NORTHWESTERN MEDICAL CENTER
FISCAL YEAR 2016 BUDGET

EXECUTIVE SUMMARY

Health care reform is evolving at an exceptionally rapid pace in the state of Vermont. While keeping up with this change can be a challenge, at Northwestern Medical Center (NMC) we are proactively transitioning systems and engaging stakeholders to achieve the necessary outcomes to bend the cost curve. We are committed to help evolve the health care "system" in Vermont by increasing clinical integration and collaboration within our community and with other neighboring hospitals – to create a system-ness around the delivery of health care. This system-ness will facilitate improving the value (higher quality, lower cost, improved access) we provide to patients, payors, and employers.

NMC is currently conducting a community-wide health needs assessment to ensure our priority focus is on serving the needs of the community collectively with our partners. This provides the basis for our work and for the planning of the municipalities and community organizations of Franklin and Grand Isle counties.

We are proud to recognize our entire NMC family for receiving three Avatar Patient Satisfaction Awards in the areas of Exceeding Expectations, Best Overall Performer, and Exemplary Service – Most Improved – Ambulatory Services. Our intentional efforts to engage staff and providers around the patient experience are now evidenced in our results.

As the largest health care provider in our community, NMC has taken a leadership role in working with other health care entities and governmental agencies to drive health care reform in our service area. We briefly describe some of these efforts below.

The Community Committee on Healthy Lifestyles and RISE VT Launch!

RiseVT is our region's innovative, engaging, community-based best practice wellness initiative designed by our Community Committee on Healthy Lifestyles to help our population embrace healthier choices and behaviors. For too long, our northwestern Vermont has felt the burden of poor health indicators, such as sedentary lifestyles, challenging food choices, and tobacco use. Our health has suffered from this and our personal health care costs are higher than they need to be as a result. RiseVT was created by a broad-based group of local leaders to help change that. RiseVT provides a formal framework – we call them scorecards – for individuals, families, schools, businesses, and municipalities to use in guiding their improvement efforts. RiseVT works on each level of the socio-ecological model of health improvement, supporting individuals' efforts to improve their personal health by facilitating efforts to address organizational, policy, and infrastructure issues to help create a healthier community in which positive behavior change can be nurtured and sustained. Our Community Committee on Healthy Lifestyles that oversees RiseVT is a result based collaborative initiative led by Northwestern Medical Center and the Vermont Department of Health. It features key leaders from all aspects

of our community: healthcare, education, local government, local businesses, the media, agencies, etc. With our hospital Board setting a strategic priority for Wellness, RiseVT is made possible by operational funding from NMC of up to $200,000 in our FY'15 budget, with that same amount designated in the proposed FY'16 budget. This local investment is matched by a $400,000 SIMS grant from the State over two years to implement RiseVT as a population health improvement strategy within Vermont's long-term health care reform effort.

RiseVT launched in June of 2015 with a month of interactive outreach. Teams from RiseVT were at June Dairy Days in Enosburgh, the Health & Wellness Day in North Hero, the Vermont Days at our state parks in Grand Isle and Franklin, "show up" events in St. Albans, significant social media interaction, local media attention, and more. Our adult and child "smoothie bikes" are becoming famous among event planners in the region. We have had crowds of 20+ people at our weekly 6am "show up" physical activity events and have already had three other towns ask us to bring those events to their town greens as well. One of the particularly visible RiseVT kickoff events was held at St. Albans City School where more than 750 children and their entire staff celebrated the school's achievement of "Gold" status in RiseVT through their adoption of healthy habits and policies by following a lap on their new walking track, coming together on the school field to spell out RiseVT for an aerial photo, and then enjoying healthy smoothies from the RiseVT smoothie bikes. It was a sight to be seen that made it to the front page of the daily newspaper. Special thanks to Dr. Alan Ramsey and Dr. Harry Chen for joining us for this kick-off event.

Our launch efforts are beginning to create traction with our general community. 529 individuals have already taken the RiseVT pledge to adopt healthier lifestyles. They are now within the RiseVT system that includes the personal scorecards, health coaching support, access to the Cerner wellness portal, and more. Twelve businesses have signed up to be RiseVT businesses and are working with the RiseVT health coaches and health advocates to work through their scorecards and adjust policies and practices and infrastructure to better support their employees in living healthy lifestyles. Four schools are already formally involved with a focus on healthier children. Three municipalities have joined as well and are working through what evidence and best practice has shown a village can do to help improve population health among their residents. The role of social media and online connections has been key. We have more than 1,000 likes on the RiseVT Facebook page and the first 21 posts in our launch drew 302 comments, had 239 shares, and were seen by 34,128 people! RiseVT had 2,264 visitors come to its website in the first three weeks of June for an average of more than 100 per day. For a first month, we believe that is a remarkable start.

As this momentum grows and the RiseVT efforts expand, the focus is making a measurable improvement in the health of our community. We recognize that creating a cultural movement in a community of 55,000 people takes time and that large scale health indicators take years to improve. Still, by focusing on research-based strategies, maintaining and growing engagement, and addressing each level of the socio-ecological model, we can improve population health. We are marking our progress on this mission at first through the kind of participation numbers we have shared here. Our SIMS grant carries with it specified goals (both short and long-term) that we are working towards during our two-year grant cycle. The impacts that we are measuring through those specified goals include:

- Decreasing the percentage of obese and overweight individuals;
- Increasing the number of employers with 50% or more of their workforce participating in an onsite wellness program;
- Increasing smoke/tobacco free environments;
- Increasing fruit and vegetable consumption;
- Decreasing the number of people with no physical activity time;
- Expanding community resources for biking and walking;
- Increasing the number of students who walk or bike to school.

It is exciting to see schools creating safe routes for children to bike and walk to school; to see municipalities creating smoke-free parks and considering better sidewalks; to have employers making policy changes to help encourage better health; and to have so many individuals actively participating in physical activities and healthier eating. RiseVT drew strong interest from the Prevention Institute of California in their work for the State's Population Health Workgroup on national best practices and promising efforts here in Vermont that the State can build upon. Even before that report goes public, we have already started fielding inquiries from other communities in Vermont interested in replicating RiseVT for their area. RiseVT is meant to be a community-wide cultural movement towards population health and three weeks in, we are proud to say the movement has started!

