Fiscal Year 2026 Hospital Budget Submission to the Green Mountain Care Board

On behalf of Central Vermont Medical Center

July 1, 2025

University of Vermont Health Network

The health care organizations that comprise University of Vermont Health Network have worked together for more than 100 years. Each has built local trust by responding to the needs of its community through high-quality care delivered by dedicated staff who are also community members, neighbors and friends of the people we serve. Our purpose is deeply rooted in our role as nonprofit health care providers, which means that individually and together, we are driven by improving the health of our patients and our communities above all else. Working together as a health system, we share our resources and expertise to offer life-saving and preventative care to communities across our region that would otherwise not be available.

These budget submissions come at an inflection point – a moment of crisis and opportunity for rural health care across the country. The status quo of health care in our state is unaffordable for the Vermonters who rely on us. To survive and ensure we are here for the future generations who will need health care, we must think differently and act with more determination than ever before. We recognize that we have not yet fully realized the benefits of our rural academic health system – we know we must deliver more value to our communities.

As the sole integrated health system based in Vermont, we share common goals and resources to work smarter and deliver high-quality care to communities throughout our region that is more affordable and responsive to their needs. That means finding the right combination of care, ranging from care in the community and at home, critical access and community hospitals, as well as our anchor academic medical center. Our work begins and ends with a focus on our patients – a commitment reflected in our Fiscal Year 2026 (FY26) budgets to be a stronger partner and neighbor in the years ahead.

Our FY26 budgets reflect our work to adapt, innovate and lead to improve the value and sustainability of the rural academic health care we provide. Our budgets support the advancement of three overarching goals:

- Provide high-quality care to our patients to drive outcomes toward top quartile performance.
- Accelerate our efforts to address the rising cost of health care in our region.
- Invest in maintaining or improving access to care, focusing on outpatient care and telehealth.

These budgets are submitted to be in compliance with the Green Mountain Care Board's (GMCB) FY26 budget guidance. The current state of health care in Vermont and across the United States means Vermont's hospitals must find new ways to control health care costs, while working to limit the impact on clinical services. Our budgets reflect the difficult decisions required to get to this point.

UVM Health Network's FY26 budget submissions to GMCB:

	NPR growth	**Commercial rate growth**	**Operating expense growth**
UVM Medical Center	2.2%	-7.9%	3.2%*
Central Vermont Medical Center	3.5%	-3.3%	2.8%
Porter Hospital	3.5%	3.0%	2.6%

**This is 0.2 higher than GMCB budget guidance. The overage is due to Vermont provider tax, which is allowed as an exemption per GMCB budget guidance.*

We challenged ourselves and our teams to find new opportunities to reduce costs while protecting clinical services. This means that the burden of cost reduction will primarily impact non-clinical areas of our organization, which are nonetheless vital to running our hospitals and supporting the care they provide. As a consequence, reductions to our non-clinical areas may be felt by providers and patients across the state.

We do not take these decisions lightly, but there is no alternative if we are to remain sustainable and serve future generations of Vermonters and meaningfully do our part to address health care affordability in our state. We are committed to navigating these challenges with transparency, accountability and a continued focus on delivering safe, high-quality care to every patient.

About UVM Health Network

UVM Health Network is a rural academic health system serving more than one million people living in rural communities across Vermont and northern New York. Our health system employs 15,000 people in our region and is comprised of six partner hospitals, a children's hospital, a home health and hospice agency, 154 outpatient care sites, three skilled nursing facilities, a multispecialty medical group with over 1,000 employed physicians, approximately 500 advanced practice providers and a population health services organization.

Each of our partner organizations is deeply connected to its local community, providing compassionate, personal care shaped by the latest medical advances and delivered by highly skilled experts. Meanwhile, our essential academic partnerships with local colleges and universities in Vermont help us train the next generation of caregivers and bring leading-edge research to the bedside. These partnerships include the University of Vermont Larner College of Medicine and College of Nursing and Health Sciences, Community College of Vermont, Norwich University and Vermont State University. Our three Vermont hospitals are subject to GMCB budget approval under 18 V.S.A. § 9375(b)(7).

As a nonprofit health system, every dollar that comes into UVM Health Network stays within our health system to support the care we provide. Across all our health care partner organizations, we are working hard each day to make the most of these resources and enhance the experience of our patients and caregivers: making it easier to access care physically and financially, strengthening our workforce and responsibly investing in the critical resources we need to deliver the high-quality care our patients deserve, now and in the future.

Central Vermont Medical Center

A. Executive Summary

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

High-Level Overview: Central Vermont Medical Center (CVMC) is submitting a FY26 budget that is compliant with the GMCB budget guidance for net patient revenue growth, major commercial rate growth, and operating expense growth. Our budget aims to maintain financial stability without compromising the hospital's mission to provide high-quality, accessible care to the community we serve. It reflects our goal of providing our staff with competitive wages, benefits and a safe and supportive working environment.

Focus on Quality and Operational Efficiency: At CVMC, we utilize Lean and other methodologies to advance our culture of continuous improvement. Our goal is to optimize clinical outcomes for our patients and improve the efficiency of the services we provide. To meet budget goals in FY26, CVMC is reducing administrative and operational costs and working collaboratively to reduce redundant services within CVMC and across UVM Health Network.

Woodridge Rehabilitation and Nursing: Our skilled nursing and rehabilitation center falls under CVMC's tax ID and is integrated into CVMC's FY26 budget. The demand for post-acute care services continues to increase. The FY26 budget reflects an average daily census of 145, a commitment to provide post-acute care services to our community.

	FY25 Budget	FY25 GMCB Proj	FY26 Budget **
TOTAL NPSR + FPP + OCV REVENUE	291,502,431	301,745,993	301,705,016
Total Other Revenue	17,934,098	20,706,373	16,322,366
TOTAL UNRESTRICTED REVENUE & OTHER	309,436,529	322,452,366	318,027,382
Total Salaries	157,316,043	166,794,769	165,144,954
Payroll Tax & Fringe	34,817,094	37,306,285	40,072,283
Salaries, Payroll Taxes, and Fringe Benefits	192,133,138	204,101,054	205,217,237
Total Non-Salary Expense	117,187,908	121,055,277	112,676,823
TOTAL EXPENSES	309,321,046	325,156,331	317,894,060

***FY26 Total NPSR +OCR in compliance within budget guidelines of 3.45%. FY26 Total Expenses are in compliance within budget guidelines of 3.0%.*

B. Background

a) Explain any changes that occurred to your corporate structure within the last year.

There have been no changes to CVMC's corporate structure within the last year.

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

CVMC is not currently considering any corporate affiliations. When we do consider participating in corporate affiliations, the primary consideration is whether the affiliation will allow us to better serve our patients' health care needs.

c) Explain and quantify any service-line closures, transfers, reductions, or additions since the prior year budget review.

The Inpatient Psychiatry Unit closed on January 21, 2025, with the last admission on January 17, 2025. In anticipation of the closure, we increased the resources available in the ED and primary care settings to assist in caring for patients with mental health conditions. This includes on-site psychiatrist coverage seven days a week, 8:30 AM – 5 PM in the CVMC ED, and telemedicine 5 PM -11 PM, seven days per week. We have added 6.7 FTEs of mental health professionals, including two psychiatric physicians, three APP psychiatric providers and four therapists. We anticipated generating approximately 4,200 visits in FY25.

Beginning in January 2025, CVMC, Washington County Mental Health and the Department of Mental Health initiated a collaborative work group to expand mental health urgent care services in central Vermont. CVMC is providing project management support for this effort. The work is ongoing, with an anticipated goal of presenting a proposal to the GMCB in fall 2025.

Mad River and Berlin Family Medicine clinics are being consolidated into existing CVMC practice locations. The current timeline for completion is October 2025. The first phase, scheduled for mid-August 2025, is for Berlin main campus patients, providers and staff to transition to the Berlin Granger Road and Barre locations. Three staff members will transfer to Montpelier Family Medicine to better distribute staffing resources across CVMC locations. Mad River patients, providers and staff will transition to Waterbury Family Medicine in October 2025.

We have engaged with the Mad River Health Center (MRVHC) board to support their exploration of other parties who might be interested in operating a practice in the Mad River Valley. There were two interested parties who explored assuming the practice earlier this year. Both signed non-disclosure agreements with CVMC so we could share confidential data to inform their decision. After reviewing the information provided, both parties declined to proceed. A third interested party explored the potential of an urgent care service in the Mad River Valley, but they chose not to pursue the engagement. Working with the MRVHC board, we have honored our lease terms and offered support for transitioning the space to a new tenant.

We remain committed to supporting our patients through the transition, including expanded use of telemedicine and mail-order pharmacy services. In collaboration with our care management team, we are actively surveying patients to better understand transportation needs, the support they require for

telehealth visits and additional ways we can support our patients impacted by this consolidation.

We are not introducing new services or divesting existing services, and there are no significant physician transfers or staffing changes anticipated. Additionally, no major accounting adjustments are planned. The proposed budget maintains continuity with our current operational structure and strategic direction while reducing expenses significantly.

As demand for health care services increases throughout our region, CVMC's hospital outpatient services will not be able to meet this need in increased volume as we reduce expenses to achieve compliance with the GMCB budget guidance for FY26. The goal will be to support core services, protect the most vulnerable and prioritize care that promotes the best outcomes and mitigates costs from deferred care and treatment.

C. Budget Questions

a) Concisely describe substantive variations from current year approved budget to current year projected, and to the proposed budget, in terms of service line changes (differentiate between new or divested services, and volume changes that necessitate changes in staffing), physician transfers, accounting adjustments, etc.

CVMC has no new service lines, physician transfers or accounting changes to report from our FY25 budget, other than the service changes that were made to comply with FY25 budget orders. These changes were made to the FY25 budget that was submitted to the GMCB Adaptive budget system on November 27, 2024.

The favorable and unfavorable impacts to FY25 projection versus FY25 approved budget are noted below:

- **Gross Revenue:** Increased volumes in outpatient services for endoscopy, imaging (diagnostic, CT, PET and ultrasound), lab services and pharmaceutical services.

