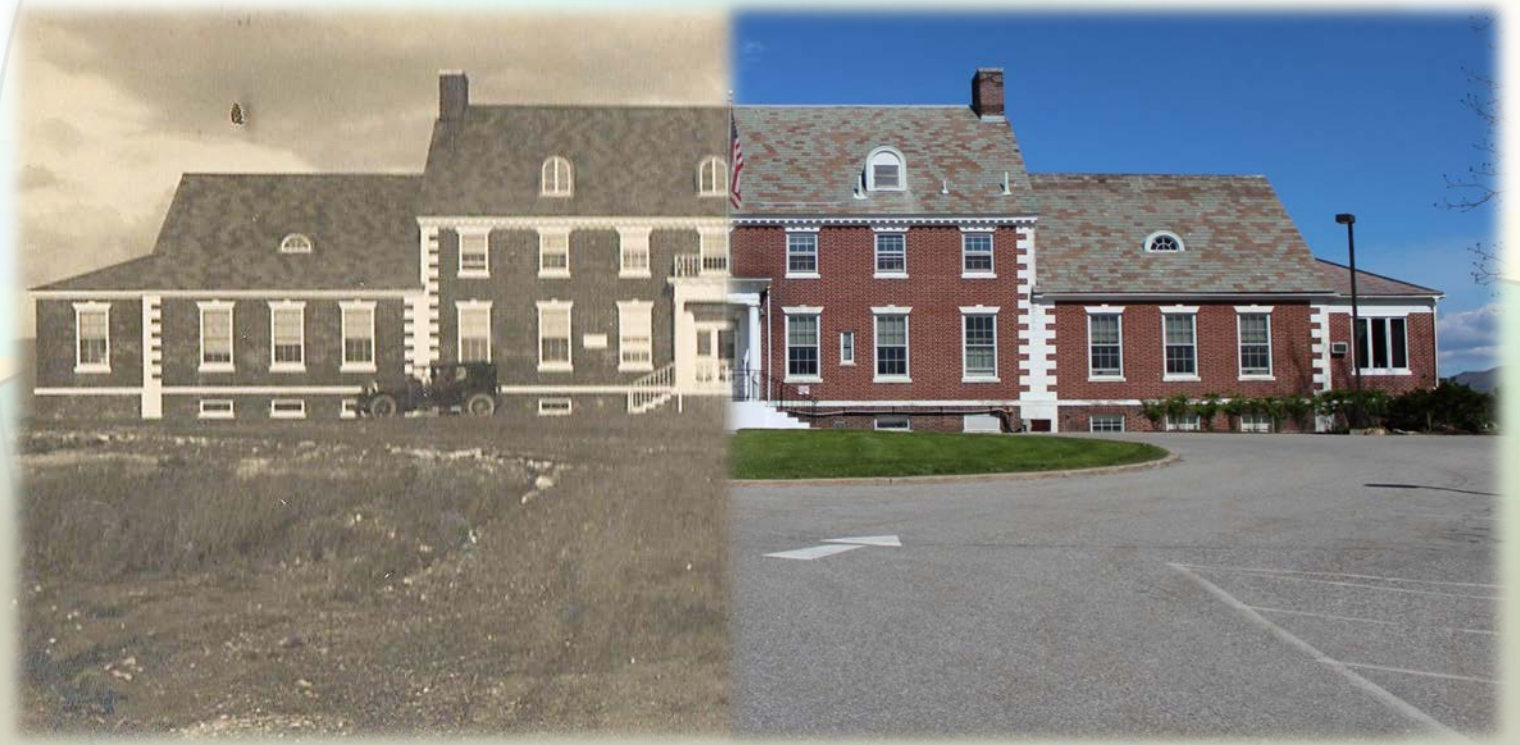
Porter Hospital FY 2017 Budget Presentation
Green Mountain Care Board



