Springfield Hospital

Where People Come First

SECTION V: BUDGET NARRATIVE

This section outlines the elements required in the budget 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 each question. Hospitals that are part of a network must provide separate narratives for each hospital.

A. EXECUTIVE SUMMARY

Provide a high-level overview of key considerations for the proposed budget. Include discussion of variations from the current year approved budget, including any assumptions about current year projections relative to the approved budget. Indicate areas where the proposed budget deviates from parameters specified in this Guidance, providing justifications for such deviations, including credible and substantive evidence to support those justifications. For hospitals that are part of a network, affiliation, or have a financial arrangement with another legal entity (e.g. nursing home), explain any differences in what is happening at the hospital versus the network level, and quantify any financial impact on the hospital budget as a result of the relationship with any non-hospital entities.

About Us

Springfield Hospital (SH) is a Critical Access Hospital (CAH) with 25 Acute/Swing beds and 10 Mental Health beds which are a distinct part unit located in Bellows Falls, VT. The Medical/Surgical/Observation unit is currently staffed to a patient census of 17 beds and The Windham Center for Psychiatric Care is staffed for 10. Hospital utilization for fiscal year to date (FYTD) through May 2024 includes:

	YTD 5/2024	YTD 5/2023
• Avg daily census for acute patients	7.3	6.8
• Avg daily census for swing patients	1.1	1.5
• Avg daily census for psychiatric patients	7.1	7.2
• Emergency visits/day	36.5	36.5
• Surgery volume	714	601
• Endoscopy	704	659
• Specialty practice visits	14,254	12,451
• Diagnostic Imaging Services	18,062	18,227
• Physical Therapy	32,143	30,380

Springfield Hospital currently has 385 employees and is a major economic contributor in Springfield and the surrounding region.

Goals for FY25

In FY25, Springfield Hospital (SH) will focus on continuing to improve our financial stabilization and rebuild volume. We will focus on identified core services and work to recapture utilization that is currently leaving our service area and, in many cases, leaving Vermont with less convenience for patients and higher cost.

Our recent Community Health Needs Assessment (CHNA) identified access to primary care and specialty medical care services as a priority. Cost of insurance, health care and prescription drugs, and availability of services were also identified as key barriers. SH continues to work with our community partners to inform the community regarding insurance and other social services available to help meet their needs. We also hired a full-time Certified Assister who works at the hospital offering patients financial assistance counseling and options to help address affordability issues.

Primary Care in the Springfield service area is owned and managed by the local FQHC network (North Star Health). North Star Health has made progress adding new medical staff to help improve access to primary care. Springfield Hospital's availability of appointments for specialty care is prompt, so we are planning further research to probe more deeply into this area of concern to determine whether there are opportunities for new local services or other barriers that we need to better understand.

Primary Care Network Relationship Evolving:

SH continues a strong working relationship with North Star Health (the local FQHC network formerly known as Springfield Medical Care Systems and the former parent corporation to Springfield Hospital) since the two organizations split into distinct corporations as part of a Chapter 11 reorganization in December 2020.

This relationship has continued to mature and, at present, the services being shared between our organizations are Materials Management and Pharmacy.

The FQHC network has primary care practice locations conveniently located throughout our service area that continue to be a strong referral source to SH. We also plan to collaborate on our 2025 CHNA which will begin over the coming months.

Significant Changes:

As our medical staff team has developed over the past 24 months (with the exception of one recent notification of a move out of the area for family reasons), we are now well positioned to move forward with our recapture strategy. We will move swiftly with recruitment plans for replacement of this open position, and we do not expect this unexpected vacancy to change our strategy.

We continue our search for collaborative options and a regional approach to bring Cardiology back to the Springfield area as this is a greatly needed service.

We have made a significant investment in Diagnostic Imaging renovations and upgrades are now nearly complete with all services fully functioning. Nuclear Medicine was completed much later than anticipated, so you will see that reflected in our FY24 utilization results. However, the service is now available and we are currently scheduling Nuclear Medicine patients.

Utilization: (Refer to Attachment A and C)

Volume for Medical/Surgical inpatient is budgeted flat as the trend is decreasing inpatient utilization and more services being provided on an outpatient basis. We are holding the budget projection for Psychiatry at 8.4 as an attainable goal. We experienced some downtime due to room repairs over the past year that impacted our FY24 actual numbers. We have successfully recruited new mental health providers that have stabilized our permanent staff at The Windham Center which is a valuable community resource and aligns well with our Community Health Needs Assessment.

Other projected increases in volume include the Operating Room, Diagnostic Imaging, General Surgery and Gynecology. See volume projection details in **Attachments A and C.**

While we continue our ACO work targeting and reducing unnecessary Emergency Department (ED) visits, we are budgeting flat for ED visits this year since the FQHC has reduced walk-in availability and that may impact our ED visits and offset ACO progress.

Income Statement: (Refer to Attachment B and C)

We are conservatively budgeting for a 1.4% Operating Margin. Our Gross Patient Revenue (GPR) is increasing due to a combination of increasing outpatient service line growth (reference **Attachment A and B**) and a 5.5% charge increase request. Inpatient Gross Revenue is increasing over projected FY24 due to anticipated growth in Mental Health admissions (The Windham Center). Total Operating Revenue is budgeted to increase 9% overall from FY24 projected, and 12.8% from FY24 Budget. Expenses overall are budgeted to increase 7.6% over FY24 projected, and 13% over FY24 budget. Please refer to **Attachment B** for FY 25 Income Statement and **Attachment C** for further details regarding the FY25 Income Statement and Comparisons to FY24 budget and FY24 projected results.

Summary of Budget Request:

In summary, Springfield Hospital is requesting:

- 5.5% price increase, resulting in $8,314,276 increase to Gross Revenue without a price increase (see below)

Gross Patient Revenue		
With price increase	$ 159,482,929	
Without increase	151,168,653	
	$ 8,314,276	5.5%

The requested price increase of 5.5% would result in a **5.8% growth** to Gross Patient Revenue (GPR) over the FY24 budget. See breakdown below. Total GPR growth over the FY24 budget would be 11.4% or $16.3M, with 5.6% coming from utilization and volume assumptions **(Reference Attachments A, B and C).**

Utilization/Volume	$ 7,987,592	5.6%
Charge Increase	8,314,276	**5.8%**
Total GPR Increase over FY24 budget	$ 16,301,868	11.4%

The requested price increase of 5.5% would result in an additional **$1,417,052** in Net Patient Revenue (NPR), which represents **2.3%** growth to NPR over the FY24 budget. Total NPR growth over the FY24 budget would be 13.0%, with the majority of 10.6% coming from utilization and volume assumptions (See breakdown below).