Regional Clinical Performance Council

NMC is a member of both the OneCare VT and the Community Health Accountable Care (CHAC) accountable care organizations (ACOs). What is unique about our community partnerships is the collaboration for clinical integration while working with two ACOs that impact our community. Each ACO has its own governing board and clinical advisory boards. Although the two ACOs are operating separately, we have found a way to create one Regional Clinical Performance Council (RCPC) that can incorporate both ACO's priorities. This multi-disciplinary RCPC, comprised of .a Federally Qualified Health Center, Blueprint, long-term care, mental health, home health, public health, private and employed physicians, and hospital representatives, has been instrumental in advancing standardized evidence-based practice in the past year. Working closely with both ACOs, and with physicians paving the way, standard protocols for Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease, and Fall Risk Screening have been developed. Additional efforts to increase hospice utilization, decrease unnecessary ED visits of low acuity conditions, and decrease all cause re-admissions have occurred.

Over the past two years, the St. Albans Health Service Area (HSA) realized a 28% collective increase in OneCare ACO performance measures, the highest in the State, compared to a 5% statewide OneCare Vermont improvement. Primary care, including strong efforts from CHAC, has been a driver of many of the initiatives to improve preventative screening and drive best practices in the at-risk population conditions. This fully integrated approach, while challenging, is reaping benefits in meeting the priorities of the two ACOs with whom we are partnering. Representatives from the OneCare Vermont ACO repeatedly are speaking to the extraordinary results this community is achieving with broad representation and participation within our

regional health care system. Other regions frequently call to solicit guidance on approaches the St. Albans RCPC has utilized to advance our efforts. We clearly advocate for the strength that is found in engaging committed physicians and community partners in creating integrated systems of care. With the RISEVT initiative we are actively connecting the dots between our community–wide healthy lifestyle initiatives and our population health work to implement evidenced based best practice protocols across our health care partners. We currently are blending the work of the Blueprint with the RCPC. It is truly amazing to see the advancements and outcomes with an engaged community.

Vermont Blueprint for Health Initiative

Since 2010, NMC has implemented the VT Blueprint for Health initiative in the St. Albans HSA. Fifteen advanced primary care practices participate in NCQA recognition as Patient-Centered Medical Homes and have embedded Community Health Team resources at the point of service. As the NCQA standards focus more on care management and coordination and transitions of care, practices develop new models to deliver care using nurses, social workers, mental health counselors and nutritionists. The Blueprint program funds nine full-time equivalents (FTEs), plus eight FTEs focused on addiction care coordination with nurses and substance abuse counselors, an identified community need which was reinforced at this year's NMC Incorporator meeting when discussing regional health priorities. These Community Health teams are fully embedded in our primary care practices and document all their work in the respective practice electronic health records.

Blueprint activities have fully aligned with all accountable care activities. In January, the Blueprint Integrated Health Service meeting folded, with clinicians and members in leadership positions now attending the RCPC, and care managers forming a new work group focused on Care Management and Coordination. The Care Management and Coordination work group will participate in this fall's statewide Care Coordination Learning Collaborative. In addition, the St. Albans Blueprint Manager has already initiated a Learning Collaborative consisting of three phases which commenced in June, 2015. This facilitated St. Albans Regional HSA Learning Collaborative was attended by over 70 individuals representing teams of health care entities from throughout our region seeking to enhance our systems of care to exceed ACO performance measure targets in collaborative and innovative ways.

Our HSA has commenced discussions about how to move to the Unified Community Collaborative model of governance, quality improvement and resource allocation. We are exploring ways to test collaborative relationships through oversight of the Blueprint grant and Community Health Team resources. Through this process, we expect to develop a framework for making decisions about HSA-level operations and accountability in the next phases of delivery and payment reform.

Collaboration with Other Hospitals and Federally Qualified Health Center (FQHC)

NMC continues to be a catalyst for conversations to create local and regional system integration. We have developed a sub-committee of our hospital board and the local FQHC board to discuss integration of care above and beyond the ACO collaboration. Currently we are making space

available on our campus for the local FQHC practice to co-locate. This will further enhance programs and communication around transitions of care. In addition we are facilitating discussions with the FQHC, Mental Health provider, and a local Home Care provider to discuss opportunities to improve services. For example, a team effort has been charged with integrating Hospice Care. We are also actively involved in discussions with area hospitals to identify opportunities to enhance care to our respective communities while discussing strategies to share services, reduce duplication, and ultimately reduce costs and advance quality. We are motivated to be a leader in improving quality and enhancing the patient experience, while reducing costs. We also recognize this change in thinking and providing care as a system takes time and persistence.

Healthy Ü Incorporates a Wellness Clinic

We believe that bending the health care cost curve and promoting wellness starts with our own employees. We continue to invest in our Healthy Ü program designed to provide incentives and opportunities for our employees to become healthier. We also continue to offer this program to area businesses. In alignment with the RiseVT effort we have implemented a wellness clinic under the direction of Dr. Elisabeth Fontaine using evidenced based coaching. The implementation has started with a pilot targeting high risk employees. Based on results we will expand this program to the community as an extension of primary care targeting healthy behavioral choices to include a focus on sustainable activities. We must focus on healthy behaviors in order to bend the cost curve and to impact the potential overuse of medical systems. We continue to talk with Blue Cross of Vermont on how we might partner with them to integrate our employee wellness program with theirs to increase employer wellness program participation.

Narcotic Addiction

Chronic pain and prescription drug abuse have a high prevalence in Franklin County. NMC has developed an agreement with the Howard Center, Public Health, law enforcement, pharmacies, and NCSS to collaborate in developing a seamless system to care for individuals facing these diseases. The demand for this type of service is escalating. The Blueprint model continues to be a great platform to support our addiction program. Our program is continuing to develop and has increased our level of expertise by requiring Board Certification for our physicians. We are collaborating with Primary Care physicians to provide onsite access in our clinic for the management of this population. We are also working closely with local agencies to provide group education to include: Stress and Anger Management, Relationship Dynamics, Nurturing Parent Program, and Financial Strategies… just to name a few. As our program has grown we have felt it necessary to create a witnessed urine toxicology site to monitor compliance with program protocols as well as reduce the risk of diversion in the community. Our program continues to grow and has now reached over 200 patients with, unfortunately, no end in sight for demand for these services.

