Northwestern Medical Center (NMC)
Fiscal Year 2018 (FY2018) Budget Narrative

1. Executive Summary:

Northwestern Medical Center is devoted to our long-standing mission of providing exceptional care to our community and we were gratified to be honored earlier in 2017 as one of the nation's "Top 100 Rural & Community Hospitals" in recognition of our excellence in: costs, charges, quality, outcomes, patient perspectives, market share, and financial stability. The breadth and depth of this recognition is a strong testament to the prudent approach NMC takes to the tremendous responsibility of caring for our community. At the same time, NMC is devoted to being a leader in the reform of our healthcare delivery system for both our local community and for the state of Vermont through RiseVT and taking on risk in new payment pilots.

NMC is leading the way – locally and at the state level -- in integrating primary prevention into healthcare reform through the innovative, exciting RiseVT movement to embrace healthier lifestyles, as we believe the best way to pull costs from the healthcare system and bend the cost curve long-term is to improve the health of the population and prevent the need and demand for costly treatments and services. At the local level, in alignment with our Community Health Needs Assessment (CHNA) and in partnership with entities throughout our region, RiseVT continues to strengthen its engagement of families and its penetration into our schools, businesses, and municipalities. This collaborative, proactive, positive approach and its promising initial progress, which has been lauded and encouraged by the Green Mountain Care Board (GMCB), has garnered attention across the state from hospitals, the Vermont Department of Health, Blue Cross/Blue Shield, OneCareVT, the Vermont Business Roundtable, and others. NMC's efforts have inspired the creation of a formal RiseVT corporation with a high-powered Board of Directors at the State level on a mission to bring this positive primary prevention force throughout the state for the benefit of all Vermonters.

NMC has also stepped forward as the only non-UVMMC affiliated hospital to participate in risk taking through Vermont Medicaid Nex-Gen (VMNG) and is one of seven Vermont hospitals currently planning to participate in risk taking through the All Payor Model. We are also a leading participant in our region's Unified Community Collaborative which brings together leaders from many sectors – health care and social determinant areas – to work together for a healthier future for all as we pursue shared savings and improved population health. We are 100% committed to helping Vermont make a successful transition from old style 'fee for service' medicine to the value-based approach of an integrated population health system.

In the midst of this incredible work, NMC's FY2018 budget was arguably the most difficult budget we have had to prepare. All budgets are built on assumptions, but in healthcare at this time there are so many more moving parts and outside influences affecting this budget compared to recent years. Amidst that uncertainty, NMC is operating at a loss in our current fiscal year due to lower than budgeted volumes, higher than projected bad debt and free care, and other factors. In preparing NMC's FY2018 budget, our management staff, medical directors, leadership team, and community Board of Directors have worked diligently to carefully balance the needs of our patients, the demands of healthcare reform, and financial prudence while working within the budgetary guidance and requirements of the Green Mountain Care Board (GMCB). NMC has had the lowest overall average annual rate increase among all Vermont hospitals since 2011 at 1.79% and yet, based primarily on some significant external factors, this year's budget demands a requested rate that is higher than our average, even with a

reduced bottom line. Even with this, our community Board of Directors endorses this budget as the right thing for our community and Vermont in order to allow NMC to continue to provide exceptional care and be an effective leader in the expansion of prevention, the improvement of health, and the advancement of system reform. Within the budget, the significant programmatic, staffing, and operational changes include:

- Our continued significant investment in health reform and primary prevention through several of our programs including Rise VT. The total amount included in the 2018 budget is nearly $2 million. This does not include the investment in care coordination that we have made within our primary care physician practices.
- Through an internal review of our organizational structure we have eliminated three management level positions including a senior level management position in an effort to continue to right size our staffing structure to reduce healthcare costs.
- As is consistent with the last few years the growth in our net patient revenue is occurring through a continued focus on access to care in our service area. We have been successful in recruiting to fill important vacancies and shortfalls in provider positions including Primary Care, Orthopedics, Sports Medicine and Otolaryngology.
- As outlined further in this narrative the hospital plans to continue to participate in risk based payment reform initiatives including the Vermont Medicaid Next Gen pilot and both Medicare and Blue Cross risk based programs through the ACO One Care. This includes the organization accepting significant risk as well as funding of the infrastructure of the ACO program.