Utilization/Volume		6,467,164	10.6%
Charge Increase		**1,417,052**	**2.3%**
Total NPR Increase over FY24 bud	$	7,884,216	13.0%

Springfield Hospital's goal continues to be to deliver the right care, at the right time, at the right cost – with improving population health outcomes and high patient satisfaction. We invested in specialty medical staff to respond to community needs to improve access to specialty services that can be delivered locally with quality outcomes and less cost.

We continue to rebuild consumer confidence and our financial footing post Chapter 11 reorganization. We are making good progress but the task takes considerable time and patience. The daily work continues and requires ongoing perseverance to balance financial resources, never ending inflation, staffing challenges and other unpredictable expenses that may arise as we work to improve operations and make steady progress toward long-term sustainability.

B. BACKGROUND

***a) Corporate structure changes**: Explain any changes that occurred within the last year.*

Springfield Hospital experienced the following changes over the past year:
• Lori Profota, DNP, RN, NE-BC, CNO/COO, hired 1/31/24 (was interim prior to that date).
• Lynne Perkins, MSN, RN, CCRN, Interim Associate Chief Nursing Officer, effective 3/18/24
• Michael Sutch, MA, PMP, CPHQ, CPHRM, Director of Quality, Risk & Compliance, hired 5/6/24

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

All current SH affiliations are agreements with entities that provide services to SH (or vice versa) on a contractual basis. SH currently has no affiliations where the hospital has a financial stake.

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

The hospital is currently a member of the New England Alliance for Health (NEAH) which represents annual cost savings through group purchasing and employee benefits savings.

We are currently evaluating future participation in the New England Collaborative Health Network.

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

Closures:

- ***Pain Clinic*:** SH made the decision to close the Pain Clinic effective May 16, 2024, due to insufficient financial and staff resources to properly maintain program.
- ***Cardiology Clinic*:** Our outpatient Cardiology Clinic (collaborative effort with Cheshire Medical Center) was closed June 30, 2023 due to provider relocation. SH is currently seeking a collaborative partner to reinstate the Cardiology program.
- ***Orthopaedics:*** One provider reduced time to 2.5 days in office and .5 days in Physical Therapy.

Additions:

As noted last year, we made the following service line investments to improve local access to care:

- one full-time and two permanent, part time General Surgeons (10/23 and 11/23)
- two full-time Gynecologists (9/22 and 3/23)
- added hours to two part-time Urologists (8/23)
- one part time (2x/month) Uro/Gyn specialist (11/23)
- added hours/Podiatry availability (1x/week 10/21; 2x/week 3/22; and full time in 3/23)
- added hours/ENT availability (10/23)

Service Interruptions:

Diagnostic Imaging: We made significant investment renovating our diagnostic imaging department and replacing equipment. This process required some down time for construction and equipment installation:

- *Nuclear Medicine* – Aug 2023-March 2024
- *Xray Room 2* – Feb 2024-May 2024
- *Xray Room 1* – May 2024 – July 2024

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.*

Please refer to Attachments A, B and C for details on Volume and Income Statement with comparison to FY24 Budget and FY24 Projected, and Notes detailing assumptions.

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

Deviation – Net Patient Service Revenue *(Guidance 3.5% over FY24 budget)*
As highlighted previously in the Executive Summary, we are seeking NPR growth over the FY24 budget of 2.4% which is the impact of our 5.5% requested charge increase and an additional 10.6% as a result of utilization growth—for a total of 13% Net Patient Service Revenue.

Please note that the impact of NPR growth related to the price increase of 2.4% comes in 1.1% lower than the benchmark of 3.5%.

Our strategy is to recapture utilization that is leaking from our service area at a much higher cost with longer wait times. For every dollar we bring back to our service area, there is cost savings to the overall health system due to cost efficiency. This is a win/win strategy for Springfield Hospital and the overall healthcare system, and aligns well with improved access, reduced cost, improved patient satisfaction goals.

We believe our goals are reasonable and achievable. We are projecting to exceed FY24 targets for Gross Patient Service Revenue, Net Patient Service Revenue, and Total Operating Revenue.

Deviation – Commercial Rate Growth *(Guidance 3.4% over FY24 budget)*
The impact of our 5.5% requested charge increase to GPR over the FY24 budget is $8,314,276 or 5.8% as referenced previously in the Executive Summary. While above the 3.4% guidance in total, the total stemming from Commercial is only 1.9% excluding Medicare Advantage. A charge increase must be applied for all payers. See breakdown of GPR increase below.

B/C & Commercial	2,777,357	1.9%
Medicare Advantage	1,296,064	0.9%
Medicaid/Medicare	3,992,821	2.8%
Private Pay	248,035	0.2%
Total	$ 8,314,276	5.8%

*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.*

Please refer to Attachment A, B and C — Volume, Income Statement and FY25 Budget Overview Notes for assumptions regarding Volume and Income Statement, and FY24 budget comparison details.

*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.*

Below is a breakdown of employed versus contracted labor categories:

	FY25 Budget - % of Total Expenses
• Full time and per diem employed staff (included in Salaries & Wages - non-provider staff)	33.0 %
• Contracted Providers and Management (included in Management & Contract Services)	9.0 %
• Physician fees (employed and locum)	6.7 %
• Travelers	7.5 %

• Totals approximately 56.3% of total budgeted expenses

Budget to budget:

• **Salaries and Wages** is increasing $885K (4.1%) over FY24 budget. This includes wage, market, and merit adjustments, and rebuilding staffing models since the 2019 reduction in force. Market pressure for competitive wages is growing more difficult each day. This budget also plans for staffing due to volume increases.

• **Employee Benefits and Payroll Taxes** is increasing 3.7%, or $198K. The new Vermont Childcare Payroll Tax makes up $117K of this amount.

• **Management and Contracted Services** (M&CS) includes contracted providers and management as well as other contracted services (diagnostic imaging and maintenance contracts, for example). M&CS is increasing $1.3M (14.9%) and

includes a $500K increase for contracted physicians, resulting in a reduction in locum expense. This category also includes a reclassification for diagnostic imaging contracts of $576K which is being moved from the Other Purchased Services category.

Physician Fees is increasing $411K budget to budget, or 9.7%, due to staffing in General Surgery, recruiting for a Cardiac Nurse Practitioner, one additional day for Gynecology, and Windham Center staffing.

Travelers are increasing $2M budget to budget due to necessary increased reliance on traveler staff in respiratory, diagnostic imaging, inpatient care, mental health care, emergency room, operating room, and endoscopy.