Emergency Department (ED) Utilization and Care Management

We transitioned our ED pilot program that began in early 2013 into a permanent program in 2014. We hired a full time ED Care Manager who works with our high utilizer patients and others needing aggressive support with the transition of care. We partner closely with our local health care providers and our Primary Care/Medical Homes to reduce non-emergency and repeat visits to our emergency room. This program was developed in the best interest of providing the right care at the right time for our community and it has proven to be the right thing to do. Since the inception of this project in 2013, our ED volumes have declined by 10 % overall and our avoidable visit volume has been reduced by 5% year to date (January – May, 2015) against a 5% target for this calendar year; so we have met our goal only 5 months into this year. Our system of care management in the ED is producing excellent outcomes and the value of the seamless continuum of care and communication with our health care partners is immeasurable. Recently we expressed our interest to participate in a pending grant which would provide access to a mental health counselor within the emergency department which will also support our patients in securing the right follow-up resources in the community.

Urgent Care

Our St. Albans and Georgia Urgent Care Centers continue to work closely with Primary Care providers in the community to provide patients with quick, reliable, and affordable care for non-emergent needs that do not require an ED visit. The Urgent Care team understands that their role is to treat the patient's chief complaint and make sure that they follow up with appropriate care. For most of our patients, that follow-up is with their Primary Care provider. To support this, Urgent Care staff makes sure that all notes are sent to the Primary Care provider's office within 24 hours of the patient's visit and that for patients with multiple co-morbidities, a follow up appointment is made with their Primary Care provider before the patient leaves the Urgent Care Center.

The Urgent Care management team works very closely with NMC's management team through our ED Utilization Committee to ensure that the patients we serve are getting the right care at the right time in the right location. This collaboration and related initiatives have contributed to the declines in ED volumes noted above.

Strategic Planning

Our Board recognizes that the future requires change in how we deliver care. With a strong emphasis on population health, we are embarking on a facilitated strategic direction setting exercise. This process will include not only our board members but administration and our medical staff leaders. These are extraordinary times requiring critical strategic analysis. The community is entrusting us to lead this transformation to ensure access to affordable health care for all while continuing to provide exceptional care and services.

HEALTH REFORM INVESTMENTS

We are identifying the increase of OneCare Vermont ACO fees anticipated for next year ($132,000) as a health care reform investment as this term is defined in the GMCB budget instructions. Per the letter from OneCare's CEO dated March 16, 2015, our ACO fees will be $216,000 in 2016. The health care reform investment we are requesting equates to a .15% net revenue increase versus the allowable .60% increase.

All of the work we describe in the Executive Summary above also supports health care reform. This work is being funded by a combination of grant funds and our own internal funding. Excluding grant funded activities, and ACO fees, we will be making an investment in health care reform in 2016 totaling in the hundreds of thousands of dollars for additional software systems and people. This is a substantial amount of money for an organization our size, and further demonstrates our commitment to move from a fee for service delivery model to a wellness and population health approach to health care.

The health care reform investments that we specifically identified and received approval for in our 2015 budget submission, and the return on investment thereon, are described below.

RiseVT

Please refer to the RiseVT discussion in the Executive Summary above.

OneCare Vermont ACO Participation Fees

Please refer to the Executive Summary above that discusses our ACO participation and our ACO performance results.

RN Quality Specialist and IT Technician

The RN Quality Specialist is integral to our efforts to support the myriad of health care related data collection, data analysis, and process improvement initiatives that will be required to continue to create and standardize care in our community. In this regard, she has been the single source for chart auditing for Medicare, Medicaid, and Commercial ACO measures, as well as coordinator of ACO mediated initiatives to decrease ED utilization and prevent readmissions. While focused upon NMC clinical care performance measures, this role has also been instrumental to forwarding the efforts of both ACOs (OneCare and CHAC) and the St. Albans Regional Clinical Performance Counsel to create and sustain new health care models in our community.

Due to different measures being submitted for tracking with the Vermont Blueprint, Meaningful Use, PQRS, CMS, and ACOs, the IT Technician was instrumental in building reports to meet all these extraction needs. These reports have assisted us in our efforts to improve quality performance, as evidenced by our 2014 ACO performance. In addition, the IT Technician has

been instrumental in obtaining data used to support our readmissions task force which is currently focused on long-term care facility care practices as a priority.

Please refer to the information contained in the Executive Summary section for evidence of results we are achieving on our health care reform efforts which these two positions provide support for.

OVERALL BUDGET NET PATIENT REVENUE BUDGET TO BUDGET INCREASE

In 2013, as a means of controlling health care expenditures, the GMCB established a 3% limit on the increase in budgeted net patient revenue from year to year for Vermont hospitals for fiscal years 2014 through 2016. There are small exceptions allowed for demonstrated investments in health care reform if approved by the GMCB. In addition, exceptions may be granted for net revenue associated with employing physicians that were true net adds to the organization (not just backfill of vacant existing positions).

Beginning for fiscal year 2014, the GMCB established a process to enforce the 3% cap. This process was only broadly defined, with few specifics other than a requirement that hospitals exceeding their budgeted net revenue by more than .5% provide the GMCB with an explanation of their net revenue variance. The process provided the GMCB broad authority to take action against those hospitals that exceeded the .5% variance.

The GMCB has had specific meetings this past year to review and focus on the handful of hospitals (including NMC) that exceeded their net revenue budget in 2014 by more than .5%. NMC has received a higher level of attention than these other hospitals given our track record of exceeding our net revenue budget in recent years, our 2015 results showing we are exceeding our 2015 net revenue budget, and our relatively high operating margins and days cash on hand compared to other Vermont hospitals. The table below gives you a sense of just how much of an outlier NMC is on operating margin and days cash on hand when compared to the other Vermont hospitals.