August 18, 2016

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Introductions

Dr. Fred Kniffin – Interim CEO

Steven T. Ciampa – CFO

Dr. Carrie Wulfman – CMO

Peter Igneri – VP of Porter Medical Group

Ron Hallman – VP of Development & Public Relations

Jennifer Bertrand - Controller

FY 2017 Budget Development

Two Channel Approach

- Status Quo – Baseline
- Key Initiatives

Development of Margin Target

($ in thousands)	FY 2016 Budget	FY 2017 Budget
Total Expenses	$ 77,255	$ 77,327
Depreciation and Amortization	$ (3,390)	$ (3,289)
Net "Cash" Expenses	**$ 73,865**	**$ 74,038**
Days in Year	366	365
Total Expense Per Day	$ 201.8	$ 202.8
Cash & Investments (Revised Forecast as of 9-30-16)	$ 16,933	$ 16,933
Days Cash on Hand	83.9	83.5
Net Change in Days Cash on Hand		**(0.4)**
Margin Target Development:		
Required to Maintain DCOH		$ 86
5 Days Growth DCOH		$ 1,014
Debt Payments		$ 717
Pension Funding		$ 465
Capital Spending		$ 4,006
Subtotal		$ 6,288
Less Depreciation & Amortization		$ (3,289)
Margin Target		**$ 2,999**
FY 2017 Total Margin Budget Request		**$ 3,802**
Target Variance		**$ 803**

Sources & Uses Statement

($ in thousands)	FY 2016 Revised Forecast	FY 2017 Budget
Net Patient Service Revenue	$73,831	$76,095
Other Operating Revenue	$2,872	$1,987
340b Revenue	$2,966	$2,694
Other Non-Operating Revenue	$233	$354
Total Revenue	$79,902	$81,129
Total Expenses	($76,448)	($77,327)
Total Margin	**$3,454**	**$3,802**
Add Back Required Accruals	($500)	$139
Depreciation and Amortization	$2,903	$3,289
Total Net "Sources" of Cash	**$5,856**	**$7,230**
Debt Payments	($780)	($717)
Pension Funding	($437)	($465)
Equity Transfer To Affiliate	($2,250)	($2,350)
Capital Spending	($2,300)	($4,006)
Total Net "Uses" of Cash	**($5,767)**	**($7,538)**
Net Cash Flow	**$89**	**($308)**
Beginning Days Cash on Hand	**84.4**	**84.8**
Ending Days Cash on Hand	**84.8**	**83.3**
Net Change Days Cash on Hand	**0.4**	**(1.5)**
Total Expense Per Day	($201)	($203)

Comparative Operating Statement

	FY 2014 Actual	FY 2015 Actual	FY 2016 Budget	FY 2016 Forecast	FY 2017 Budget	Budget to Budget % Δ
REVENUE						
Total Gross Patient Revenues	133,682,767	142,245,626	155,893,897	155,541,273	161,257,384	
Total Contractual Allowance and Discounts	(65,651,131)	(68,340,342)	(77,384,575)	(79,850,592)	(83,208,233)	
Provision for Bad Debts	(2,006,852)	(3,256,656)	(3,429,666)	(2,740,325)	(2,460,639)	
Disproportionate Share Revenue	691,760	847,101	501,426	506,408	506,408	
Net Patient Service Revenue	66,716,544	71,495,729	75,581,083	73,456,765	76,094,920	0.7%
Meaningful Use	751,268	681,617	270,352	459,620	125,001	
Total Other Revenue	2,080,942	1,991,031	1,689,570	1,864,684	1,861,662	
Other Operating Revenue	2,832,210	2,672,648	1,959,922	2,324,304	1,986,663	
TOTAL NET OPERATING REVENUE	69,548,754	74,168,377	77,541,005	75,781,069	78,081,583	0.7%
EXPENSES						
Management Contracts	2,247,457	2,710,040	2,232,155	5,149,222	3,898,379	
Salaries and Wages Expense	32,200,341	33,942,747	36,576,151	34,631,246	35,025,754	
Benefits	8,949,602	8,942,445	9,785,502	9,319,921	9,400,483	
Supplies & Expenses	11,533,200	12,190,267	12,243,723	12,519,445	12,558,459	
Purchased Services	7,951,025	9,688,046	8,697,407	9,313,022	8,599,722	
VT Medicaid Tax	3,910,935	4,046,887	4,016,414	4,180,236	4,180,236	
Depreciation and Amortization	4,501,518	3,174,885	3,390,087	3,223,896	3,288,613	
Interest	409,809	322,120	313,280	391,004	375,258	
TOTAL OPERATING EXPENSES	71,703,887	75,017,437	77,254,719	78,727,992	77,326,904	0.1%
OPERATING MARGIN	**(2,155,133)**	**(849,060)**	**286,286**	**(2,946,923)**	**754,679**	
340B Revenue	3,222,965	3,269,714	2,952,914	2,913,656	2,693,560	
Other Non-Operating Revenue	718,556	340,404	402,425	305,395	353,714	
TOTAL NON-OPERATING REVENUE	3,941,521	3,610,118	3,355,339	3,219,051	3,047,274	-9.2%
TOTAL MARGIN	**$ 1,786,388**	**$ 2,761,058**	**$ 3,641,625**	**$ 272,128**	**$ 3,801,953**	
Total Margin %	*2.6%*	*3.7%*	*4.7%*	*0.4%*	*4.9%*	