***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.*

We made significant investment in medical staff to align with the health care services needed by our community that are most appropriate for SH to provide with more convenience for patients and cost savings for the system. We are projecting slow and steady growth, increasing utilization and surgery volume.

Please refer to Attachments A and C for full details and assumptions on utilization.

***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.*

Our budget includes a 10% inflation factor for pharmaceuticals, which anticipates increases in volume for Urology and GYN. Our estimated reimbursement percentages over cost range from 1.51% - 2.24% for the time periods outlined above. Please see the schedule below for the calculation of the estimate.

	FY23 Actual	FY24 Budget	FY24 Projection	FY25 Budget
Pharmacy Gross Revenue	12,375,121	13,006,134	12,296,275	13,958,539
NPR%	44%	42%	44%	43%
Net Pharmacy Revenue	5,425,748	5,524,211	5,358,668	6,012,773
Pharmaceutical Exp	1,974,207	1,706,297	2,088,748	2,395,743
Excess Reimbursements over Cost	**3,451,541**	**3,817,914**	**3,269,920**	**3,617,030**
Excess Reimbursements over Cost %	**1.75**	**2.24**	**1.57**	**1.51**

Regarding 340B specifically, we do not receive rebates from the 340B program. We do experience cost savings as a result of being a 340B hospital, and these savings fluctuate based on volume and mix of drugs used. Our 340B savings for FY24 is projected to be $700K and we anticipate a slight improvement in FY25.

SH also contracts with outside pharmacies that fill prescriptions for patients that have been seen at the hospital in the outpatient setting. We have $50K in contract pharmacy revenue included in the FY25 budget which is reflected in the "Other Operating Revenue" category.

***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.*

The budget generally includes a 5% inflation factor for supplies and services, and 10% for pharmaceuticals. The inflation impact is $634,509 and was factored into areas where prices for FY25 did not have known increases. See breakdown of the inflation impact by expense category below.

Drugs	153,958
Management & Contract Services	105,306
Medical Supplies	109,782
Other Purchased Services	74,242
Other Expenses*	191,221
Total	**634,509**

*Includes food, non-medical/office supplies, utilities, maintenance and repairs, postage/freight, employee wearing apparel, data processing, lease/rent building and equipment.

***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.*

As a critical access hospital (CAH), we do not anticipate CMI having any impact on reimbursement. We also do not anticipate any major fluctuation in our CMI over the previous year.

***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).*

For Blue Cross Blue Shield and Commercial payers, a 2% rate increase was assumed for all services rendered. We assumed no rate changes for Medicaid or Medicaid ACO. Medicare is budgeted at allowable cost based on FY24 rates effective April 2024, using the Critical Access Hospital reimbursement methodology where a reconciliation is performed annually for the fiscal year. The Medicare cost report process determines if a rate change is needed and a settlement is due to or due from the Medicare program. Medicare Advantage adopts traditional Medicare rates within 30-60 days from a Medicare rate change; the FY25 budget assumes being paid at current Medicare payment rates. Our budget assumes the same payer mix (based on gross revenue) for all payers for FY25 as current FY24. See payer mix budgeted below:

Springfield Hospital
Payer Mix - FY25 Budget

(%'s Rounded)	Inpatient	Outpatient	Psych
Blue Cross	4.0%	15.3%	20.8%
Commercial	11.1%	20.1%	11.6%
Medicaid	5.8%	5.7%	10.9%
Medicaid ACO	8.0%	14.2%	30.4%
Medicare	39.8%	27.0%	17.6%
Medicare Advantage	26.5%	14.9%	6.0%
Private Pay	4.8%	2.8%	2.8%
	100.0%	100.0%	100.0%

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

- Boiler and chiller replacement – researching and applying for grant funding
- Roof repairs – exploring grant funding
- Parking lot repair/resurfacing – capital expenditure, timing depends on capital
- Inpatient Care Unit upgrades – annual giving fundraising campaign
- Information technology upgrades – capital expenditure and possible grant funding
- Specialty clinic building modification – capital expenditure
- Upgrade to Emergency Department clean utility room – capital expenditure
- Telephone system upgrades – This is renegotiation and upgrade of equipment, and we expect this to be a monthly cost savings with installation of state-of-the-art equipment.

Our capital list will be submitted by August 1st in accordance with GMCB guidance.

***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.*

FY25 Operating Margin (1.4% up from .1% FY24 projected), FY25 Debt Service Coverage Ratio (3.10% up from 2.71 FY24 projected), and FY25 Days Cash on Hand (56.01 up from 50.40 FY24 projected) are all trending improvement over FY24 projected based on the FY25 budget assumptions… albeit not yet where we want them to be and we have more work to do in these areas.

We have made significant investment in rebuilding infrastructure, resulting in corresponding pressure on debt service — and recruiting medical staff, resulting in pressure on Days Cash on Hand and Operating Margin.

We are now prepared to move forward with our strategy to recapture utilization that was lost during the time of our financial difficulties. With providers in place, and having made equipment and infrastructure investments, we are now in a position to build volume and Net Patient Revenue — which will ultimately have a positive impact on Operating Margin and Days Cash on Hand through improved daily operations.

***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.*

Patient needs: Lack of insurance or high deductible insurance plans are a barrier for patients. Many patients do not want to explore financial assistance for several reasons

including not wanting to disclose personal financial information or the stigma of applying for "charity care." Many patients feel health care should be free so personal responsibility toward unpaid balances is a challenge. Also, the high cost of health care and the limited personal financial resources for some patients add additional stress leading to a lack of cooperation.

Business process: We recently expanded our program to comply with Act 119. The expansion of the program will increase our charity care in the community and reduce bad debt. We are also working with our patient access areas to improve patient education regarding the benefits of accessing the financial assistance program at the point of service.

***Collections process*:** Patients receive three statements and two collection letters. Unpaid balances are referred for outside collection activity at the conclusion of the patient statement cycle. These accounts remain with the agency and are closed and returned after one year if no collection activity.

Bad debt to free care ratio: For FY23, our Bad Debt percentage of Gross Revenue was 2.47%, which was the third highest in the state, with 11 of the 14 Vermont hospitals having percentages lower than SH. Our free care for FY23 was .58% (middle of the group) with 6 of the 14 hospitals having higher percentages and 7 being lower.