	Operating Margin			Days Cash on Hand		
	Actual			Actual		
	2012	2013	2014	2012	2013	2014
NMC	**9.00%**	**8.00%**	**7.90%**	**275**	**312**	**371**
Best performing Vermont hospital (other than NMC)	7.60%	4.40%	6.90%	187	186	211
Worst performing Vermont hospital	-10.00%	-5.70%	-7.30%	38	53	62
Vermont hospital mean average (excluding NMC)	0.60%	1.00%	1.10%	119	126	136
UVM Medical Center	3.40%	3.90%	4.60%	183	183	197
Standard & Poors Stand-Alone Not-for-Profit Hospital Ratings for AA- rated Hospitals	4.40%	5.70%	*	301	310	*

* Information not made available yet

While there is no doubt that our results for these two metrics are much more favorable than other Vermont hospitals, they are comparable, and not excessive, when compared to the top performing hospitals in the country. It is also important to note that these are only two financial metrics and looking at a very limited number of financial measures does not tell the whole financial picture of an organization.

With respect to net patient revenues, this is a complex amount to budget for. As a result, having actuals not exceed budget by more than the GMCB limit of .5% is extremely difficult. For instance, our 2015 net patient revenue budget was about $91 million. Based on the State's guidelines, we could only exceed this amount by $455,000 before we were deemed to be out of compliance. To further simplify this and equate it to actual volumes, a .5% variance translates to less than 1 inpatient admission per week over budget for 2015. The various factors that can impact net patient revenues are:

- Patient volumes
- Payor mix
- Reimbursement levels from Medicare, Medicaid, and insurance companies
- Bad debt and charity write-offs

Due to the number of factors that can impact net patient revenues, from a prudent business perspective, we budget net patient revenues with a level of conservatism to reduce the likelihood that we materially come under our net revenue target. Below is a table that shows the amounts we budgeted for gross and net patient revenue in fiscal years 2014 and 2015, and the actuals we have incurred, with green indicating that we came in under the budgeted amount, and red indicating that we came in over the budgeted amount.

	Gross Revenue				Net Revenue				
	Budget	Actual *	Variance	Variance %	Budget	Actual *	Variance	Variance %	Allowed Variance
FY 2014	$ 175,627,000	$ 174,476,000	$ 1,151,000	0.66%	$ 87,759,000	$ 91,165,000	$(3,406,000)	-3.88%	$ (438,795)
FY 2015	$ 180,018,000	$ 190,647,000	$ (10,629,000)	-5.90%	$ 90,796,000	$ 97,067,000	$(6,271,000)	-6.91%	$ (453,980)
CUMMULATIVE	$ 355,645,000	$ 365,123,000	$ (9,478,000)	-2.67%	$ 178,555,000	$ 188,232,000	$(9,677,000)	-5.42%	$ (892,775)
* FY 2015 is projected									

For 2014, as indicated, our actual gross revenues (the amounts we charge before insurance company discounts, bad debts, and charity care write-offs are applied) came extremely close to budget; in fact they were slightly lower. Our net revenues; however, exceeded budget. The components of that variance are as follows:

Medicare low volume payment – This reimbursement was not approved by the federal government to continue for the full fiscal year 2014. We prepared our budget to reflect this. Well after the budgets had been finalized and approved by the GMCB, the rules changed that extended this reimbursement through March 31, 2015. This resulted in approximately $400,000 of additional net revenue to NMC.

Medicaid provider based reimbursement – Prior to 2014, Medicaid provider based reimbursement did not exist, and there was no notification by the State that they were going to begin this reimbursement at the time our 2014 budget was prepared. Accordingly, our 2014 budget did not include revenues for this. In early calendar year 2014, we were advised that the State was going to begin provider based reimbursement to be consistent with the Medicare program. This resulted in additional net revenue to NMC of approximately $650,000. After the fiscal year 2015 began, the State advised hospitals that they underestimated the cost of paying hospitals for provider based reimbursement and therefore implemented reimbursement reductions in other areas in early calendar year 2015 to offset the cost of paying for provider based reimbursement.

Vermont Managed Care risk based contract payment – NMC participated in a risk based contract through Vermont Managed Care. Under this contract, a certain amount of money was withheld from our claim payments and evaluated for payout at the end of the year depending if utilization targets were met. We have not included any payouts under this program in our budgets as these amounts are not known to us when we prepare the budget and can vary significantly from year to year. We disclose this approach to the GMCB annually as part of our budget documentation. In 2014, we recorded revenues from this contract arrangement of $1.475 million due to outstanding management of patient health care service utilization.

Charity and bad debts - Charity and bad debt write-offs (combined) as a percentage of gross revenues was under budget by .3 percentage points. This area has been particularly challenging to budget for given the significant shifts in insurance coverage that have taken place as a result of the Affordable Care Act within the past few years. We feel that given the unknowns of the impact of these shifts in coverages, and the increasing levels of patient financial responsibility that come along with high deductible plans, a .3% variance from budget is reasonable. This variance resulted in additional net revenues of $443,000.

For 2015, our net revenue variance is a much different story. The net revenue we are projecting in excess of our budget is largely due to volumes and the corresponding gross revenue exceeding budget. Some of the larger variances include:

Outpatient surgeries and outpatient surgical procedures combined are exceeding budget by 10% resulting in a $1.4 million positive gross revenue variance through April. Our fiscal year 2015 outpatient surgery volumes were based on the actual run rate in surgeries at the time we prepared the budget, with some adjustments for known changes, including an increase we expected as a result of the urology deal with UVM Medical Center, and a decrease related to having an orthopedic locum here for several months in 2015. The net resulted in a 1% increase in total surgeries from our 2015 run rate. Outpatient surgeries and surgical procedures ran under budget last year, and to be conservative, we did not have a basis for increasing the 2015 budget back to the budgeted 2014 level. However, the 2015 actuals through April are running almost exactly on target with the amount we budgeted through April in 2014.