NPSR Increase Request

FY 2017 NPSR Budget to Budget Increase of 0.7%

Budget to Budget Change		%Δ
FY 2016 Budget	75,581,085	
FY 2017 Budget	76,094,920	0.7%
	513,835	

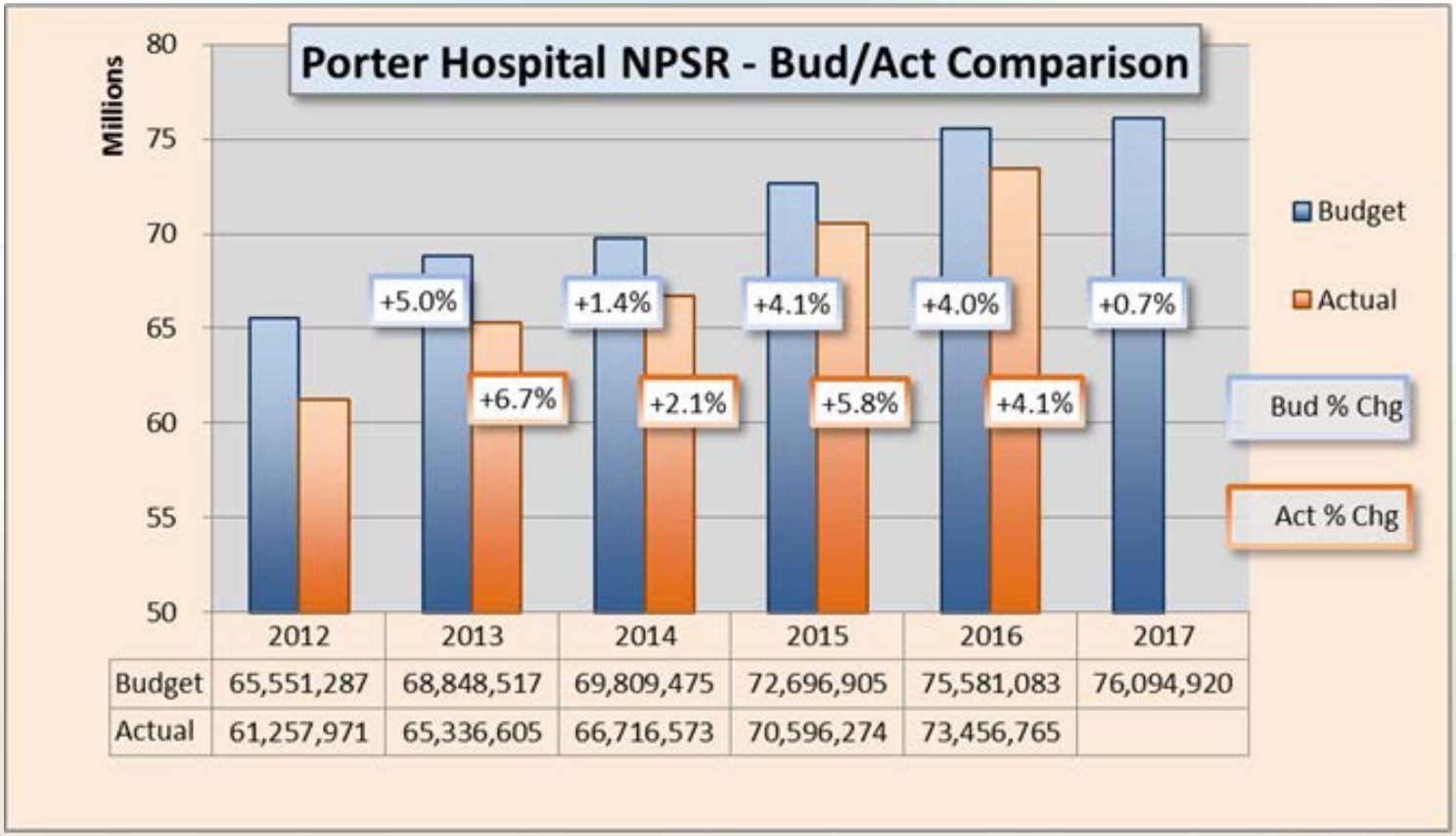
($ in Millions)