Our projected FY24 Bad Debt is substantially over the FY24 budget where budgeted targets were set aggressively (2.86% and 1.81% respectively of Gross Patient Revenue) and a large portion of bad debt experience for the hospital is driven by patients that come to the Emergency Department and for the reasons discussed in *Patient Needs above*. The FY25 Budget for Bad Debt is projecting an approximate .5% decrease (to 2.34%). Due to revenue cycle improvements, and our recently updated Financial Assistance Program to comply with Act 119, we anticipate a shift to Charity Care. The flexibility of the new Financial Assistance Program in FY24, as well as in-house financial counseling that we now offer, Charity Care is anticipated to rise to .95% (a $565K annual increase) of Gross Patient Revenue in FY25 (up from .66% in FY24). This results in a FY25 Bad Debt to Free Care ratio of 2.47 vs. 4.32 projected for FY24.

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

Springfield Hospital provided $378,553 financial assistance at cost in FY22, and $3,556,363 in net community benefit expense for Medicaid. In addition, Springfield Hospital participates in numerous community efforts toward population health and community safety. We sponsor several public events (Fastest Kid in Town, Lace Up for Laura, Apple Blossom) that benefit the community; are active in the Community Collaborative and the Project Action population health efforts, and work with Southern Vermont Area Education Center and sponsor scholarships to facilitate educational opportunities in the health care field.

d) 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.*

Health care expense management is a very fluid situation from day-to-day. Supply chain, claims denials and reimbursement days in accounts receivable, variability in volumes, travelers/labor, pharmacy expense, inflation are all factors that need to be managed daily. New this year is the Medicaid redetermination which could negatively impact our uninsured population, and the Vermont State Childcare Tax which we project will add $117K expense per year. We anticipate a malpractice insurance premium increase in June. We are awaiting settlement news from OneCare which, due to our adding services that were not built into the base, may put us at risk and we are discussing this with OneCare. Provider and staff turnover is an ongoing challenge.

e) 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.*

[2] *Wang Y, Bai G, Anderson G. U.S. Hospitals' Administrative Expenses Increased Sharply During COVID-19. J Gen Intern Med. 2023 Jun;38(8):1887-1893. doi: 10.1007/s11606-023-08158-8. Epub 2023 Mar 23. PMID: 36952083; PMCID: PMC10035469.*

The table below shows the percentage breakdown for administrative vs. clinical expenses for FY23 actual, FY24 projected and FY25 budget. There is a modest decrease in administrative, and corresponding increase in clinical costs, for FY25 budget compared to FY24 projected.

	FY23 Actual	FY24 Proj	FY25 Budget
Administrative	41.7%	40.7%	**40.57%**
Clinical	58.3%	59.3%	**59.43%**

The table below shows the percentage increase by administrative vs. clinical expenses over FY23 actual, FY24 projected and FY25 budget.

	FY24 Proj vs. FY23 Actual	Fy25 Budget vs. FY24 Proj	FY25 Bud vs. FY23 Actual
Administrative	3.5%	6.9%	**10.62%**
Clinical	7.9%	7.6%	**16.01%**

Both categories include wage and merit adjustments in FY25 for employee retention and recruitment as it has been an ongoing challenge to stay competitive in a tight labor market. Also reported are staffing costs budgeted in FY25 that were unfilled positions and not expensed in FY24. Projected FY24 over actual FY23 includes overall inflation for drugs, supplies, various contracts, fuel, food, etc. Additionally, recall that the FY25 budget includes a 5.5% inflation for various supplies and services, and 10% inflation for pharmaceuticals.

Administrative costs: FY24 projected costs are estimated at a 3.5% increase over FY23 actual costs; and FY25 budgeted costs are 6.9% higher than FY24 projected, resulting in a total increase of 10.6% over a two-year period. The major contributors to the FY24 projected increase over FY23 are capital costs (depreciation) due to significant capital investments in FY24 (**See Capital Improvement Schedule D**), provider taxes, revenue cycle, purchasing, and social services (the latter three areas due to staff turnover). FY25 budgeted costs are anticipated to be 6.9% over FY24 projected due to capital costs, provider taxes, employee benefits, the new Vermont Childcare Tax (effective 7/1/24), housekeeping and dietary staffing costs which were understaffed in FY24.

Clinical costs: Projected FY24 are estimated at a 7.9% increase over FY23 actual, and FY25 budgeted costs are 7.6% higher than FY24 projected—resulting in a total increase of 16% over a two-year period. Most results for FY24 projected over FY23 actual are primarily traveler agency costs, operating room supplies due to increased volume, investment in specialty providers and The Windham Center (inpatient mental health) providers. Compared to FY24 projected, the FY25 budget increase includes a full year of FY24 provider growth, collective bargaining agreement and wage increases, rebuilding staff in patient care areas (that have been lean since Chapter 11 and the associated reduction in force) that are necessary for quality patient care and patient satisfaction, supply and drug increases tied to volume (**Reference the Comparative Statistical Report Attachment A**), inflation, and annual contracted services.

***f) 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.*

Facility fees help cover the cost of maintaining facilities and are established in accordance with the Medicare facility fee policy **42 CFR § 413.65.** SH's hospital-owned, provider-based outpatient clinics are guided by the same Medicare regulatory requirements as the main hospital following the **42 CFR § 413.65** regulatory policy. The total charge for Medicare billing is split between a 1) professional component and 2) a facility component. The total of each of these components for Medicare equal the same charge that is billed for Medicaid and Commercial. Medicaid and Commercial are only billed on the professional bill and not split into two components like Medicare. Please note that facility fees are not a separate fee; but combined with the professional fees, which are required to be split billing into these two components under the above referenced regulation, equal the same charge as billed to Medicaid or Commercial.

Facility fees (gross) for SH provider-based outpatient clinics totaled $395,455 for FY23. It is too early to project FY24 or FY25.

***g) Affordability**: Does your budget increase request consider consumer affordability and, if so, how?*

The challenge in preparing hospital budgets is balancing the community need for services, inflation and reimbursement consideration relative to expenses, Hospital sustainability, and reimbursement, against a 3.5% NPSR goal. The issue of affordability ranked high in our most recent CHNA—not unlike the rest of the State of Vermont and across the country. Some of the affordability question and its solution lies with insurance companies, regarding premiums, deductibles, co-pays, etc. which are all out of the control of hospitals.

Regarding affordability, SH updated our Financial Assistance Policy and application process. We broadened the policy to align with Act 119 requirements. We hired a full-time Certified Assister to meet with patients in person and discuss financial assistance options. We also invested in having the certified assister meet with our front-facing, front-line staff at various points of entry throughout the hospital to ensure they are fully knowledgeable and have the tools they need to make an appropriate referral for financial counseling relative to health care costs and affordability. Financial assistance information is placed at every point of entry, on our website, and in welcome packets.