2. Investing in the All-Payer Model:

Payment reform is a critical component to the advancement of changes in the healthcare delivery system. During FY2017 NMC participated in the Vermont Medicaid Next Gen (VMNG) payment pilot for a portion of our Medicaid enrollees. This initiative put a portion of our revenue at risk as we worked together to coordinate the care of nearly 30,000 Medicaid lives amongst four participating hospitals. In FY2018 we have signed up to expand this pilot to include Medicaid, Medicare and Blue Cross increasing the covered lives to nearly 140,000 with seven hospitals participating. This advancement of payment reform does not come without a significant amount of uncertainty, risk and funding challenges. Due to State budgeting challenges they have been unable to contribute to the advancement of this payment reform leaving the cost to be borne by the participating hospitals. In addition to the risk and uncertainty that comes with these initiatives NMC has budgeted for over $600,000 in added expense to contribute to the funding of the OneCareVT ACO operating budget. The exact amount has yet to be determined but we feel this is an accurate projection of the cost of implementing this important strategy.

3. Addressing the Community Health Needs Assessment:

Our region's current Community Health Needs Assessment, adopted by the NMC Board of Directors in Fiscal Year 2017, identified six top priorities: Mental Health & Substance Abuse; Obesity; Smoking; Cancer; Suicide; and Domestic & Sexual Abuse. Action plans have been created to help address each of these priorities and the awareness of these priorities is part of the thought process in all of our planning.

As discussed in greater detail in the specified section of this narrative on the topic, NMC has taken a leading role improving access to care and services relating to Mental Health & Substance Abuse, including: the SBIRT initiative in the Emergency Department; integration within Primary Care; exploration of collaborative opportunities with Northwestern Counseling & Support Services; work with

the Howard Center to help facilitate expansion of their services; advocacy for improvements to access to inpatient mental health services at the state level; temporary hosting of the new BARRT Hub to provide more timely start of strongly needed services; and continued care to patients through our Comprehensive Pain & Addiction practice. NMC CEO Jill Bowen is serving on Vermont's new Opioid Coordination Council to directly assist in statewide efforts to address one of the most pressing issues within this priority.

NMC has taken a leading role in the significant expansion and re-energization of primary prevention efforts within northwestern Vermont through the exciting and innovative RiseVT community campaign to embrace healthy lifestyles. This directly addresses the priorities of obesity, smoking, and cancer – and can contribute to a healthier overall perspective on life which may help reduce incidence of our other priority issues. RiseVT continues to strengthen its engagement of families and its penetration into our schools, businesses, and municipalities. This collaborative, proactive, positive approach and its promising initial progress, which has been lauded and encouraged by the GMCB, has garnered attention across the state from hospitals, the Vermont Department of Health, Blue Cross/Blue Shield, OneCareVT, the Vermont Business Roundtable, and others. NMC's efforts have inspired the creation of a formal RiseVT corporation with a high-powered Board of Directors at the State level on a mission to bring this positive primary prevention force throughout the state for the benefit of all Vermonters. The primary prevention work of RiseVT is supplemented by strong and aligned secondary prevention work (treatment, education, cessation, support, etc.) relating to obesity, smoking, cancer through NMC's Lifestyle Medicine, Blueprint & Primary Care, and the NMC Cancer Program.

NMC has a strong Sexual Assault Nurse Examiners program in our Emergency Department, close working relationships with law enforcement, and serves as a resource to individuals who have been victims of sexual or domestic assault. We are a collaborative partner with organizations in our community working to address sexual assault and domestic abuse, such as Laurie's House / Voices Against Violence.