Charge Increase	1.1
Payor Mix	-
Medicare/Medicaid	(0.6)
Commercial Ask	1.2
Utilization	(2.4)
Bad Debt	1.0
Charity Care	0.3
DSH	-
Total	**$ 0.5**

FY 2017 Healthcare Reform Initiatives:

- ACO Participation
  - Continued OneCare Vermont SSP participation through CY 2016.
  - Anticipated participation in CHAC SSP for CY 2017.
    - Porter, along with 5 other CAHs have made a non-binding decision to participate in this "non-risk" program.

NPSR Comparison – Budget / Actual



	2012	2013	2014	2015	2016	2017
Budget	65,551,287	68,848,517	69,809,475	72,696,905	75,581,083	76,094,920
Actual	61,257,971	65,336,605	66,716,573	70,596,274	73,456,765	

- Budget FY 2017 vs. Actual FY 2016: 3.6%
- Actual FY 2012 vs. Budget FY 2012: (7.0%)
- Average Annual Budget Increase: 3.0%
- Average Annual Actual Increase: 4.7%

GPSR Increase Request

Most Hospital Charges Increased by 5.30%.

- Overall Effective Rate of Increase = 3.7%
- No Increase in Price for Physician Services
- Pharmacy, Med/Surg Supplies, and Contracted Lab Prices are based on cost.

Payor Impact

	GPSR	NPSR
Medicare	2,354	-
Medicaid	921	-
Commercial	2,078	817
Self-Pay/Other	372	320
Budget to Budget Change	**5,725**	**1,137**
Percent Increase vs. FY 2016 Budget	*3.68%*	*1.51%*

A 1% increase ≈ $1.1M of GPSR and $0.2M of NPSR.

Inpatient Utilization

FY 2017 Budget

	2015 Actual	FY 2016 Budget	FY 2016 Forecast	FY 2017 Budget
ADMISSIONS:				
MEDICAL SURGICAL	**1165**	**1,236**	**1,133**	**1,164**
OBSTETRICS	**371**	**357**	**340**	**379**
TOTAL ACUTE HOSPITAL ADMISSIONS	**1,536**	**1,593**	**1,472**	**1,543**
NEWBORN NURSERY	**376**	**369**	**362**	**379**
SWING BED	**55**	**66**	**55**	**34**
TOTAL ADMISSIONS	**1,967**	**2,028**	**1,888**	**1,955**
AVERAGE LENGTH OF STAY	**3.1**	**3.4**	**3.3**	**3.2**
PATIENT DAYS:				
MEDICAL SURGICAL	**4020**	**4,595**	**4,124**	**4,089**
OBSTETRICS	**870**	**825**	**776**	**884**
TOTAL ACUTE HOSPITAL PATIENT DAYS	**4,890**	**5,420**	**4,900**	**4,973**
NEWBORN NURSERY	**800**	**795**	**733**	**810**
SWING BED	**667**	**581**	**557**	**409**
TOTAL PATIENT DAYS	**6,357**	**6,796**	**6,190**	**6,192**
AVERAGE DAILY CENSUS	**17.42**	**18.62**	**16.91**	**16.96**

Outpatient Utilization

FY 2017 Budget

	2015 Actual	FY 2016 Budget	FY 2016 Forecast	FY 2017 Budget
EMERGENCY ROOM VISITS	15,374	14,673	15,036	15,196
OP SURGERY PROCEDURES	3,279	3,228	3,350	3,370
PORTER PRACTICE MANAGEMENT VISITS	99,287	107,220	106,875	102,614

