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

On behalf of Porter Hospital

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.

Porter Hospital

A. Executive Summary

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

High-Level Overview: Porter Hospital's proposed FY26 budget is guided by a patient-first approach, ensuring that financial decisions support our strategic priorities aimed at enhancing quality of care, access and affordability. This budget strengthens our ability to modernize care delivery, invest in critical infrastructure and recruit and retain top talent—all essential to meeting the evolving needs of our community. By working in collaboration within UVM Health Network to improve operational efficiency and implement strategic cost-containment efforts—such as administrative streamlining and thoughtful staffing changes—we are not only meeting regulatory requirements but also freeing up resources to reinvest in what matters most: advancing care and improving the health of our patients and community.

Volume & Efficiency Enhancements: While the majority of the overall volumes/stats remain consistent with FY25 projections, an anticipated increase in surgical/operating room (OR) cases and related ancillary services will enhance efficiency, collaboration and access to care within UVM Health Network.

Net Patient Revenue Compliance: NPR growth aligns with the GMCB's 3.5% cap, including a commercial rate increase of 3%, also at the budget guidance cap.

Expense Management & Staffing Efficiencies: The budget meets the 3% expense growth benchmark through staff restructuring, administrative efficiencies and a 44.6% reduction in Contract Labor/Traveler full time employees (FTEs) compared to FY25 budget, aided by enhanced recruitment and retention efforts.

Strategic Investments: Porter remains committed to enhancing patient care, safety and access through key infrastructure improvements – including relocating our musculoskeletal service and other capital projects/purchases that increase the annual depreciation and interest expense associated with new debt in the FY26 budget.

Operational Efficiency: Operational efficiency remains a key focus, with volume projections aligning closely with FY25 activity, except for an anticipated increase in Operating Room/Surgical (OR) cases and associated ancillary services. This increase has been carefully evaluated by UVM Health Network Medical Group and Porter's nursing leadership to ensure appropriate staffing and resources. Cost containment measures, including staffing model improvements, have enabled a 44.6% reduction in Contract Labor/Traveler FTEs, further supporting financial sustainability and long-term workforce stability. Additionally, the staffing model associated with inpatient service coverage has been restructured to better align nursing credentials with patient coverage requirements, resulting in annual salary savings of $1.2M.

Labor Considerations: Workforce retention is reinforced by the Support Staff and Technical Professionals bargaining unit, with approximately two-thirds of staff now unionized.

Financial Performance: The hospital projects an operating margin of 6.9%, and when combined with continued support for Helen Porter Rehabilitation and Nursing operations, the consolidated budgeted operating margin stands at 3.3%.

Account Description	FY25 Budget	FY25 GMCB Proj	FY26 Budget
TOTAL NPSR + FPP + OCV REVENUE	130,329,326	129,377,368	134,850,642
Total Other Revenue	4,718,191	6,078,303	6,887,484
TOTAL UNRESTRICTED REVENUE & OTHER	135,047,517	135,455,672	141,738,126
Total Salaries	65,310,155	67,798,690	64,833,282
Payroll Tax & Fringe	13,298,425	12,070,205	14,197,142
Salaries, Payroll Taxes, and Fringe Benefits	78,608,580	79,868,895	79,030,424
Total Non-Salary Expense	50,125,074	49,384,344	52,937,260
TOTAL EXPENSES	128,733,653	129,253,239	131,967,685
NET INCOME (LOSS) FROM OPERATIONS	6,313,863	6,202,433	9,770,442
Income (Loss) Margin	*4.7%*	*4.6%*	*6.9%*

B. Background

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

There have been no changes to Porter Hospital'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.

Porter Hospital is focused on delivering exceptional care to our community. Though we are not currently considering any corporate affiliations, our top priority remains meeting our patients' health care needs, and we will only explore partnerships if they clearly strengthen our ability to do so.

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

There has been no change to service lines at Porter Hospital.

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.

FY25 Budget to FY25 Projected:
We are committed to transparency in our financial reporting. As described in the monthly GMCB budget submissions, the following highlights the key differences between the approved budget and the current year projection.

Volumes:

Volume Metric	FY25 Budget	FY25 YTD May Anlzd	# Variance	% Variance
Total ED Visits	13,500	14,055	555	104%
MG Professional Worked RVUs (including Anes)	319,382	327,173	7,791	102%
Total OR Cases	2,345	2,432	87	104%
Total MRI	1,770	2,144	374	121%
Total CT Scan	8,328	9,728	1,400	117%
Total Nuc Med + PET	807	665	(142)	82%
Total Billed Lab Test	243,684	272,000	28,316	112%
Total Pharmacy Doses	193,040	173,691	(19,349)	90%

Average Daily Census	FY25 Budget	FY25 YTD May Anlzd	# Variance	% Variance
Acute - Inpatient	11.7	11.4	(0.3)	97%
Swing - Inpatient	6.4	3.1	(3.3)	48%
Birthing Center - Inpatient	1.6	1.7	0.1	106%

- **Average Daily Census** (ADC) and total patient days are projected to fall short of FY25 budget expectations. We are working closely withing our system's Utilization Management to better utilize available capacity.

- **Surgical/Operating Room (OR) -** Volume is on track with the FY25 budget, however, revenue per case is lower than anticipated. This is due to a shift in case mix, with the procedures performed generating less revenue on average.