4. Addressing Mental Health & Substance Abuse:

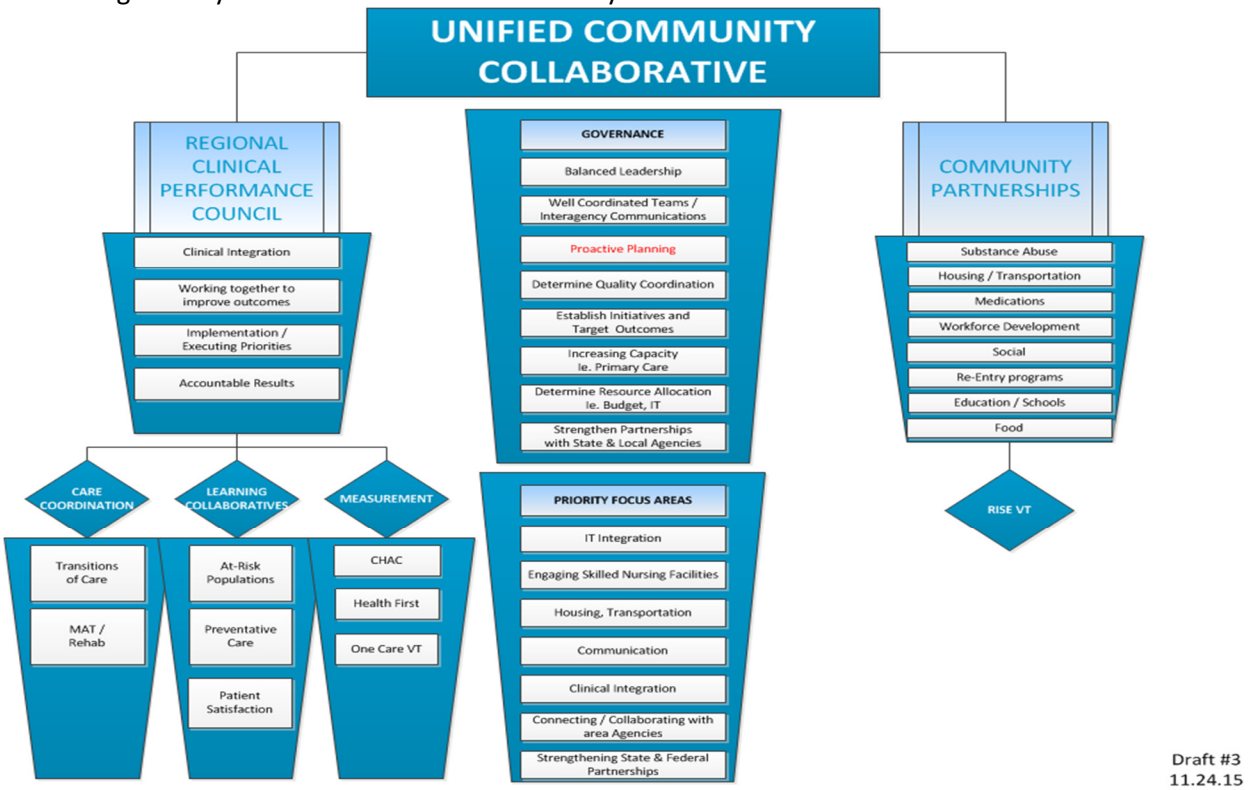
Through our most recent CHNA Mental Health and Substance Abuse services was one of the top priorities identified. For years NMC has been an important part of addressing the Mental Health and Substance Abuse needs of the communities we serve. Over the last several years we have built our Comprehensive Pain and Addiction program to include four providers. Included in this budget is the continued growth and development of that program. In 2016 we opened a Urine Toxicology program to support our comprehensive program as well as other programs and services throughout our community. Through the Unified Community Collaborative (UCC) our organization has been at the forefront of collaboration and partnership with other local social and healthcare entities. We have partnered closely with Northwestern Counselling and Support Services (NCSS) to increase local access to mental health services including the placement of behavioral health clinicians, funded by the Blueprint for Health, in nearly every primary care office in Franklin County. We also partner with The Howard Center to bring the critical services they provide to our community on our campus. Most recently we are partnering with BARRT to temporarily house their new hub and spoke services on our campus as a permanent site is completed.

5. Investing in Health Reform:

There are many aspects to reforming the healthcare delivery system that need to be pursued. We believe the two most important pieces are the advancement of healthy lifestyles through prevention

and wellness initiatives, including our RiseVT program and the advancement of payment reform. As you will see in this budget we are 100% committed to the advancement of both of these initiatives.

The first piece of this healthcare transformation is the advancement of healthy lifestyles. NMC has been on this journey for over three years including the launching of our signature program RiseVT. This initiative originated as our strategic initiative to address the priority elements of CHNA. It has been the primary priority of the local Unified Community Collaborative (UCC) that was formed in 2015. The chart below shows the structure of the UCC and how it brings together all elements of the community and includes critical social determinants in improving the health of the community all with the end in mind of building healthy communities that will ultimately bend the cost curve.



In addition to the UCC our organization has been at the forefront of collaboration and partnership with other local social and healthcare entities. For years we have worked closely with Northwestern Counselling and Support Services (NCSS) to increase local access to mental health services. This has been a critical strategy to us addressing key elements of NMC's CHNA. We continue to do joint strategic planning with both the University of Vermont Heath Network (UVHN) and the Northern Tier Center for Health (NOTCH) in order to address the most effective and efficient ways to address the critical health needs of our Franklin and Grand Isle communities. In addition to these initiatives we are partnering with others to advance the health of the community including partnering with Copley Hospitals for Pathology services and the Department of Health and other hospitals for the advancement of RiseVT as a program that can benefit the entire State of Vermont.