- **NPR:** CVMC will be implementing a mid-year rate reduction for major commercial payers for an estimated $6M for August 1, 2025 through December 31, 2025. This will be achieved by adopting the legislative orders from H.266 on August 1, 2025 for an estimated impact of $2.4M and by reducing commercial rates in targeted outpatient services.

- **Expenses:**
    - Staff salaries are over budget by $7.1M related to increased volumes and negotiated union contracts for RN and technical professional bargaining units and the support staff union contract negotiated in April 2025.
    - Fringe benefits are $4.4M higher than budget related to higher employee health care costs and pharmaceutical benefits.
    - Traveler use is $3.2M higher than budget to cover essential patient care areas.
    - Medical staff salaries are higher than budget by $2.3M.
    - Medical-surgical supplies are under budget by $2.1M.
    - Pharmaceutical costs are higher than budget by $1.8M related to high-cost oncology drugs.
    - Purchased services are over budget by $833K for anesthesia coverage and a management contract for Woodridge Rehabilitation and Nursing facility.

FY26 budget changes from FY25 budget:

- **Gross Revenue:** CVMC has built a 3.03% chargemaster increase into its budget for FY26.

- **NPR:** CVMC has filed a budget that is aligned with the GMCB benchmarks of 3.5% total NPR and 3.0% commercial rate request for FY26. The calculation behind the Major Commercial rate increase request for the FY26 budget is built with a 3% increase from the FY25 budget and then removes an estimate for the drug impact mid-year. For governmental payers, we use all available information at the time of budget preparation to update reimbursement rates. The table below summarizes the NPR for estimated increases:

	Inpatient	Outpatient	Professional
Medicare	-1.4%	3.4%	1.3%
Medicare Advantage	-1.4%	3.4%	1.3%
Medicaid	0.0%	0.0%	0.0%
Commercial	-3.0%	-3.0%	-3.0%

- **NPR:** FY25 Budget to FY26 Budget – Please refer to the Appendix.

- **FPP:** No material changes.

- **Other revenue** decrease of $1.6M related to additional 340B contract revenue manufacturer restrictions.

- **Expenses:** The FY26 budget is within GMCB guidance of 3% and includes:
    - $5.1M increase due to inflationary increases, more than half of which is for salaries.
    - $1.9M increase due to volume increases for pharmaceuticals and supplies.
    - $1.5M increase due to increases in medical staff salaries.
    - $6.3M is an offset for clinical efficiency that is currently reported as other expenses reductions.
    - Overall, CVMC is budgeting a reduction in overall staff FTEs of 34. This is inclusive of traveler reductions of 23.2 FTEs.

b) Explain the charge master increase, if necessary, to support your submitted commercial reimbursement rate increase. This should match the value provided in the rate decomposition sheet - "Chargemaster Increase Required for reimbursement increase requested."

CVMC has built a 3.03% chargemaster increase into the budget for FY26. A chargemaster increase does not necessarily result in a commercial reimbursement rate increase. The amount a commercial payer spends for a service is not necessarily correlated with the hospital's charge for the service. Specifically, if a service is paid according to a commercial payer's fee schedule or DRG rate, the hospital's charge for that service is not relevant. For CVMC's major commercial payers, most services are paid according to some fixed fee, like a DRG or fee schedule. This means that an increase in the hospital's charges will not result in an increase in the payer's reimbursement rates. There are reasons to not have a chargemaster change match a commercial reimbursement change. Decreasing charges to match commercial reimbursement decreases could have the following unintended consequences:

- A government payer like Medicare might pay for a service at the lesser of a hospital's charge or a specified rate so if a hospital's charge is less than the government payer's specified rate, the hospital leaves money on the table by charging less than the specified rate.
- CMS uses the hospital's charges to calculate the hospital's cost-to-charge ratio, which means that decreasing charges could adversely impact this calculation on the Medicare cost report. This, in turn, could result in lesser Medicare reimbursement.

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

CVMC is submitting a budget in compliance with Section I benchmarks for net patient service revenues, commercial rate requests and overall expense benchmarks established by the GMCB.

d) Explain the assumptions embedded in your proposed budget for each of the bulleted points a-i below, providing evidence to support your assumption(s), as well as any substantive variations from FY25 (budget & projected). For applicable sections, fill out the accompanying table in the supplemental budget workbook.

a. Labor expenses. Please complete the supplemental table "Labor Expense" in the workbook for projected 2025 & budgeted 2026. Differentiate between the use of employed versus contracted labor, separating nursing from other clinical and nonclinical staff. In your narrative response, highlight any trends that are specific to particular clinical domains. Explain where these costs are reflected on the income statement.

Labor Expense Budget Development
The labor expense budget begins with projecting Full-Time Equivalents (FTEs) for staff and physicians. The baseline is established using actual FTEs as of the end of January of the current fiscal year, with the October–January period serving as the reference. Adjustments are then made for:

- Anticipated volume changes
- Planned recruitments
- Modifications in service lines
- Department consolidations
- Cost reduction initiatives
- Position eliminations

Current salary rates, shift differentials, and on-call compensation are applied to the adjusted FTEs. For vacant roles, the midpoint of the salary range is used. The resulting salary cost is then adjusted for any known or planned wage increases not captured in the October–January baseline.

Benefits Budget
The benefits budget is calculated line-by-line (e.g., health, dental, life insurance, vacation, retirement) based on the total budgeted FTEs and projected covered household members under UVM Health Network plans.

Inflation Adjustment
The final step is applying inflation factors, which include:

- Contractual increases (e.g., union agreements)
- Market-driven salary adjustments
- Merit and market increases

For FY26, the average labor expense inflation factor at CVMC is 5.0%, primarily driven by current and recently negotiated first union contract obligations:

- Central Vermont Healthcare United Nurses – 4.5%
- Central Vermont Healthcare United Technical – 4.5%
- Central Vermont Healthcare United Support – 5.0%

- Costs for newly ratified support staff include the following increases:
    - Immediate wage increases, averaging over 6%, with no employee receiving less than 6% for FY25. This agreement and adjustment will increase the wage floor for the support staff from $17.30 to $21.00. These go live on June 23, 2025. Further wage increases of an additional 13.0% over the 3-year contract, with 5.0% increases in October 2025, and 4% increases in 2026 and 2027.
    - Increased differentials, including night, weekend, evening, and per diem.
    - Adding a floating holiday for all support staff at the start of 2026.
    - New incentive and urgent pay opportunities.

		FY26 Budget		
Union Category	**Contracted Incr for FY26**	**FTEs**	**Salary Expense**	**FTEs as % of Total**
VFNHP Nurses	5.0%	5.90	$ 682,026	0.4%
CVHU Nurses	4.5%	249.26	$ 30,545,014	18.1%
CVHU Technical	4.5%	120.11	$ 10,689,430	8.7%
AFTVT Support	5.0%	8.00	$ 515,667	0.6%
CVHU Support	5.0%	413.70	$ 27,923,769	30.1%
Subtotal - Union	4.8%	796.97	$ 70,355,907	58.0%
Other Non-Union*	5.0%	576.42	$ 94,789,178	42.0%
Total		**1,373.39**	**$ 165,145,085**	**100.0%**

*Not contracted

CVMC is budgeting a reduction from the FY25 budget in Traveler FTEs of 23.2 for an estimated cost reduction of $3.4M.

	FY24 Actual	FY25 Budget	FY25 YTD May	FY26 Budget
Hospital				
Staff Nurse	37.4	31.9	30.2	21.5
Advanced Practice RN	-	-	1.8	-
Tech	15.1	11.0	16.9	11.3
Respiratory Therapist	6.2	5.2	4.8	5.2
Other(LNA, Phlebotomist)	1.5	-	2.6	2.0
Subtotal	60.2	48.1	56.3	40.0
Woodridge				
Staff Nurse/LPN	6.8	6.3	10.6	6.6
Physical Therapist	0.8	-	1.0	1.2
Other(LNA, Phlebotomist)	26.5	33.5	25.4	16.9
Subtotal	34.1	39.8	37.0	24.7
Total	94.3	87.8	93.3	64.7

The table below summarizes traveler use by location and the percentage of total staff:

	TRAVELERS AS % of TOTAL FTES			TRAVELERS AS % of TOTAL STAFF SALARIES		
DIVISION	**FY25 Budget**	**FY25 YTD Apr Act**	**FY26 Budget**	**FY25 Budget**	**FY25 YTD Apr Act**	**FY26 Budget**
Nursing - SNF	41.6%	35.1%	32.3%	53.6%	50.2%	45.2%
Nursing - Med Surg and Specialties	17.1%	17.2%	13.6%	30.1%	33.6%	24.5%
HS Radiology	12.0%	21.7%	11.9%	25.3%	42.2%	24.8%
Respiratory Therapy	31.4%	26.1%	31.4%	46.4%	38.6%	44.2%
HS Path and Lab	7.5%	15.0%	12.6%	16.3%	24.7%	20.0%
Perioperative Services	6.4%	8.2%	4.5%	15.7%	16.9%	9.8%
Nursing - Critical Care	12.3%	4.8%	6.7%	24.2%	12.7%	11.3%
HS Emergency Med	4.7%	0.0%	2.3%	10.5%	2.9%	5.5%
Cardiology	17.9%	21.5%	21.0%	37.8%	44.6%	43.2%
SNF Rehabilitation Therapies	0.0%	9.5%	7.6%	0.0%	17.7%	13.6%
Hospital Oncology	0.0%	7.2%	7.0%	0.0%	11.9%	11.2%
SNF Administration	0.0%	0.0%	118.8%	0.0%	0.0%	129.4%

The table below references the breakdown of clinical, nonclinical and leadership FTEs and estimated salary cost comparisons between FY25 budget and FY26 budget:

		Appendix U15: FTEs FY25 Budget To FY26 Budget							
		FTES				SALARIES			
		FY25 Bud	FY26 Bud	Variance		FY25 Bud	FY26 Bud	Variance	
		Total	Total	Amount	%	Total	Total	Amount	%
TOTAL SALARIES / FTES		**1,405**	**1,373**	**32.1**	**2.3%**	**157,316,043**	**165,145,085**	**(7,829,041)**	**-5.0%**
TOTAL PHYSICIAN	Clinical	**91.2**	**93.2**	**(1.9)**	**-2.1%**	**32,749,812**	**34,207,908**	**(1,458,096)**	**-4.5%**
Physicians	Clinical	87.4	92.2	(4.8)	-5.4%	30,568,945	33,991,311	(3,422,366)	-11.2%
Locums	Clinical	3.8	1.0	2.8	73.9%	2,180,867	216,597	1,964,270	90.1%
TOTAL STAFF		**1,314.3**	**1,280.2**	**34.0**	**2.6%**	**120,388,231**	**125,564,243**	**(5,176,013)**	**-4.3%**
Resident	Clinical	-	-	-	0.0%	-	-	-	0.0%
APP	Clinical	65.2	66.6	(1.4)	-2.1%	9,826,906	10,691,173	(864,267)	-8.8%
Traveler	Clinical	87.8	64.7	23.2	26.4%	15,082,302	11,726,821	3,355,481	22.2%
RN	Clinical	248.6	253.8	(5.2)	-2.1%	26,045,060	29,078,664	(3,033,604)	-11.6%
LPN	Clinical	37.5	38.2	(0.7)	-1.8%	3,288,354	2,971,101	317,253	9.6%
Tech	Clinical	93.6	94.6	(1.0)	-1.0%	7,225,662	8,116,305	(890,643)	-12.3%
Other Clinical	Clinical	294.9	294.4	0.4	0.1%	21,476,869	23,083,557	(1,606,688)	-7.5%
Management	Non-Clinical**	130.8	132.7	(1.9)	-1.5%	16,386,734	16,956,960	(570,227)	-3.5%
Staff Other	Non-Clinical**	355.7	335.2	20.6	5.8%	21,056,344	22,939,661	(1,883,317)	-8.9%
TOTAL STAFF OTHER	Non-Clinical**	**-**	**-**	**-**	**0.0%**	**3,865,828**	**4,836,315**	**(970,487)**	**-25.1%**
TOTAL PHYSICIAN OTHER	Non-Clinical**	**-**	**-**	**-**	**0.0%**	**312,173**	**536,619**	**(224,446)**	**-71.9%**
Clinical FTEs *		919	905	13	1.5%	115,694,965	119,875,529	(4,180,564)	-0.0361
Clinical %		65.38%	65.93%	-0.55%	-0.8%	73.54%	72.59%	0.96%	1.3%

** Clinical FTEs include total paid FTEs for job classifications Resident, APP, Traveler, RN, LPN, Tech, Other Clinical, & Physician. This total includes non-productive and admin time.*

*** While classified as Non-clinical, some may have clinical duties.*

b. Utilization. Explain and quantify any anticipated changes in utilization across care settings (e.g. inpatient/outpatient), or any other expected deviations from historical trends. Indicate the method(s) used to derive utilization changes in proposed budgets. If utilization assumptions include increases associated with hiring additional staff or other capacity changes, provide evidence to support estimated impact on utilization. Any referenced impact to net revenue should tie to the submitted Rate Decomposition worksheet.

As noted in our monthly submissions for FY25 to the GMCB staff, we continue to see increased demand for services, specifically imaging services, endoscopy services and operating room services. The increase in patient demand necessitates contracted staff to meet patients' needs. Below is the total NPR related to utilization:

Net Patient Service Revenue		**Total**
Utilization(excluding inflation)		
All Payers	$	5,283,570
Disproportionate Share Payments (DSH)	$	1,686
Denials	$	358,127
Bad Debt	$	5,105,607
Charity	$	1,531,829
Total Utilization(excluding inflation) Impact	$	12,280,818

There is no common utilization measurement across all volume types (inpatient, outpatient and professional), therefore we use changes in gross revenue trends. Below is a table for how gross revenues are trending by area from FY25 budget to FY26 base budget. The FY26 base budget is based on the same gross charge price as FY25. The difference between FY26 base and FY26 inflated budget is the gross charge price increase included in the FY26 budget submission.

As with all components of the budget, for utilization (i.e. volume), the budget process starts with actual volume levels from the October to January period.

From there, the following considerations are added or subtracted that impact volume assumptions:

- New recruits
- Departures
- New equipment
- Access initiatives
- Seasonal factors that we know that are not present in the October to January base

The key volume metrics budget drives the gross revenue budget (revenue before deductions are applied):

- Inpatient admissions and discharges
- Inpatient days
- OR cases
- ED visits
- Professional work RVUs
- Radiology exams (MRI, CT, nuclear medicine, mammography, ultrasound, diagnostic)
- Endoscopy procedures
- Radiation oncology procedures
- Lab tests
- Pharmaceuticals

Volume Metric	FY25 Budget	FY26 Budget	% Change
Inpatient Discharges	4,198	4,008	-4.5%
Inpatient Patient Days	18,017	17,197	-4.6%
Inpatient Patient Days SNF	52,925	52,925	0.0%
MG Professional Arrived Visits (including Anes)	232,270	239,545	3.1%
MG Professional Worked RVUs (including Anes)	634,740	662,636	4.4%
Total ED Visits	28,029	27,522	-1.8%
Total OR Cases	4,175	4,336	3.9%
Total OR Hours	5,190	5,236	0.9%
Total CT Scan	20,336	21,389	5.2%
Total Mammography	9,177	9,123	-0.6%
Total MRI	4,617	4,545	-1.6%
Total GI/Endoscopy	6,045	6,218	2.9%
Total Billed Lab Test	491,375	533,132	8.5%

PET imaging services were not budgeted for in FY25 due to the instability of scans from our mobile vendor; the concerns were resolved and service resumed in FY25. CVMC will continue this service for our community, and it is included in the FY26 budget submission. PET imaging scans are estimated to be 400 for FY25 and 500 for FY26. In addition, during FY25 the Linear Accelerator was replaced, causing a dip in volumes for FY25. FY26 is expected to return to pre-FY25 volumes.

c. Pharmaceutical expenses. Explain assumptions regarding growth due to price from volume, or product mix. Please estimate reimbursements received in excess of the cost of pharmaceuticals (FY24 actuals, FY25 budget and projection, and FY26 proposed budget), noting how you arrived at those estimates.

With respect to assumptions regarding growth, October to January expense is used as the base, and adjustments are made for known volume changes and planned introduction of new drugs. Adjustments for new drugs that have a material impact on the budget are in chemotherapy. Inflation factors are then applied. In the FY26 budget, the inflation factor for pharmaceuticals is 5.0%.

In the outpatient context, CVMC reports the expense for these drugs as part of hospital operating expenses, but these are not split out at the level of detail being requested here. Similarly, CVMC does not split out drug revenue from other lines of revenue, in part because drug revenue often comes from multiple sources. Because of the integrated nature of reporting revenue for drugs delivered in the outpatient setting, it is not possible, based on how this information is reported in budget information today, to determine a precise "margin" for these drugs specifically. That said, below, we are providing reimbursement and drug purchase amounts for separately billable medications that require detailed coding in the outpatient setting (Revenue Code 636 with status indicators G, K, and K1), but this estimation is not precise.

The reimbursement is from the 835 and 837 remittance files. Drug purchases are from Sentry, our split billing system (same parent company as Trisus). The pharmaceutical purchases are likely higher than what was administered, since we do keep a small inventory on-hand. Not all of the drug purchases are used in the outpatient setting. There is some overlap between inpatient and outpatient use (e.g. Alteplase for stroke).

	FY24		
	Reimbursement	Drug Cost	Reimbursement Less Drug Cost
CVMC	$ 21,748,234	$ 22,703,316	$ (955,082)

The costs of drugs administered in the inpatient setting depends on the terms of the contract with the source of the medication. Reimbursement for drugs administered in the inpatient setting is driven by the terms of a patient's medical benefits and the terms of our participation agreements with payers. Most of CVMC's major commercial payers reimburse for inpatient services on a case rate/DRG basis, meaning that we typically do not receive a line-item reimbursement for drugs administered in this context. Based on how this information is reported in the budget today, we are unable to determine a "margin" for specific drugs. That said, we are willing to work with the GMCB to create an agreed-upon approach moving forward to get to the information the GMCB is seeking.

CVMC	FY24 Actual	FY25 Budget	FY25 Anlzd YTD May **	FY26 Budget
Pharmaceuticals				
IP Non Chemo Pharmaceuticals*	$ 29,268,027	$ 29,463,033	$ 21,572,648	$ 25,055,335
IP Chemo Drugs			$ 11,757,547	$ 18,602,907
Total	$ 29,268,027	$ 29,463,033	$ 33,330,195	$ 43,658,242
Pharmacy Volumes				
Total Doses	513,745	513,745	503,433	476,013
Total	513,745	513,745	503,433	476,013

**includes Woodridge*

***CVMC did not split out Chemo from non-chemo until halfway through the month of February*

For more information related to the 340B program and pricing, please refer to the 340B Supplement section of the budget narrative.

d. Case Mix Index (CMI). Explain any expected substantive changes in CMI by Payer, providing evidence to justify anticipated changes. i. Quantify any impacts on your budget by payer.

	FY23 Act	FY24 Act	FY25 Budg	FY25 YTD Thru May 2025	FY26 Budg
Medicare	1.53	1.60	1.62	1.59	1.62
Medicaid	n/a	n/a	n/a	n/a	n/a
Medicare Advantage	n/a	n/a	n/a	n/a	n/a
Commercial Payer 1	n/a	n/a	n/a	n/a	n/a
Commercial Payer 2	n/a	n/a	n/a	n/a	n/a
Commercial Payer 3	n/a	n/a	n/a	n/a	n/a
All Others	n/a	n/a	n/a	n/a	n/a
All Payers	1.39	1.45	1.49	1.48	1.49

Note: CMI is only calculated at the All Payer and Medicare level.

There are no material changes in CMI from FY25 budget, FY25 projection, or FY26 budget.

e. Rate Changes by Payer. Explain any assumptions related to rate changes for Medicare, Medicare Advantage, Medicaid (e.g. In State/Out of State), and Commercial Payers overall and by setting of care (inpatient, outpatient, professional services). This should align with the rate decomposition worksheet.

Medicare/Medicare Advantage assumptions were based on the latest proposed IPPS rule published in late April. Wage index change was the biggest driver for IP/OP. No assumed Medicaid changes (in or out of

state). Commercial increase was determined by the 3% guidance for the F26 budget slightly offsetting the H.266 impact.