- Turnover in Primary Care
- Practice Operation Efficiency

Expense Drivers
Budget 2016 vs. Budget 2017

	BUDGET FY16	BUDGET FY17	VARIANCE BUD 16 - BUD 17
Porter Hospital	478.1	453.2	(24.9)
PMC (Via Management Contract)	15.9	29.2	13.3
Total Porter Hospital & PMC	494.0	482.4	(11.6)

- Labor
  - Reorganization of PMG
  - Holistic Management of All PMC Entities
  - Compliant with AMS/MGMA Productivity Benchmarks
- Benefits
  - Full Year of Self-Insured Health Care Benefit
- Non-Labor Expenses
  - Includes Inflation Factor of 2%
  - Pharmacy
    - Increased use of higher cost medications (E.g. Prevnar and Nexplanon)
  - Temporary labor
    - Continued demand in Med/Surg and OR.

FY 2017 Operating Strategy

Key Initiatives

- Helen Porter
- Stabilize Inpatient Operations
- Porter Medical Group

Quality & Integration Successes

- Quality ratings – Hospital CMS 4 star, HPHRC 5 star, Press Ganey improvements.
- CHAT (Community Health Action Team)
- Case Management/Transitions of Care
- Customer Service Initiatives
- Integration and Collaboration of Key Participants: CSAC, Middlebury College, ACHHH, etc.

Quality & Integration Challenges

- Mental Health Service Deficits
- Addiction Medicine Deficits
- Payment Reform
- Time to Commit to ACO work

Summary Results: 2015 CHNA Update

Community Needs Aligned With Porter Mission:

- Access to Primary Care

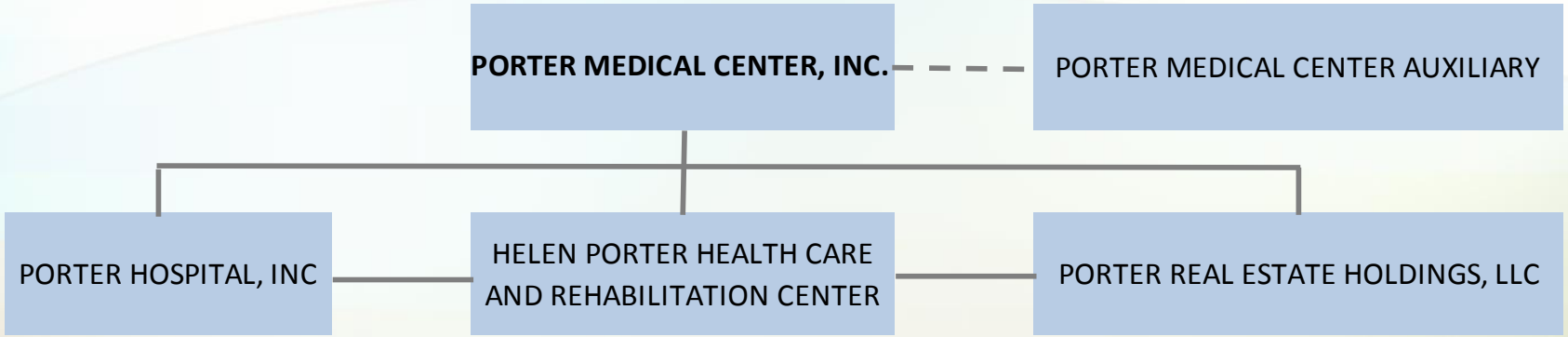
Community Needs Requiring Collaboration:

- Mental Health Services
- Substance Abuse/Opiate Addiction Services
- Obesity/Chronic Disease Management

Community Needs Beyond Porter Mission:

- Dental Services (Medicaid/Adults)
- Homelessness

Organizational Structure
Porter Medical Center, INC.



GMCB Questions & Responses

1) Since the reevaluation of your primary care network, provide an update of the size and scope of your primary care network presented in the hospital budget.

What changes have occurred? Physicians have dropped by 2 but mid-levels are increasing by 13. Explain this change. How do you examine the issue of physician capacity or need for your service area?

Our FY 2016 budget for primary care FTEs (Total of MD and Mid-Levels) were 28.8 and our FY 2017 budget includes 23.7 FTEs. We experienced a closure of one of our sites of service (Porter Internal Medicine). We still maintain a very high primary care provider per 1,000 resident ratio as compared to Vermont and national benchmarks. One of our key strategic initiatives is to improve access among the existing primary care providers such that their annual patient visits and panel sizes are reasonable as compared to surrounding markets.