- **Laboratory, Imaging and Pharmacy -** For the FY25 projection:
    - Lab tests are up 11.6% compared to the FY25 budget.
    - Imaging procedures are up 14.9%, driven primarily by increased ED volumes.
    - Pharmacy doses are projected to be below budget, however.
        - Infusion visits have increased by 25%, resulting in higher pharmacy revenue and expenses.
    - The FY26 budget reflects these current utilization trends.

- **Medical Group Arrived Visits** – or appointments where the patient came in and was seen by a provider – are anticipated to be below budget due to open physician FTEs.

Net Patient Revenue: FY25 Budget to FY26 Budget – Please refer to the Appendix.

Deductions:

- **Charity / Free Care –** Care provided free of charge or at a reduced cost to patients who cannot afford to pay is trending 130% above budget. This is driven by more patients qualifying for financial assistance under the expanded criteria (see more details in the free care section below).

- **Denials –** Due to our improved registration and prior authorization processes, denials in FY25 are expected to be below budget.

- **Medicare Cost Reimbursement** – Medicare cost reimbursement for FY25 is projected to be 10% below budget. This is due to a recent rate adjustment based on the latest cost report. The change reflects a slight drop in Medicare patient volume and, in turn, lower total hospital costs reimbursed by Medicare.

- **Other Revenue** – Other revenue is expected to come in 28.8% to budget, driven by higher volume within the pharmacy 340B program.

Expenses:

- **Staff Salaries** – A new union for support staff and technical professionals was formed after the FY25 budget was set. While salary increases beyond the standard annual raises were expected and budgeted, the actual costs were higher than anticipated as a result of the union negotiations. Staff salaries are now projected to be 3% over budget. Savings from staff vacancies have partially offset these increased union salary expenses.

  Meanwhile, contract labor/traveler FTEs are expected to exceed budget, leading to $2.2M in additional salary expenses related to travelers.

- **Pharmacy -** Pharmacy costs are unfavorable to budget due to higher volume, as mentioned above.

FY25 Budget to FY26 Budget:

Volume Metric	FY25 Budget	FY26 Budget	# Variance	% Variance
Total ED Visits	13,500	14,000	500	104%
MG Professional Worked RVUs (including Anes)	319,382	339,378	19,996	106%
Total OR Cases	2,345	2,679	334	114%
Total MRI	1,770	2,067	297	117%
Total CT Scan	8,328	9,604	1,276	115%
Total Nuc Med + PET	807	700	(107)	87%
Total Billed Lab Test	243,684	269,271	25,587	111%
Total Pharmacy Doses	193,040	175,000	(18,040)	91%

Average Daily Census	FY25 Budget	FY26 Budget	# Variance	% Variance
Acute - Inpatient	11.7	14.0	2.3	120%
Swing - Inpatient	6.4	4.0	(2.4)	63%
Birthing Center - Inpatient	1.6	1.8	0.2	113%

For the most part, as shown in the Volumes chart, Porter Hospital's FY26 budget aligns with FY25 projections, except for the following areas:

- **Increased Average Daily Census** - The FY26 operating budget includes a higher average daily census (ADC) than FY25 projections, aligning with FY25 volume expectations. This increase reflects better collaboration and efficiency across UVM Health Network.

- **Worked RVUs -** The FY26 budget also projects higher wRVUs compared to both the FY25 budget and projections, driven by filling currently open provider vacancies and improved coding accuracy.

- **Surgical/OR Cases and Ancillary Services -** OR cases and related services—such as anesthesia and recovery (PACU)—are expected to outperform both the FY25 budget and projections. This is driven by improved OR utilization, including a 14.2% increase in surgeries in General Surgery, OBGYN and Orthopedics, helping to better meet the needs of the community.

- **Radiology- MRI/CT Scans** are expected to increase in FY26, coinciding with the increased volumes in the OR as well as ER volume increases (CT scan 15.3% increase from FY25 budget and MRI 16.8% increase).

- **Other Revenue** is budgeted to increase $2.1M from FY25 budget, reflecting the impact of the continued favorable 340B pharmacy program revenue.

Deductions:

- **Bad Debt** – For FY26, bad debt is budgeted just over 2% of GPSR, which is slightly higher than FY25 projections and FY25 budget. We believe this slight increase is reasonable based on past trends, ongoing use of high-deductible health plans, and current economic uncertainty.

- **Charity Care/Free Care** – This is budgeted for 1.42% of GPSR, a slight increase from FY25 projections, reflecting the full year of Act 119 as well as the uncertain economic environment.

Expenses:

In general, Porter Hospital's expense growth reflects the increased costs in Medical and Surgical Supplies and Pharmaceuticals, driven by higher patient volumes as well as an increase in the provider tax. In addition, Deprecation is expected to increase due to new capital assets.

Salary expense is projected to decrease compared to FY25 budget due to a $2.9M reduction in Traveler FTEs and related expenses, revised nursing structure on the medical surgical floor, as well as sharing leadership and staff with Elizabethtown Community Hospital (ECH) in New York.