ED visits are exceeding budget by just under 3%. We did budget for a 5% decrease in volumes from the run rate we had at the time we prepared the budget based on advice

from our urgent care consultant as a result of opening the urgent care in St. Albans, as well as our continued efforts to reduce avoidable ED visits. In addition, at the time we prepared the 2015 budget, we had planned on implementing the Meditech ED software in 2015, and we therefore backed off some ED revenues during the expected implementation and ramp up period. The Meditech implementation has since been delayed until a future time. Finally, we expected some changes to our coding levels as a result of some preliminary information that we had at the time the budget was prepared that would have reduced coding levels, resulting in lower gross and net revenues. After some further work that we did, this did not materialize. ED gross revenues are over budget year-to-date by $1.7 million.

Most Diagnostic Imaging modalities of service were budgeted to either remain flat from 2014 actual run rates, or decline by up to 2.5% due to the expectation that health care reform and wellness efforts would hold these volumes in check. Volumes and gross revenues for most Diagnostic Imaging modalities have exceeded budget this year – CT scanning making up the largest portion of this variance. The general x-ray, CT Scan, MRI, Ultrasound, and Echo modalities combined have exceeded budgeted gross revenues by $1.8 million. In a report we received from OneCare a few years ago, the St. Albans Heath Care Service Area did not appear to be out of line as far as advanced and standard imaging costs when compared to the ACO in total.

Our comprehensive pain clinic gross revenues are exceeding budget by $706,000. In preparing the 2015 budget for this clinic, we projected significantly less revenues due to a desire by our pain clinic medical director (the key revenue driver for this operation) advising us that he wanted to cut back his time in the clinic to pursue other interests he had. This did not come to fruition and he continues to work full-time at the clinic.

There is a small portion of the projected net revenue variance for 2015 that can be directly attributable to a change in reimbursement and not due to volumes. Specifically, the Medicare low volume adjustment that was set to expire on March 31, 2015 was extended through September 30, 2017. We prepared our budget according to the law that existed at the time, and therefore only budgeted the low volume reimbursement for half of 2015. The additional reimbursement that we expect due to this change is $510,000. In addition, we will be receiving a final payment from Vermont Managed Care (under a risk based contract arrangement) to close out the 2013 calendar year in the amount of $273,000. This program was discontinued at the end of calendar 2013 and any payments we have received from this program have not been budgeted due to the uncertainty of the amounts. The approach of not budgeting for these amounts has been disclosed to the GMCB as part of our budget presentation annually.

As a result of our fiscal year 2014 actual results showing a net patient variance over the .5% allowed variance threshold and our actual and projected 2015 net revenues showing the same, the GMCB has provided NMC with supplemental fiscal year 2016 budget instructions to specifically address this issue. These instructions indicate that in the preparation of NMC's 2016 budget, we should, among other things, "consider both 2014 actuals and 2015 projections and examine the extent that your approved rates were too high…".

After careful review and analysis of the net patient revenue variances for 2014 and 2015, we believe that we have a reasonable basis to demonstrate that a portion of the variances should be accepted by the GMCB. The portions of the variances that we believe should be acceptable are:

Vermont Managed Care (VMC) payments – The VMC arrangement we participated in was a risk based contract, tying ultimate reimbursement to meeting a utilization budget. Overutilization of health care services meant less favorable financial performance for NMC under the contract, while underutilization of budgeted health care dollars meant more favorable financial performance by NMC and the other contract participants. VMC was established for the purpose of facilitating, coordinating, and helping improve the delivery of high quality, cost effective managed health care services through independent contracts with health care providers to enrollees in, or beneficiaries of, managed care insurance plans. VMC administered a care management program which included utilization review, case management, and appeal and grievance functions. The costs of health care and key metrics on a per-member-per month measurement under this program were favorable to national averages. It is exactly these types of programs where providers take on risk to achieve a targeted health care budget that the GMCB is encouraging us to do, and we were doing this well before the GMCB ever came into existence. The risk payments that NMC received under the VMC contract would be similar to any shared savings that we might receive under the OneCare ACO that we participate in – a program that the GMCB supports. Not permitting the VMC risk based payments to NMC as an exception to the net revenue cap would be akin to the GMCB penalizing hospitals for exceeding their net revenue cap if any payments related to ACO shared savings caused them to exceed their approved budgeted net revenue amount. This is counterintuitive to us and does not support the direction that we have been encouraged to take by the GMCB.

2015 Volumes Exceeding Budget – We believe that we prepared our 2015 revenue budget prudently and that the net revenue variances in 2015 caused by volumes exceeding budget are reasonable based on the assumptions we made at the time the budget was prepared, considering facts and circumstances that existed at that time. We recognize that this still represents a variance from GMCB policy; however, we believe that since we did provide the health care services to patients, we should at least be allowed to cover the variable costs associated with providing that care.

Even after considering the exceptions noted above, NMC is left with a large variance over the net revenue cap when you take 2014 and 2015 combined. As required by the GMCB, we have prepared our 2016 budget to in effect, make a cumulative correction to our net patient revenues (through a rate reduction) to ensure that our combined 2014, 2015, and 2016 net patient revenues do not exceed the cumulative 9% cap (combined for the three years), excluding the exceptions above, new physicians and the new urine toxicology program in 2016, and the investment in health care reform in 2016 that are all subject to GMCB approval.

Attached is a schedule that provides the detail we have prepared showing the value of the exceptions described above. If approved, these will result in a rate *decrease* of 8.0%.

We are delighted to be able to present a budget that produces such a substantial rate decrease, which continues our very favorable rate increase history over the past several years relative to the rest of the Vermont hospitals. In fact, looking at the last twelve years, NMC has the lowest cumulative rate increase of any hospital in the state of Vermont, which is more than **twenty percentage points** lower than the highest hospital in the state. This is evident when reviewing the common charges posted on the Internet for all Vermont hospitals. Based on the most current charge data available, for the common outpatient charges, which make up a large portion of our business, NMC's charges are less than nearly 90% of the average statewide charges for the same services.