Data captured to date for FY23 is as follows:

- Total Number of fully processed Applications (FY23) 325
- Total number of Applicants granted any amount of financial assistance 296
- Number of Applicants granted 100% hospital discount 233
- Number of Applicants granted less than 100% hospital discount 63
    - 90% = 17
    - 80% = 15
    - 70% = 10
    - 60% = 10
    - 50% = 11
    - TOTAL = 63
- Total Applicants denied financial assistance 29
- Breakdown of reason for denial:
    - Over Income = 25 (86%)
    - NH patients living outside Sullivan/Cheshire Counties = 4 (14%)

***h) 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.*

SH's operating margin is already razor thin and, after rebuilding since Chapter 11 and the COVID pandemic, we feel a charge increase request of 5.5% is necessary to accomplish our goal for sustainability. While the impact of a 5.5% charge increase results in 5.8% GPR growth over the FY24 budget, which falls above the 3.4% guidance target, the dollar amount of the increase and impact to NPR of $1.4M must also be carefully considered. Please refer to **Section C b) Deviations**. Our projected NPR growth results primarily from budgeted utilization increases of 10.6% with a minimal impact from a charge increase of 2.4%. Any reduction by the GMCB in the NPSR or rate request is likely to impact services or staffing, as well as quality of care, as the budget is considerably lean and includes costs necessary to support volume and quality of care.

***i) Lobbying & marketing costs**: 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: From total dues paid to VAHHS, approximately $6,427.20 (7.8%) is reported to the State of Vermont as applying toward lobbying. Those expenses are used to create awareness of important issues impacting the health care industry.

Marketing: Our annual marketing budget, including salary and benefits for two full-time staff members, is .6% of YTD Total Revenue through March 2024. All creative, web and social media, media placement, print supervision, grant writing and grant management is handled in-house with no outside expense.

***j) Fundraising**: Describe planned fundraising efforts and anticipated donations for FY25.*

Our annual fundraising (excluding grants) consists of the following campaigns.

Annual Giving mailing – 2 mailings each year, supported by social media and public relations events.
Fundraising Goal: $130,000

Apple Blossom – This event is held annually in May, with funds raised earmarked for scholarships and our annual giving campaign.
Fundraising Goal: $6,000-$10,000

Golf Challenge – Event held annually in September, supported by social media and public relations. Proceeds go toward annual giving campaign.
Fundraising Goal: $22,000

Hearts of Hope – Event held annually in December to support annual giving fundraising. Proceeds go toward annual giving campaign.
Fundraising Goal: $10,000

Grant research and application submissions are ongoing throughout the year.

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

SH has no current investment accounts and, as a result, no investment income.

l) Payment based on quality*: 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.*

Medicare does not make quality adjustments for Critical Access Hospitals.

m) Workforce development*: Describe the hospital's investments in workforce development initiatives, including nursing workforce pipeline collaborations with nursing schools and compensation and other support for nurse preceptors, residency programs, and any other workforce development initiatives in which you are participating. Include a description of the program and where the accounting entries show up in your proposed budget (income statement and balance sheet).*

Our COO/CNO is working with River Valley Technical Center (RVTC) to develop their LNA program. We believe we have recruited an RN to teach the program, which has been a challenge for RVTC in recent past. Associate Degree RN candidates from RVTC will be able to complete some rotations at Springfield Hospital.

n) Workforce retention*: Please describe the hospital's investments in workforce retention such as housing, daycare, and other employee benefits. Include a description of the program and where the associated accounting entries show up in your proposed budget (income statement and balance sheet).*

Daycare is an identified need in our Community Health Needs Assessment (CHNA). We are currently assessing regional availability in collaboration with our local Parent Child Center and will be exploring opportunities and researching options to assist. We have built the additional Vermont Childcare Payroll Tax into our FY25 budget and expect to not allocate any portion of the tax to staff.

Housing continues to be a challenge in this market. We inquired about grant funding to renovate a 3-unit building on the hospital campus, but that funding was not applicable. We continue to research options as renovating this building would be an enormous help in housing for new hospital staff that needs housing.

***o) Hold harmless**: For what drivers of expense growth do you feel hospitals should be "held harmless" and why?*

The following costs are out of our control and the hospital should be held harmless for these costs:

- Inflation due to supply chain and other expense increases out of our control
- Travelers
- Increased labor and benefit costs
- EMS transport
- Childcare Tax
- Provider Tax
- Potential DSH reduction impact
- Medicaid revalidation – uninsured rates
- Health Insurance claims – self insured

D. HOSPITAL & HEALTH SYSTEM IMPROVEMENT

***a) Access challenges**: 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.*

SH has successfully recruited permanent mental health providers to staff our Windham Center for Psychiatric Care. We continue to collaborate with Turning Point in our Emergency Department, and also with our local designated agency (HCRS) and North Star Health (FQHC) which offers outpatient mental health services to our region. We also continue to work with other area agencies to collaborate on hospital swing bed availability and other community services.

***b) Collaboration**: 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.*

See a) above.

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

N/A

***d) Hospital networks**: Explain your shared services strategy, any additional revenues associated with such investments and methodologies for allocating associated costs. Quantify any*

efficiencies to date, and when you expect to achieve any future efficiencies.

SH doesn't have any joint ventures or collaborations where we share a revenue stream. Our collaborative efforts as described in the past, i.e. Dartmouth Health, UVM, Brattleboro Memorial Hospital, are designed to offer broader services in a more efficient and cost effective manner.

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)?*

Post Chapter 11, expense management at Springfield Hospital is under close monitoring. All annual expense budgets proposed by managers must be reviewed by line item with the Division Head for approval prior to inclusion in the budget, and then are monitored throughout the year by managers and leadership.

b) Patient Financial Assistance*:*

a. Third party collections*: 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.*

We have a contract with a third-party collection vendor. Contract terms include a confidentiality clause, and it would be a breach of contract to disclose the terms of the contract without written consent from the vendor.

b. Third party collections ROI*: 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?*

Springfield Hospital analyzed the cost of full-time staff vs. the fee for an outside vendor and determined at the time that it was more cost-effective to use an outside service. We are due to re-evaluate that comparison. The comparison included labor, expenses and overhead and was a cost-saving initiative at the time the decision was made. We also need to consider the convenience factor for patients and overall customer service.

c. Financial Assistance Program (FAP) Screening*: Please describe how patients are screened for Patient Financial Assistance at your hospital.*

Patients are screened at registration for 'uninsured or underinsured status' and referred to our full-time, certified financial assistance counselor who is available

to meet with patients one-on-one at the time and place that is convenient to the patient and their families. We provide plain language summary brochures at each point of entry. Information is also included in our patient welcome packets for any inpatient stay.