Focusing on efficiency and collaboration, Porter and ECH have aligned key leadership roles and resources to better support both hospitals and the region. Shared leadership positions now include the President, Chief Medical Officer, Chief Financial Officer, Pharmacy Director, Lab Director, Case Management/Utilization Management Supervisor and Human Resources Director.

In addition, the Finance departments are operating as a single, integrated team – leveraging staff, systems and shared expertise across both sites. Communications and grant writing functions have also been unified, supporting a more coordinated and cost-effective approach.

Beside the staff/cost containment, the value of the shared leadership team/department collaborations provides knowledge sharing through joint executive team huddles – monthly for shared learnings and strategic planning, nursing leadership collaboration to identify and share staffing models, nursing education, and informatics. In addition, our Quality/Safety departments are sharing knowledge relating to the Lean process and incorporating a consistent approach across organizations.

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."

Porter has built a 3% chargemaster increase into its budget for FY26.

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

Porter Hospital has met the benchmarks outlined in Section I.

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.

		FY26 Budget		
Union Category	Contracted Incr for FY26	FTEs	Salary Expense	FTE as % of Total
Nurses	4.5%	100.54	$ 10,469,144	21.3%
TECHNICAL	4.5%	34.92	$ 2,915,365	7.4%
SUPPORT	4.5%	170.32	$ 9,724,132	36.1%
Subtotal - Union	4.5%	305.78	$ 23,108,641	64.8%
Other Non-Union*	4.5%	166.18	$ 20,815,936	35.2%
Total		**471.96**	**$ 43,924,577**	**100.0%**
*Not contracted				

Porter Hospital's labor expense budget for FY26 reflects a strategic approach to workforce management, ensuring financial sustainability while prioritizing patient care and operational efficiency. By optimizing staffing models, reducing reliance on contract labor and reinforcing workforce retention initiatives, the hospital remains committed to maintaining a stable and highly skilled workforce.

The budgeting process begins with projecting full-time equivalents (FTEs), using end-of-January staffing levels as a baseline. Adjustments are made for vacant positions, anticipated volume changes, planned recruitments, service line modifications, department consolidations, cost reduction targets and position eliminations. Salary rates, shift differentials and on-call payments are applied to determine total salary costs, with vacant positions calculated at the mid-point of their salary range. Known or planned salary increases that were not accounted for in the baseline period are incorporated to ensure accuracy.

We develop our benefits budget line by line – including health, dental, life insurance, vacation and retirement – based on projected FTEs and additional household members covered under UVM Health Network benefits. Inflation adjustments include position-specific increases such as negotiated union contract raises, market-driven salary adjustments, and general merit/cost-of-living increases. For FY26, the staff labor expense inflation factor is 3.8%.

Trends Supporting Expense Management

Our focused efforts on recruitment and workforce stabilization have led to a significant reduction in traveler FTEs. These gains reflect a shift away from reliance on contract labor, particularly in our nursing units, helping us retain experienced staff and preserve institutional knowledge where stability matters most.

As a result, Nursing FTEs are expected to increase in FY26 compared to FY25 projections, driven by continued recruitment success and reduced dependence on travelers. Additionally, recent nursing staff restructuring has supported this transition by improving efficiency and further limiting the need for contract labor.

Challenges to Expense Management
Current multi-year contracts for employees covered by collective bargaining units, which include significant pay escalations exceed the newly introduced expense growth cap. This reduces financial flexibility and introduces fixed costs that are difficult to adjust in response to changing operational needs and regulatory requirements. We remain committed to working collaboratively within these frameworks to support both our teams and our long-term sustainability.

Collective Bargaining Agreements – Porter Hospital maintains two agreements; one for Support Staff and Technical Professionals, and one for Nurses. This represents approximately two-thirds of our total workforce. The FY26 budget includes a 4% Union Staff salary increase, along with step adjustments for eligible employees.

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.

We do not expect any major changes in patient volume beyond what is already planned – including a projected increase in operating room procedures, outpatient services and average daily census. This growth reflects the needs of our community and will not require any additional staffing or operational changes at this time.

How we estimate volume:
To plan for patient volume, or utilization, we start by looking at trends from October through January. From there, we adjust based on expected changes – like new providers joining or leaving, new equipment coming online, seasonal patterns and efforts to improve access.

The main types of volume we track and budget for include inpatient admissions and discharges, ED visits, inpatient days, OR cases, professional work RVUs, radiology exams (MRI, CT, nuclear medicine, mammography, ultrasound, diagnostic), and lab tests and pharmaceuticals. These help us estimate the revenue we expect to generate before any insurance or other deductions are applied.

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.

The FY26 budget is initially based on year-to-date data through January FY25. As the budgeting process continues, we update it to reflect actual results and account for seasonal trends. The budget also factors in FY25 actuals and past patterns to adjust for expected changes in volume and the planned introduction of new drugs – some of which will require updates to how we purchase and price them. A 5% inflation rate for pharmaceuticals is included in the FY26 budget.

At Porter, for drugs delivered in both the inpatient and outpatient settings, drug expenses are reported as part of overall hospital operating expenses, without separating outpatient from inpatient costs. Likewise, drug revenue – which includes payments from multiple sources – is not reported separately from other revenue sources. Because of this integrated reporting, it is not currently possible to calculate a specific "margin" on inpatient and outpatient drugs. For outpatient drugs, however, we are providing the below table that compares drug cost to reimbursement, but this information is imprecise and incomplete.