	Inpatient	Outpatient	Professional
Medicare	-1.4%	3.4%	1.3%
Medicare Advantage	-1.4%	3.4%	1.3%
Medicaid	0.0%	0.0%	0.0%
Commercial	-3.0%	-3.0%	-3.0%

f. Financial indicators. Explain any changes (key drivers) to your Operating Margin, Days Cash on Hand, and Debt Service Coverage Ratio relative to your FY25 projections, as well as any other key financial indicators that are important to consider in relation to your budget request.

While the data below show calculated financial indicators for CVMC specifically, it is important to note that for bond rating agency ratings, annual bank and debt covenant testing thresholds, these financial indicators are calculated at the UVM Health Network level, rather than as individual hospitals:

	FY25 Budget	FY25 Projection	FY26 Budget
Operating Margin	0.04%	-0.84%	0.04%
Days Cash on Hand	73.1	74.2	79.0
Debt Service Coverage Ratio	4.4	4.0	5.6

g. Uncompensated care. Differentiate any assumptions/changes as they relate to exogenous trends (e.g. patient needs) or internal practices (e.g. changes in accounting or business processes) related to bad debt and free care. Please include a description of collection processes. Report your budgeted bad debt to free care ratio and how you derived your estimates for bad debt and free care.

There are no significant changes in internal practices related to accounting for bad debt and free care. We use previous actual experiences to model future impacts for services provided. As actual experiences fluctuate, the model is updated to reflect changes in previous actual experiences to estimate future impacts.

CVMC has updated its financial assistance policy to align with Vermont's Act 119 requirements. This includes expanding income eligibility, making more patients eligible for help. As a result, the percentage of free care provided – measured against Gross Revenue – has increased.

Bad debt and free care are tracked, monitored and estimated as a percentage of gross revenue. Below are the trends used to inform the FY26 budget.

	FY24 Actual	FY25 Budget	FY25 Anlzed YTD May	FY26 Budget
CVMC				
Bad Debt as a % of Gross Revenue	1.24%	1.30%	1.30%	1.18%
Free Care as a % of Gross Revenue	0.40%	0.83%	0.68%	0.65%
Total Bad Debt & Free Care as a % of Gross Revenue	1.64%	2.13%	1.98%	1.83%

h. Community Benefit. Differentiate between the various drivers of community benefit.

	FY23 Net community benefit	Prior Year Net community
Financial Assistance at cost	1,495,928	1,136,759
Medicaid	36,477,238	30,652,725
Cost of other means-tested government programs		
Total Financial Assistance and Means-Tested Government Programs	**37,973,166**	**31,789,484**
Community health improvement services and community benefit operations	114,970	183,698
Health professions education	342,670	386,461
Subsidized health services (A)	3,236,059	21,209,311
Research		
Cash and in-kind contributions for community benefit	119,171	146,198
Total Other Benefits	**3,812,870**	**21,925,668**
Total	**41,786,036**	**53,715,152**

(A) - change in report collection of data with conversion to EPIC for reporting.

The largest drivers of net community benefit expenses are Medicaid, subsidized health services and financial assistance.

Community health improvement services and discretionary community benefit expenses are focused on access and include the following priority areas:

- Chronic disease prevention
- Mental health
- Substance Use Disorder
- Equity in access to health care services

These priorities are a distillation of our CHNA, conducted with community partners and non-profit organizations within our service areas.

i. List any other factors not included above that may be material to your budget along with supporting material. This includes any assumptions that are uncertain but could have a potential budgetary impact. For such assumptions that are not reflected in your budget, quantify the range of potential impact.

Please see below for the list of uncertain assumptions that could potentially impact our budget.

e) Briefly summarize known risks in the budget as submitted, including the potential impact of and any known timelines associated with the risk, as well as any risk mitigation efforts, and their cost or potential benefit.

Below are the uncertain items that could impact our budget. We are not able to quantify the impact these might have. If any of these items negatively impact our finances, we would seek ways to offset them with additional cost reductions to maintain the margin we have budgeted. We need those resources to reinvest in our rapidly aging facilities and equipment, or we will need to further restrict our planned capital spend, as our already low days cash on hand (DCOH) cannot absorb any further deterioration.

In light of the federal government's current deliberations on the *One Big Beautiful Bill Act*, we recognize the potential for significant impacts on the people we serve – chiefly lower-income, vulnerable populations – as well as health care funding streams that support our operations, either directly or indirectly. While our submitted budget reflects current funding levels, several key areas present notable risks:

- **Medicaid funding:** Potential changes to Medicaid reimbursement rates or eligibility criteria could materially impact our revenue. Even small changes to this program could result in a substantial impact on our budget. We are closely monitoring state and federal policy developments and engaging in advocacy efforts to mitigate this risk.
    - Medicaid work requirements and increased redeterminations resulting in increased self-pay / bad debt expense
    - Medicaid rate cuts
    - Reduction in FMAP and Directed Payments
- **Other risks:**
    - Expiration of Premium Tax Credits would lead to a significant reduction in commercially insured patients
    - Cuts to 340B program
    - Additional commercial rate cuts
- **Potential tariffs and other unknown inflation factors:** May have a post-budget impact unknown at the time of submission.

We will continue to monitor these risks closely and adjust our mitigation strategies as more information becomes available.

In addition, there are several internal risks that are in the budget:

- Timely implementation of clinical expense reductions. CVMC has approximately $6M estimated savings recorded in the budget.

- The ability to reduce the volumes in the outpatient settings as noted above for $9.3M estimated NPR reductions and $6.8M in expense reductions.

f) Administrative vs. Clinical Expenses: using the Medicare Cost Report definition of administrative, clinical, and mixed expenses in Wang & Bai (2023)1, also defined in the Uniform Reporting Manual, please comment on the relative trends in each of these expense categories over time.

CVMC files its Medicare cost report in accordance with the Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Hospital & Hospital Health Care (Form CMS 2552-10). Woodridge Nursing Home does not have its own Tax ID and is included as a cost center on the CVMC Medicare cost report. On the CVMC cost report, the shared CVMC/Woodridge administrative expenses are included with the CVMC administrative expenses; however, the Woodridge clinical expenses are excluded.

The combined CVMC and Woodridge administrative and clinical labor expenses per adjusted discharge based on Medicare cost report data are trending as follows over the last three years:

	FY22	FY23	FY24
Direct Patient Care Labor Costs	6,004	5,963	6,532
Non-Patient Labor Costs	3,414	3,280	3,135
Management & Administrative Labor Costs	1,875	1,651	1,562

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

We recognize that the status quo of health care is unaffordable for the Vermonters who rely on us. We hear from our patients how the rising cost of living, including health care costs and the shortage of affordable housing and childcare options, are making it more difficult to live in our state.

We know we must think differently about how we operate as a unified health system and act with more determination than ever before to make health care more affordable. To be clear, we have not yet fully realized the benefits of our rural academic health system. We know that by sharing common goals and resources, we can work smarter and deliver high-quality medicine that is more affordable and responsive to our patients' needs.

Our FY26 budgets reflect our work to adapt, innovate and lead to improve the value of health care we provide. Our budgets support the advancement of three overarching goals:

- Provide high-quality care to our patients to drive outcomes toward top quartile performance.
- Accelerate our efforts to address the rising cost of health care in our region.
- Invest in maintaining or improving access to care, focusing on outpatient care and telehealth.

h) Describe planned fundraising efforts and anticipated donations for FY26.

We estimate that in FY26 we will receive donations totaling $500,000. The primary areas of focus will include workforce development, patient and family support funds, the Branches of Hope Cancer Patient

Fund, Health Care Share Fund, wellness and respite, and the annual fund to support our mission. We will also seek support for investments in our aging facilities and equipment, including strategic renovation to patient care units to better serve our community.

i) Has your hospital experienced a reduction in payment from any payer based on quality performance in the last two years? If so, please explain the nature of the penalty, the revenue impact, and steps taken to remediate the situation.

		2023	2024
Hospital	Adjustment	Amount	Amount
CVMC	Readmission	$ (236,599)	$(201,325)
	VBP		$ 219,287
	HAC		$(335,091)
	Total	$ (236,599)	$(317,129)

In 2024, CVMC received a penalty for Readmissions and Hospital Acquired Conditions (HAC). This penalty was based on performance during calendar year 2022 (data from 2021 was not used in this calculation due to ongoing stress on hospitals emerging from the pandemic). Performance thresholds vary each year as they are based on cohort performance. CVMC is committed to data-driven quality and has a performance improvement program that is guided by foundational quality and patient safety measures, including those within the CMS Stars Rating. While CMS measures are important in ensuring we are providing high-quality, reliable care, they only reflect a subset of our patient population. To advance our performance improvement efforts, we are a participating member of Vizient. This organization provides data, best practices and performance improvement services to support over 5,000 nonprofit health system members to improve quality and lower cost.

The organization has identified and implemented areas of focused improvement in:

Readmission Rates:

- Implemented centralized Transition of Care nurse in September 2024, who reviews all inpatient and ED discharges. Identifies patients who will require follow-up phone calls and/or visits, based on risk of readmission.
- Increased staffing with Care Management team, including expansion into the ED.
- Collaboration with Central Vermont Home Health and Hospice to enhance palliative/hospice care through formal hospice admission designation and coordination of care.
- We are working with our system's Population Health Services Organization (PHSO) to develop a system-wide congestive heart failure (CHF) pathway to reduce readmission rates of this high-risk population.

Hospital-Acquired Conditions (HACs):

- Clostridium Difficile (C Diff) Infections: Implemented best practices to leverage our electronic health record, education of providers on C Diff stewardship, use of EHR.
- Catheter-Associated Urinary Tract Infections (CAUTI): Implemented daily monitoring of devices, to identify and facilitate timely removal.
- Central Line-Associated Bloodstream Infections (CLABSI): Reinforced indications for use, implemented daily monitoring of devices to facilitate timely removal.

- Surgical Site Infections (Total Hip and Knee Surgeries): Implemented surgical site infection prevention bundle in pre-operative, intra-operative and post-operative settings. Implemented new central sterile and reprocessing quality assurance standards and invested in new equipment.
- Inpatient Falls with Serious Harm (PSI 08): Implemented post-fall huddles, Hester Davis fall risk assessments, and general fall prevention practices.

