ECU HEALTH

Martin County Proposal for Hospital Reopening

ECU Health Response to RFP

April 4, 2025

INTRODUCTION

Dear Martin County Board of Commissioners,

Thank you for the opportunity for ECU Health to respond to your February 13, 2025, Request for Proposals to Lease, Sell or Convey Martin General Hospital. Our leadership team has carefully considered your request, and we are pleased to present this non-binding proposal, which outlines our desire to establish the state's first Rural Emergency Hospital and create an integrated, high-acuity outpatient delivery model to meet the health care needs of Martin County. ECU Health is proud of its decades-long history of being a trusted health care provider for the people of Martin County, and we are deeply committed to the growth and success of the communities we serve. We believe our proposal reflects a shared goal of meeting the current and future health care needs in Martin County through a sustainable, integrated regional system of care.

ECU Health recognizes that the challenges leading to the closure of Martin General Hospital in August 2023 continue to persist – increasing costs of capital, particularly impacting aging health care facilities like those in eastern NC; health care workforce shortages that amplify existing access constraints in rural communities; and an uncertain regulatory environment with downward pressure on health care reimbursement that is magnified in rural areas. Despite these challenges, ECU Health remains a mission-focused rural academic health care organization committed to transformation of traditional care delivery systems that enhance access to high-quality, reliable, patient-centered care; ensure sustainability; and result in improved outcomes for the patients and communities we have the privilege to serve.

Our system has a rich history partnering in communities across eastern NC through strategic collaborations and hospital acquisitions, by lease or conveyance, that solve the complex challenges of maintaining and enhancing local health care access across our rural region. We believe our proposal demonstrates this experience and emphasizes our ability to execute on our proposed high-acuity outpatient delivery model for Martin County, which would integrate into the ECU Health system. Importantly, our leadership team has extensive knowledge of the circumstances leading to rural hospital closures, including Martin General Hospital, and the ongoing challenges associated with rural health care sustainability. As part of this proposal, we have identified certain contingencies that require assurances or permanent solutions prior to our organization entering into any agreements or transactions that would effectuate a binding commitment by ECU Health. Never has sustainability of rural health care been more challenging, underscoring the importance of state and federal support needed to maintain and improve access to care in rural communities. These contingencies are critical to ensuring the long-term sustainability of the proposed regional system of care for Martin County and our health system's ability to meet its mission of improving the health and well-being of eastern NC for generations to come.

It is a privilege to have an opportunity to positively shape the future of health care in Martin County. We appreciate the thorough process the County has taken to reach this critical point in its journey to reestablish local health care services. ECU Health looks forward to the opportunity to engage in further dialogue with county leadership and community members around our vision for how health care services might not only be restored, but positioned to thrive, both now and in the future.

Thank you,

Michael Waldrum, MD, MSc, MBA
CEO, ECU Health
Dean, Brody School of Medicine at ECU

OVERVIEW

ECU Health is a private, not-for-profit academic health system organized in the late 1990s through mergers and acquisitions of not-for-profit healthcare entities across eastern North Carolina (eastern NC) in an effort to maintain healthcare access throughout our largely rural and underserved region. The system has established a reputation for patient- and family-centered excellence, and for providing comprehensive, high-quality healthcare to the people of eastern NC close to where they live. Not only keeping, but continually enhancing, local access to care is fundamental to ECU Health's unwavering commitment to improving the health status of the people we are privileged to serve. Today, we provide a full continuum of services to more than 1.4 million people across our 29-county service area. Our system of care includes 1,708 beds across a two-campus academic medical center and seven community hospitals, and numerous outpatient facilities, home health, hospice, and wellness centers throughout the region. The health system has grown to include more than 14,000 team members, and more than 1,200 academic and community providers practicing in over 185 primary and specialty clinics in more than 105 locations. ECU Health's clinical network and care delivery system is supported by a robust corporate shared services infrastructure as well as integrated information technology solutions such as our Epic electronic health record (EHR). While our system has grown over the years, we remain committed to our mission, vision, and values which commit us to excellence.

Mission

To improve the health and well-being of eastern North Carolina

ECU Health is a *mission-driven health system*. We are deeply committed to addressing all aspects of health, including social determinants of health, to positively impact the health and well-being of eastern North Carolinians.

Vision

To become the national model for rural health and wellness by creating a premier, trusted health care delivery and education system

Our vision to become the national model for rural health and wellness continues to guide us on our journey toward excellence.

Our values guide us in all that we do:
Integrity – doing the right thing, being honest, and being ethical
Education – learning, adapting, improving, and transforming
Safety – achieving zero harm to patients, visitors, families, and team members
Compassion – connecting, caring, and comforting unconditionally
Accountability – taking responsibility for what we do
Teamwork – contributing to our goals

On January 1, 2022, the health system and the Brody School of Medicine at East Carolina University (BSOM) further evolved our more than 50-year affiliation by becoming a clinically integrated academic health care organization. This integration further speaks to our commitment to becoming the national model for academic rural health care. Together, we can more effectively enhance access and coordinate healthcare delivery for the people of our region. We are a leader in training physicians and other healthcare professionals to serve our state, particularly eastern NC where we have had much success retaining graduates to practice in our rural communities. BSOM continues to expand its class size in service to meeting the future healthcare needs of the state. In 2024, 100 percent of BSOM graduates matched to a training program—well above the national average. In 2025, ECU Health had its highest number of BSOM medical students who matched to an ECU Health residency program for training in their specialty. On average, the majority of BSOM graduates remain in the state, many remaining local, which reflects the BSOM's tripartite mission to increase the supply of primary care physicians serving the state, to improve the health and well-being of the region, and to train physicians who will meet the healthcare needs of the state. In 2021, we launched a new Rural Family Medicine Residency Program which not only enhances rural training but expands access to care in our rural and underserved communities.

One of our newest initiatives demonstrating commitment to our academic mission and the future of rural healthcare is the *Investing in Our Future Endowment* – a philanthropic initiative to create a source of perpetual funds to provide critical support for health sciences students, clinician recruitment, and leaders. ECU Health provided $10 million in seed funding to the ECU Health Foundation to establish the endowment, with a goal of reaching $20 million. In its first year, the endowment has supported the recruitment of five primary care physicians who will serve eastern NC.

In addition to providing comprehensive, integrated healthcare services throughout our communities, ECU Health is also proud to support the economic vitality of eastern NC. ECU Health's operations create a significant source of employment in most communities in which we operate, and our system's operations are estimated to create a $4 billion economic impact to North Carolina's gross state product. In partnership with ECU Health hospitals, the ECU Health Foundation distributed more than $1.51 million in grants to more than 100 programs in communities across eastern NC in FY2024.

Martin General Hospital, prior to its closure, had a long history of partnering collaboratively with ECU Health to serve the healthcare needs of Martin County and surrounding areas. Prior to the County entering into a long-term partnership with Community Health Systems (CHS), Martin General Hospital served as a training site for BSOM students and residents and participated as a host site in the telemedicine program developed through a partnership between the school of medicine and then-Pitt County Memorial Hospital (PCMH). PCMH also provided Pediatric Asthma Program services and school nurses for Martin County supported by funding from a Duke Endowment grant. Martin County and ECU Health also have a history of close collaboration to develop the county's Community Health Needs Assessments (CHNA) which has led to shared priorities to improve the health and well-being of Martin County residents.

ECU Health has consistently served the Martin County community in our emergency departments and community hospitals, and prior to closure, Martin General Hospital and ECU Health Medical Center maintained a long-standing transfer partnership for patients requiring care at our Level I trauma center or other advanced tertiary care. Year over year, ECU Health hospitals have consistently cared for all levels of inpatient care needs from the Martin County community. In FY23, more than 70 percent of all inpatient care from Martin County was delivered by an ECU Health hospital.