In the FY 2016 budget submission, there are 15 Mid-Levels who were not reported as Mid-Levels. These Mid-Levels were reported as non-MD FTEs and should have been reported under the Mid-Level category.

GMCB Questions & Responses

2) The hospital's net patient revenues (NPR) are increasing 0.7% over 2016 budget. This easily meets the target as the hospital has revised its budget base to reflect the changes outlined in their narrative.

a) Explain your NPR changes at the budget hearing using the payer schedule provided in the staff's analysis. Specifically explain the amounts for each payer that are not related to the rate increase. The GMCB is interested in understanding the changes occurring from budget to budget by payer.

The overall budget to budget change in NPR is $0.5M. This change breaks down as follows:

- **Change due to requested increase in charges = $1.1M**
- **Change due to volume = ($2.4M)**
- **Changes related to Bad Debt / Sliding Scale = $1.3M**
- **Changes due to price paid by insurers = $0.5M**
  - **Negotiations with commercial payors = $1.1M**
  - **Anticipated reductions in Medicaid PPS = ($0.3M)**
  - **Anticipated Medicare cost report impact = ($0.3M)**

b) A $600,000 loss in NPR is identified as budgeted losses due to anticipated changes to reimbursement for Medicare and Medicaid. Provide an update on the status of these assumptions.

The Medicaid NPR rate variance of ($0.3M) is the anticipated result of future PPS changes unknown to us at the time of budget submission and based on previous years' experience.

The Medicare NPR rate variance of ($0.3M) is the anticipated reserve expense as per our calculation of critical access hospital reimbursement via the Medicare cost report.

GMCB Questions & Responses

3) The hospital is requesting a 3.7% overall rate increase. Hospital inpatient (4.3%), outpatient (4.6%), and physician services (0%) are all priced differently. Describe the strategy for pricing services differently.

The difference in inpatient and outpatient percentage of charge increase is due to the distribution of pharmacy and chargeable medical / surgical supplies between in and outpatient. Porter does not apply a standard charge increase to these items, whereas their pricing is based on cost, and applied based on tiers of cost. The standard charge applied to all other procedures is actually 5.3%, but averages out to 4.3% Inpatient, 4.6% inpatient, and an overall average of 3.7%. No increase is applied to physician services whereas all of Porter's insurance payments are based on fee schedules, and not percentage of charge. The only patients who would participate in a price increase for physician services would be those with no insurance whatsoever (a/k/a Self Pay).

4) The hospital has identified the NPR dollars related to the rate increase at $1,137,777. These dollars will be earned from payers by raising prices by the effective rate increase. In addition, the hospital identifies NPR dollars they anticipate as part of their negotiations with insurers of $1,150,595. This is called their "commercial ask". Explain the differences from the hospital's perspective.

As all hospitals try to address the cost shift, continually created by the fact that the Medicaid system reimburses at a rate significantly below true cost and has no annual update this coming year, we have made our best effort to negotiate fair and reasonable increases with our commercial insurance contracts (a/k/a, "commercial ask"). Porter then determined how much of a charge increase might be reasonable to request considering the desire to achieve an acceptable margin, balanced with continued concerns for charge transparency and consumer decisions.

GMCB Questions & Responses

5) Describe the purpose for transferring FTEs to the parent organization and rehiring them under Management contracts. Explain this rationale – who do they now work for and why? Will this help the hospital reduce overall administrative and per unit costs? Discuss how this is related to the labor benchmarking work that is intended to find greater efficiency and reduce overall FTE needs.

The transfer of FTEs to the Parent Company ("Porter Medical Center", a/k/a "PMC") is budget neutral, in that it did not result in any corporate-wide FTE growth. Our labor benchmarking system considers not only hospital specific paid hours, but also the allocated hours as well as consideration for any temporary labor hours (including nurse travelers), therefore regardless of the corporate location or use of temporary labor, all labor hours are considered for the purpose of measuring against labor management targets. The purpose of the move was to create a more holistic and consistent environment across all business units of PMC. We believe that this has had a positive effect on intercompany communications and employee engagement.

6) Explain the changes being seen in utilization. Acute admissions are expected to increase over projected 2016 while physician visits are expected to decline. Explain the assumptions used to develop these estimates. Describe the infusion program and the data and assumptions that were examined to support launching this new service.