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

Investments in CVMC workforce development initiatives aim to reduce the costs of care through the recruitment and retention of the health care workforce while decreasing dependence on expensive agency labor costs and increasing access to high quality care. The following investment initiatives undertaken by UVM Health Network and CVMC upskill Vermont's entry-level workforce for high demand positions like nursing and respiratory therapy.

CVMC is supported by the UVM Health Network's Center for Workforce Development to implement advancement pathways and programs that upskill the workforce. Partnerships with Vermont State University, Norwich University, the University of Vermont and the Community College of Vermont provide the necessary resources to develop our workforce.

The Center plans to diversify its future pathway programs to meet the growing talent needs across the health system to include laboratory, surgical, and radiologic careers. This includes expanding existing programs and introducing new ones to cater to a wider range of health care roles and business needs throughout our system.

Specific workforce development initiatives at Central Vermont Medical Center include:

- **Pathfinder Program**: The investment of up to $180,000 annually in partnership with the Community College of Vermont in which UVM Health Network prepays for the prerequisites and corequisite courses to enter a health professional educational program. The result of this program is that more employees are academically prepared to enter the pathway programs offered by our system. We anticipate up to 20 individuals benefiting from this program in FY26 from CVMC and other Vermont partners.

- **Licensed Practical Nursing (LPN) Pathway Program**: In 2018, CVMC pioneered a new approach to career progression, enabling employees to pursue further education while maintaining full-time salary and benefits. This initiative, in partnership with Community College of Vermont and Vermont State University, led to the creation of a program that allowed employees to graduate as Licensed Practical Nurses (LPNs). This successful model has now been scaled across our system and is available to employees of all Vermont partners. The first network LPN cohort is graduating in 2025 with eight CVMC LPNs. Replacing an LPN traveler with permanent staff members will save our system around $100,000 annually per pathway graduate.

- **Registered Nurse (RN) Pathway Program:** Building on the success of the LPN program, we expanded our offerings to include the RN Pathway Program. This successful model has also been scaled across our system and is available to employees of all Vermont partners. Up to 20 employees will be selected for the RN Pathway Program starting in late 2025. In June 2025, our

hospital celebrated the graduation of another eight RNs. Replacing an RN traveler with a permanent staff member saves our system around $140,000 annually per pathway graduate.

- **Accelerated Bachelor of Nursing (ABSN) Pathway Program:** In partnership with AHS and Norwich University, UVM Health Network invested in employees that held previous college degrees to become registered nurses in 18 months through Norwich's ABSN program. Instead of a traditional 4-year bachelor's or seeking a 2-year associate degree, this program utilizes previous college credit to contribute to the Bachelor of Nursing degree. CVMC has two employees who will graduate in December 2025 from this program and will fill vacant RN positions, replacing costly contract nurses. The estimated annual savings related to replacing contract staffing with employed staff is up to $280,000 annually for this graduating cohort.

- **Master of Science in Nursing (MSN) Pathway Program:** In partnership with AHS, Vermont State University, and Norwich University, the organization invested in 25 nurses to complete their Master of Science in Nursing Education, of which three are from CVMC. The program requires the employees to serve as Clinical Nurse Faculty for a Vermont academic nursing program for a two-year dual service agreement. This investment provides professional development for our current nursing staff, which increases retention, while also contributing to the stability of our academic nursing programs that need nursing faculty.

- **Respiratory Therapy Pathway Program:** The Center has significantly invested in ensuring the VTSU Respiratory Therapy program is viable for the state. The partnership includes a cost-sharing agreement, community scholarship, and developing an employee pathway program for employees of all Vermont partners. Of the eight active participants employed through the system, there are two CVMC participants. Preserving and maintaining this essential program for our region not only strengthens our health care system but also enhances patient access to affordable care and supports other hospitals in Vermont in achieving the same goals. The estimated annual savings related to replacing contract staffing with employed staff is up to $120,000 per program graduate.

- **Licensed Nursing Assistant (LNA) Training Program:** CVMC invests in developing the entry-level nursing role through our state approved LNA training program. This paid training program prepares entry level employees for the licensure exam and competency demonstration to be a Licensed Nursing Assistant. The program is offered up to 4 times per year, with a maximum class size of 15 students per class. This program can contribute up to 60 new LNAs per year. The LNA role is also a steppingstone to advancement to nursing roles like LPN and RN.

Investing in our workforce and developing our local community are priorities for CVMC. These programs aid in removing barriers and supporting our local talent in pursuing a career in health care. CVMC continues to partner with state and national agencies and organizations to pursue efficiency and resources to support these programs and our individuals.

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

CVMC Housing & Childcare Investments:

- To promote workforce recruitment and retention, CVMC leases 20 market rate rental units within five miles of the hospital campus and subleases these to CVMC employees.
- In support of expanding childcare options for employees, CVMC has made an investment in a regional childcare provider to be located near the hospital campus. CVMC will have 25 spaces per year reserved for CVMC families over the next five years.
- CVMC continues to absorb the employee share of the Child Care Contribution that was enacted in July 2024 for FY26.
- We also provide tuition reimbursement for all eligible staff and offer several wellness programs for physical and mental wellbeing.
- These expenses are reflected in CVMC's areas of fringe expenses, lease and rental expense, facility and equipment maintenance and repairs, and utilities. Any revenue will be seen in other revenue.

In addition, the housing and childcare initiatives in Chittenden County, supported by UVM Health Network, are available to all system employees.

l) For what drivers of expense growth do you feel hospitals should be "held harmless" and why? For any identified drivers reference the amount and account code in adaptive where those expenses are allocated.

Not applicable. CVMC has submitted a compliant budget for FY26.

D. Hospital & Health System Improvement

a) Given the access challenges related to Mental Health, Substance Use Disorder, Long Term Care, and Primary Care, please share any investments you are making and/or the steps you are taking to improve access in each of those areas, with specific ties to your budget, where appropriate.

Our primary care providers have completed the transition away from tracking "productivity" via wRVUs and instead work within a "risk-adjusted panel size model." This, coupled with operational improvements, such as standardized schedules, has allowed CVMC to create more access to primary care providers. At the end of May 2025, CVMC has added 291 patients to primary care over FY25. CVMC providers have performed 1,239 electronic consults as of May 2025, a 15.6% increase over this time last fiscal year. We believe this effort, when combined with our planned and previously announced clinic consolidations, will lead to greater efficiency and support patient access.

CVMC and UVM Health Network Community Benefit investment dollars were used to support the coordination of the coalition and contributed to the following community projects:

- NaloxBox project: Ensuring access to emergency use of naloxone in community organizations and businesses. The NaloxBox project installed 18 boxes at three locations and co-hosted

overdose prevention training for 30 food pantry managers. Established three sites to have naloxone (Narcan) available at all times.

- Project BEACON: A community based post-overdose response initiative connecting survivors to harm reduction, treatment, and recovery resources.
- Central Vermont Prevention Coalition (CVPC) continues to fight stigma around substance use. Dr. Javad Mashkuri, an Emergency Medicine physician at CVMC, received the Davida Coady Gorham Medical Professional of the Year Award for his work in addiction medicine.
- CVPC secured a 5-year and $1.875M SAMSHA grant: FUTURE VT—Families Uniting to Understand and Resolve Substance Use Effects in Vermont.
- Event sponsor of Barre Heritage Festival, Barre's free 4-day cultural celebration, supporting a community with higher poverty levels and social health challenges.
- Sponsor of It Takes a Village – A free family event on May 10, 2025 by Good Beginnings of Central Vermont.
- Annual contribution to Vermont Ethics Network, ensuring access to a vital statewide health care resource.
- Sponsor of annual diaper drive fundraiser with Family Center of Washington County.
- Co-hosted a screening of Just Getting By with Capstone Community Action, highlighting the challenges and resilience of low-income Vermonters and the need for more support.

b) Describe how you work with other providers in your community, including the FQHC, designated agencies, other community-based services etc., being sure to include opportunities and obstacles to ensuring smooth transitions of care along the care continuum.

Centralized Blueprint Team

UVM Health Network partners with Blueprint for Health to administer programs across the three Vermont health service areas (HSAs) we serve – Burlington, Barre, and Middlebury. In each HSA, our system leverages Blueprint resources to support community collaboratives, offer community health team services and facilitate Patient-Centered Medical Home (PCMH) accreditation. Each area is also supported by a dedicated Blueprint-funded UVM Health Network quality improvement facilitator who brings expertise in PCMH care and guides continuous improvement efforts for both UVM Health Network and independent primary care practices.

In 2024, UVM Health Network established a centralized team within its PHSO to enhance coordination with independent primary care practices, designated agencies, Federally Qualified Health Centers (FQHCs) and other community-based services through our partnership with Blueprint for Health. This centralized structure enables operational efficiencies, promotes shared learning and ensures fiscal and programmatic alignment across HSAs. Additionally, it allows UVM Health Network to create robust relationships with partners in independent primary care. The PHSO also provides the infrastructure to support data-informed decision-making within local community collaboratives such as CACH in Burlington, THRIVE in Barre and CHAT in Middlebury. Through this model, UVM Health Network strengthens community partnerships, supports PCMH accreditation, and deploys community health team members to ensure patients receive coordinated, person-centered care and timely access to community resources.

Additionally, UVM Health Network facilitates access for community providers to EpicCare Link. This provides a much-needed care coordination tool for independent practices and enables timely access to critical information about the care of their attributed patients. In lieu of a statewide, or contracted, Admission, Discharge and Transfer (ADT) alert system, EpicCare Link has become the primary tool for enabling community providers to engage their patients in timely post-discharge follow-up care. This is a

key function of improving acute care utilization patterns and reducing readmissions.

WRAP
With the expansion of the Working to Reduce Admissions Program (WRAP) Network Program to UVM Medical Center, Central Vermont Medical Center and Porter, our care managers have tackled some of the region's most complex patient scenarios. Reducing unnecessary utilization and readmissions is crucial, and our primary focus is connecting patients to longitudinal support in real-time. To achieve this, we have strengthened partnerships with designated mental health agencies, FQHCs, shelters, drop-in clinics and centers for Medications for Opioid Use Disorder (MOUD) treatment. Our strategy to enhance care transitions involves increasing WRAP care management visibility, leading to better treatment coordination and reduced duplication.