Martin County Inpatient Market Share Assessment

	Inpatient Discharges					Inpatient Market Share				
Hospital	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**
ECU Health Medical Center	1,606	1,606	1,435	1,651	1,462	46.9%	49.5%	48.6%	54.2%	49.8%
Martin General Hospital	1,035	775	512	513	470	30.3%	23.9%	17.4%	16.8%	16.0%
ECU Health Beaufort Hospital	241	285	433	393	377	7.0%	8.8%	14.7%	12.9%	12.8%
ECU Health Edgecombe Hospital	137	164	170	113	139	4.0%	5.1%	5.8%	3.7%	4.7%
ECU Health Roanoke-Chowan Hospital	66	71	68	59	83	1.9%	2.2%	2.3%	1.9%	2.8%
Duke University Hospital	50	44	47	35	53	1.5%	1.4%	1.6%	1.1%	1.8%
UNC REX Healthcare	21	6	17	9	42	0.6%	0.2%	0.6%	0.3%	1.4%
Nash UNC Health Care	6	10	17	15	36	0.2%	0.3%	0.6%	0.5%	1.2%
UNC Hospitals	34	37	24	27	35	1.0%	1.1%	0.8%	0.9%	1.2%
ECU Health Bertie Hospital	24	37	14	26	29	0.7%	1.1%	0.5%	0.9%	1.0%
Duke Raleigh Hospital	23	20	16	16	28	0.7%	0.6%	0.5%	0.5%	1.0%
ECU Health Chowan Hospital	12	34	38	23	26	0.4%	1.0%	1.3%	0.8%	0.9%
CarolinaEast Health System	38	30	20	18	21	1.1%	0.9%	0.7%	0.6%	0.7%
Holly Hill Hospital	9	11	15	9	16	0.3%	0.3%	0.5%	0.3%	0.5%
Old Vineyard Behavioral Health Services	-	7	15	12	14	0.0%	0.2%	0.5%	0.4%	0.5%
WakeMed Raleigh Campus	15	13	17	31	11	0.4%	0.4%	0.6%	1.0%	0.4%
All Other (<10 IP DCs in FY23)	104	94	93	95	93	3.0%	2.9%	3.2%	3.1%	3.2%
Grand Total	**3,421**	**3,244**	**2,951**	**3,045**	**2,935**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
TOTAL ECU HEALTH*	2,091	2,219	2,169	2,275	2,130	61.1%	68.4%	73.5%	74.7%	72.6%

** Includes ECUH Hospitals in "All Other"*

Source: Hospital Industry Data Institute (HIDI) statewide inpatient database

As the people of Martin County and the Martin County Board of Commissioners are acutely aware, the healthcare delivery landscape has changed rapidly over the last 25 years and challenges are most evident in rural communities like those in eastern NC. ECU Health is a leader in health care delivery transformation designed to ensure those in our region continue to benefit from high-quality care close to home for generations to come. As a mission-driven, regionally integrated academic health system, our organization is uniquely positioned – geographically, operationally, and culturally – to execute on a plan for integrating Martin County into a sustainable, regional system of care that is designed with the health and well-being of eastern North Carolinians in mind. We look forward to the opportunity to help return essential healthcare services to Martin County by pursuing innovative models such as the Rural Emergency Hospital as proposed herein.

SECTION 1: RESPONDENT QUALIFICATIONS

1.1 Current Operations Experience

1.1.a Number, type, and location of facilities in operation

ECU Health is an integrated, academic health system comprised of a two-campus academic medical center and seven community hospitals, three of which are Critical Access Hospitals. The integrated system includes numerous outpatient facilities, home health, hospice, and wellness centers. We operate over 185 primary and specialty clinics in more than 105 locations across eastern NC.

ECU Health Medical Center is the flagship teaching hospital for BSOM at ECU. As a Level I Trauma Center, the medical center is part of an existing comprehensive statewide trauma system organized in 1998. As the Lead Trauma Center for the state's eastern referral region, ECU Health Medical ensures trauma care is coordinated regionally, by partnering with other hospitals and emergency medical services providers across our 29-county region to implement trauma-related best practice guidelines, education, and performance improvement initiatives. While most ECU Health hospitals have intensive care units (ICU), ECU Health Medical Center has a dedicated surgical intensive care unit, neurosurgical intensive care unit, and a Trauma ICU. Other services include The Burn Outpatient Service, an outpatient Trauma Clinic, and an Acute Care Surgery Clinic.

In addition to adult trauma care, ECU Health Medical Center provides specialized newborn and pediatric care for the region at ECU Health Maynard Children's Hospital. Maynard Children's Hospital provides emergency care for children under age 18 in a dedicated children's emergency department and is also home to a 71-bed multi-level neonatal intensive care unit (NICU) staffed by board-certified neonatologists, advanced practice professionals, and specially trained nurses who provide compassionate, expert care for critically ill or premature newborns. Maynard Children's Hospital is also a proud member of various networks focused on improving neonatal quality of care, including the Vermont Oxford Network, the Neonatal Network, and the Perinatal Quality Collaborative of North Carolina.

ECU Health Medical Center accreditations and key statistics include but are not limited to:

- Ventricular Assist Device, The Joint Commission
- Get With The Guidelines Awards for Heart Failure, Mission: Lifeline STEMI & NSTEMI, Stroke, Type II Diabetes and Resuscitation
- Lung Cancer Screening Center of Excellence
- American College of Surgeons Commissoin on Cancer
- MBSAQIP Accredited Bariatric Surgery Center
- SRC Center of Excellence in Robotic Surgery and in Minimally Invasive Surgery
- National Accreditation Program for Breast Centers (NAPBC)

See Appendix A for additional detailed information about ECU Health hospitals.

1.1.b Length of time operating each facility

ECU Health has grown over time through a series of acquisitions by lease or conveyance of mostly former county-owned hospitals.[1]

- Pre-1997: Pitt County Memorial Hospital (now ECU Health Medical Center) operated as a public hospital.
- 1997: ECU Health Roanoke-Chowan Hospital in Ahoskie, NC was integrated into the health system being formed by Pitt County Memorial Hospital (now ECU Health Medical Center).
- 1998: ECU Health Medical Center became a private, not-for-profit hospital through a N.C.G.S. 131E-8 statutory conversion; University Health Systems of Eastern Carolina (now ECU Health) was formed to serve as the parent corporation for the health system; ECU Health Bertie Hospital in Windsor, ECU Health Chowan Hospital in Edenton, and ECU Health Edgecombe Hospital in Tarboro were integrated into the health system.
- 2002: ECU Health opened Outer Banks Health Hospital in partnership with Chesapeake Regional Healthcare.
- 2010: ECU Health Duplin Hospital in Kenansville was integrated into the system.
- 2011: ECU Health Beaufort Hospital joined the system; today, Beaufort is a campus of ECU Health Medical Center.
- 2019: ECU Health North Hospital in Roanoke Rapids was integrated into the system.
- Numerous practices have been added to the system over the last 28 years.

1.1.c Regulatory compliance history

Assuring compliance with The Joint Commission (TJC) standards, Medicare Conditions of Participation (CoPs), and the North Carolina licensure regulations for hospitals is central to our ongoing quality work across ECU Health. ECU Health maintains a state of continuous survey readiness, as evidenced by the more than 185 mock surveys that were conducted across the system in FY2024. The results of these mock surveys, which are based on TJC standards and CoPs, are assessed, scored, and reported to each entity. Each ECU Health hospital is accredited by TJC and has a history of compliance with Medicare and Medicaid participant regulatory requirements.

See Appendix B for ECU Health hospitals' accreditation information.

1.2 Quality and Accreditation Status

1.2a Current certification/accreditation status at all facilities

ECU Health facilities are accredited by TJC, which conducts site surveys and assesses compliance with Medicare and Medicaid program requirements on behalf of the Centers for Medicare & Medicaid Services (CMS). All ECU Health hospitals are surveyed every three years by TJC to ensure compliance. CMS may also conduct ad hoc surveys in response to patient complaints. CMS delegates the responsibility for performing complaint-based site surveys to the North Carolina Division of Health Service Regulation (NCDHSR), a department of the North Carolina Department of Health and Human Services (NCDHHS). While complaints resulting in NCDHSR site visits

[1] All ECU Health hospitals with exception of ECU Health Medical Center are referred to herein as ECU Health community hospitals.

are rare, ECU Health has a formal process in place for managing site visits, assessing deficiencies, and developing corrective action plans as needed.

Certain ECU Health entities hold various other accreditations/certifications including but not limited to American College of Surgeons Commission on Cancer, Clinical Laboratory Improvement Amendments program (CLIA), Intersocietal Accreditation Commission accreditation of the ECU Health Medical Center Electrophysiology Lab (first in state), Acute Stroke Ready, Primary Stroke Center, and Comprehensive Stroke Center.

See Appendix B for ECU Health hospitals' accreditation information.

1.2.b Recent survey results or corrective actions

See Appendix B for ECU Health hospitals' accreditation information.

1.2.c Timeline and process for obtaining certification/accreditation for Martin County facility

The following represents a general anticipated timeline for conducting accreditation and certification surveys as part of the reopening of Martin General Hospital as an ECU Health Rural Emergency Hospital (REH) following the closing of the proposed transaction with Martin County. This timeline includes key steps such as on-site inspections by ECU Health internal teams and time for correcting deficiencies prior to the final survey by the State's designated Survey Agency, presumably the Division of Health Service Regulation of NC DHHS (State Survey Agency) or other accrediting bodies.

Phase 1: Initial Assessment and Planning (1-3 months)

1. **Initial Assessment**: Conduct a thorough facilities assessment of the closed hospital's current state by ECU Health Facilities and Properties; Identify necessary repairs, upgrades, and compliance requirements.
2. **Planning:** Document findings and develop a corrective action plan; Develop a detailed project plan outlining tasks, timelines, and responsibilities; Secure resources for the reopening process.

Phase 2: Renovation and Compliance (3-6 months)

3. **Renovation:** Begin necessary renovations and upgrades to meet REH standards; Ensure compliance with building codes, safety regulations, and healthcare standards.
4. **Staffing:** Recruit and hire qualified staff, including medical, administrative, and support personnel; Provide training on REH-specific protocols and procedures; Complete competency validation of team members.
5. **Policy and Procedure Development:** Develop and implement policies and procedures to meet Medicare's REH CoPs.