The projection for FY 2016 includes the impact of our first quarter experience, which reflected a significant decrease in acute admissions for both Medical Surgical and Swing Bed. We do not anticipate this experience to recur in FY 2017; therefore, acute admissions were budgeted at a more comparative level to previous year's trends.

Physician visits have declined primarily due to the aforementioned closure of Porter Internal Medicine.

Infusion services had previously been provided on a limited and urgent basis by the nursing staff of our inpatient unit. We utilized market data provided by VAHHS to identify patients from our HSA who were traveling both North and South for these services. Recognizing that there was a market opportunity, Porter identified and repurposed space within our existing building capable of providing this service in a far more patient friendly environment.

GMCB Questions & Responses

7) The hospital moved to a self-insured health care insurance product to save costs. What are the trade-offs for making such a change? What is the risk for the hospital?

The potential risk would be that Porter might incur an atypical increase in claims vs. the most recent five year trend. We believe that the reinsurance limits of $175,000 per claimant mitigate the risk. $650,000 in reduced overall program savings is offset by $800,000 of required reserve expenses in FY 2016. An additional reserve of approximately $400,000 is included in the FY 2017 budget in order to build reserves to an appropriate level.

8) Bad debt and free care are budgeted to drop over 20% from 2016 budget levels. The hospital explains that bad debt and free care is lower (less cost) because Financial Advocates at Porter have helped more patients obtain insurance coverage. Quantify the changes the hospital is seeing with bad debt/free care services. Describe any changes being seen for the number of patients or cases.

When budgeting for bad debt and sliding scale, a recent actual trend rate is applied to gross charges as the basis for the FY 2017 budget calculation.

The budget to budget decrease for bad debt was based on a decrease in the accounts receivable aging of self-pay balances during FY 2015. This improvement in the aging was not a consideration for the FY 2016 budget. If we exclude the anomaly year of FY 2015, and use FY 2014 and FY 2016 revised forecast as a basis, the FY 2017 budget is reasonably comparative.

Self-Pay balances have materially decreased over the last three years, thusly affecting our sliding scale discount and resulting in a decrease of the trend rate.

GMCB Questions & Responses

9) Describe the hospital's efforts with local mental health and other providers to strengthen community health services. Describe any successes and identify limitations of those efforts.

The Middlebury health service area's community health action team (CHAT) includes more than 25 local agency members including the Counseling Service of Addison County (CSAC), Addison County Home Health and Hospice (ACHHH), the Turning Point Center of Addison County, Blueprint for Health, and Addison Respite Care Home (ARCH), as well as the newly-formed case management department at Porter Medical Center, help form the foundation of integration and collaboration that is strengthening Porter's coordination of care and overall quality. Successes of these efforts include a decrease in ER visits and readmissions, an increase in hospice care, and improvements in preventive care metrics. Leaders from several of these organizations, including the executive directors of both CSAC and ACHHH, now sit on the Porter Medical Center Board.

Limitations we continue to experience are particularly identified in categories of mental health services and addiction medicine.

10) Are the FY 16 projections for net revenues, expenditures, and surplus as reported still valid? If not, describe any material changes.

The FY 2016 Projection was based on a continuation of the historical trend in the physician practices at Porter, which did not consider the improvement strategy that followed soon thereafter. Through the combination of turnover and specific operational initiatives, the physician practices have experienced discernible improvement in recent months.

11) What are the hospital's current plans for CONs identified in 2018 and 2020?

We included place holders of $3.5M for an EMR and $20M for an MOB for future consideration. These key purchases are under further consideration as we explore affiliation options.

FY 2017 Capital Budget

FY 2017 Capital Budget = $4.0M

Clinical Replacements Include:	
NUCLEAR MEDICINE CAMERA	400,000
ULTRASOUND UNIT (2)	350,000
FULLY DIGITIAL X-RAY EQUIPMENT	129,500
DEFIBRILLATORS	110,000
MINI C ARM	100,000

Infrastructure Improvements Include:	
PMA BUILDING RENOVATION	350,000
PARKING LOT REPAIR/RESURFACE	125,000
AFM PRACTICE RENOVATION	100,000

Information Technology:	
TOTAL IT REPLACEMENTS & UPDATES	500,000

QUESTIONS?