As was outlined in the opening executive summary NMC is fully committed to advancing payment reform. We expect in FY2018 to continue our current participation in the Vermont Medicaid Next Gen (VMNG) payment pilot. This reform has allowed us to prepare for the advancement of this methodology to include other payors as well. In FY2017 there were approximately 3,600 lives in our Health Service Area (HSA) that were covered by this payment reform pilot. We expect that number to grow to approximately 4,700. The total population statewide participating in this model is expected to grow from 30,000 to 55,000.

In addition to continuing the VMNG pilot we are also anticipating that both Medicare and Blue Cross of Vermont will join the payment reform process. These payment methodologies will largely follow the same model that was used for VMNG. This will add an additional 4,600 Medicare lives and 3,000 Blue Cross lives for our HSA bringing the total attributed lives covered under capitations to just over 12,000 lives. The total lives covered statewide is currently expected to be nearly 140,000 lives.

These methodologies will depend heavily on a robust care coordination model to lower the cost of care and eliminate over utilization of healthcare services.

6. Net Patient Revenue:

We are requesting a 3.77% increase in net patient revenue compared to budget FY2017. Of this increase, .37% is related to what we believe to be a qualified physician transfer, .4% is for increased investment in healthcare reform and the remaining 3% is the allowable growth factor. This increase is needed to maintain a very modest operating margin of 2% at a time when risk in the healthcare industry, and in the state of Vermont in particular, is being shifted away from insurance providers and toward hospitals. NMC supports the work of One Care and is pleased to be part of payment reform and we feel that a budgeted margin of at least 2% is needed for us to be able to absorb the additional risk that comes along with a capitated payment system.

In calculating the budgeted net patient revenue for FY2018, we are requesting an exception to the net patient revenue cap under the physician transfer rules. With the completion of the clinic space as part of the Master Facility Plan, we are seeking partners to offer clinic services on a rotating basis. We are currently in talks with UVM Medical Center to bring services here on a part time basis. No specific programs or clinics have been agreed upon at this time; however, the budget includes a placeholder for the assumption that the rotating clinic space will be utilized one third of the time. This amounts to $375,000 of net patient revenue that is included in the budget as a physician transfer exception.

We are also seeking to utilize the full amount allowed for healthcare reform investments. Commitments to fund payment reform through OneCare, the largest Accountable Care Organization in Vermont, have increased by over $460,000 compared to our FY2017 budget. A .4% growth in net patient revenue for us in FY2018 is worth just under $408,000 the additional $52,000 which cannot be funded by increased net patient revenue under the FY2018 budget guidelines is an increased expense that is being absorbed by the hospital.

We have calculated the total net revenue to be included in the FY2018 budget as follows:

FY2018 Net Patient Revenue (NPR) Budget Calculation

FY2017 Budgeted NPR	$ 101,935,936	
3% Growth	3,058,077	
Total with Inflation		104,994,013
Healthcare Reform	407,744	
Physician transfers	375,000	
Total Exceptions		782,744
FY2018 Budgeted NPR		**$ 105,776,757**

6. a. Significant Changes:

We have not made changes to our FY2017 budget and variances are not related to external factors such as changes in reimbursement, physician acquisitions or certificates of need. We have experienced unfavorable variances in both volumes and expenses which have resulted in a loss from operations year-to-date through May and we expect to finish FY2017 with a loss from operations.

In preparing the FY2018 budget, a twelve month period was used as a base so as to avoid overweighting a small period of time. Because of this, the revenue base used in preparing the FY2018 budget is higher than the annualized value of fiscal year to date revenue. We have had vacancies in a number of the NMC owned physician practices throughout the fiscal year which will be filled prior to the start of FY2018 so we believe that it is reasonable to expect volumes to rebound.

Expenses are running over budget and nearly all of the variance is related to wages and benefits.