Phase 3: Pre-Survey Preparation (1-2 months)

6. **Final Preparations:** Conduct a final review of all documentation, policies, and procedures; Ensure all staff are prepared for the survey process; Ensure all areas meet REH standards and are ready for the state survey.
7. **Mock Survey:** Conduct a mock survey with the ECU Health team to simulate the state survey; Document findings and develop a corrective action plan; Address any last-minute issues or concerns.

Phase 4: State Survey and Accreditation (1-3 months)

8. **Licensure and Accreditation Surveys:** Schedule and undergo the State Survey Agency's on-site surveys; Provide all required documentation and facilitate the survey processes.
9. **Post-Survey Corrections:** Address any deficiencies identified during the state surveys; Submit evidence of compliance to the State Survey Agency.
10. **Final Licensure and Accreditation:** Receive accreditation as a REH.

This timeline is a general guide and will vary based on specific circumstances and requirements, and ability to complete certain tasks during due diligence. This timeline does not reflect third-party and/or ancillary certifications/accreditations required to participate in CMS programs. As of the writing of this proposal it is ECU Health's understanding that a new Medicare provider number will be required prior to opening. The process to enroll the facility as a new Medicare provider is likely to take many months, culminating in a separate on-site survey on behalf of CMS. Flexibility will be necessary given the REH is a new facility type in NC, and as such, the timeline may require adjustments to ensure all standards and requirements are met prior to required on-site surveys.

1.3 REH Operational Knowledge

1.3.a Experience operating under REH or similar regulatory frameworks

Given the novelty of the REH designation, Martin General Hospital would become the first REH that ECU Health has operated. ECU Health has decades of experience operating other types of healthcare facilities with similarly complex regulatory frameworks including but not limited to fully accredited and CMS-certified tertiary and general community acute care hospitals, critical access hospitals, rural health clinics and other physician offices.

As of March 2025, there were 38 REH facilities operating in the United States, but none in North Carolina. An REH in Martin County would potentially be the first of its kind in the state and the first non-operational acute care hospital in the country to reopen as an REH. ECU Health recognizes that Martin County experienced the loss of essential healthcare services in August 2023 when Martin General Hospital abruptly closed and subsequently announced the imminent closure of multiple associated physician practices. Partnering with Martin County to establish an innovative model for rural healthcare is an opportunity for ECU Health to further deliver on its vision of being the national model for rural healthcare.

See section 5.2 for additional details regarding ECU Health's experience operating under similar regulatory frameworks.

1.3.b Knowledge of specific REH requirements and how they will be met

Although ECU Health does not operate a REH, we are confident in our understanding of the Medicare CoPs and our ability to successfully operationalize and integrate the model into our regional system of care. The following sections highlight our understanding of and ability to meet REH requirements.

Reimbursement

REH facilities receive enhanced reimbursement from Medicare for outpatient services provided to Medicare beneficiaries, flexibility in staffing and services offered, and technical assistance via the Rural Emergency Hospital-Technical Assistance Center (REH-TAC). Medicare enhanced reimbursement does not apply to services

which are not part of the REH, such as laboratory and Skilled Nursing Facility (SNF) services, nor does the enhanced rate apply to services rendered to Medicaid beneficiaries. Importantly, the state's Medicaid Program has not recognized REH as a hospital type as of the writing of this proposal. Therefore, REHs in NC are only eligible for outpatient/office-based payment from Medicaid. For the REH to be a sustainable model, particularly in eastern NC where approximately 70 percent of reimbursement is from government payor programs, emergency services provided to Medicaid beneficiaries must be reimbursed at levels commensurate with other hospital-based reimbursement for emergency services or in line with the Medicare Outpatient Prospective Payment System (OPPS) final rule for REHs.

Eligibility and Accreditation

Per Martin County leadership and Ascendient, CMS has confirmed Martin General Hospital meets eligibility requirements to reopen as an REH. As there is no CMS-deemed accrediting body for REHs, the State Survey Agency must perform on-site surveys of the operational facility to ensure compliance with REH regulations, fire safety regulations and the 2012 Healthcare Facilities Code. ECU Health has extensive experience with successful facility and quality surveys from a host of regulatory and accrediting bodies for both new and existing facilities. *See sections 1.2.a, 4.2 and Appendix B for additional quality and accreditation information.*

Required Services

REHs must offer the following services: 24-hour emergency and observation services, laboratory services consistent with Critical Access Hospital CoPs, diagnostic radiology services, pharmacy or drug storage, and discharge planning supervised by a licensed professional such as a registered nurse or social worker. Specifically for Emergency Services, the REH CoPs require 24/7 staffing and availability of a qualified medical provider (MD, DO, NP, PA) on-site or on-site within 30 minutes of being called. REHs may determine the appropriate licensures and credentials for staffing emergency and observation services within state guidelines. ECU Health Physicians currently staffs all ECU Health hospital emergency departments, including The Outer Banks Health Hospital, with board certified physicians and advanced level practitioners consistent with community demand for emergency services.

ECU Health has provided emergency, laboratory, imaging, pharmacy and discharge planning services through its acute care and critical access hospitals in eastern NC since its inception. ECU Health is confident in our ability to meet the CoPs for REHs as designated by Medicare within all delineated domains: governance, medical staff, emergency services, lab services, radiologic services, pharmaceutical services, infection prevention and control, staffing and staff responsibilities, nursing services, discharge planning, patients' rights, quality assessment and performance improvement, transfer agreements, medical records, emergency preparedness, and physical environment.

Optional Outpatient Services

ECU Health recognizes that REHs may offer additional, non-required outpatient services and/or a skilled nursing facility in a separately licensed, distinct unit from the REH. Services provided within 250 yards of the main campus may be considered a department of the REH. The REH may include a Rural Health Center (RHC) but may not include a Federally Qualified Health Center (FQHC) for primary care and behavioral health services. The REH is not eligible to serve as a National Health Services Corps (NHSC) site, but if collocated with an RHC, the RHC may apply for the NHSC designation. If the REH offers optional outpatient services, the services offered must align with community needs and be provided within standard of care guidelines.

ECU Health Bertie Hospital in Windsor, NC provides a reasonable proxy for how REH services can be established and evolved in Martin County. ECU Health understands the importance of collocating primary care and core specialty services and currently operates a Rural Health Center (RHC) at ECU Health Bertie Hospital, as well as surgical, rehabilitation and other specialized services. ECU Health envisions the services of the proposed REH could potentially expand to enhance access to these other optional outpatient services in the future following development of the proposed new de novo facility. *See Sections 1.3.a, 4.4.c and 5.2.a-c for additional information about ECU Health's experience with similar models and service implementation plan.*

1.4 Transfer Capability

1.4.a Existing transfer relationships

As the tertiary referral center for all of eastern NC, ECU Health Medical Center has transfer agreements with all referring hospitals in the region, including military hospitals. There are also existing transfer relationships with hospitals outside our service area as well as with post-acute and other providers. It is worth noting that ECU Health Medical Center has maintained certain transfer relationships/agreements since before the facility became a regional tertiary referral center for eastern NC. This history serves as evidence of our long-standing reputation and service as a transfer partner. ECU Health community hospitals, including Outer Banks Health Hospital, also have transfer agreements with the ECU Health Medical Center, other regional hospitals, post-acute providers, and other healthcare entities. In total, there are nearly 140 agreements for the system facilities, including almost 80 agreements with acute care hospitals, 30 post-acute care providers, and nearly 30 surgery and endoscopy centers, dialysis providers and medical transport companies.

1.4.b Proposed transfer partners for Martin County

Should ECU Health's proposal be selected, the proposed REH would enter into a formal transfer agreement with ECU Health Medical Center as the Medicare-certified Level I Trauma Center partner. However, ECU Health envisions a regional system of care whereby Martin County patients not requiring tertiary or trauma care would be transferred to ECU Health Beaufort Hospital, a campus of ECU Health Medical Center, for admission. This regional system of care approach ensures optimization of inpatient capacity across all care sites such that patients can access the right care site for the acuity of their condition. The proposed REH will be integrated into the ECU Health Transfer Center's operations, which will ultimately direct patient placement based upon clinical need and system capacity. *See Section 6.1.a for more information about the ECU Health Transfer Center.*

1.4.c Process for establishing and maintaining agreements

To establish a transfer relationship, the transferring (proposed REH) and receiving ECU Health facilities must enter into a written transfer agreement. This agreement may include but is not limited to procedures regarding the exchange of medical information, maintaining confidentiality of patient information, establishing transfer procedures, and delineating the roles and responsibilities of each party.

1.5 Financial Capability

1.5.a Recent audited financial statements

See Appendix C for the 2024 audited financials for the health system.

1.5.b Current bond ratings, if applicable

ECU Health has an "A2" stable outlook credit rating from Moody's and an "A" stable outlook credit rating from Standard & Poor's (S&P). These bond ratings reflect the opinions of these crediting agencies that ECU Health has strong and sustainable operational performance, a stable operating cash flow margin, and anticipates that ECU Health's market and financial position will continue to strengthen.