Despite the GMCB's good intentions to translate net revenue overages into hospital rate decreases, the reality is that these decreases do not find their way to reduced premiums for our community in any meaningful way. In discussion with a Blue Cross representative, Blue Cross does not set rates for our community that specifically correlate to NMC's rate increases or decreases. Furthermore, Blue Cross has submitted a request to the GMCB to increase overall premiums in 2016 by 8%, which is due to be finalized by the GMCB before our budget is finalized. Assuming we decreased our rates by 8%, there would potentially be a 16% variance in what rates our community should see versus the rates they will actually be charged. Blue Cross is by far our largest payor, outside of Medicare and Medicaid. Our rate decrease will however have direct impact on health care costs paid by patients who do not have insurance, or who have deductible or coinsurance amounts that they are responsible to pay.

Physician and Other Program Transfers/Acquisitions

Our fiscal year 2016 budget includes costs and revenues associated with a dermatologist, contracted ENT services from UVM Medical Center, and a urine toxicology program. Since the combination of the net revenues associated with these programs would cause us to exceed our net revenue cap, we have provided as part of our budget submission the required physician transfer worksheets. We have also further described these transfers below.

Dermatologist – Net Revenue Exception Request of $855,487

Our community had two part-time dermatology providers; however, they were not replaced when they left in 2012. Since that time, patients from our area have had to travel to Burlington or Colchester for access to dermatology services. Wait times to be seen have averaged between seven weeks to six months, depending on type of insurance held by the patient. Medicaid patients in particular have difficulty accessing dermatology services, and if they are able to get an appointment, often face the longest wait times to be seen.

The need for dermatology services in our community were identified in our 2012 community needs assessment and is confirmed by physician needs and population based needs analyses performed by independent parties that indicate that our community requires anywhere between 1.2 and 1.8 dermatologist FTEs.

Initially, NMC attempted to partner with the private practice of Four Seasons Dermatology in Burlington; however, we could not come to a common place on the structure of a clinic here.

We also thoroughly investigated the option of tele-dermatology with the University of Vermont Medical Center (UVMMC) using one of our Physician Assistants as the clinical point person on site with the support of the UVM Dermatology team. The system proposed did not provide real-time answers for patients and did not provide streamlined access to care. These options were not ultimately meeting the needs of this community.

ENT – Net Revenue Exception Request of $204,179

UVM Medical Center previously provided ENT physician services in St. Albans twice a week. About a year ago, this service was discontinued, essentially leaving our community lacking in ENT services. Based on discussions we are now having with UVM Medical Center representatives, we expect that we will enter into a contract with them to provide an ENT physician in our community two days per month for office visits, and one day per month for surgeries. Under this contract arrangement, the revenues will belong to NMC, unlike previously when revenues went to UVM Medical Center. So this represents a transfer of net revenues from UVM Medical Center to NMC.

Urine Toxicology Program – Net Revenue Exception Request of $791,176

NMC currently operates a robust drug addiction program within its Comprehensive Pain Management Clinic, as more fully described in the Executive Summary section above. A key element of the drug addiction program is regular controlled urine testing of patients to validate program compliance. NMC has used an independent lab for these services. The independent lab handled all patient and insurance billing and received the revenues for such billings. NMC plans to bring this testing in-house, thereby transferring the revenues from the independent lab to NMC.

Major Volume Assumptions

Admissions

Based on national trends, we had budgeted admissions to decrease slightly this year. However, year-to-date through May, our admissions are 2% higher than the same time last year. We continue to believe that our Med-Surg/ICU admissions will decline despite the results we have seen this year, and based on projected births for the remainder of this year, that our Family Birth Center volume will decrease even further into next year. As a result, we have budgeted an overall decrease in admissions from budget 2015 to budget 2016 of 1.1%. This represents a 6% decrease off of a straight annualization of our admissions year-to-date through May; however, we believe admissions will start to drop off during the remaining months of this fiscal year due to seasonality and actual data we have on births scheduled.

Surgeries

We based our fiscal year 2016 budgeted surgeries on our current run rate, making adjustments for an increase related to GYN and fertility procedures that are now being performed here by an independent group of surgeons, along with other increases related to the orthopedic and ENT

physicians we expect to see. This resulted in about a 1% increase in total surgeries being budgeted for fiscal year 2016 compared to our current run rate.

Compared to budget 2015, our 2016 budgeted surgeries are up about 7%. This increase is due to a lower number of surgeries budgeted for 2015 which was based largely on the 2015 run rate at the time we prepared our 2015 budget. Surgeries in 2015 started out very slow early in the year and were running under budget. Volumes did not pick up until later in the year and we were unclear whether these higher volumes would hold.

ED Visits

As a result of continued case management efforts and the opening of two urgent care locations in St. Albans, in fiscal year 2015 we budgeted for a 5% decrease in ED visits compared to the 2014 volumes that were projected at the time we prepared our 2015 budget. The number of ED visits exceeded our projections during the second half of 2014 such that the 2015 budget represented a 7.5% decrease compared to the final 2014 ED visit volume. Year-to-date through April, ED visits are down 1.8% compared to prior year. We believe that there is additional opportunity to reduce avoidable visits in the ED and therefore have prepared our 2016 budget to reflect a decrease of 5.7% from the total ED volumes we have experienced in the past twelve months.

Major Revenue and Reimbursement Assumptions

Medicare and Medicaid

Based on the proposed Medicare inpatient rules recently issued, we are budgeting for a 1.9% increase in Medicare inpatient reimbursement effective October 1st. This includes a full year of low volume payments which CMS extended through October 31, 2017. No proposed regulations have been issued at this time for Medicare outpatient. However, based on proposed inpatient rules, we are budgeting an increase in reimbursement of 1.55% effective January 1, 2016. Based on regulations passed earlier this year, we have prepared our 2016 budget to reflect a .5% increase in Medicare physician service reimbursement effective July 1, 2015 and an additional .5% increase effective January 1, 2016.

The budget instructions from the GMCB stipulated that no changes to Medicaid reimbursement should be budgeted for. Accordingly, no increases or decreases in Medicaid reimbursement were included in the 2016 budget.

DSH

Based on the State's calculation, our State DSH reimbursement is budgeted to increase by $170,000 comparing 2016 to 2015 budgeted amounts.