Wages began the year significantly over budget and have come down throughout the year although we still expect to finish the year well over a million dollars above budget (MD and non-MD combined). We are using third-party benchmarking data to compare ourselves to other similarly sized hospitals and carefully reviewing all open positions before filling them. As the hospital industry moves more and more toward a capitated payment model, it will become increasingly important to reevaluate our organizational structure. Included in the FY2018 budget is a reorganization of our Quality and Process Improvement departments along with a consolidation of the management of our Primary Care practice with Northwestern Urgent Care (operated by Northwestern Occupational Health). Both of these reorganizations capitalize on existing openings and have resulted in a reduction of 3 management level positions. Initiatives like this have allowed us to prepare a budget for FY2018 that includes a total increase in salaries and wages of 2% compared to the FY2017 budget while still providing for a highly competitive annual increase for our staff.

We have experienced a high cost year in our self-insured health plan with 8 high dollar cases year-to-date compared with a historic average of 2-3 high dollar cases per year. This type of variation is expected in a self-insured plan and we have positioned ourselves to be able to absorb unfavorable years and we know that we will also experience favorable years. Our FY2018 budget assumes that we will have an average year with 3 high dollar claims.

6. b. Cost Saving Initiatives:

Through our constant process of benchmarking FTE levels with external sources and challenging all positions that become vacant we have eliminated nearly 12 full time equivalent positions. In addition, as part of the restructuring of the Process Improvement department mentioned above, we have reassigned an assistant vice president to focus full time on organizational efficiency with an emphasis on quantifiable cost reduction. Accordingly, the budget includes $500,000 of savings to be identified.

6. c. Payer Specific NPR Changes:

We discuss the assumptions of individual payers throughout this section and it is important to note that the modeling for the FY2018 was done using traditional fee for services models since we did not have an analysis of the impact of the All Payor Model at the time this budget was prepared. Since receiving the models from OneCareVT, we have determined that the difference between the All Payor Model and the previously calculated net patient revenue for FY2018 are immaterial and did not necessitate any changes to the FY2018 net patient revenue budget and would not require changes if enacted in its current form. It is important to note impact of risk associated with the model is an important factor to consider as we move through 2018.

6. c. i. Medicare Net Patient Revenue:

The current proposed Medicare rules include a total increase of 1.15% for inpatient payment rates effective October 1st and a net increase of 1.75% for outpatient payment rates effective January 1st. The net impact to NMC is $333,000. The current proposals also include the elimination of low volume adjustment payments which are set to expire by October 1st. The elimination of these payments results in a decrease in net patient revenue of $543,000 in the FY2018 budget.

We are budgeting for Medicare to make up a larger portion of total revenue in FY2018 compared to FY2017 budget. We expect Medicare to make up 36.4% of gross charges, up from 35% in the FY2017 budget. This is reflective of current year results and the growth in some of our physician practices that have a high Medicare mix such as Dermatology, Ophthalmology and Orthopedics. A portion of the Medicare increase is attributed to payer mix shift (there is a decrease in Medicaid) on the rate schedule and the remainder is shown as a utilization increase. The combined total of these changes is an increase in Medicare reimbursement of approximately $2.85 million.

We have also experienced a higher case mix index in FY2017 than anticipated. Small changes in the case mix index can have a significant impact on reimbursement rates. The FY2017 budget, that was prepared during FY2016, called for a Medicare case mix index of 1.329. We ended FY2016 with a Medicare case

mix index of 1.390 and through May of FY2017 we are running at 1.427. The FY2018 budget includes a Medicare case mix index of 1.389 and this change from the FY2017 budget results in a net increase of approximately $750,000.

The remaining changes are a result of normal variations in patient type and service mix and are based on actual results over the last twelve months.

It is important to note that our historical Medicare Spending per Beneficiary (MSPB) is 7% lower than the state average and 6% lower than the national average as reported by QualityNet.org. This shows that there is a significantly lower cost to the healthcare system on average when Medicare beneficiaries are treated at NMC compared to the average result of hospitals in the state of Vermont.

Efficiency and Cost Reduction

Hospital-Specific Report

May 2017

Medicare Spending Per Beneficiary (MSPB) Measure

Table 3: Detailed Statistics of Your Hospital's MSPB Performance*
NORTHWESTERN MEDICAL CENTER INC

	Your Hospital	State	U.S.
Number of Eligible Admissions	838	40,052	5,389,267
Average Spending per Episode	16,367.54	19,660.94	20,301.91
MSPB Amount (Avg. Risk-Adjusted Spending)	18,635.03	20,019.85	19,999.85
U.S. National Median MSPB Amount	20,308.36	20,308.36	20,308.36
MSPB Measure	0.92	0.99	0.98

*Only the fifth row ("MSPB Measure") will be posted on Hospital Compare for hospitals with more than 25 eligible admissions. For hospitals with fewer than 25 eligible admissions, only the state and national values from the fifth row will be posted on Hospital Compare.