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.

	FY24			FY25 YTD (April)			FY25 Annualized		
	Reimbursement	Drug Cost	Reimbursement Less Drug Cost	Reimbursement	Drug Cost	Reimbursement Less Drug Cost	Reimbursement	Drug Cost	Reimbursement Less Drug Cost
PMC	$ 6,223,439	$ 4,244,384	$ 1,979,055	$ 5,361,842	$ 2,907,026	$ 2,454,816	$ 9,191,729	$ 4,983,473	$ 4,208,256

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.

In FY25, Porter Hospital is experiencing a decline in CMI, largely due to turnover in physician and APP positions. Understanding locum providers are less familiar with Porter's documentation procedures - which has contributed to the decrease - targeted training has been implemented to improve documentation practices. With these improvements in place and the planned recruitment of permanent providers in FY26, Porter Hospital anticipates a return to a CMI of 1.12.

	FY25 Budget	FY25 Anlzd YTD Jan	FY25 Anlzd YTD Apr	FY26 Budget
CMI - All Payers				
Porter Hospital	*1.16*	*1.11*	*1.09*	*1.12*

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.

Porter Hospital's FY26 budget includes a 3% rate increase for commercial payers, as allowed by GMCB, as well as a 3% anticipated rate increase for Medicare and Medicaid Advantage to reflect the increased costs. Medicaid rates, however, will remain flat with no increase.

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.

	FY25 Budget	FY25 Projection	FY26 Budget
Operating Margin	4.68%	4.58%	6.89%
Days Cash on Hand	93.2	109.6	110.8
Debt Service Coverage Ratio	12.0	12.8	17.2

While the chart above reflects the calculated financial indicators for Porter Hospital, it is important to note the bond agency rating assessments and annual bank debt covenant testing thresholds are calculated for UVM Health Network, rather than its individual hospitals.

As mentioned in other areas of this narrative, operating margin is expected to increase as a result of the following drivers:

- **Increased Average Daily Census** - The FY26 operating budget includes a higher average daily census (ADC) than FY25 projections, aligning with FY25 volume expectations. This increase reflects better collaboration and efficiency across UVM Health Network.

- **Surgical/OR Cases and Ancillary Services -** OR cases and related services—such as anesthesia and recovery (PACU)—are expected to outperform both the FY25 budget and projections. This is driven by improved OR utilization, including a 14.2% increase in surgeries in General Surgery, OBGYN and Orthopedics, helping to better meet the needs of the community.

- **Other Revenue** is budgeted to increase $2.1M from FY25 budget reflecting the impact of the continued favorable 340B pharmacy program revenue.

- Reduction in the traveler FTEs resulting in $2.9M salary expense savings.

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.

Porter Hospital has not made any significant changes to its internal accounting practices for bad debt and free care, except as noted below. Any changes in trends are based on past actual experience. We use that past experience to help predict the future impact of current services. As those actual results change over time, we update our model to reflect those changes and improve future estimates.

Porter Hospital 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 assumptions used in the FY26 budget. Note that both Bad Debt and Free Care have increased slightly from current year actual as we anticipate an increase in the Free Care with the recently approved Act 119 as well a slight increase in Bad Debt due the economic challenges anticipated in the upcoming FY26 budget period.

Porter Hospital	FY24 Actual	FY25 Budget	FY25 Anlzd YTD May	FY26 Budget
Bad Debt as a % of Gross Revenue	2.35%	1.91%	1.91%	2.04%
Free Care as a % of Gross Revenue	0.69%	0.58%	1.30%	1.42%
Total Bad Debt + Free Care as a % of Gross Revene	3.04%	2.49%	3.21%	3.46%

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

Please refer to Porter's most recent 990.

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

	FY24 Net community benefit	Prior Year Net community benefit
Financial Assistance at cost	769,508	762,022
Medicaid	7,531,677	9,800,401
Costs of other means-tested government programs		
Total Financial Assistance and Means-Tested Government Programs	**10,301,185**	**10,562,423**
Community health improvement services and community benefit operations	248,957	177,187
Health professions education	48,443	77,205
Subsidized health services	2,292,048	1,787,558
Research		
Cash and in-kind contributions to community groups	28,376	54,369
Total Other Benefits	**2,617,824**	**2,096,319**
Total	**12,919,009**	**12,658,742**

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

- Access to health care services

- Housing

- Mental health and substance use disorders

These priorities are a distillation of our Community Health Needs Assessment, conducted in partnership 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.
- **Contract labor/travelers:** The Staff Contract Labor/Travelers FY26 budget of 18.9 FTEs reflects a 44.5% reduction from the FY25 budget (34.1 FTEs) and a 44.6% reduction in Staff Contract Labor/Travelers as compared to the FY25 projection. The salary expense reduction from

FY25 budget to FY26 budget is $2.9M in salary cost reduction. The risk associated with achieving this budget assumption in Staff Contract Labor/Travelers is dependent on staff retention. The workforce programs and the recently established union for tech and support staff provide a mitigation framework.

We will continue to monitor these risks closely and adjust our mitigation strategies as more information becomes available. At this time, no definitive timelines for funding changes have been announced, but we are preparing for potential impacts in the next fiscal year.

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.