***d. FAP on Bills**: 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?*

We send patient statements including language to guide the patient/guarantor about how to access financial assistance if desired. Information is also available at every point of entry and on our website.

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

SH does not have the ability to easily track this type of information. However, we can report that Boarding patients in the Emergency Department (ED) continues to climb and is a huge barrier to patient care. We are running into issues of higher-level hospitals not accepting patients, and we also have a transport issue statewide. Patients may be accepted elsewhere but arranging transport can sometimes take hours or even days. This backlogs the ED, increases wait times due to bed availability in the ED and can cause a negative patient experience or patients leaving without being seen. Regarding mental health patients in the ED, SH had 143 mental health patients with a stay greater than 24 hours from 5/1/23-5/31/24.

ATTACHMENT A

Comparative Statistical Report Volume/Utilization - FY2025 Budget	FY23 Actual	Projected FY24	FY25 Budget	Change from Projected FY24	Fy24 Budget	Change From Bud FY24
Admissions						
Medical/Surgical	652	648	648	0.0%	721	-10.1%
Swing	63	67	67	0.0%	65	3.4%
Psychiatric Admissions	307	307	367	19.6%	366	0.4%
Total Hospital	**1,022**	**1022**	**1082**	**5.9%**	**1,152**	**-6.0%**
Observation	379	650	650	0.0%	365	78.0%
Patient Days						
Medical/Surgical	2,876	2,549	2,549	0.0%	2,884	-11.6%
Swing	628	504	504	0.0%	700	-28.0%
Psychiatric	2,676	2,575	3,079	19.6%	3,079	0.0%
Total Hospital	**6,180**	**5,628**	**6,132**	**9.0%**	**6,663**	**-8.0%**
Observation	644	811	811	0.0%	700	15.9%
Average Daily Census						
Medical/Surgical	7.9	7.0	7.0	0.0%	7.9	-11.6%
Swing	1.7	1.4	1.4	0.0%	1.9	-28.0%
Observation	1.8	2.2	2.2	0.0%	1.9	15.9%
Psychiatric	7.3	7.1	8.4	19.6%	8.4	0.0%
Ancillary Services						
Emergency Room Visits	13,197	13,738	13,737	0.0%	13,505	1.7%
Emergency Room Visit/Day	36.2	37.6	37.6	0.0%	37.0	1.7%
Operating Room Cases	890	1,068	1,308	22.5%	1,197	9.3%
Pain Management - OR	-	66	-	-100.0%	180	-100.0%
Endoscopy Procedures	1,111	953	1,219	28.0%	1,000	21.9%
Laboratory Tests	229,010	155,119	158,080	1.9%	204,000	-22.5%
Pharmacy Drugs Dispensed	260,937	213,451	220,949	3.5%	225,727	-2.1%
Clinic	2,649	1,044	1,050	0.6%	1,712	-38.7%
Xray Exams	8,629	9,994	10,132	1.4%	9,500	6.7%
Bone Density	-	590	580	-1.8%	550	5.4%
MRI Procedures	1,302	1,217	1,363	12.0%	1,350	1.0%
Nuclear Medicine Proc.	16	75	240	220.0%	390	-38.5%
Mammography	2,213	2,750	2,812	2.2%	3,000	-6.3%
Ultrasound Procedures	2,294	2,225	2,240	0.7%	2,250	-0.4%
Echo	771	778	792	1.9%	725	9.2%
CT Procedures	4,890	5,556	5,552	-0.1%	5,000	11.0%
EKG Procedures	4,803	4,786	4,782	-0.1%	5,508	-13.2%
Respiratory Procedures	22,372	32,976	32,974	0.0%	16,976	94.2%
PT Units	44,714	42,211	43,212	2.4%	50,971	-15.2%
Adult Day	3,158	4,786	4,800	0.3%	4,000	20.0%
Specialty Practice Office Visits						
General Surgery	612	926	975	5.2%	1,000	-2.5%
Orthopedics	5,558	5,333	5,370	0.7%	6,000	-10.5%
ENT	1,744	1,897	1,946	2.6%	1,750	11.2%
Urology	2,502	2,631	2,650	0.7%	2,600	1.9%
Gynecology	1,429	2,628	3,025	15.1%	2,500	21.0%
Podiatry	1,187	2,399	2,100	-12.5%	2,400	-12.5%
Specialty Practices Total	**13,032**	**15,814**	**16,066**	**1.6%**	**16,250**	**-1.1%**
Hospitalist	4,291	4,106	4,105	0.0%	4,352	-5.7%
Pain Management Clinic	411	242	-	-100.0%	480	-100.0%

*Please note that the FY2024 Projected and FY2025 Budgeted stats are compiled using charge data which ensures consistency, versus FY23 Actual which was compiled using manual data by department managers.