Source: Quality Net Hospital Specific Report

We have reached the point in the Meaningful Use program where there are little to no incentive payments left to be earned so the FY2018 budget, like the FY2017 budget, includes no Meaningful Use revenue.

We continue to partner with local pharmacies to maximize the use of the 340b prescription drug program that has lowered prescription costs for our community. We received $440,000 in revenue associated with this program in FY2016 and are projecting to receive a little over $530,000 in FY2017 and we are budgeting a similar number, $527,000, in FY2018. This revenue is reported in the Other Operating Revenue section of our income statement.

6. c. ii. Medicaid Net Patient Revenue:

Our budget assumes no increase in Medicaid reimbursement rates for FY2018 with the most significant changes related to observed utilization. Total Medicaid reimbursement in FY2018 is budgeted to be $1.15 million lower than the budget in FY2017 as we have seen the share of Medicaid gross revenue as a percent of total gross revenue go down from 24.0% in FY2016 to 22.6% through April in FY2017 against a budget of 24.3%. Medicaid gross revenue is budgeted to make up 22.3% of total gross revenue in FY2018.

6. c. iii. Commercial Net Patient Revenue:

Net patient revenue from commercial payers is impacted by the proposed rate increase included in this budget. We estimate that the rate increase request will result in just over $3 million of additional net patient revenue. We are seeing a very small increase in Commercial revenue as a percentage of total patient revenue, moving from a budget of 40.7% in FY2017 to 41.3% in FY2018 to mirror the slight increase that we have seen in FY2017.

7. Operating Expenses

Total operating expenses are budgeted to increase by $4.8 million compared to the FY2017 budget. The main components of this increase are as follows:

Depreciation Expense: As we continue to make significant investment in not only our buildings and equipment but also in information systems this category of expense will increase significantly over the next several years. Depreciation expense is budgeted to increase by $1.35 million from the FY2017 budget with nearly all of this increase being related to the master facility plan project which has components that have already been completed in FY2017 and all remaining components scheduled to be completed in early FY2018.

Interest and Amortization: This expense category includes interest cost on our debt and amortization of bond issuance costs. The interest expense related to new borrowing to fund the master facility plan has been capitalized as part of the construction cost throughout FY2017 while the work is underway. Once the project is complete, all interest paid will appear as a monthly expense. The result of this is that interest and amortization expense will increase by $650,000 in FY2018.

Salaries and Wages: Salary costs are budgeted to increase by $1.0 million, or 2% from the FY2017 budgeted amount. This represents a decrease of (2%) from the current YTD projection. As discussed earlier, we are actively looking for ways to increase efficiency and to optimize staffing. A total increase of 2% in this line is very modest.

Employee Benefits: As previously mentioned, health insurance claims are the main driver of employee benefits costs. While we are budgeting for this expense to be below what we have experienced in FY2017, the FY2018 budget is approximately $500,000 higher than the FY2017 budget.

Our health plan will continue to place accountability on employees for preventive health. If identified required preventive health is not obtained by an employee, they will pay a higher health plan premium than an employee that completes their required preventive health. Premiums paid by employees are recorded as an offset to claims paid.

Supplies: Supply expense is budgeted to increase by 4.3% compared to the FY2017 budget. The main components of this increase are the startup costs related to the ENT practice which account for approximately 1.7% of this increase. The remaining 2.6% includes an overall inflationary increase of 2% with 3% increases applied to surgical implants and pharmaceuticals. All remaining changes are related to volumes.

Contracted Services: Contracted services includes contract purchases, maintenance agreement costs, legal fees, equipment rentals, and audit fees. The contract services budgeted for FY2017 is an increase of $464,000 or 3.4% over the FY2017 budgeted amount. This increase is primarily driven by contracted providers in the physician practices and clinics and expenses in the laboratory.

The net change in the total cost for contracted services in the physician practices and clinics from budget FY2017 to budget FY2018 is $263,000 with the major components being the locum providers in Pulmonology, Comprehensive Pain and the new rotating clinics. These costs are partially offset by the elimination of locum providers in primary care as employed providers in those practices are included in the FY2018 budget.

The laboratory has seen an increase in the total cost of samples that are sent to outside labs for testing (UVM Medical Center, Mayo Clinic) primarily related to a higher than anticipated need for confirmation testing related to the urine toxicology program. These additional costs are included in the FY2018 budget and result in an increase of $152,000.