Bad Debts and Charity Care

Bad debt and charity care are generally measured in the industry as a percentage of gross revenues. In 2014, NMC's bad debt write-offs as a percentage of gross revenues were slightly

over budget, and slightly higher than the actuals for the two prior years. In 2015, our bad debt write-offs as a percentage of gross revenues are running under budget, and down from the 2014 actuals. The table below shows the historical budget and actual write-off percentages for both charity and bad debt.

	Actual as a percentage of gross revenues				
	2012	2013	2014	2015*	
Bad debt	2.30%	2.60%	3.00%	2.20%	
Charity	1.20%	1.00%	0.70%	0.70%	
Total	3.50%	3.60%	3.70%	2.90%	
					Budget
	Budget as a percentage of gross revenues				2016
Bad debt	3.30%	2.70%	2.80%	3.20%	2.80%
Charity	1.00%	1.30%	1.20%	1.00%	0.90%
Total	4.30%	4.00%	4.00%	4.20%	3.70%
*Through April					

The GMCB notes in their budget instructions that the bad debt and charity care write-offs have shown declines when looking at the 2014 actual results of Vermont hospitals. Based on these results, the GMCB has required hospitals to address the trends and provide rationale for the 2016 budgeted amounts.

NMC's bad debt trend for 2014 was not consistent with the general decline seen by other hospitals that the GMCB notes. In fact, given the increased number of high deductible plans that we see patients present with, our 2014 actual results were not all that unexpected, despite the Medicaid expansion which presumably has moved some self-pay patients to Medicaid coverage, and the implementation of Vermont's Health Connect (Vermont's insurance exchange). With respect to the insurance exchange, we continue to find many patients either choosing not to purchase insurance through the exchange despite tax credits being offered because there is still cost involved, or patients signing up for insurance through the exchange but choosing mostly the high deductible plans in order to pay lower monthly premiums. For these reasons, the results many of the other Vermont hospitals are seeing seem somewhat counterintuitive. Our 2015 results to date of lower bad debt write-offs surprise us given the proliferation of high deductible plans, and we are hesitant to conclude that the results for only a portion of a year constitute any meaningful trend that we can rely on. Accordingly, while we reduced our bad debt write-off budget for 2016 from the amount that was budgeted in 2015, we increased it from our actual write-off experience in 2015. If the 2015 bad debt write-off rate continues to hold at the same level for the remainder of the year, and the 2016 actuals track closer to our full year 2015 actual

write-off rate, we will consider lowering our 2017 budget amount to more closely approximate the actual results.

With respect to charity write-offs, our actual 2015 results which are below budget are not what we expected as we have increased the visibility of our program to our community through regular newspaper ads and provided publications about our program at the local United Way and Health Department offices, among other locations. We would like to see our charity write-offs approach the 1% level and therefore are targeting our charity write-offs in 2016 to increase over our 2015 actual rate.

Meaningful Use Funds

We have budgeted to receive $497,000 in meaningful use funds in 2016. This is classified as Other Operating Revenue in our budget.

Major Cost and Inflation Assumptions

Our budget has been prepared to include an average 3% pay increase for staff. Although we recently concluded a comprehensive compensation consultation with resulting waves of market adjustments to many positions, we continue to find it challenging to retain staff with our close neighbor UVM Medical Center generally paying higher rates of pay, especially high demand nursing staff. It is likely that UVM Medical Center compares to other tertiary centers in their salary structures which is quite different than the small community hospital market. Nevertheless even with the small hospital environment, young staffers do change positions for pay and growth within specialty services not found in a small community hospital. We have a targeted goal to reduce nursing staff turnover at less than two years of service. Our recent ASPIRE hiring program is proving to be successful for young nurses.

Physician salary and contract costs include increases being generated by our physicians under our physician incentive compensation plan and employment or contracting of additional providers as noted in the Physician Transfer/Acquisition section above. These costs also include a contracted anesthesia program, and contracted urology and cardiology programs with UVM Medical Center.

We applied a 2% inflation increase to most of our supply costs. These inflation amounts are based on inflation data we receive from Quorum Health Resources, and other economic forecast information available to us.

Cost Saving Initiatives

As we appear to be moving closer to some sort of global budget environment in the State of Vermont, it is a challenge to balance the need for cost reduction with the need to invest in the infrastructure and resources to be successful in a global budget world which requires a focus on population health. While we believe we still have opportunities to reduce costs and find ways to do things more efficiently, these opportunities are becoming harder and harder to find as we have already identified and implemented a number of improvements during recent years. Rating

agencies for the health care industry also recognize that a lot of the low hanging fruit for cost reductions have already been harvested, and coupled with the reimbursement pressures hospitals face, the agencies continue to give hospitals a negative outlook. Some of the cost reductions we have achieved in the past few years include the following:

- Rebid and changed courier service.
- Renegotiated copier leases and eliminated several stand-alone printers that are much more costly to operate.
- Standardized sutures used in Surgical Services.
- Increased the use of reprocessed supplies in Surgical Services.
- Went to a new tier level with a major vendor of supplies for Surgical Services resulting in increased discounts.
- Brought certain patient infusion and lab services in-house that were previously being sent to UVM Medical Center.
- Reduced energy use as a result of implementing energy efficient solutions.
- Moved several clinical equipment service contracts from high cost original manufacturer arrangements to our contracted lower cost bio medical equipment company.
- Consolidated and eliminated a number of telephone and cable lines.
- Did not replace certain management staff when they left the organization and moved their areas of responsibility under another existing manager.
- Changed corporate credit card program which has produced significantly higher reward program rebates.
- Engaged QHR to review labor productivity standards and meet with each manager to review specific department productivity levels. This review identified certain opportunities that we continue to work towards.
- Engaged a consulting firm to assist us in taking orthopedic implants out to a competitive bid, which is still in process.
- Conducted clinical productivity review by an independent firm to ensure we are meeting best practice standards.
- Conducted LEAN linen distribution process to reduce waste in the system and supply.
- Conducted LEAN lab registration process to reduce steps in process and enhance service.