Recent efforts include weekly WRAP nurse care manager presence at COTS Day Station facilitating meetings with the Burlington Police Department and Howard Center Street Outreach and holding structured meetings with FQHCs, like Plainfield Health Center. Challenges include the lack of a centralized electronic medical record among community agencies, which hampers communication and can lead to duplication. To address this, we rely on recurring meetings to discuss mutual patients, create care plans and assign responsibilities. Additionally, our collaboration with Blueprint for Health has been vital in reducing duplication and addressing patient needs efficiently.

THRIVE
THRIVE is central Vermont's Accountable Community for Health (ACH) – a regional partnership created to support the health and well-being of residents in Washington and northern Orange Counties. Member organizations are committed to building thriving communities by using informed, collaborative and innovative solutions to optimize public health. The group's areas of focus are aligned with priorities identified in the hospital's Community Health Needs Assessment (CHNA).

CVMC has served as the group's convener and fiscal sponsor supporting collaboration and information-sharing among its 16 partners, as well as advancing health and prevention initiatives in communities throughout the region.

Those initiatives range from COVID-era work supporting individuals experiencing homelessness; a campaign focused on lowering the rate of single female head of households living in poverty; and gathering community feedback on critical health and wellness needs in communities throughout the region.

THRIVE was honored in 2025 as a Public Health Champion by the Vermont Public Health Association. The award, presented at the Association's annual meeting, highlights the work of THRIVE collaborative both in promoting public health and in crisis response – specifically the group's "effective tactical flood response and collaboration to meet vital community needs" following regional flooding in the summer of 2024.

c) Please describe your incoming & outgoing referral process in regards to providers outside of the hospital system. For an incoming referral from an outside provider - what is the process for continued treatment and care, once the patient has received referral care? For an outgoing referral, are there any methodologies in place to refer care outside of the hospital system to a private practice provider, particularly if there are wait times or more affordable options possibly available to the patient?

The community provider-to-UVM Health Network provider referral process is a structured communication and coordination pathway, ensuring patients receive specialized care when needed. Below is a step-by-step breakdown of how our referral process typically works from our community providers:

1. **Referral Initiation:** The referring physician sends a referral request form to the needed specialty department.

2. **Authorization:** Designated staff monitor the outgoing work queue to manage authorizations. Each order should be acted upon within three business days of receiving the order.

3. **Specialist Review and Scheduling**
   - The receiving specialist's office reviews the referral request, supporting clinical documentation and determines priority status.
   - The receiving specialist's office contacts the patient to schedule an appointment.
     a. The specialty office makes up to three attempts to reach the patient over a 10-day business period.

4. **Specialist Consultation or Procedure/Imaging/Test**
   - The patient sees the specialist, who evaluates the condition and may order further tests or begin treatment.
   - If for procedure, imaging, test, results routed to referring provider for review and additional evaluation determination.

5. **Feedback to Referring Physician/Post-Appointment Follow-up**
   - The specialist sends a consultation note or summary back to the referring physician, detailing: diagnosis, treatment plan and follow-up recommendations.
     a. Clinical documentation is reviewed, and appropriate actions are taken as directed by the referring provider. The referral status is updated to "Specialty Report Received," closing the referral loop and removing it from the work queues. The expectation is to close the loop and send above within five business days to the referring provider's office.

When a UVM Health Network provider refers a patient to a non-UVM Health Network provider:

1. **Placing the Order**

   - When a provider places an order for services to be performed at an outside organization, the class is marked as "External" in the Electronic Medical Record.
   - Checkout staff review the order to determine if all external referrals have a "to provider" identified. If not, staff will ask the patient where they plan to go for the referral and enter the "to provider" information.

2. **Managing the External Work Queue**

- Designated staff track referrals for external providers, ensuring critical referrals are followed up. Staff contact the community provider/organization to request the date, provider, location and any additional comments about the appointment.
- Staff manually enter the external appointment details into the scheduling section of the referral and make multiple attempts to reach the patient or external provider to confirm the appointment. If unable to contact, the referral status is updated to "Unable to Contact," and the ordering provider is notified.

3. **Follow up**

- Staff follow up with the community provider's office to obtain the specialty report. If the report is received, the referral status is updated to "Specialty Report Received," completing the referral process.
- If no information is received from the community provider's office after multiple attempts, the supervisor will be notified for further action.
    - UVM Health Network staff will make up to three attempts to reach the community provider office over a 10-day period to obtain the notes.
        - If no information is received from the community provider office, a referral message to the ordering provider notifies them of our attempts.

Addressing Wait Times and Affordability

Providers are always welcome to refer a patient anywhere, external or internal to the hospital system. If there are shorter wait times or more affordable options available to our patient, staff may refer care outside of our system to a private practice provider. This involves identifying alternative providers who can offer timely and cost-effective care, which is not automated and can be a labor-intensive and inconsistent process.

Staff will communicate with the patient about these options and assist in coordinating the referral to ensure the patient's needs are met efficiently.

These processes are in place to ensure referrals, both incoming and outgoing, are managed efficiently, maintaining continuity of care and addressing patient needs promptly.

SECTION VI: HOSPITAL REPORTING REQUIREMENTS

1. FY2024 Medicare Cost Report (completed 4/1/25)
Submit a pdf of your full FY24 Medicare Cost Report as submitted to the Centers for Medicare and Medicaid Services (CMS).

2. Verification under Oath
Attestation to truth of filing on which the hospital Board, CEO and CFO, swears and affirms that the information provided is true and accurate to the best of their knowledge. The hospital should submit an individual document for each of these Executives.

3. Budget Narrative

For each hospital, submit a budget narrative (see Section V for specific requirements and questions to be answered).

4. FY2026 Budget Request

Each hospital must submit details of its budget request in the Adaptive database using the following Sheets. Projections for FY25 should also be provided in those same sheets. These Adaptive sheets are listed below in the most efficient order of completion since some accounts populate accounts in other sheets. More detailed definitions and requirements can be found in the Uniform Reporting Manual and Adaptive User Guide.

Hospital and Physician Revenue

The Hospital and Physician Revenue Sheet collects units of service and Net Patient Revenues and Fixed Prospective Payments, Reserves and Other Payments at the Department level.

Payer Revenue

The Payer Revenue sheet records Gross Patient Revenues and Deductions by Payer, where payer is broken by Medicaid, Traditional Medicare, and Commercial; and Commercial is broken out by Traditional Commercial, Medicare Advantage, Workers Comp, Self-Pay, Commercial FPP, and Other. The Net Patient Revenue by Payer calculated from these submitted values should tie to the totals reflected in the Rate Increase Decomposition sheet.

Other Revenue

The Other Revenue sheet includes both Other Operating Revenues (for example, grant income, 340B pharmacy, etc.) and Non-Operating Revenues.

Staff/FTE

The Staff/FTE (Full Time Equivalent) sheet collects all budgeted FTEs for each Hospital by department and service area by clinical and non-clinical FTEs per the Uniform Reporting Manual.

CON Sheets (Non-CON Detail, CON Detail, Capital Summary)

The CON sheets provide information on hospitals' planned capital expenses. The Non-CON Detail sheet includes information on projects costing more than $500K but not triggering a Certificate of Need reviews, while the CON Detail sheet includes all CON projects. The Capital Summary sheet combines the Non-CON and CON detail sheets, and also allows entry of the aggregated cost of non-CON projects less than $500K each.

Balance Sheet

If your budget is entered in the order above, several accounts in the Adaptive Balance sheet will be populated by entries made on other sheets. Please see the Uniform Reporting Manual for more detailed requirements and definitions.

Income Statement

Like the Balance Sheet, several accounts will be automatically populated if your entries are made in the order above. Where accounts are not linked, please ensure that all figures reported on your income statement tie to the relevant figures on the Other Revenue and Payer Revenue sheets. Please see the Uniform Reporting Manual for more detailed requirements and definitions. Income statement will be driven by entries on the payer revenue sheet and other revenue.

Network Shared Services Financials

Adaptive sheets will be used to collect financial details associated with network-level shared services, including Network Administration, Revenue Cycle, Other Fiscal Services, Human Resources, Information Technology, Supply Chain, Marketing & Advertising, Quality, Population Health Services, and other.

Utilization

The utilization sheets collect Beds, Admissions, and Patient Days by various departments, as well as outpatient visits.

5. Supplemental Workbook

While the data requested below are not viewed as being wholly reflective of a hospital's operating performance, it will be considered in the broader context of administrative data and other types of data noted in other sections of this guidance.

340B Supplement

Each hospital must submit certain financial information on drugs purchased through the 340B program and dispensed to patients during the fiscal year. Financial information includes total revenues from the sale of 340B drugs, the estimated subset of revenues from patient costsharing, and total expenditures associated with purchasing and distributing 340B drugs. GMCB has refrained from requesting any 340B data that does not have immediate relevance to the Hospital Budget Review.

Health Resources & Services Administration (HRSA) states the intent of the 340B program is to "enable covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." HRSA's 340B prescription drug discount program is critically important to our rural providers, as it is a vital lifeline for safety net health care organizations providing a high level of services to low-income individuals or serving isolated rural communities. Significantly more 340B hospitals provide vital, yet money-losing, health services than non-340B hospitals – services like mental health and substance use disorder treatment, trauma centers, and neonatal intensive care units.

CVMC procures medications from wholesale distributors, 503B compounders and directly from manufacturers at 340B and group purchasing organization (GPO) price points. The 340B prescription drug pricing program is only available for medications used in the outpatient setting based on qualifying patient visits. The 340B drug pricing program lessens the gap between the cost of care and reimbursement from governmental payers. The 340B program is a cost-avoidance program that is funded by pharmaceutical manufacturers and not by taxpayers. Without the federal 340B prescription drug pricing program, our pharmaceutical expenses would be significantly higher.

340B revenues, patient cost-sharing and total expenditures cannot be separated from the other lines of revenue and operating expenses. Contract pharmacy data, which is specific to 340B revenue and expense, retail pharmacy gross margin and hospital outpatient estimated 340B cost-avoidance are depicted in the table below.