1.5.c Evidence of access to capital

ECU Health has an approved capital budget for 2025, and a 3-to-5-year capital plan that provides for operational and maintenance capital, and strategic reinvestments into the health system. Additionally, ECU Health has a favorable position with respect to debt measures as evidenced by our successful ability to refinance existing outstanding bonds and be issued new lines of credit to create access to capital. *See page 76 of the audited financial statements listed as Appendix C for details related to capital position.*

1.5.d Documentation of funds available for startup and operations

See response to section 1.5.c. See Appendix C for ECU Health's Audited Financial statements for information related to capital position and profitability.

1.6 Implementation Timeline

1.6.a Detailed timeline for reopening

ECU Health acknowledges that reestablishing essential healthcare services in Martin County in a timely manner is of utmost importance to the community. ECU Health will use best efforts to meet the close date proposed herein and operationalize the existing facility as an REH within a reasonable period following close of the transaction. However, reopening will be dependent upon post-closure processes and timelines required to meet all state and federal regulatory and third-party requirements pertaining to licensure, accreditations, payor enrollment, and other processes as may be required by applicable law. As of the time of proposal development, additional information and discussions are necessary to accurately scope the reopening effort and timeline, including confirmation of facility readiness. Importantly, ECU Health does not anticipate the ability to reopen the facility as an REH absent a permanent solution to Medicaid reimbursement for REHs. A key early milestone will be the August 3, 2025 deadline to satisfy notice of intent to reopen the facility under the Legacy Medical Care Facility provisions of N.C.G.S. 131E-176(14f) and N.C.G.S. 131E-84(h) which will allow the reopening of the facility to be exempt from the Certificate of Need (CON) review process. We anticipate organizing internal and external stakeholders to develop a more reliable timeline and detailed project plans to guide timely reopening efforts as discussions advance. We look forward to further discussions with the County regarding reopening expectations and feasibility.

1.6.b Resource allocation plan

Resource allocation for the reopened facility will be based on a phased approach to service implementation and will meet ECU Health's high standards for safe, effective, and efficient care delivery while ensuring compliance with all REH regulatory requirements. Upon reopening as an REH, the existing facility would, at a minimum, operate with all required services of an REH as defined by the Medicare CoPs. The resource allocation plan will be developed based on required resources, skills and competency needs; forecasted resource utilization; existing or pooled resource availability and allocation of corporate shared resources; and determination of requirements to optimize resources of the REH and the system overall. It is our position that initial resource allocation planning for reopening the existing facility could be conducted during due diligence with more detailed planning to occur following close. Resource allocation will be reassessed during the planning phase for the proposed new, de novo facility and contingent on community need and the associated level of clinical activity required to meet the needs within the context of a highly efficient regional system of care.

1.6.c Major milestones and dependencies

Should ECU Health's proposal be selected, additional discussions with the County and internal and external stakeholders will inform a detailed project plan, which will identify specific project milestones and dependencies across all project phases and components. While ECU Health will use best efforts to achieve the close date proposed herein, we anticipate a period between transaction close and reopening (post-close period) whereby services will not be available to the public until all required regulatory and payor enrollment processes are satisfied. The following represent high level milestones or dependencies that can be expected to guide our approach to day-one operations planning.

- Successful close by the proposed date herein.
- Post-close third-party filings and notices, as required.
- Execution of a facility readiness plan; ideally a thorough facility assessment will be conducted during due diligence such that plan execution can begin timely following close, including commencement of necessary repairs and refurbishments in addition to those for which the County is responsible; execute wayfinding and signage plan.
- Equipment and supply acquisition.
- Receipt of ancillary licensure, permits, and certifications/accreditations, as required.
- Recruit and hire qualified staff, including medical, administrative, and support personnel; assess team member and provider training and education requirements and implement plan as appropriate.
- Internal mock survey process and resolution of deficiencies.
- State Survey Agency on-site surveys.
- Resolution of certain payor/reimbursement and funding requirements as outlined in section 3.

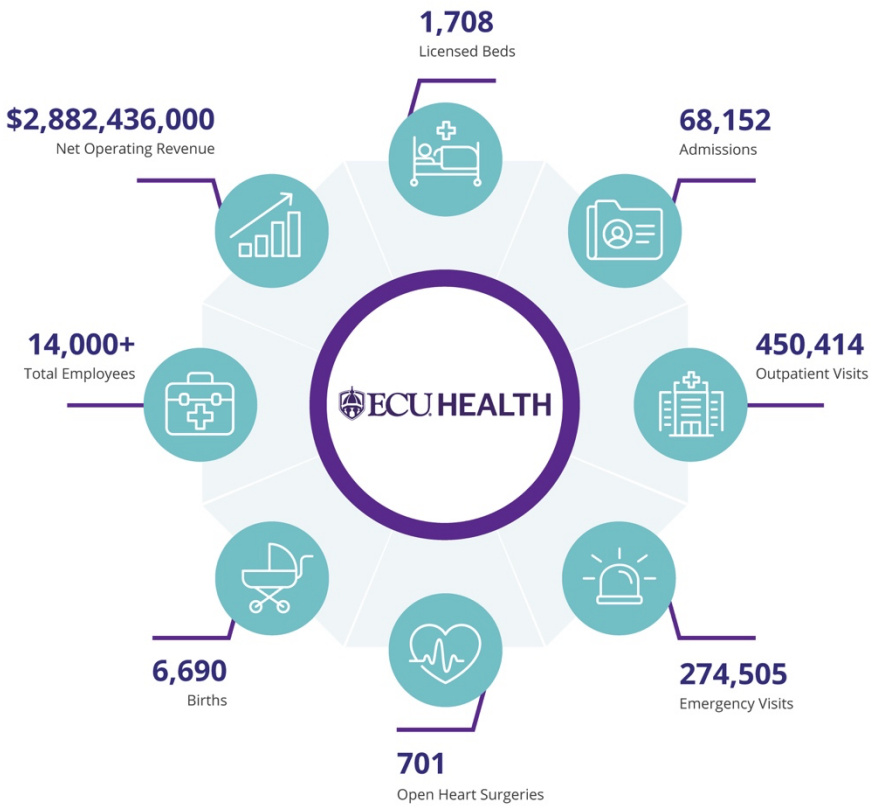
SECTION 2: RESPONDENT BACKGROUND

2.1 Strategic Vision and Regional Presence

2.1.a Current size and scope of operations

ECU Health's combined operations include more than $2.8 billion in net operating revenue. We have an expansive inpatient enterprise, with 1,708 licensed beds systemwide. In FY24 ECU Health had 68,152 inpatient admissions and 450,414 outpatient visits systemwide. As previously mentioned, ECU Health Medical Center serves the entire 29-county region as the only Level I Trauma Center in eastern NC. In FY24, ECU Health Medical Center had more than 119,000 emergency department visits which made up more than 43% of all emergency visits systemwide. The facility's emergency department is consistently ranked as one of the busiest in the country.[2]

ECU Health has expanded its system of care over the last 28 years to meet the healthcare needs of the region. The system has a broad continuum of service offerings and is continually implementing new and expanded programs, services and advanced clinical technologies to ensure eastern North Carolinians have the same access to advanced, high-quality care as patients in non-rural areas.



We maintain numerous affiliations with other local community hospitals and organizations to support our region's healthcare. Our vision to become the national model for rural health and wellness by creating a premier, trusted health care delivery and education system includes collaborating with other hospitals, physicians, providers, and community organizations to deliver population-focused care under a care and reimbursement model that rewards efficient care and high-quality clinical outcomes.

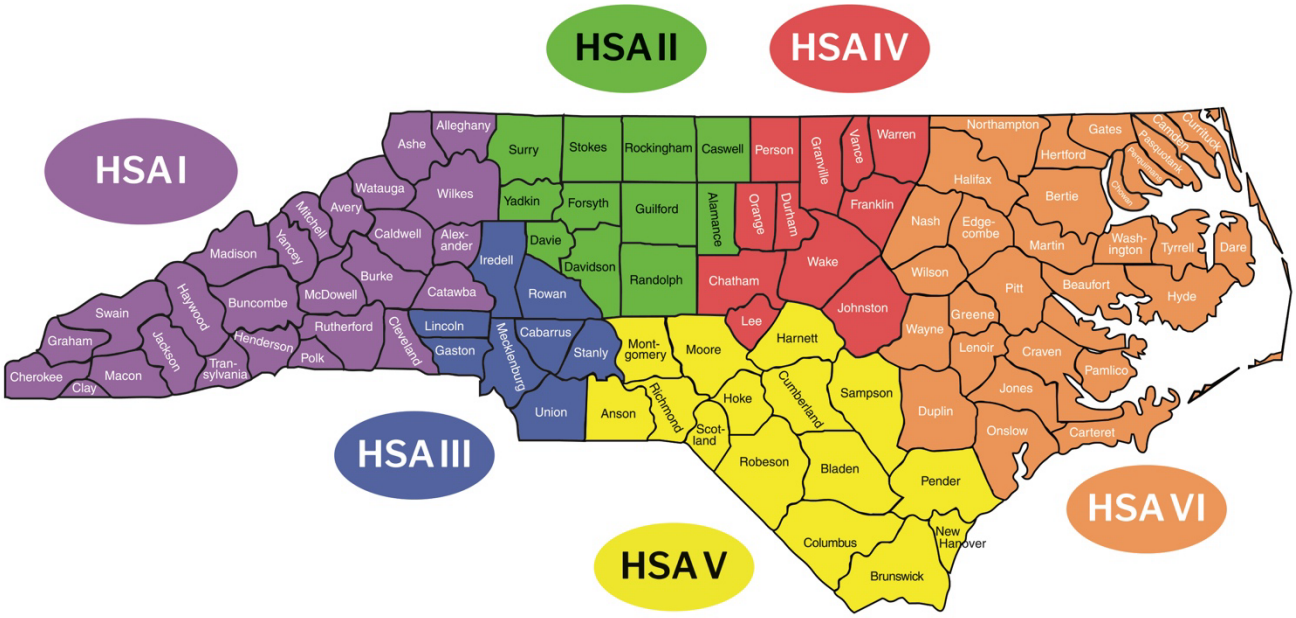
See Sections 1.1a and 1.1b and Appendix A for additional information about ECU Health's current size and scope of operations.