Porter files their 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).

As a Critical Access Hospital, Porter is not required to complete specific labor-related Medicare cost report worksheets S-3, Part II and Part III that outside organizations such as NASHP have utilized to calculate administrative and clinical labor expenses. The Wang & Bai grouping methodology utilizing Medicare cost report Worksheet A labor costs and unadjusted discharges shows the following three-year trend:

	FY22	FY23	FY24
Direct Patient Care Labor Costs per Unadjusted Discharge	$ 12,686	$ 14,005	$ 13,042
Non-Patient Labor Costs per Unadjusted Discharge	$ 4,572	$ 5,044	$ 4,322
Management & Administrative Total Labor per Unadjusted Discharge	$ 5,030	$ 5,625	$ 5,072

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.

At Porter, we estimate donations in FY26 will total $1.4M. Priority areas will be unrestricted dollars, patient and family support funds, workforce development and investments in our facilities and equipment.

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.

Porter Hospital saw no reduction in payment in the last two years based on quality.

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).

At Porter, we believe that supporting and developing our health care professionals directly improves patient outcomes. Our workforce development initiatives help train and retain skilled caregivers, ensuring high-quality care and an enhanced patient experience. The highlighted programs remove barriers and empower local talent to build careers in health care, strengthened by Porter's ongoing partnerships with state and national agencies to enhance efficiency and expand resources.

Key Programs:

- **Pathfinder Program**: In partnership with the Community College of Vermont, UVM Health Network invests up to $180,000 annually to prepay for prerequisite and corequisite courses required for entry into health professional education programs. This initiative helps employees build a strong academic foundation, increasing their eligibility for UVM Health Network pathway programs. We anticipate up to 20 individuals from Porter and other Vermont health care partners will benefit from this program in FY26. Accounting entry is through our fringe benefits category.

- **Licensed Practical Nursing (LPN) Pathway Program**: Through our partnership with Community College of Vermont and Vermont State University, our Network LPN Pathway Program allows hospital employees to continue earning a salary while taking classes toward an advanced health care degree. In FY25, three Porter employees enrolled in the program. We continue to recruit for a cohort that starts this fall. Graduates from our LPN Pathway Program may elect to matriculate to the RN Pathway Program. The estimated annual savings related to replacing contract staffing with employed staff is up to $100,000 per program graduate. Accounting entry for this program is through our benefits for tuition and salaries expense for study time while the reduction in contract staffing would be in salary expense.

- **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 scaled to

the system level and is available to employees across our system. Up to 20 employees, many from Porter, will be selected for the RN Pathway Program starting in late 2025. The estimated annual savings related to replacing contract staffing with employed staff is up to $140,000 per program graduate. Accounting entry for this program is through our benefits for tuition and salaries expense for study time while reduction the reduction in contract staffing would be in salary expense.

- **Respiratory Therapy Pathway Program:** UVM Health Network has invested significantly to ensure the VTSU Respiratory Therapy program is viable for the state. The partnership includes a cost-sharing agreement, community scholarship and the development of an employee pathway program for employees across our system. Of the eight active participants employed through UVM Health Network, there is one participant from Porter. Preserving and maintaining this essential program for our region not only strengthens our health care system but also enhances patient access to affordable care. The estimated annual savings related to replacing contract staffing with employed staff is up to $120,000 per program graduate. Accounting entry for this program is through our benefits for tuition and salaries expense for study time while the reduction in contract staffing would be in salary expense.

- **Licensed Nursing Assistant (LNA) Training Program:** Porter invests in developing the entry-level nursing role through our LNA training program in partnership with Hannaford Career Center. This paid training program prepares entry level employees for the licensure exam and competency demonstration to be a Licensed Nursing Assistant. We expect this program to add 8-12 LNAs in the next fiscal year. The LNA role serves as a foundation for career growth, providing a direct pathway to advanced nursing positions such as LPN and RN. Accounting entry for this program is through staff education expense.

- **Preceptor Differential**: To emphasize the value placed on training and mentorship within our nursing program – and encourage experienced staff to support the growth of their peers – we offer a preceptor differential for core staff members. Accounting entry for this is salary expense.

- **Simulation Lab:** By the close of FY25, we will finalize our Simulation Lab development project, funded through a 36-month grant from the Northern Border Regional Commission, awarded in 2023. A portion of this new space is leased to Vermont State University's Nursing Program, ensuring the continuation of its Middlebury site for clinical training. Accounting for the Simulation Lab will be offsetting entries to other revenue-grants and small equipment expense.

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).

Porter ensures that caregivers are present, prepared and focused on delivering high-quality care by providing essential housing and on-call accommodations. These investments help sustain a stable and dedicated health care team, reinforcing our ability to provide compassionate and reliable care to our patients.

- $30,000 annual commitment for support staff on-call rentals; is accounted for in rental expense.
- $24,000 annual commitment for provider and locum accommodations; is accounted for in rental expense.

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. Porter Hospital 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.

As a Critical Access Hospital serving Addison County, Porter is deeply committed to addressing the access challenges that impact the health and well-being of our rural community. Guided by our 2024 Community Health Needs Assessment and Community Health Improvement Plan, we are investing in the following areas:

Mental Health
Integrated Mental Health Services - Through the Blueprint for Health's Mental Health Integration initiative, we are embedding mental health professionals within our primary care practices to provide timely, team-based behavioral health support.