ATTACHMENT B
FY25 Income Statement Budget

Springfield Hospital Income Statement Summary	FY25 Budget	FY24 Projected	FY25 Budget to FY24 Projected $ Change	FY25 Budget to FY24 Projected % Change	FY24 Budget	FY25 Budget to FY24 Budget $ Change	FY25 Budget to FY24 Budget % Change
GROSS PATIENT SERVICE REVENUE:							
Inpatient Revenue	$ 21,013,247	$ 18,384,539	$ 2,628,708	14.3%	$ 21,543,058	$ (529,811)	-2.5%
Outpatient Revenue	122,079,888	112,458,815	9,621,073	8.6%	106,494,025	15,585,863	14.6%
Professional Services	16,389,794	13,002,979	3,386,815	26.0%	15,143,978	1,245,816	8.2%
Total Gross Patient Service Revenue	159,482,929	143,846,333	15,636,596	10.9%	143,181,061	16,301,868	11.4%
Deductions from Revenue:					-	-	
Contractual Allowances*	86,080,824	76,670,669	9,410,155	12.3%	78,998,988	7,081,837	9.0%
Charity Care &Other Allowances	1,515,088	950,282	564,806	59.4%	1,332,378	182,710	13.7%
Provision for Bad Debts	3,738,239	4,107,234	(368,996)	-9.0%	2,585,133	1,153,106	44.6%
Disproportionate Share	(550,000)	(569,515)	19,515	-3.4%	(550,000)	-	0.0%
Total Deductions from Revenue	90,784,151	81,158,670	9,625,480	11.9%	82,366,499	8,417,652	10.2%
Net Patient Service Revenue	68,698,778	62,687,663	6,011,116	9.6%	60,814,562	7,884,216	13.0%
Other Operating Revenue	939,000	1,215,299	(276,299)	-22.7%	944,863	(5,863)	-0.6%
TOTAL OPERATING REVENUE	69,637,778	63,902,961	5,734,817	9.0%	61,759,425	7,878,353	12.8%
OPERATING EXPENSES:							
Salaries & Wages	22,642,378	19,734,445	2,907,932	14.7%	21,757,873	884,505	4.1%
Employee Benefits &Payroll Taxes	5,567,700	4,942,820	624,880	12.6%	5,369,826	197,875	3.7%
Medical Supplies	3,245,160	2,664,997	580,163	21.8%	2,123,653	1,121,508	52.8%
Drugs	2,395,743	2,088,748	306,995	14.7%	1,706,297	689,446	40.4%
Management &Contract Services	9,963,229	9,576,705	386,524	4.0%	8,669,067	1,294,162	14.9%
Other Purchased Services	2,120,081	2,714,133	(594,052)	-21.9%	2,805,672	(685,591)	-24.4%
Physician Fees	4,632,254	4,736,391	(104,137)	-2.2%	4,220,984	411,270	9.7%
Travelers	5,173,131	5,579,314	(406,183)	-7.3%	3,167,374	2,005,757	63.3%
Depreciation	1,500,000	1,313,590	186,410	14.2%	1,200,000	300,000	25.0%
Interest	352,113	226,004	126,110	55.8%	260,000	92,113	35.4%
Insurance	876,670	806,878	69,792	8.6%	605,735	270,935	44.7%
Provider Tax	3,795,283	3,465,112	330,172	9.5%	3,232,692	562,591	17.4%
Other Expenses	6,385,117	5,977,464	407,653	6.8%	6,156,581	228,535	3.7%
TOTAL OPERATING EXPENSES	68,648,859	63,826,600	4,822,259	7.6%	60,759,753	7,889,107	13.0%
OPERATING INCOME (LOSS)	988,919	76,361	912,558	1195.1%	483,672	505,247	104.5%
NON-OPERATING REVENUE (NET)	400,000	801,315	(401,315)	-50.1%	5,000	395,000	7900.0%
PENSION COSTS/UNRECOGNIZED PENSION EXPENSE	(450,000)	(420,000)	(30,000)	7.1%	-	(450,000)	
INCR. (DECR.) IN UNRESTRICTED NET ASSETS	$ 938,919	$ 457,676	$ 481,243	105.1%	$ 488,672	$ 450,247	92.1%
Operating Margin	1.4%	0.1%			0.8%		

ATTACHMENT C
FY25 Budget Overview Notes (page 1 of 3)

VOLUME

- **Medical Surgical** is flat – trend is decreasing inpatient and increasing outpatient observation utilization
- **Observation admissions** considerable growth over FY24 budget – flat to FY24 projections.
- **Swing admissions** and number of days are virtually flat from projected FY24, but census is dropping .5 budget to budget due to shorter length of stay
- **Psychiatric admissions** and days budget to budget are flat but increase over projected FY24 from 7.1 to 8.4 average daily census due to improved staffing.
- **Emergency Room visits** include a slight increase over FY24 budget; flat to projected FY24. While population is growing older and that demographic will continue to need increasing ED visits, we anticipate our population health work will shift to reduce avoidable ED visits and hold the utilization steady.
- **Operating Room** cases are projected to increase as we have added 3 general surgeons (1 full time and two part time), increased clinic time for one GYN provider, added fusion biopsy capability to Urology, increased orthopaedics, and we are working to recapture market leakage of existing services leaving the area—ultimately saving cost to the system.
- **Pain Management** program was discontinued effective May 16, 2024.
- **Endoscopy Procedures** are expected to grow due to additional General Surgery staff (1 day/week).
- **Clinic** decrease due to loss of cardiology services. We expect to bring these services back to the local area but until we can accomplish recruitment of appropriate providers, we are not budgeting for volume.
- **Diagnostic Imaging** is budgeting modest increases budget to budget with the exception of X-ray which is projected to increase due to discontinued service at FQHC locations.
  - MRI is now offering prostate imaging, and is budgeted to increase from Projected FY24 and budget to budget.
  - Nuclear Medicine came back online March 11, 2024, and is budgeted at 20 exams per month, well exceeding Projected FY24 of 75.
  - Mammography is performing well above FY23 numbers, and showing steady growth year over year from FY23, to Projected FY24, to budgeted FY25.
  - Ultrasound is budgeted virtually flat from FY24 to budget FY25.
  - Echocardiogram performed ahead of FY24 budget and is projecting a slight increase for FY25.
  - CT scans FY25 budget is comparable to projected FY24, which shows substantial growth over FY23 and FY24 budget.

- **Physical Therapy** budgeting modest growth over projected FY24, currently limited by space.
- **Adult Day Service** projecting 20% growth from FY24 to FY25 budget to budget, with modest growth over projected FY24, and substantial growth of FY23 actual.
- **Specialty practices** are showing modest growth budget to budget and from projected FY24, with the exception of Orthopaedics and Podiatry. Reduced Orthopaedic clinic time for one provider resulted in a corresponding reduction from FY24 budget to projected FY24. Orthopaedics FY25 budget includes a modest increase from projected FY24. Podiatry is budgeted with a reduction since the podiatrist is serving on the VT Medical Board, resulting in a 12.5% reduction in his clinic time.

ATTACHMENT C
FY25 Budget Overview Notes (Page 2 of 3)