[2] https://www.beckershospitalreview.com/rankings-and-ratings/hospitals-with-the-most-ed-visits-in-2024/

2.1.b Geographic service area and regional presence

The mission of ECU Health is to improve the health and well-being of eastern NC – a geography approximately the size of Maryland, spanning 14,000 square miles across 29 rural counties. Our regional reach allows us to serve approximately 1.4 million people. The traditional service area for the health system is essentially bound by I-40 to the south, I-95 to the west, the North Carolina/Virginia border to the north, and the NC coast on the east. This service area definition matches the Health Service Area (HSA) VI geography outlined by the NCDHSR as shown by the map below.

North Carolina Health Service Areas



Growing our health care system has led to a stable, efficient, and accessible health care delivery system in eastern NC, and we will continue to enhance system services and locations with the goal of sustainably improving the delivery of health care, regardless of geography.

See sections 1.1.a and 1.1b and Appendix A for additional information about our service area and locations.

2.1.c Strategic goals for rural healthcare delivery

Despite NC being one of the fastest growing states, it is home to the second largest rural population in the nation, behind only Texas. Approximately one-third of the state's rural population calls eastern NC home—a region where 27 of our 29 counties are considered rural. These 27 rural counties are also designated Health Professional Shortage areas for primary care, dental, and mental/behavioral health by the Health Resources and Services Administration (HRSA). We have flat or declining population growth across much of our already sparsely populated service area, requiring thoughtful approaches to how we expand and sustain our reach to bring access to high quality care to our communities. The population in eastern NC is aging, and due to high incidence of chronic disease and comorbidities, tends to require greater complexity of care. Our market is also challenged in that approximately 70 percent of ECU Health revenues are reliant on government-based payment programs (Medicare and Medicaid) that historically reimburse at- or below-cost. Much of our nation's rural health infrastructure, including in eastern NC, was originally built using Hill-Burton era funding dating back to the 1940s. These facilities are in need of critical but capital-intensive investments. All but two of eastern NC's 29 counties are designated Tier 1 or Tier 2 counties based on economic well-being.[3] Sixteen of the state's 40 Tier 1 counties (most distressed) are in eastern NC, a statistic that includes Martin County.

Dating back to our beginning as a regional health system, ECU Health's strategy has always been defined by our rural health roots and unique rural geography, and our deep understanding of the challenges of providing comprehensive healthcare access locally and sustainably, while also respecting the economic impact of healthcare in our local communities. The following represent core principles around which we design our strategic goals for rural healthcare delivery.

With these principles in mind, ECU Health has adopted three strategic transformations that guide our approach to achieving our rural health goals and initiatives.

[3] https://www.commerce.nc.gov/grants-incentives/county-distress-rankings-tiers

Academic, Rural Health Leader

The expansion of rural academic medical education, training, and research is a critical element of our rural health strategy and goals. The clinical integration of the health system and BSOM in 2022 through the execution of a joint operating agreement was a significant step on our journey, as it allowed our organizations to begin working together more effectively to address the future healthcare delivery and workforce needs of our complex region. We aim to position BSOM to continue its expansion as a leader in training primary care providers for our state and region. We know when medical students train in rural areas like eastern NC, our chances of retaining graduates to practice in our region are much higher. The integration of ECU Health and BSOM represents a commitment by our organizations to pursuing excellence in academic medicine and creating a world-class rural clinical education and care delivery system in service to the health outcomes of our rural region.

Modern Delivery System

ECU Health recognizes that achieving our goals within the aforementioned principles requires an integrated, patient-centered regional system of care that leverages new models and solutions to optimize the healthcare delivery system. Creating the modern rural delivery system means investing in our ambulatory footprint, advancing innovative care models that expand our reach, and ensuring we are optimizing the capacity of our hospitals to care for the rising acuity of our unique population. The progress and investments we are already making are a testament to what is possible in eastern NC.

Brody School of Medicine Center for Medical Education Building: BSOM recently broke ground on a new, state-of-the-art medical education building, made possible thanks to our state leaders who recognize the value of ECU Health's academic healthcare mission. The new, modernized facility is expected to open in 2027 and will allow us to expand the number of medical students we educate and train each year in our rural environment.

Behavioral Health: ECU Health is taking important steps to expand access to much-needed high-quality behavioral health care, including by breaking ground on a new 144-bed behavioral health hospital. This new facility, which has been developed in partnership with Acadia Healthcare, is expected to open in Greenville in summer 2025. We are proud to be able to expand inpatient behavioral health care to our most vulnerable – children and adolescents. The facility will include 24 beds dedicated to the child and adolescent population, the only such beds within 75 miles of Greenville. Additionally, we are in the design phase of developing a new state-of-the-art regional behavioral health facility that will house specialized outpatient behavioral health services and support our ability to expand training for psychiatry providers – a specialty experiencing significant shortages. This major OP behavioral health facility project is also made possible in thanks to the support we receive from the state legislature to address these complex care needs. We continue to expand access to regional behavioral health services through Collaborative Care – a model that emphasizes the integration of behavioral health care into primary care through a team-based approach.

Managing Lives

Our efforts to build a trusted, rural academic modern delivery system will enable ECU Health to improve population health more effectively and successfully transition to value-based care delivery models. Primary care access is at the core of our ability to effectively manage the health and well-being of eastern North Carolinians. Our goal is to become a leader in primary care by implementing next-generation team-based primary care models, integrating prevention and wellness as a core component of the care delivery system, and continuing to expand our community-based partnerships to address social determinants of health (SDOH) – the non-medical factors that significantly influence the health outcomes of our patients.

Central to ECU Health's rural health strategy is the regional system of care, which is an integrated care delivery model designed to provide comprehensive, cross-continuum healthcare services in rural areas in a seamless, consistent, and highly efficient manner. Through the establishment of the NC Care initiative as outlined by NC Session Law 2023-134, it was the intent of the NC General Assembly that ECU Health, UNC Health, and our affiliated schools of medicine would collaborate to improve access to high quality health care for citizens and communities located in rural areas of NC by establishing outcome driven regional systems of care, beginning in eastern NC. To that end, the NC legislature authorized $210 million for the development of rural care centers and $150 million to invest in strengthening and providing operational support for community hospitals affiliated with our health systems. ECU Health is uniquely positioned to achieve the legislature's goals to improve health outcomes in our state's rural areas, beginning in places like Martin County, and proposes to use these funds to invest in the integrated, regional system of care described herein, which would include funding for the proposed new REH to serve as a rural care center, as well as investments in ECU Health Beaufort Hospital to expand inpatient access and augment services to serve as an advanced general community hospital.

The rural care centers, such as the proposed REH, are intended to deliver comprehensive care from wellness and preventive services and primary care through high-acuity outpatient care, in a patient-centric and cost-effective manner. This model allows the health system to meet the increasing demand for higher complexity outpatient care as advancements in technology facilitate moving care out of the inpatient setting.

While most of a patient's interactions with the health system are outside the inpatient setting, high acuity outpatient sites like the REH require partnership with general acute care hospitals in their region for advanced services and care that cannot safely be delivered in the rural care center. In the regional system of care, general community inpatient hospitals are optimized to work in harmony with the high-acuity outpatient rural care centers. Importantly, through the coordination of care across the regional system of care, the health system's tertiary referral center can be optimized to better serve patients requiring the advanced care capabilities that can only be provided at ECU Health Medical Center. Ultimately, the regional system of care allows the health system to advance our rural medical training goals, improve provider experience by enhancing coverage capabilities, and deliver greater accessibility to all levels of care in a highly efficient and effective manner.