CVMC ($ in millions*)	FY23 Actual	FY24 Actual	FY25 Budget	FY25 YTD April Annualized	FY26 Budget
Contract 340B	9.1	9.1	11.1	13.3	9.8
Retail: Rx/Mail/Specialty	0.0	0.0	0.0	0.0	0.0
Total Gross Margin	9.1	9.1	11.1	13.3	9.8
Cost Avoidance					
Estimated 340B cost-avoidance on pharmaceuticals provided through hospital outpatient & physician office patient encounters**	1.9	4.3	0.0	6.8	0.0
Total With Estimated Cost-avoidance	11.0	13.4	11.1	20.1	9.8
Medicaid Share Back (Inpatient Pharmacy)	(0.2)	(0.2)	0.0	(0.2)	0.0
Total With Medicaid Share Back	10.8	13.2	11.1	19.9	9.8

*Gross Margin = Other Revenue less Cost of Goods Sold. Does not include employee costs or GPSR.

**Cost-avoidance is difference between GPO cost and 340B cost.

Hospital Pharmacy

340B revenues, patient cost-sharing and total expenditures for hospital pharmacy cannot be separated from the other lines of revenue and operating expenses. We estimate approximately 30-40% of drug supply replenishment cost for hospital outpatient provided pharmaceuticals for qualifying sites of service are eligible for the 340B drug pricing program. CVMC pharmaceutical expenses are categorized into two major general ledger accounts: non-chemo pharmaceuticals and chemo drugs. The two accounts comprise most of the hospital pharmaceutical expenses.

CVMC strives to minimize and avoid cost by purchasing medications at both 340B and GPO price points. The table below contains hospital pharmacy pharmaceutical expenses for FY25 YTD (April):

CVMC	FY25 YTD April Expense ($)
General Ledger Account	--
Non-Chemo Pharmaceuticals	11.1 M
Chemo Drugs	5.5 M

CVMC does not have the ability to break out reimbursement for pharmaceuticals from the total reimbursement. The charges billed in the hospital inpatient and outpatient settings are generated through the hospital pharmacy chargemaster. Revenue derived through the hospital inpatient and outpatient setting are included in NPR.

Rate Decomposition

The Rate Decomposition sheet collects Net Patient Revenue due to reimbursement rate (i.e. charges less discounts) versus Net Patient Revenue due to non-reimbursement rate changes (i.e. utilization,

payer mix, case mix, service, etc.), by core service line (inpatient, outpatient, and professional services) and payer, where payer is broken out by payer category and major commercial payers as defined in the uniform reporting manual.

Network Supplemental Financials
Networks that generate more than 50% of total network and member hospital revenue from Vermont hospitals are required to submit a supplemental financial workbook. This workbook is comprised of consolidating financial statements (balance sheet, income statement, change in net assets, cash flows) reflecting the network's submitted FY26 budget. Vermont hospitals must be broken out separately on these statements.

Referral and Visit Lags
Each hospital must submit data on referral and visit lags (see definitions below) for all referrals or appointments requested from April 1, 2025 - April 14, 2025. Please report such lags for each hospital-owned primary care practice, each hospital-owned specialty care practice, and the same imaging procedures as the hospital reported in FY25. If the five most frequent imaging procedures have changed, please add the new imaging procedures as well.

Referral lags: the percentage of appointments scheduled within 3 business days of referral (that is, the percentage of all referrals where the clinic or hospital has completed scheduling an appointment within 3 business days of receiving the referral, regardless of the date on which the appointment will take place).

Visit lags: the percentage of new patient appointments scheduled for the patient to be seen within 14 days, 30 days, 90 days, and 180 days of their scheduling date. (The scheduling date is the date the hospital or practice schedules the appointment, not the date the referral was received.) This metric only concerns appointments for new patients. Please include all holidays and weekends in your calculation.

Margin on Services
Each hospital must submit their top 5 "highest margin" services & "lowest margin" services. For each service, please include Revenue attributed to these services, (weighted) average historical margin, as well as (weighted) average commercial reimbursement (price?) over Medicare.

Clinical Productivity
Please report average work RVUs per clinical FTE by department – both the level and the associated percentile of national benchmarks, or similar, for the most recent year available. Report the number of clinical and budgeted FTEs (if different) that are included in the denominator. Hospitals must benchmark on year 2024.

Contingency Plan
A hospital which submits a budget that doesn't meet the benchmarks established in Section I must provide a comparison of gross revenue by department/service area for a compliant budget vs. their submitted budget.

Not applicable. CVMC meets all Section I benchmarks.

Labor Expense
Each hospital must submit a detailed breakout of labor expenses, with a distinction between clinical and non-clinical staff

Case Mix
Each hospital must complete a table providing historical and budgeted case mix index by payer.

Capital Expenses
Each hospital must provide a breakout of FY2026 planned Capital Expenditures at the summary level, as well as funding sources.

Regional Collaborations
Each hospital must complete a table detailing regional collaborations, including the partner organization(s), a description, and financial impact.

Cost Inflation
Each hospital must complete a table breaking out cost inflation, with a distinction between growth due to price and utilization.

6. Community Health Needs Assessment (CHNA) and Implementation Plan
Submit a complete copy of the hospital's most recent Community Health Needs Assessment (CHNA) and, if applicable, the most recent Implementation Strategy, as required by the Patient Protection and Affordable Care Act.

To view the most recent Community Health Needs Assessment and associated materials, please visit:
https://www.uvmhealth.org/health-wellness/uvm-health-network-community-benefit
https://www.cvmc.org/about-cvmc/community/community-health-needs-assessment

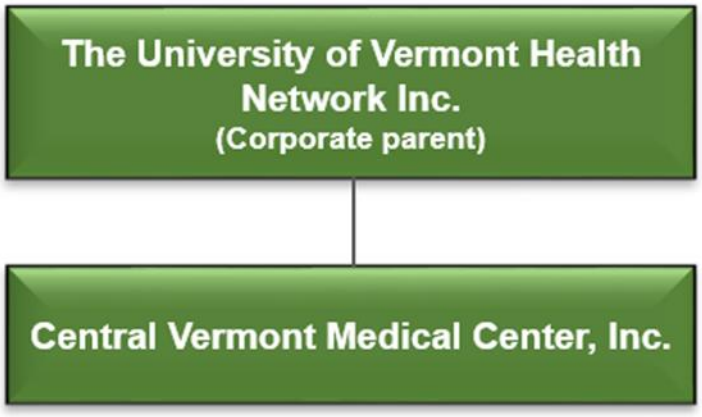
7. Financial Assistance Policy & Reporting
In accordance with Act 119 of 2022, hospitals are required to submit a plain language summary of their financial assistance policy (FAP). In addition, please report the following:
• Total number of applicants granted any amount of FAP
• Number of applicants granted 100% FAP
• Number of applicants granted less than 100% FAP
• Total applicants denied FAP
• Breakdown of reason for denial (% or #)

FY 2024	
Central Vermont Medical Center	**Volumes**
Total Applications	1,515
Total Household Members	1,736
Approved/Granted	
Free Care	723
Reduced Care	568
Total Approved	1,291
Denied	
Denied - No Eligible Charges	0
Denied - No Current/Scheduled Charges	1
Denied - Other Reason	6
Denied - Out of Service Area	0
Denied - Over Assets	16
Denied - Over Income	42
Denied - Over Income & Assets	5
Incomplete Application or Documentation	148
No Response from Patient	0
Qualified for Medicaid	2
Qualified for Other Assistance Programs	1
Total Denied	221

Please click here to view the current plain language summary (as of January 1, 2025) for Central Vermont Medical Center's financial assistance policy.

8. Corporate Structure

Provide an up-to-date chart or graphic outlining the corporate structure associated with the Hospital.



9. Salary

Provide the FY25 and budgeted FY26 salaries, including any bonuses, variable payments, or incentive plans (potential or paid), for the hospital's executive and clinical leadership and the hospital's salary spread, so that the Board may consider that salary information and consider a comparison of median salaries to the medians of northern New England states in accordance with 18 V.S.A. § 9456(b)(13). Provide any benchmarks and/or bases on which such compensation was established, including the bases for any bonuses, variable payments, or inventive plans.

10. Net Revenue & Public Payer Reimbursement

File an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid, Medicare, or another public health care program reimbursements, and to any reduction in bad debt or charity care due to an increase in the number of insured individuals as specified in 18 V.S.A. § 9456(b)(8) and (b)(9).