INCOME STATEMENT

Compared to FY24 Budget

- **Gross Patient Revenue** is increasing, primarily attributable to a 5.5% charge increase (see FY25 Revenue and Rate Request Summary) coupled with outpatient service line growth (reference volume highlights above). Overall, utilization is shifting from inpatient to outpatient services, resulting in a budget-to-budget decrease in gross inpatient revenue and an increase in outpatient revenue. However, inpatient gross revenue is increasing over projected FY24 due to anticipated growth in psychiatric admissions (The Windham Center for Psychiatric Care 10-bed inpatient unit in Bellows Falls, VT).
- **Contractual Allowances** are increasing due to gross patient revenue increases, with payer mix assumed consistent with the current year.
- **Charity Care & Other Allowances** is budgeted for an anticipated increase due to Act 119 implementation, which broadens eligibility, and increasing gross patient revenue. This, coupled with our improved patient access registration process and financial assistance counseling, is anticipated to offset Provision for Bad Debts as a percent of revenue.
- **Disproportionate Share Revenue** is anticipated to be relatively flat at $550K.
- **Other Operating Revenue** is flat budget to budget but decreased from projected FY24. This includes a reduction in Master Shared Services Agreement (MSSA) fees, rental income, and grant revenue.
- **Operating expenses** for FY25 budget are increasing by $7.9M over FY24 budget, which includes a 5% inflation factor on some supplies and services. The largest increases in this category are due to:
- **Salaries and wages** is increasing $885K (4.1%) over FY24 budget, which includes wage market and merit adjustments and rebuilding staffing models (since the 2019 reduction in force) and planned volume increases.
- **Employee Benefits and Payroll Taxes** category increases 3.7%, budget to budget, or $198K. The new Vermont Childcare Payroll Tax effective July 1st makes up $117K of this increase.
- **Medical Supplies** (projecting an OR volume increase and $284K in reclassification of certain supplies from the Other Expenses line),
- **Pharmaceuticals** include a 10% inflation factor and pharmaceutical increases for GYN and Urology. Correspondingly there are pharmaceutical revenue increases due to the markups.
- **Management and Contracted Services** (includes a $500K increase for contracted physicians). This results in a reduction in the locum expense. Management and contracted services also include a reclassification for diagnostic imaging contracts of $576K being moved from the Other Purchased Services category.
- **Other Purchased Services** is declining due to a reclassification to Management and Contracted Services (see further detail above).
- **Physician Fees** are increasing by $411K budget to budget, or 9.7%, due to newly employed general surgeon, recruiting for a cardiac nurse practitioner, one additional day for gynecology, and Windham Center staff.
- **Travelers** are increasing $2M over the FY24 budget, or 63%, due to necessary increased reliance on traveler staff in respiratory, diagnostic imaging, inpatient care, psychiatric care, emergency room, operating room, and endoscopy.
- **Depreciation** includes a $300K increase (25%) over FY24 budget reflecting increases in capital investments.
- **Interest** is increasing budget to budget by $92K (35%) as a reflection of capital improvements and increased capital leases.

ATTACHMENT C
FY25 Budget Overview Notes (Page 3 of 3)

- **Insurance** is increasing $271K (45%) over FY24 budget which includes a 30% increase in professional and general liability premiums and increased cybersecurity and property coverage premiums.
- **Provider Tax** is increasing 17.4% over FY24 budget based on the new assessment as of July 2024, annualized.
- **Other Expenses** increased $228K (3.7%) budget to budget, with the increase due primarily to increases in maintenance and repairs and minor equipment.
- **Operating Income is budgeted for a $989K profit (double FY24 budget) which represents a 1.4% margin.**
- **Non-Operating Income**, budget to budget, is increasing $420K which is made up of interest income now being earned on our bank accounts.
- **Unrecognized Pension Expense** is an estimate of net plan expense for our frozen defined benefit plan.

Compared to FY24 Projected

- **Total Gross Patient Service Revenue** includes utilization growth and a 5.5% charge increase—and is projected to increase to $159M, or 10.9%. The increase is made up of Inpatient Revenue (primarily Windham Center), Outpatient Revenue (OR cases, observation patients, Endoscopy, Xray, MRI, and Nuclear Med) and Professional Services (specialty practice office visits, and professional fees related to the increase in OR cases). Please reference the *FY25 Revenue and Rate Request Summary* page for a breakdown of utilization and rate request detail.
- The 5.5% **charge increase** is projected to result in a $1.4M increase in net patient service revenue.
- **Net Patient Service Revenue** is projected to increase to $69M, or a 9.6% increase over projected FY24 primarily resulting from revenue growth.
- **Total Operating Revenue** is increasing to $69.6M, a 9% increase over FY24 which is the result of increased volume and the rate increase.
- **Total Operating Expenses** are budgeted to $68.6M, or 7.6%. Wage increases appear high due to having budgeted unfilled positions through FY24. Employee Benefits (12.6% increase) and Other Expenses (6.8% increase) over projected FY24 appear to be high increases, but that is due to not spending to budget in FY24. This is true of many items in the operating expense category. Please refer to expense detail in *Income Statement Compared to FY24 Budget* above for similar changes from FY25 budget to projected FY24.
- **Non-operating Revenue** projected FY24 includes interest income that began mid-March, and grant funding for capital projects. The FY25 budget is a full year of interest income and does not include any grant funding.

ATTACHMENT D (Page 1 of 2)
Springfield Hospital Capital Improvements

LABORATORY	**$ 83,000**
Urinalysis Analyzer Blood Gas Analyzer 2 Coagulation Analyzers SED Rate Analyzer 2 Chemistry Analyzers	
Operating Room HVAC & PACU Renovation	**499,000**
Air Handler Unit Upgrade PACU New Ceiling and Refinished Walls Equipment Upgrades	
Pharmacy HVAC	**407,000**
Air Handler & Compounding Suite Upgrades	
Urology	**38,000**
Urodynamics Machine and HD Flex Cystonephrology Videoscope	
Respiratory Therapy	**52,000**
Equipment Upgrades	
Engineering/Plant	**438,000**
Fire doors, carpeting, generator control unit, pedestrian bridge	
Emergency Department	**229,000**
New stretchers, furniture, portable ultrasound, carts on wheels, nurse call system	

ATTACHMENT D (Page 2 of 2)
Springfield Hospital Capital Improvements

Inpatient Care Unit	**352,000**
Nurse call system, new infusion pumps	
Dietary	**19,000**
Equipment	
Diagnostic Imaging	**2,569,000**
Digital C-arm	
Echo hardware/software	
Mobile Xray	
CT battery replacement	
Digital Diagnost C90	
Proxi Diagnostic	
MRI Upgrade	
Nuclear Medicine Upgrade	
Renovations	
TOTAL	**$ 4,686,000**



Springfield Hospital

Where People Come First

GMCB REPORTING CHECKLIST

- FY2023 Medicare Cost Report — Uploaded 4-1-24
- Verification under Oath — Upload
- Budget Narrative — Upload
- FY2025 Budget Request — Adaptive
- Hospital Operations — Adaptive
- Community Health Needs Assessment — Upload
- Financial Assistance Reporting — Upload
  - Financial Assistance Policy
  - Plain Language Brochure
  - Reporting
- Affiliations & Third Party Contracts — N/A

  Springfield Hospital has no unique MA contracts.
- Corporate Structure – Org Chart — Upload
- Salary Information — Upload
- Net Revenue & Public Payer Reimbursement — Upload
- Capital Expenditures (Due 8/1/24) — Adaptive
- IRS Form 990 for CY2022 (including Schedule H) — Upload