2.1.d How Martin County fits within this framework

Based upon ECU Health's assessment of utilization trends, overall local characteristics, and future-state care delivery expectations, ECU Health envisions the proposed new, de novo REH serving as the rural care center for a multi-county area of the region, connected to an expanded ECU Health Beaufort Hospital in Washington for patients in the region requiring inpatient admission for the care of general community acuity conditions. Investments in ECU Health Beaufort Hospital are a critical component of the regional system of care, as the proposed REH will not have an inpatient service.

As a rural care center, the future-state new REH would potentially expand beyond emergency care to also consist of services and programs designed to meet the cross-continuum care needs of the community. These services would be anchored by the facility's emergency department which would be designed to meet the needs of the Martin County community and work harmoniously within the integrated regional system of care.

2.2 Interest and Organizational Alignment

2.2.a Explain why Respondent has chosen to pursue this opportunity

ECU Health believes that as an integrated, not-for-profit, rural health focused, mission-driven organization we are uniquely positioned to respond to the opportunities the County has outlined throughout the RFP:

- *Implementation of an innovative healthcare model designed specifically for rural markets.*
- *Focused investment in services that meet community demand.*
- *Ensuring access to higher levels of care through regional partnerships.*
- *Implementation of a long-term sustainable solution for healthcare services in Martin County.*

Our deep understanding of the healthcare challenges and opportunities in Martin County and surrounding communities is unmatched. ECU Health believes the REH model proposed by Martin County is the appropriate hospital model for the community based on historical healthcare utilization patterns and projected need, and with necessary commitments, ECU Health has a clear and executable vision for integrating the existing facility into our regional system of care as an REH providing essential healthcare services, and in the future, a new de novo facility. As is evidenced throughout this proposal, ECU Health is invested in the sustainability of the rural healthcare delivery system serving eastern NC. We have chosen to pursue this opportunity because we believe the integration of the proposed facility into a local comprehensive, regional system of care is what will produce the greatest value for Martin County and the surrounding communities, and the greatest opportunity for long-term sustainability.

2.2.b Explain specific benefits a Martin County facility would bring to Respondent's organization

The proposal to reopen Martin General Hospital as a REH is directly aligned with ECU Health's transformational rural health goals. Geographically, Martin County is in a unique area of the region where it is feasible for the proposed REH to be effective in serving the county and surrounding communities. This geographic benefit is an enabler of ECU Health's goals to improve local and equitable access to care.

Importantly, ECU Health is a leader in driving rural health expansion by leveraging novel federal and state programs that target rural health delivery sustainability. When the current ECU Health Bertie Hospital facility was constructed, it was the first hospital in the country to be developed in accordance with CAH standards, which at the time represented an historic effort to address rural hospital closures. Now 25 years later, ECU Health and Martin County have an opportunity to continue leading the way in sustaining rural health care access and transformation by opening the first REH in the state and being the first in the nation to reopen a formerly closed facility as an REH in our efforts to preserve access to rural health care. It is our position that, just as ECU Health Bertie Hospital's conversion to CAH and integration into the larger health system was vital to its success, the REH designation offers a stabilizing care model to Martin County, but integration into a regional system of care is required for long-term sustainability. The preservation and potential expansion of services that can be achieved through REH designation and the regional system of care are not only critical for the people of Martin County, but surrounding communities as well.

2.2.c Explain how the facility would be integrated into Respondent's operational structure

We envision the Martin REH integrating into the ECU Health operational structure similar to other ECU Health community hospitals, whereby a local management team would oversee day-to-day operations of the facility, reporting to the President of ECU Health Community Hospitals (ECOM). Through this reporting structure, the community hospitals integrate into the operations of the clinical enterprise which is overseen by ECU Health's Chief Operating Officer and includes the operations of ECU Health Medical Center, ECU Health Physicians, Information Services, Nursing Operations, and Human Resources.

The REH would be further integrated into the operational structure of the system through allocation of corporate shared services. As a large regional health system, ECU Health has a corporate shared services infrastructure that can be scaled as needed to support all our entities. Corporate shared services promote organizational efficiency, standardization of processes, and allow local entities to focus on day-to-day operations and care delivery to the patient. The following are corporate shared services that could be allocated to the REH to support facility operations and system alignment: Facilities & Properties; Financial Services; Community Health; Care Management; Human Resources; Information Services; Audit and Compliance; Strategic Planning and Network Development; Legal; Company Police.

2.2.d Explain the Respondent's experience with similar facilities or markets

See Sections 1.3, 4.4.c, 5.2.a, and 6.2.c for detailed information about ECU Health's experience with similar facilities or markets.

2.3 Operational and Quality Performance

2.3.a Financial performance indicators, provided in accordance with N.C.G.S. 131E-13(d)(4) for all owned, leased, or managed facilities

N.C.G.S. 131E-13(d)(4) states the following:

> *Before considering any proposal to lease or purchase, the municipality or hospital authority shall require information on charges, services and indigent care at similar facilities owned or operated by the proposed lessee or buyer.*

See sections 2.3.c-e and 3.2.a-b and Appendix C for information on ECU Health's financial policies with respect to N.C.G.S. 131E-13(d)(4) and audited financials with respect to financial indicators.

2.3.b Quality metrics and outcomes, provided in accordance with N.C.G.S. 131E-13(d)(4) for all owned, leased, or managed facilities

See Section 4 for detailed information about ECU Health's quality metrics and outcomes.

2.3.c Service volumes and scope, provided in accordance with N.C.G.S. 131E-13(d)(4) for all owned, leased, or managed facilities

N.C.G.S. 131E-13(d)(4) states the following:

> *Before considering any proposal to lease or purchase, the municipality or hospital authority shall require information on charges, services and indigent care at similar facilities owned or operated by the proposed lessee or buyer.*

ECU Health offers a comprehensive set of inpatient and outpatient services in all our communities. The following table represents key service utilization statistics across all ECU Health entities in FY24. ECU Health provides all patients with access to services regardless of ability to pay or source of payment. The following table provides FY24 service volumes and scope for each of our hospitals.

Patient Service Statistics

Hospital	Admissions	Surgeries	Births	ED Visits	Outpatient Visits
ECU Health Medical Center*	44,575	39,670	4,205	95,412	223,599
ECU Health Beaufort Hospital A Campus of ECU Health Medical Center	4,887	3,776	314	24,182	26,188
ECU Health Bertie Hospital	352	514	0	14,814	16,449
ECU Health Chowan Hospital	2,004	1,231	400	19,223	26,704
ECU Health Duplin Hospital	3,047	1,863	419	27,279	18,075
ECU Health Edgecombe Hospital	3,136	2,463	379	25,304	24,970
ECU Health North Hospital	4,379	2,615	432	26,704	35,728
ECU Health Roanoke-Chowan Hospital	4,137	1,526	253	21,303	45,078
Outer Banks Health Hospital	1,635	2,354	288	20,284	33,623
Total	**68,152**	**56,012**	**6,690**	**274,505**	**450,414**

**Surgeries for ECU Health SurgiCenter included in total*

2.3.d Charges, provided in accordance with N.C.G.S. 131E-13(d)(4) for all owned, leased, or managed facilities

N.C.G.S. 131E-13(d)(4) states the following:

> *Before considering any proposal to lease or purchase, the municipality or hospital authority shall require information on charges, services and indigent care at similar facilities owned or operated by the proposed lessee or buyer.*

ECU Health provides care to patients across eastern NC, including Martin County residents, regardless of their ability to pay. ECU Health Financial Assistance policies establish guidelines for charity care, prompt pay discounts, and payment plans to assist patients with managing their medical costs. We have significant relationships with the following payors, who also serve a large number of Martin County patients: Medicare; United Healthcare (Medicare Advantage); Humana; Blue Cross Blue Shield of North Carolina; Medicaid; Cigna.

Additionally, ECU Health is compliant with pricing transparency requirements and all data, including comparative data, can be found on our website: ***https://www.ecuhealth.org/patients-and-families/your-bill/price-transparency/***

See Sections 2.3.e, 3.2.a and 3.2.b for additional information on indigent care policies and charity care.

2.3.e Indigent care policies and amounts, provided in accordance with N.C.G.S. 131E-13(d)(4) for all owned, leased, or managed facilities

N.C.G.S. 131E-13(d)(4) states the following:

> *Before considering any proposal to lease or purchase, the municipality or hospital authority shall require information on charges, services and indigent care at similar facilities owned or operated by the proposed lessee or buyer.*

See sections 3.2.a and 3.2.b for details on ECU Health's indigent care policies and amounts.