General inflation rates of 2% for supplies, 3% for drugs and 3% for surgical implants were also included.

8. Rate Request:

To achieve a net patient revenue increase of 3% plus the exceptions noted above, we will be requesting an overall average increase in prices of 6.0%. Hospital based charges will be increased 7.89% and physician practice professional fees will receive an increase of 0%.

Over the last couple of years there has been a reset of our net patient revenue. In FY2016 we reduced rates by (8%) in recognition of net patient revenue overages in previous years. The impact on daily operations was much larger as an additional 2% in rates were redirected to fund the growth in our lifestyle medicine and prevention and wellness initiatives as part of advancing healthcare reform. These changes were followed in FY2017 with a 0% rate increase as part of a continued level setting of our revenue structure based on previous year overages. These have had a significant effect on our revenue

stream as we are now both lower than budget and losing money for the first time in many years. A 6.0% rate increase is higher than the increases that we have received in recent years (below), but will still leave us with prices that are lower than they were in FY2015. Since FY2011 we have the lowest aggregate rate increase of any hospital in the state.

Hospital Rate Increases	2011	2012	2013	2014	2015	2016	2017	Total Since 2011	Average Annual Increase
Grace Cottage Hospital	5.5%	10.6%	6.5%	6.0%	5.00%	5.00%	5.00%	52.49%	6.21%
Porter Medical Center	6.5%	10.3%	5.0%	6.0%	5.00%	5.30%	5.30%	52.22%	6.19%
Gifford Medical Center	5.8%	7.0%	6.1%	7.6%	5.60%	5.80%	3.90%	50.02%	5.97%
UVM Medical Center	5.7%	5.9%	9.4%	4.4%	7.80%	6.00%	2.45%	49.67%	5.93%
North Country Hospital	4.4%	5.1%	4.6%	8.0%	8.30%	4.80%	3.50%	45.61%	5.51%
Southwestern VT Medical Center	6.0%	5.5%	6.8%	7.2%	4.50%	3.80%	3.40%	43.60%	5.31%
Rutland Regional Medical Center	5.5%	9.8%	10.3%	4.8%	8.40%	3.70%	-5.10%	42.85%	5.23%
Northeastern VT Regional Hospital	4.8%	7.5%	6.5%	5.6%	5.00%	3.20%	3.80%	42.51%	5.19%
Central Vermont Medical Center	5.2%	6.0%	5.0%	6.9%	5.90%	4.70%	2.45%	42.18%	5.16%
Mount Ascutney Hospital	6.5%	3.5%	7.0%	5.0%	3.22%	5.70%	4.90%	41.74%	5.11%
Brattleboro Memorial Hospital	6.0%	7.4%	5.2%	5.8%	2.70%	-1.40%	3.50%	32.80%	4.14%
Springfield Hospital	3.8%	5.8%	6.0%	4.6%	5.45%	2.80%	0.00%	32.00%	4.05%
Copley Hospital	5.5%	6.0%	3.0%	6.0%	0.00%	-4.00%	0.00%	17.21%	2.29%
Northwestern Medical Center	1.8%	6.3%	2.9%	3.9%	6.40%	-8.00%	0.00%	13.25%	1.79%
Health Connect – Blue Cross					7.70%	5.90%	7.30%		
Health Connect – MVP					15.30%	3.00%	8.80%		

There are a number of pressures on the FY2018 budget which create the need for a higher than normal rate increase. Some are external issues that must be absorbed within the budget including increases in bad debt and charity care, the discontinuation of Medicare low volume adjustment payments and the decrease in disproportionate share payments (DSH) in accordance with the latest FY2018 budget proposal for the State of Vermont.

In addition to these external factors, we are compelled to continue to invest in population health and the All Payor Model. The FY2018 budget includes increases in our population health program of over $750,000 and approximately $50,000 of the increased funding for OneCareVT falls outside of the .4% allowance for investments in health reform as part of the net patient revenue cap.

The budget also includes general inflation assumptions for both supplies and salaries. As the table below shows, to fully fund each of these items through a rate increase, we would need to request nearly 10%. It is not reasonable to believe that all of these items should be funded through a rate increase to commercial payers so we are asking for 6% with an operating margin of 2.1% compared to a prior year budget of 3.1%. In order to achieve an operating margin of 2.1%, significant expense efficiencies are needed as discussed in section 6. b.