Community Partnerships - We are strengthening collaborations with local mental health agencies to improve care coordination and crisis response capacity.

Access Expansion - We are working to increase appointment availability and reduce wait times for mental health services by optimizing scheduling and leveraging telehealth in our practices and emergency department.

Substance Use Disorder (SUD)
Care Coordination - Our Community Health Team includes care coordinators who support patients with SUD by connecting them to recovery services, housing, and social supports.

Prevention and Harm Reduction - We support local harm reduction efforts and provide education and naloxone distribution through our ED and community partners. We support the local Turning Point Center and welcome their recovery coaches into our ED.

Long-Term Care
Helen Porter Rehabilitation and Nursing - As part of our integrated campus, Helen Porter provides skilled nursing, memory care, and rehabilitation services. We are investing in staff training and facility improvements to enhance quality of care.

Care Transitions Program - We have implemented improvements to a nurse-led care management/transitions program to support patients moving between hospital, home, and long-term care settings, reducing readmissions and improving outcomes.

Primary Care
Patient-Centered Medical Homes - All Porter primary care practices offer comprehensive, coordinated

care with a focus on prevention and chronic disease management.

Access Improvements - We have reprioritized scheduling to open more appointment slots, including same-day access, and are expanding hours to better meet community needs. As of May 2025, Porter primary care physicians have added 323 patients this fiscal year. Clinicians have performed 573 electronic consults as of May 2025, a 21% increase as compared to this time last fiscal year.

Workforce Development - We are actively recruiting and retaining primary care providers through partnerships with the University of Vermont Health Network, offering clinical training opportunities and loan repayment support.

These initiatives reflect our mission to provide high-quality, accessible care to all residents of Addison County. We remain committed to addressing social drivers of health, reducing disparities, and improving health outcomes through collaboration, innovation, and community engagement.

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.

Strategic Partnerships
Porter Hospital is committed to collaborating with community providers to ensure seamless transitions of care and improve access to essential health services. Through strategic partnerships, we work to remove barriers, support vulnerable populations, and enhance the continuity of care across the region.

- **Open Door Clinic Partnership** – Porter provides free, on-site clinical space for the Open Door Clinic, serving uninsured and underinsured adults in Addison County. Through a voucher system, Open Door patients receive certain diagnostic lab and imaging tests at no cost.
- **Middlebury College Partnership** – Porter is currently planning a partnership with Middlebury College to address their health care needs.

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.

<u>5. Supplemental Workbook</u>
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.

Porter 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 and cost of goods sold 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.

Porter ($ in millions*)	FY23 Actual	FY24 Actual	FY25 Budget	FY25 YTD April Annualized	FY26 Budget
Contract 340B	1.2	1.8	1.3	2.5	3.6
Retail: Rx/Mail/Specialty	0.0	0.0	0.0	0.0	0.0
Total Gross Margin	1.2	1.8	1.3	2.2	3.6
Cost Avoidance					
Estimated 340B cost-avoidance on pharmaceuticals provided through hospital outpatient & physician office patient encounters**	0.8	1.2	0.0	1.3	0.0
Total With Estimated Cost-avoidance	2.0	3.0	1.3	3.5	3.6

*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. Porter pharmaceutical expenses are categorized into one major general ledger account: non-chemo pharmaceuticals.

Porter 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):

Porter	FY25 YTD April Expense ($)
General Ledger Account	--
Non-Chemo Pharmaceuticals	3.8 M
Chemo Drugs*	0

*Chemo Drugs are included in Non-Chemo Pharmaceuticals GL Account line for Porter.

Porter 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. Porter Hospital 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.portermedical.org/about/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:

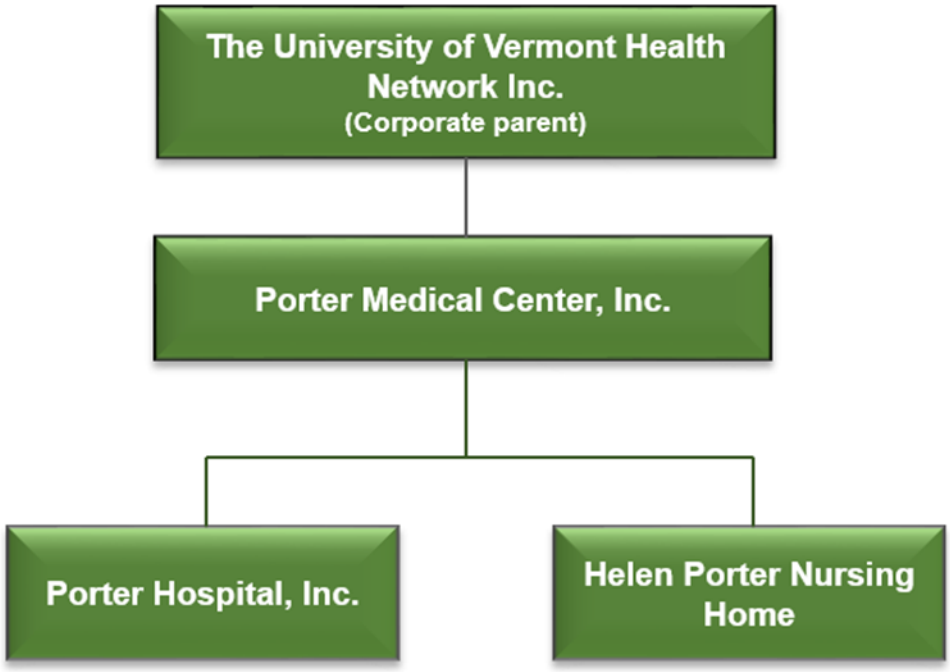
- **Total number of applicants granted any amount of FAP**
- **Number of applicants granted 100% FAP**
- **Number of applicants granted less than 100% FAP**
- **Total applicants denied FAP**
- **Breakdown of reason for denial (% or #)**