SECTION 3: PROPOSED TERMS

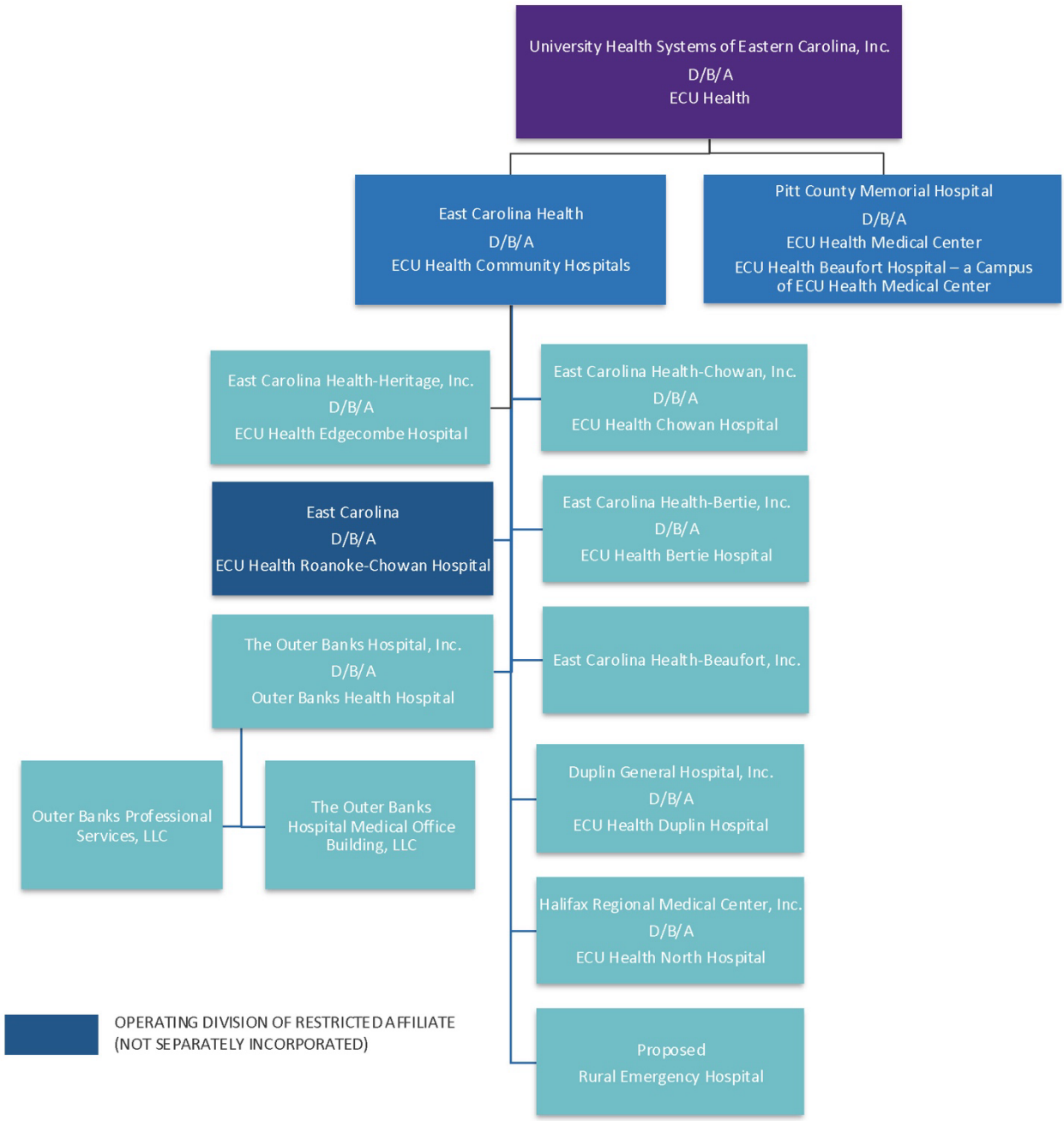
3.1 Transaction Structure

As of the writing of this proposal, the following represent certain understandings held by ECU Health, which inform the proposed transaction structure.

- The existing Medicare Provider Number is not able to be assumed by a new operator; therefore, the REH must be newly enrolled and receive a new Medicare Provider Number.
- Ownership of the real estate, improvements related to the hospital facility, and possibly other personal property are held by Martin County, without any encumbrances.

ECU Health proposes that at close an ECU Health controlled affiliate would assume responsibility for state licensure of the facility, and likely after close (or perhaps as of closing), ECU Health would assume responsibility for obtaining other required licensure and accreditation (i.e. CLIA, Radiation Protection, DEA and state pharmacy licensure) and then pursue enrollment with Medicare as well as other payors. ECU Health proposes that its acquisition of Martin General Hospital would best be accomplished through the negotiation and execution of a lease and operating agreement and/or other ancillary agreements by and between ECU Health (and/or an ECU Health controlled affiliate) and Martin County, with respect to the assets and section(s) of the hospital property proposed to be reopened and operated as a REH. ECU Health also proposes to acquire pertinent personal property through a conveyance agreement. The proposed transaction would be dependent upon fulfillment of the contingencies and commitments outlined in Section 3.1.b, as permitted by law.

The chart below visualizes how ECU Health envisions the REH would integrate into the ECU Health legal structure following the transaction.



3.1.a Proposed financial terms

ECU Health proposes an agreement whereby the Martin General Hospital real property and facility, in pertinent part, would be leased to a fully controlled subsidiary of ECU Health. ECU Health will assume responsibility for reopening and operating the existing facility as a REH as described herein, pursuant to the contingencies and commitments proposed in Section 3.1.c. ECU Health will also use best efforts to develop a new REH, dependent upon the contingencies and commitments provided in Section 3.1.c. Consideration for this transaction is the

commitment set forth herein on the part of ECU Health; however, no monetary purchase price or other exchange is included as part of this proposal. ECU Health proposes to partner with Martin County to identify and pursue viable sources of funding to support the development of a new REH facility and to fund any ongoing losses associated with operating the REH facility, and looks forward to opportunities to discuss financial terms in more detail as the County's process continues.

3.1.b Timeline for closing

Close of the proposed transaction is dependent upon the process and timing required to fulfill the procedural requirements Martin County must meet in order to sell, lease, or otherwise convey the facility in accordance with N.C. Gen. Stat. § 131E-13(d), and successful completion of due diligence and pre-closing approvals and consents. ECU Health proposes a close date of December 31, 2025, and offers the following anticipated timeline to meet the proposed close date. Of note, the proposed close date does not likely represent the date the facility can become operational. ECU Health anticipates a deferred closing whereby parties will agree to and sign the Definitive Agreement(s) in advance of the transaction close date.

RFP Release & Proposal Submission Phase	
February 13, 2025-April 4, 2025	• RFP process launched; site visits as needed • **Milestone:** Submissions by 5 p.m. on April 4, 2025
Assessment of Minimum Qualifications, Public Hearing(s), Selection	
April-May 2025	• County assessment of ECU Health qualifications • Notice of public hearing(s) in accordance with NCGS 131E • Public hearing in accordance with NCGS 131E; ECU Health presentation to Martin County • **Milestone:** Martin County final selection of a Respondent
Binding Letter of Intent and Board Approvals	
June-July 2025	• Establish scope of due diligence • Draft required Definitive Agreement(s) necessary to accomplish the transaction • Martin County Board of Commissioners approval of binding Definitive Agreement(s), pursuant to NC G.S. 131E-13(d)(7) • ECU Health Board of Directors approval of execution of Definitive Agreement(s) • **Milestone:** Submit notice of intent to reopen facility, pursuant to NC G.S. 131E-184(h) by August 3, 2025
Due Diligence and Closing	
August-December	• Confirmatory due diligence process completed • Pre-closing regulatory/third-party approvals and consents • **Milestone:** Close transaction by December 31, 2025; complete necessary post-close filings/notices

3.1.c Key conditions and contingencies

ECU Health leadership has carefully considered Martin County's RFP and our health system's ability to execute on this proposal. While ECU Health is dedicated to making every reasonable effort to successfully execute upon this proposal, there are existing known and potentially new circumstances that could make the transaction itself or commitments to certain provisions herein unfeasible. Therefore, this proposal is subject to the following contingencies:

Prior to Submission of Exemption Notice (on or before August 3, 2025)

1) Successful fulfillment of any applicable, Chapter 131E-13 statutory requirements.
2) Execution of Definitive Agreement(s) including all usual and customary terms for transactions of this type.
3) Commitment by Martin County to make good faith efforts to work with ECU Health to develop a funding framework to guide funding solutions to support the funding needs identified within this proposal prior to the reopening of the REH.
4) Approval(s) by the ECU Health Board of Directors, as required.
5) Approval(s) by the Martin County Board of Commissioners, as required.

Prior to Closing of the Transaction (on or before December 31, 2025)

6) Successful completion or receipt of necessary regulatory surveys and/or approvals, including anti-trust, and/or other third-party consents as may be required by law.
7) Completion of confirmatory due diligence as is customary for transactions such as that contemplated by this proposal. No material adverse changes to the facility and property to be conveyed prior to close of the proposed transaction.

Prior to Reopening of Hospital as REH (on or before August 2, 2028)

8) Approval of a permanent reimbursement solution, by either State or Federal government, authorizing Medicaid rates equivalent to Medicare based on the OPPS final rule for REHs. ECU Health will be unable to reopen the facility as an REH absent this or another viable solution to the existing Medicaid reimbursement model for REHs.
9) Execution of a funding agreement between ECU Health and Martin County as it relates to the reopening and ongoing operation of the REH. The funding agreement will be developed and executed in alignment with the previously mentioned funding framework.
10) Receipt of NC Care funds as authorized and described by North Carolina Session Law 2023-134, "Current Operations Appropriations Act of 2023," for the purposes of supporting the rural regional system of care through rural care center and hospital investments. Reopening of the existing facility as a REH will be contingent upon securing sufficient funding to expand inpatient capacity at ECU Health Beaufort Hospital, and supporting the development of the proposed new, de novo REH.