Rate Increase Demands	Amount	Rate Increase
Bad Debt and Charity Care	2,179,451	4.31%
General Inflation (includes wages)	950,000	1.88%
Population Health Investment	759,007	1.50%
Medicare Low Volume Adjustment	547,000	1.08%
Disproportionate Share Payments	475,733	0.94%
Unfunded ACO Participation Cost	52,000	.10%
Total	**4,963,191**	**9.81%**

Bad debt and charity care write-offs have fluctuated over the last six years, particularly with the enactment of the Affordable Care Act. Initially, write-offs decreased but the decrease now appears to be an anomaly as the prevalence of high deductible plans has increased the patient portion of bills to insured patients. In FY2017, write-offs have returned to the same historical levels that we had experienced prior to the Affordable Care Act of approximately 3.75% of gross patient revenue which is reflected in the FY2018 budget.

Fiscal Year	Bad Debt %	Free Care %	Total %
FY2012	2.42%	1.30%	3.72%
FY2013	2.64%	1.07%	3.71%
FY2014	3.15%	0.66%	3.81%
FY2015	2.27%	0.67%	2.94%
FY2016	1.48%	0.77%	2.25%
FY2017 April YTD	3.28%	0.55%	3.83%
FY2018 Requested	3.00%	0.75%	3.75%

The impact of the increase in bad debt and charity care write-offs on the rate request is calculated based on the change from the approved FY2017 budget compared to the requested FY2018 budget. These write-offs had become a key point of discussion between us and the GMCB because we had exceeded the budgeted net patient revenue in FY2015 and were on track to do so again in FY2016 and lower than anticipated bad debt and charity care write-offs were a key factor in this variance. In recognition of this, during the FY2017 budget process, we had requested to budget bad debt and charity care write-offs at 3.00%, still an aggressive target and lower than the historical rates that we have experienced.

When the GMCB lowered our FY2017 rate increase from the requested 2.9% to 0%, we were asked to lower the budgeted write-off rates. This further exacerbated the variance caused by the return of bad debt and charity care write-offs to historical rates and increases the rate increase being requested for FY2018.

Fiscal Year	Bad Debt %	Free Care %	Total %
FY2017 Requested	2.10%	0.90%	3.00%
FY2017 Approved	1.70%	0.80%	2.50%
FY2017 April YTD	3.28%	0.55%	3.83%

9. FY2016 Net Patient Revenue Overage

We received a letter regarding FY2016 budget-to-actual overages indicating that we need to address an overage of $685,000. FY2017 net patient revenue is running considerably under budget and we expect to finish the year over ($1.2) million under budget. This more than offsets the overage experienced in FY2016 and believe that this satisfies the requirement of NMC to "pay back" any excess revenue. Since we believe that this issue will be resolved in the form of FY2017 results, no further action has been included in the FY2018 budget.

10. Capital Budget

The FY2018 capital budget consists of routine replacement of medical equipment, information systems equipment and facilities repairs and improvements. In addition to these routine items, we are planning for a handful of larger items, most notably:

Emergency Department Renovation: Like many other hospitals in Vermont, we have been dealing with a high number of patients in our emergency department that require mental health services along with medical services. The current configuration of the department is not ideal for this patient population as we do not currently have any beds set up in private rooms where safety precautions can be implemented. This requires us to use extra staff or security personnel to monitor these patients and/or to modify other rooms in or around the emergency department to hold these patients. This renovation would eliminate curtains between beds and instead place beds in private rooms with added safety features that could be used when appropriate. This project is in the very early design phase so the budget includes a very preliminary estimate.

Meditech Ambulatory Module: This project is to move all employed physician practices into the same electronic health record system that is used by the hospital. Physician professional fee billing along with all clinical documentation associated with a visit to one of our employed physician practices is done using a system called Medent which does not easily interface with the Meditech system. We have increasing demands for data from internal and external customers that are very difficult to satisfy with two distinct systems. Patients currently receive two bills for their visits when they receive professional services from the providers as well as technical services provided by NMC staff such as an x-ray in the physician office. Receiving two bills for the same visit can be confusing to our patients and is not ideal. Having two systems is also a burden to our staff as many patients need to be registered in both systems during a single visit and nurses and providers must know which system to look in when trying to find information related to a visit or patient. Taken together, these issues present a clear need to transition all billing to the same platform. This project has an expected cost of $2,241,000 and based on the expected timing of this project, it will span two fiscal years with $1,071,500 budget in FY2018 and the remaining $1,169,500 in FY2019.