These cost reductions have helped us achieve an average cost per Medicare beneficiary as most recently published by Medicare which is 14% less than Vermont and US hospitals.

RATE REQUEST

NMC is requesting an overall rate ***decrease*** of 8.0%. The budget has been prepared applying the rate decrease to all services, other than our physician practices and clinics which rates will remain unchanged. However, we anticipate applying the rate decrease differently across the services of our organization, to be determined based upon the final approval of our rate decrease.

The overall rate decrease was developed to result in an operating margin of 3.6% (3.2% excluding meaningful use funds) based on the revenue and cost assumptions provided herein.

CAPITAL BUDGET INVESTMENTS

The major capital investments we are planning are as follows:

FY 2016

Meditech Hardware Replacement and Meditech Clinical System Upgrade to 6.1 - $1,719,670

The Meditech system (hardware and software) was implemented in October 2010. The servers that run this system will be over five years old shortly and past their useful life. Due to the criticality of the Meditech system to our organization, these servers need to be replaced in FY 2016 and we estimate these will cost $850,000. In addition, Meditech is implementing a major software upgrade. The additional payments due in 2016 for this upgrade total $293,714. The software upgrade costs represent implementation hours incurred by Meditech, with the implementation scheduled for completion in 2017. There are no additional software licensing charges as our contract with Meditech provides us with a perpetual license. An additional cost of just over $575,000 represents capitalized NMC staff time to work on the implementation, as well as a project consultant.

OR Chiller Replacement - $991,083

This project includes the replacement and upgrade of the chiller that provides cooling to the Operating Rooms and Surgical Services. This project is designed to address ongoing issues (equipment failure, noise, temperature and humidity control) from a failing unit which was not able to be fully restored through last year's repairs. The upgrades included in this project will positions us for better redundancy (achieved through the chilled water system tie in project described below) that we need but have not previously had. There will also be energy efficiency benefits of this project.

Georgia Location Consolidation - $700,000

Currently we lease space in two different locations in Georgia, one for our Georgia Health Center primary care practice, and one for our urgent care operations. We are exploring the possibility of identifying a location in Georgia to combine these operations to reduce space costs and provide synergies between the services provided at each of these separate locations. The amount included in our capital budget for 2016 for this project are estimated initial costs related to this project.

HVAC HeatEx Unit Replacement (Lab) - $204,750
Admin Hallway Air Handling Unit - $233,325
Courtyard AHU - $116,000
Combined Cost for Project - $554,075

This three-faceted project involves the planned replacement of a 20-year old air handling unit which is in poor condition and problematic, resulting in downtimes in service. The scope of this

project properly splits the areas of the units served which are the Laboratory, Administration, and Support Services (Facilities and Environmental Services administrative areas, the maintenance shop, and Environmental Services staff work area and break room) to provide more appropriate and efficient air handing based on the differing demands of those separate areas. In addition this project replaces the similarly aged and problematic roof top unit serving the Courtyard Café, and expands HVAC service to the cafeteria (food serving and cashier area) which currently uses window units for cooling.

Virtual Desktop Deployment - $322,180

Virtual Desktop Infrastructure (VDI) creates a highly reliable and scalable workstation environment that allows desktop sessions to be run on end user devices of all types. In essence, users get a brand new computer session each time they log in, always getting a consistent, updated and high-functioning session with the only interruption to their day being a reboot of the device. VDI presents significant ROI through extended life of end-user devices, more efficient and responsive support, and overall staff productivity and efficiency. Existing workstations become “dumb terminals” that simply display a computing session that actually runs on a server in our datacenter. This means the hard drive and other physical components of existing workstations will last longer and require much less support over the life of these devices. Any software related issue is generally resolved remotely by IT staff, virtually eliminating the need for IT staff to respond to a physical location of a computer device.

VDI presents a significant improvement to physician and other provider workflow through "Follow-Me" roaming workstation sessions, that keep providers connected and productive as they move from exam room to exam room. Because the computer session is running on a server, served up on the mobile workstation, providers will not need to wait for long computer operating system boot-ups and log-ins. Implementation of VDI at NMC will facilitate the elimination of expensive and cumbersome mobile carts in our future nursing areas (as computer devices will remain in patient rooms), creating a safer and vastly improved workflow for care providers.

FY 2017-FY 2019

Major capital expenditures planned for fiscal years 2017 through 2019, excluding CON items, are as follows:

2017

Georgia Location Consolidation - $3.2 million

We are exploring properties to purchase in Georgia to consolidate our Georgia urgent care and Georgia Health Center primary care operations. This will eliminate rental costs and provide operational efficiencies. The amount budgeted represents initial costs related to this project. Depending on the final scope of this project, a CON may be required.

ED Renovation - $1.9 million

This project has been through conceptual design and focuses on increasing privacy, improving patient and staff safety, and adapting workspaces for more efficient workflow. This renovation has been significantly scaled back from initial concepts to match efforts to focus the Emergency Department on emergent care while shifting non-emergent care to primary care, urgent care, mental health offices, and other more appropriate settings.

2018

OR Cameras and Displays - $453,000

This represents a routine replacement of cameras and related display monitors used in surgeries.

Digital X-Ray Equipment - $360,000

This represents the routine replacement of imaging equipment.

2019

Conference Center Renovation - $1.2 million

Due to the increased use of our conference room area within the hospital, this area is in need of renovation and expansion.

Effect on Income Statement of Proposed CONs

We currently have two CONs in review with the GMCB. Both have the specific income statement impacts of these projects included in the financial tables that have been submitted to the GMCB as part of our CON submissions.

DEFINITION OF ALL OUTPATIENT VISITS

Outpatient visits includes outpatient surgical procedures (excluding surgeries performed in the operating rooms), patient visits to our clinics and physician practices, and observation days.

COMMUNITY NEEDS ASSESSMENT

Northwestern Medical Center is currently in the data collection phase of our work on the 2015 Community Health Needs Assessment for our region. We are working with experts from Quorum Health Resources and following a similar process to the one used to create the 2012 Community Health Needs Assessment for our community. We expect that this document will be complete and available in the fall of 2015.

TECHNICAL CONCERNS

None at this time.