FY 2024	
Porter Medical Center	**Volumes**
Total Applications	1,014
Total Household Members	1,177
Approved/Granted	
Free Care	560
Reduced Care	291
Total Approved	851
Denied	
Denied - No Eligible Charges	0
Denied - No Current/Scheduled Charges	0
Denied - Other Reason	0
Denied - Out of Service Area	0
Denied - Over Assets	43
Denied - Over Income	39
Denied - Over Income & Assets	1
Incomplete Application or Documentation	80
No Response from Patient	0
Qualified for Medicaid	0
Qualified for Other Assistance Programs	0
Total Denied	163

Please click here to view the current plain language summary (as of January 1, 2025) for Porter'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

NPR	Ref Cells	A	B	C	D	E	F	G	H	I	J
		$ -									
		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	$ 241,468,416	$ 105,284,983	$ 36,956,619	$ 70,593,861	$ 8,548,763	$ 4,217,576	$ 9,693,499	$ 553,405	$ 5,619,709	$ -
Deductions + denials	2	$ 105,121,414	$ 49,017,620	$ 25,096,788	$ 14,551,142	$ 1,891,226	$ 2,226,179	$ 4,851,558	$ 4,586,182	$ 3,314,812	$ (414,095)
FY25 BUDGET NPR By Payer excluding BD/Charity	3	**$ 136,347,002**	***$ 56,267,362***	***$ 11,859,831***	***$ 56,042,719***	***$ 6,657,537***	***$ 1,991,397***	***$ 4,841,941***	***$ (4,032,778)***	***$ 2,304,898***	***$ 414,095***
Bad Debt / Charity By Payer	4	*$ (6,017,676)*	$ (906,538)	$ (35,860)	$ (1,254,295)	$ (126,615)	$ (3,627,775)	$ (42,626)	$ (8,029)	$ (15,938)	$ -
FY25 BUDGET	5	**$ 130,329,326**	**$ 55,360,825**	**$ 11,823,971**	**$ 54,788,424**	**$ 6,530,922**	**$ (1,636,378)**	**$ 4,799,315**	**$ (4,040,806)**	**$ 2,288,960**	**$ 414,095**
Accounting Changes											
Denials	6	$ 0	$ (1,072,366)	$ (1,714,524)	$ (2,443,739)	$ (454,841)	$ 1,379,306	$ (134,718)	$ 4,451,635	$ (10,753)	$ -
Total Accounting Changes Impact	7	**$ 0**	**$ (1,072,366)**	**$ (1,714,524)**	**$ (2,443,739)**	**$ (454,841)**	**$ 1,379,306**	**$ (134,718)**	**$ 4,451,635**	**$ (10,753)**	**$ -**
FY25 Budget After Accounting Changes	8	**$ 130,329,326**	**$ 54,288,458**	**$ 10,109,447**	**$ 52,344,685**	**$ 6,076,080**	**$ (257,072)**	**$ 4,664,597**	**$ 410,828**	**$ 2,278,207**	**$ 414,095**
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	$ 3,274,994	$ 1,809,500	$ 32,234	$ 1,325,561	$ 92,854	$ 10,892	$ 3,875	$ 31	$ 47	$ -
Denials	11	$ (155,253)	$ (47,113)	$ (41,970)	$ (45,820)	$ (6,033)	$ (9,964)	$ (4,284)	$ -	$ (70)	$ -
Bad Debt	12	$ (155,334)	$ (9,494)	$ 17,435	$ (38,113)	$ (11,725)	$ (109,761)	$ (123)	$ (1,001)	$ (2,552)	$ -
Charity	13	$ (108,258)	$ (24,623)	$ (469)	$ (17,869)	$ (7,492)	$ (56,884)	$ 36	$ (672)	$ (284)	$ -
Other Initiatives	15	$ -									
Total FY2026 Rate Changes Impact	16	**$ 2,856,150**	**$ 1,728,271**	**$ 7,230**	**$ 1,223,759**	**$ 67,604**	**$ (165,717)**	**$ (496)**	**$ (1,643)**	**$ (2,858)**	**$ -**
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	$ (5,583,331)	$ (6,129,586)	$ 396,745	$ (1,975,286)	$ 4,559	$ 1,313,629	$ 443,143	$ 18,937	$ 344,529	$ -
GME Change	19	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Disproportionate Share Payments (DSH)	20	$ 43,675	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 43,675
Denials	21	$ 352,434	$ (435,958)	$ 357,962	$ 1,916,755	$ 434,693	$ (1,959,577)	$ 27,465	$ 25	$ 11,069	$ -
