Questions:

1) Specify which direct clinical care positions were eliminated among the 45 FTEs identified in your cost reduction plan.

   Of the 45 FTEs identified as reductions, 17.7 were direct clinical care positions.

   8.50 Registered Nurses - Direct Care
   4.40 Social Workers - Direct Care
   1.90 Respiratory Therapists - Direct Care
   2.90 Advanced Practice Providers - Direct Care
   7.10 Clinic Administration Support
   8.00 Service & Trade (Food Service, Housekeeping, Security)
   6.40 Administrative Support
   4.80 Leaders
   1.00 Marketing Director

2) Page 16 of the narrative indicates 1,500 patient days for patients waiting for care that could have been provided outside the hospital's acute care setting through May of 2023 (annualized to 2,250 for FY23). How many patients were waiting in that time and/or provide the estimated days awaiting placement per patient. Indicate the most significant causes for the longer waits for placement.

   The 1,500 patient days were comprised of 75 patients with an estimated 20 days awaiting placement. Annualized would be 113 patients, with 20 days awaiting placement.

   A custodial care (awaiting placement) 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

3) Vermont's FY24 budget indicates an increase in Vermont Medicaid's RBRVS fee schedule to 110% of Medicare for primary care providers and a 3.8% inflation increase to specialty care providers. Have these increases been factored into your budget? If not, indicate what effect that would have on the submitted commercial rate increase.

   RRMC does not employ any primary care providers therefore the increase in the primary care fee schedule does not impact our reimbursement projections.

The specialty care increases were not factored into our budget as there was also a reduction of 4.5% in the Medicare conversion factor (amount Medicare pays per RVU under the physician fee schedule) which offsets the increase.

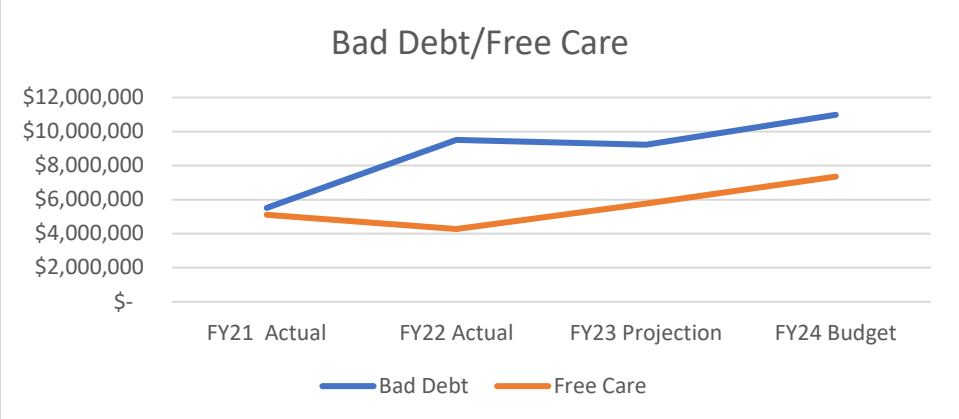
The Medicare 4.5% conversion factor decrease is estimated to reduce RRMC by $88,000, based on annualized current year Medicare Professional fee services volume. The Medicaid Physician Fee schedule increase of 3.8% to the conversion factor, is estimated to increase reimbursement by $145,000 based on annualized current year Medicaid Professional Fee Services volume. In total, this is an estimated overall increase in Professional Fee reimbursement of $57,000.

4) Elaborate on the -3754% decrease in "All Other" category of net operating income (FY23-FY24 B %) (Income Statement).

This is an increase from Budget 23 to Budget 24. The "all other" category represents unrealized market gains or losses. In Budget 23 we budgeted a loss of $198,103 in the "All Other" section and in FY 24 Budget we budgeted a positive gain of $7,238,603. We base our investment assumptions on market-driven performance projections that are specific to our asset holdings.

5) "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%" Does this projection impact how much free care is projected, or only bad debt? Please explain. (Narrative, 1).

Free Care will also be impacted by the reinstatement of eligibility review for Medicaid. Rutland Regional has seen patients in the past not qualify for Medicaid, and enroll for the lower premium, higher deductible Vermont Health Connect plans. They then apply for Financial Assistance to help with the balances owed after insurance. Patients are no longer required to carry health insurance, resulting in patients also applying for Financial Assistance as their only assistance towards medical bills.



6) Elaborate on how “rules that set limits on reimbursement for supplies, pharmaceuticals, and select services” as well as “price transparency rules for out of network services” materially reduce reimbursement (Narrative, 8).

In FY 23 some of our commercial payers have changed reimbursement methodologies that support the payment of supplies, pharmaceuticals, and procedures. Pricing Transparency rules for out of network payers require us to write off the patient responsibility on charges that out of network payers do not reimburse. We are not allowed to bill the patient.

7) How does RRMC assess the relative value of paying a collection agency versus helping patients access patient financial assistance? (Narrative, 20).

RRMC recently reviewed the value of our collection agency services and decided to eliminate our early out vendor service. Early out vendors work current balances that are in good standing. Rather than contract for this service RRMC will hire additional Financial Counselors. After considering the cost of additional staff, this is a savings of $505,000 and is included in the Budget FY 24.

Collection agency services for delinquent accounts will still be managed by a third-party vendor. The collection rate of this category of receivable is not enough to support full-time staff. However, our Financial Counselors partner with our collection agency to support patient’s enrollment in financial assistance and Vermont Health Connect.

In FY 2022 RRMC Bad Debt Collections (recoveries) totaled $753,400. Fees paid to the agency on those collections totaled $210,200. The bad debt total write offs for FY 2022 were $10,224,000.