APPENDIX

NPR Variance - FY25 BUDGET to FY26 BUDGET

	Ref Cells	A	B	C	D	E	F	G	H	I	J
		$ -									
NPR		**Total**	**Total Medicare**	**Total Medicaid**	**Total Major Comm**	**Other Commercial**	**Self-Pay**	**Public Agency/Workers Comp**	**Other**	**UVMMC Employee Self Funded Insurance Plan**	**DSH**
Gross revenue	1	$ 683,664,186	$ 330,781,195	$ 103,808,839	$ 178,108,413	$ 16,356,435	$ 12,695,032	$ 23,628,940	$ (742,649)	$ 19,027,981	$ -
Deductions + denials	2	$ 377,624,892	$ 218,680,351	$ 68,465,512	$ 50,608,067	$ 5,280,902	$ 4,253,761	$ 13,615,336	$ 6,075,340	$ 11,982,364	$ (1,336,740)
FY25 BUDGET NPR By Payer excluding BD/Charity	3	**$ 306,039,294**	**$ 112,100,844**	**$ 35,343,326**	**$ 127,500,346**	**$ 11,075,533**	**$ 8,441,271**	**$ 10,013,605**	**$ (6,817,989)**	**$ 7,045,617**	**$ 1,336,740**
Bad Debt / Charity By Payer	4	$ *(14,536,863)*	$ (4,235,174)	$ (538,883)	$ (5,971,979)	$ (924,965)	$ (4,779,487)	$ 230,521	$ 1,935,515	$ (252,411)	$ -
FY25 BUDGET	5	**$ 291,502,431**	**$ 107,865,670**	**$ 34,804,443**	**$ 121,528,367**	**$ 10,150,568**	**$ 3,661,784**	**$ 10,244,126**	**$ (4,882,473)**	**$ 6,793,207**	**$ 1,336,740**
FY2025 Accounting Changes											
Denials	6	$ 0	$ (1,385,306)	$ (1,608,394)	$ (624,599)	$ (166,717)	$ (8,302)	$ (513,444)	$ 4,327,197	$ (20,435)	$ -
Total FY2025 Accounting Changes Impact	7	**$ 0**	**$ (1,385,306)**	**$ (1,608,394)**	**$ (624,599)**	**$ (166,717)**	**$ (8,302)**	**$ (513,444)**	**$ 4,327,197**	**$ (20,435)**	**$ -**
FY25 Budget After Accounting Changes	8	**$ 291,502,431**	**$ 106,480,364**	**$ 33,196,050**	**$ 120,903,769**	**$ 9,983,852**	**$ 3,653,481**	**$ 9,730,681**	**$ (555,277)**	**$ 6,772,772**	**$ 1,336,740**
Rate Decomposition Cell Reference	9	*I223*	*I193*	*I186*	*I201*	*Included in I211 Total*	*I215*	*Included in I218 Total*	*Included in I218 Total*	*Included in I211 Total*	*I199*
FY2026 Rate Changes											
All Payers	10	$ 4,346,265	$ 975,385	$ 7,257	$ 2,981,841	$ 185,741	$ 156,906	$ 47,224	$ (8,684)	$ 596	$ -
Denials	11	$ (155,973)	$ (27,314)	$ (25,103)	$ (37,817)	$ (11,564)	$ (395)	$ (50,381)	$ (2,794)	$ (606)	$ -
Bad Debt	12	$ (247,738)	$ (19,933)	$ (1,156)	$ (49,607)	$ (7,375)	$ (169,721)	$ (652)	$ 1,610	$ (906)	$ -
Charity	13	$ (137,480)	$ (31,281)	$ (222)	$ (21,341)	$ (3,250)	$ (80,705)	$ (85)	$ (34)	$ (562)	$ -
H.266 pharmaceutical pricing reductions	14	$ (7,500,000)	$ -	$ -	$ (7,500,000)	$ -	$ -	$ -	$ -	$ -	$ -
Other Initiatives	15	$ -									
Total FY2026 Rate Changes Impact	16	**$ (3,694,926)**	**$ 896,858**	**$ (19,223)**	**$ (4,626,924)**	**$ 163,553**	**$ (93,915)**	**$ (3,895)**	**$ (9,902)**	**$ (1,479)**	**$ -**
Rate Decomposition Cell Reference	17	*AE223*	*AE193*	*AE186*	*AE201*	*Included in AE211 Total*	*AE215*	*Included in AE218 Total*	*Included in AE218 Total*	*Included in AE211 Total*	*AE199*
FY2025 Budget to Actual Collection Rate											
All Payers	18	$ 5,283,570	$ (551,647)	$ 1,334,347	$ 186,598	$ 1,206,641	$ 2,463,272	$ 1,019,831	$ (563,837)	$ 188,365	$ -
GME Change	19	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Disproportionate Share Payments (DSH)	20	$ 1,686	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,686
Denials	21	$ 358,127	$ 741,463	$ 282,543	$ 320,253	$ (17,666)	$ 2,725	$ (181,153)	$ (800,812)	$ 10,774	$ -
Bad Debt	22	$ 5,105,607	$ 1,353,391	$ 272,887	$ 2,877,692	$ 525,981	$ (919,291)	$ (224,181)	$ 1,075,035	$ 144,091	$ -
Charity	23	$ 1,531,829	$ 1,095,285	$ 245,955	$ 753,297	$ (29,590)	$ (646,539)	$ 9,554	$ 4,991	$ 98,875	$ -
Total FY2025 Budget to Actual Collection Rate Impact	24	**$ 12,280,818**	**$ 2,638,492**	**$ 2,135,733**	**$ 4,137,840**	**$ 1,685,366**	**$ 900,167**	**$ 624,051**	**$ (284,622)**	**$ 442,106**	**$ 1,686**
Rate Decomposition Cell Reference	25	*V223*	*V193*	*V186*	*V201*	*Included in V211 Total*	*V215*	*Included in V218 Total*	*Included in V218 Total*	*Included in V211 Total*	*V199*
FY2025/FY2026 Utilization											
All Payers	26	$ 9,841,761	$ 2,693,604	$ 402,868	$ 5,422,669	$ 466,758	$ 181,673	$ 327,085	$ 26,355	$ 320,750	$ -
Denials	27	$ (103,736)	$ (54,017)	$ (32,028)	$ (20,313)	$ (4,610)	$ (363)	$ (15,715)	$ 24,123	$ (812)	$ -
Bad Debt	28	$ (274,396)	$ (10,164)	$ (11,346)	$ (137,971)	$ (26,637)	$ (55,963)	$ 8,279	$ (35,009)	$ (5,585)	$ -
Charity	29	$ (146,936)	$ (33,593)	$ (7,993)	$ (34,708)	$ (4,137)	$ (62,406)	$ (424)	$ (210)	$ (3,466)	$ -
Clinical Initiatives	30	$ (3,413,564)	$ (1,202,944)	$ (166,622)	$ (1,636,316)	$ (129,354)	$ (79,738)	$ (119,264)	$ 2,108	$ (81,433)	$ -
Other Initiatives	31	$ -									
Total FY2025/FY2026 Utilization Impact	32	**$ 5,903,129**	**$ 1,392,886**	**$ 184,878**	**$ 3,593,360**	**$ 302,020**	**$ (16,797)**	**$ 199,962**	**$ 17,366**	**$ 229,454**	**$ -**
Rate Decomposition Cell Reference	33	*P223*	*P193*	*P186*	*P201*	*Included in P211 Total*	*P215*	*Included in P218 Total*	*Included in P218 Total*	*Included in P211 Total*	*P199*
FY2025/FY2026 Payer Mix Changes											
All Payers	34	$ (1,401,229)	$ (1,261,165)	$ (2,055,188)	$ (1,724,626)	$ (857,472)	$ 1,710,996	$ (194,806)	$ 2,071,815	$ 909,217	$ -
Denials	35	$ 1,624,170	$ (136,863)	$ 473,054	$ 22,903	$ 12,252	$ (1,223)	$ 40,670	$ 1,215,592	$ (2,214)	$ -
Bad Debt	36	$ (4,216,824)	$ 160,501	$ 33,323	$ 65,788	$ 84,940	$ (1,585,326)	$ (49,305)	$ (2,910,314)	$ (16,431)	$ -
Charity	37	$ (292,554)	$ (34,929)	$ (39,175)	$ 87,399	$ 21,107	$ (297,564)	$ 1,596	$ (17,300)	$ (13,689)	$ -
Total FY2025/FY2026 Payer Mix Changes Impact	38	**$ (4,286,436)**	**$ (1,272,456)**	**$ (1,587,985)**	**$ (1,548,536)**	**$ (739,174)**	**$ (173,117)**	**$ (201,844)**	**$ 359,793**	**$ 876,884**	**$ -**
Rate Decomposition Cell Reference	39	*S223*	*S193*	*S186*	*S201*	*Included in S211 Total*	*S215*	*Included in S218 Total*	*Included in S218 Total*	*Included in S211 Total*	*S199*
Provider Acquisitions/Transfers	40	$ -									
Gross revenue	41	$ 721,779,212	$ 350,676,573	$ 104,147,671	$ 186,506,651	$ 16,500,360	$ 16,778,481	$ 24,070,817	$ 258,555	$ 22,840,104	$ -
Deductions + denials	42	$ 406,858,842	$ 238,784,534	$ 70,191,608	$ 61,615,713	$ 4,740,818	$ 3,911,659	$ 13,697,167	$ 785,482	$ 14,470,286	$ (1,338,426)
FY26 BUDGET NPR By Payer excluding BD/Charity	43	*$ 314,920,370*	*$ 111,892,039*	*$ 33,956,062*	*$ 124,890,937*	*$ 11,759,542*	*$ 12,866,822*	*$ 10,373,650*	*$ (526,927)*	*$ 8,369,819*	*$ 1,338,426*
Bad Debt / Charity By Payer	44	*$ (13,215,354)*	*$ (1,755,895)*	*$ (46,610)*	*$ (2,431,429)*	*$ (363,926)*	*$ (8,597,003)*	*$ (24,695)*	*$ 54,286*	*$ (50,082)*	*$ -*
FY26 BUDGET	45	**$ 301,705,016**	**$ 110,136,144**	**$ 33,909,452**	**$ 122,459,508**	**$ 11,395,616**	**$ 4,269,819**	**$ 10,348,955**	**$ (472,641)**	**$ 8,319,736**	**$ 1,338,426**
Rate Decomposition Cell Reference	46	*K223*	*K193*	*K186*	*K201*	*Included in K211 Total*	*K215*	*Included in K218 Total*	*Included in K218 Total*	*Included in K211 Total*	*K199*
$ Change from FY26 BUDGET Approved Budget	47	**$ 10,202,585**	**$ 3,655,780**	**$ 713,403**	**$ 1,555,740**	**$ 1,411,764**	**$ 616,337**	**$ 618,274**	**$ 82,636**	**$ 1,546,965**	**$ 1,686**
Rate Decomposition Cell Reference	48	*M223*	*M193*	*M186*	*M201*	*Included in M211 Total*	*M215*	*Included in M218 Total*	*Included in M218 Total*	*Included in M211 Total*	*M199*
% Change from FY26 BUDGET Approved Budget: Payer Categ	49	**3.5%**	**3.4%**	**2.1%**	**1.3%**	**14.1%**	**16.9%**	**6.4%**	**-14.9%**	**22.8%**	**0.1%**
Rate Decomposition Cell Reference	50	*AJ223*	*AJ193*	*AJ186*	*AJ201*	*Included in AJ211 Total*	*AJ215*	*Included in AJ218 Total*	*Included in AJ218 Total*	*Included in AJ211 Total*	*AJ199*
% Change from FY26 BUDGET Approved Budget: Total NPR (W	51	**3.5%**	**1.3%**	**0.2%**	**0.5%**	**0.5%**	**0.2%**	**0.2%**	**0.0%**	**0.5%**	**0.0%**
Rate Decomposition Cell Reference	52	*AK223*	*AK193*	*AK186*	*AK201*	*Included in AK211 Total*	*AK215*	*Included in AK218 Total*	*Included in AK218 Total*	*Included in AK211 Total*	*AK199*