY & SAFETY	$ 1,959,185	18.64	$ 105,097	$ 2,158,028	18.75	$ 115,073	$ 2,142,065	19.96	$ 107,318
15 - ADMINISTRATIVE ANALYSTS	$ 4,379,260	53.64	$ 81,638	$ 4,847,434	57.08	$ 84,931	$ 4,807,712	60.67	$ 79,244
16 - CLINICAL COORDINATORS, CLINICAL EDUCATORS, RN LEADS	$ 1,198,456	11.46	$ 104,549	$ 1,324,070	11.58	$ 114,368	$ 1,667,539	15.19	$ 109,779
TOTAL SALARIES EXC PHYSICIAN	**$ 97,665,678**	**1,280.26**	**$ 76,286**	**$ 113,263,184**	1,280.57	**$ 88,447**	**$ 100,343,194**	1,239.03	**$ 80,985**
10 - PHYSICIAN	$ 30,664,741	71.96	$ 426,159	$ 33,873,342	68.57	$ 494,002	$ 34,403,725	70.75	$ 486,272
TOTAL SALARIES INC PHYSICIAN	**$ 128,330,419**	**1,352.22**	$ 94,904	**$ 147,136,526**	**1,349.14**	$ 109,060	**$ 134,746,919**	**1,309.78**	$ 102,878
TOTAL FRINGE BENEFITS	$ 35,052,346			$ 35,667,041			$ 40,782,679		
TOTAL SALARIES INCLUDING FRINGE BENEFITS	**$ 163,382,765**	**1,352.22**	$ 120,826	**$ 182,803,567**	**1,349.14**	$ 135,496	**$ 175,529,598**	1,309.78	$ 134,015
FRINGE BENEFITS AS A % OF TOTAL SALARIES	27.3%			24.2%			30.3%		

Based on Appendix 11 supporting salary information including travelers, our budgeted FY24 administrative salary costs as a percentage of the total is 22.2%. Therefore, clinical salary costs as a percentage of total is 77.8%.

Another source of information to determine clinical and administrative cost breakout can be referenced in our annual FY 2022 audited financial statements. See table below for Health Care Services and Administrative breakout. Using our audited financials, the clinical salary/benefits total

90% compared to only 10% administrative.

	2022 Health Care Services	General and Administrative	Total
Salaries & wages	$ 153,826,948	$ 16,284,069	$ 170,111,017
Employee benefits	$ 33,762,316	$ 3,574,212	$ 37,336,528
Total personnel expenses	$ 187,589,264	$ 19,858,281	$ 207,447,545
Supplies and other	$ 72,791,689	$ 31,547,752	$ 104,339,441
Medicaid DPS Tax Assessment	$ -	$ 18,349,219	$ 18,349,219
Depreciation and amortization	$ 10,917,451	$ 1,660,822	$ 12,578,273
Interest	$ 1,227,286	$ 186,702	$ 1,413,988
Total expenses	$ 84,936,426	$ 51,744,495	$ 136,680,921
Grant Total	$ 272,525,690	$ 71,602,776	$ 344,128,466
Total Salaries & Benefits	90.43%	9.57%	100.00%
Total Expenses Including DPS	62.14%	37.86%	100.00%
Total Expenses Excluding DPS	71.78%	28.22%	100.00%

The two sources of data above differ, the first being from the cost report definition of clinical and administrative and the second from our FY22 audited financial statements. This is an important distinction and reinforces the need to understand the detail of the source information.

ii. Please provide the number of FTEs by type by average and median salary and total compensation (i.e. total cost of FTE to the organization) by clinical (physicians, PAs, NPs, nurses, etc.) and non-clinical (C-suite, managerial, other).

See chart above