Bad Debt	22	$ 441,201	$ (51,258)	$ 610,309	$ (283,272)	$ (295,923)	$ 511,398	$ 29,567	$ (28,499)	$ (51,121)	$ -
Charity	23	$ (2,137,055)	$ (103,968)	$ (13,256)	$ (236,851)	$ (217,832)	$ (1,537,760)	$ 4,231	$ (22,416)	$ (9,205)	$ -
Total FY2025 Budget to Actual Collection Rate Impact	24	**$ (6,883,075)**	**$ (6,720,769)**	**$ 1,351,759**	**$ (578,653)**	**$ (74,502)**	**$ (1,672,310)**	**$ 504,406**	**$ (31,953)**	**$ 295,272**	**$ 43,675**
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	$ 6,716,645	$ 2,849,087	$ 59,843	$ 3,100,041	$ 334,845	$ (2,942)	$ 307,750	$ 3,395	$ 64,626	$ -
Denials	27	$ (155,287)	$ (60,970)	$ (23,064)	$ (154,866)	$ (29,026)	$ 119,561	$ (6,145)	$ (2)	$ (774)	$ -
Bad Debt	28	$ (287,167)	$ (11,043)	$ (146)	$ (34,914)	$ 195	$ (239,660)	$ 1,165	$ 170	$ (2,933)	$ -
Charity	29	$ (68,612)	$ (45,495)	$ 178	$ (18,790)	$ (1,374)	$ (3,134)	$ 8	$ -	$ (6)	$ -
Clinical Initiatives	30	$ 372,779	$ 101,256	$ 47,528	$ 161,633	$ 22,381	$ 16,334	$ 11,256	$ 350	$ 12,041	$ -
Other Initiatives	31	$ -									
Total FY2025/FY2026 Utilization Impact	32	**$ 6,578,358**	**$ 2,832,835**	**$ 84,339**	**$ 3,053,103**	**$ 327,020**	**$ (109,841)**	**$ 314,034**	**$ 3,913**	**$ 72,954**	**$ -**
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*
FY2025/2026 Payer Mix Changes											
All Payers	34	$ 2,234,784	$ 3,281,262	$ (1,062,966)	$ (68,884)	$ (68,417)	$ 601,613	$ (488,542)	$ (333,775)	$ 374,495	$ -
Denials	35	$ 447,773	$ (789)	$ 210,055	$ (190,525)	$ (17,280)	$ 412,261	$ 34,823	$ 131	$ (904)	$ -
Bad Debt	36	$ (706,624)	$ (11,608)	$ 5,107	$ (29,311)	$ 2,125	$ (665,759)	$ 4,845	$ 3,080	$ (15,103)	$ -
Charity	37	$ (6,049)	$ (6,536)	$ (295)	$ (6,761)	$ (799)	$ 8,171	$ 187	$ -	$ (16)	$ -
Total FY2025/2026 Payer Mix Changes Impact	38	**$ 1,969,884**	**$ 3,262,328**	**$ (848,098)**	**$ (295,482)**	**$ (84,371)**	**$ 356,286**	**$ (448,688)**	**$ (330,564)**	**$ 358,472**	**$ -**
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	$ 260,764,967	$ 116,904,517	$ 36,919,619	$ 76,377,626	$ 9,072,975	$ 5,267,535	$ 9,274,254	$ 118,450	$ 6,829,990	$ -
Deductions + denials	42	$ 116,868,752	$ 60,342,833	$ 26,797,944	$ 18,710,038	$ 2,101,705	$ 1,395,025	$ 4,237,692	$ 10,500	$ 3,730,786	$ (457,770)
FY26 BUDGET NPR By Payer excluding BD/Charity	43	*$ 143,896,215*	*$ 56,561,684*	*$ 10,121,675*	*$ 57,667,589*	*$ 6,971,270*	*$ 3,872,510*	*$ 5,036,563*	*$ 107,950*	*$ 3,099,205*	*$ 457,770*
Bad Debt / Charity By Payer	44	*$ (9,045,573)*	*$ (1,170,562)*	*$ 583,003*	*$ (1,920,176)*	*$ (659,440)*	*$ (5,721,165)*	*$ (2,710)*	*$ (57,367)*	*$ (97,157)*	*$ - *
FY26 BUDGET	45	**$ 134,850,642**	**$ 55,391,122**	**$ 10,704,678**	**$ 55,747,413**	**$ 6,311,831**	**$ (1,848,654)**	**$ 5,033,852**	**$ 50,583**	**$ 3,002,048**	**$ 457,770**
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	**$ 4,521,316**	**$ 1,102,664**	**$ 595,231**	**$ 3,402,728**	**$ 235,750**	**$ (1,591,582)**	**$ 369,256**	**$ (360,246)**	**$ 723,841**	**$ 43,675**
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	49	**3.5%**	**2.0%**	**5.0%**	**6.2%**	**3.6%**	**97.3%**	**7.7%**	**8.9%**	**31.6%**	**10.5%**
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 (WAvg	51	**3.5%**	**0.8%**	**0.5%**	**2.6%**	**0.2%**	**-1.2%**	**0.3%**	**-0.3%**	**0.6%**	**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*