In addition to these contingencies, the Definitive Agreement(s) must include the following conditions and/or commitments:

Reopening of Existing Hospital as a REH

1) Commitment by Martin County to assume all costs associated with refurbishing the existing property that is to be leased by ECU Health (or a controlled affiliate) as part of the proposed transaction. ECU Health reserves the right to establish the minimum facility and property standards/refurbishments that must be met at Martin County's expense to reopen the facility as an REH as described herein.

Opening a New, De Novo REH at new Location

1) As permitted by law, commitment by Martin County Board of Commissioners to fund the new, de novo REH facility the RFP and this proposal calls for, or otherwise secure funds sufficient to fund the new REH facility (such as NC Care funds). ECU Health is committed to partnering with Martin County to identify and pursue viable sources of funding for this purpose.
2) As permitted by law, commitment by Martin County Board of Commissioners to relinquish to ECU Health all ownership and operational control over the new REH facility as proposed to be developed herein or over its operator, which will not be subject to statutory reversion.
3) Commitment that ECU Health will have exclusive site selection rights as related to the future location of the new facility described by this proposal.

It is the expectation of ECU Health that the Definitive Agreement(s) will provide for reasonable options to modify services or unwind operations in the event financial losses of the REH become insurmountable and/or funding solutions/commitments identified by the parties are no longer viable.

3.1.d Basic parameters for new facility development rights/obligations

See section 3.1.c for new facility development rights and obligations.

3.1.e Expected County participation in funding

See section 3.1.c for expected County participation in funding.

3.2 Care Access Commitments

3.2.a Describe Respondent's commitment to ensuring availability to the indigent population, in accordance with N.C.G.S. 131E-13(a)(2), (3), and (4)

N.C.G.S. 131E-13(a)(2) reads as follows:

> *The corporation shall ensure that indigent care is available to the population of the municipality or area served by the hospital authority at levels related to need, as previously demonstrated and determined mutually by the municipality or hospital authority and the corporation.*

As a private, not-for-profit, mission-driven organization, ECU Health is committed to treating all patients regardless of ability to pay. This commitment is memorialized through numerous organizational policies covering patient rights and responsibilities, hospital and professional billing, and financial counseling services. Patients unable to pay for services may be eligible for financial assistance, including Charity Care.

ECU Health policy defines two types of Charity Care eligibility:

1) Federal Poverty Level (FPL)-based income measure, as issued annually by the Department of Health and Human Services; balance write-off and discount schedules are based on income-to-FPL thresholds. ECU Health maintains presumptive and application-based processes for income-based Charity Care eligibility.
2) Non-Income based measure; patients may be presumptively eligible for financial assistance if meeting one of four non-income-based criteria. ECU Health maintains presumptive eligibility processes for non-income-based Charity Care eligibility.

ECU Health's financial assistance policies also provide for a process whereby self-pay patients may be screened for Medicaid eligibility and assisted in the Medicaid application and determination process. ECU Health provides detailed information about Financial Assistance policies and options on our website: **https://www.ecuhealth.org/patients-and-families/your-bill/financial-assistance/**

See Appendix D for the health system's Financial Assistance, and Self-Pay and Residual Billing and Collections policies.

3.2.b Describe Respondent's commitment to preserving or enhancing historical levels of charity and indigent care, in accordance with N.C.G.S 131E-13(a)(2), (3), and (4)

ECU Health is committed to our mission of improving the health and well-being of eastern NC, including by making services accessible to all patients regardless of ability to pay or source of payment. This policy applies to all ECU Health hospitals and ambulatory practices. It would be ECU Health's intent to operate the proposed REH without discrimination based on race, creed, color, sex, national origin, and provide services to all individuals regardless of source of payment or ability to pay, consistent with ECU Health policies and all applicable laws.

In 2024, ECU Health provided more than $282 million in unreimbursed care (inclusive of charity care, bad debt, and unreimbursed government payor programs). In addition to ECU Health's existing charity care and community benefit policies and services, the health system also partners with national non-profit Undue Medical Debt to eliminate patient medical debt for those that qualify. ECU Health has eliminated more than $186 million in past medical debt for more than 32,000 qualifying patients since the debt relief initiative began, with additional phases of debt relief expected to continue elimination of medical debt for NC residents.

See Appendix D for the health system's Financial Assistance, and Self-Pay and Residual Billing and Collections policies.

3.2.c Describe Respondent's commitment to maintaining admission policies that do not restrict essential medical treatment based on immediate ability to pay, in accordance with N.C.G.S 131E-13(a)(2), (3), and (4)

N.C.G.S. 131E-13(a)(3) reads as follows:

> *The corporation shall not enact financial admission policies that have the effect of denying essential medical services or treatment solely because of a patient's immediate inability to pay for the services or treatment.*

The ECU Health Patient Rights and Responsibilities policy, which applies to all ECU Health entities, provides for the following:

> *Treatment without discrimination based on age, ethnicity, race, color, religion, culture, language, national origin, sex, gender identity or expression, sexual orientation, physical or mental disability, socioeconomic status, or source of payment.*

This policy is not only in service to our mission, but ECU Health's status as a tax-exempt organization requires its hospital facilities to remain compliant with policies that do not restrict access to services based on an individual's ability to pay.

Though the REH will itself not be an admitting facility, if selected, ECU Health will operate the proposed REH in accordance with health system policies and all applicable laws to ensure the services of the facility are available to all individuals regardless of ability to pay and source of payment. These policies will also apply to patients of the REH requiring admission to another ECU Health facility.

All ECU Health facilities maintain compliance with the Emergency Medical Treatment & Labor Act (EMTALA) which prevents Medicare-participating hospitals from restricting access to essential medical treatment based on ability to pay. ECU Health is committed to ensuring all internal policies and compliance with all such laws are applicable to the emergency department services of the proposed REH.

See Appendix E for the health system's Patient Rights and Responsibilities policy.

3.2.d Describe Respondent's commitment to providing access to Medicare and Medicaid beneficiaries without discrimination, in accordance with N.C.G.S 131E-13(a)(2), (3), and (4)

See response to Section 3.2c.

See Appendix E for the health system's Patient Rights and Responsibilities policy.

3.3 Implementation Approach

3.3.a Due diligence requirements and timeline

It is customary for ECU Health to conduct thorough due diligence when exploring transactions such as the one proposed herein to assess and mitigate risks, and ensure the transaction is ultimately able to close and be executed in a manner that meets the objectives of all parties. ECU Health anticipates the following areas of due diligence for the proposed transaction: Financial; Legal, Risk and Compliance; Operations; Regulatory; Physical Plant, Equipment and Grounds. The timeline will be dependent upon the scope of due diligence.

3.3.b Key milestones to closing

See Section 3.1.b for an anticipated timeline expected to meet ECU Health's proposed close date.

3.3.c Desired closing date(s)

ECU Health anticipates a deferred close and believes December 31, 2025, to be a reasonable target close date. Final close date will be dependent on ability to meet the milestones outlined by the timeline and contingencies and commitments proposed in sections 3.1.b-c. Due to the need to enroll with Medicare as a new REH and obtain a new provider number, closing will not likely represent the date on which the REH will become operational.

3.4 Risk Assessment

3.4.a Potential obstacles to completing the transaction

Failure to meet the stated contingencies and commitments outlined in section 3.1.c, or otherwise present solutions that would sufficiently secure long-term sustainability of this plan, represents the primary risk to completing the proposed transaction.

Per N.C.G.S. 131E-176(14f) Martin General Hospital currently meets the definition of a Legacy Medical Care Facility, which qualifies the reopening of the facility to be exempt from CON review until August 3, 2025. As the potential operator of the reopened facility, ECU Health would be required to provide notice of intent to reopen the facility to the NCDHHS no later than said date, in compliance with N.C.G.S. 131E-184(h). Inability to meet key milestones represented by the timeline proposed under section 3.1.b, including reaching a Definitive Agreement(s), may present potential obstacles to timely close and/or completing the transaction.

Because the proposed REH will not have inpatient services, the expansion of inpatient capacity at ECU Health Beaufort Hospital represents a key dependency for the reopening of the existing facility as a REH, and therefore represents a potential risk to successfully executing on ECU Health's proposal. Expansion of ECU Health Beaufort Hospital's inpatient capacity to better serve the inpatient needs of REH patients and the broader Martin County community is a critical component of the regional system of care.

3.4.b Mitigation strategies for identified risks

Timely satisfaction of the procedural requirements to sell, lease, or otherwise convey the facility as required by law is the most significant strategy to ensuring the transaction can close on or near the proposed close date. Ensuring sufficient capital is secured to invest in the expansion of inpatient capacity at ECU Health Beaufort Hospital will ensure ECU Health can successfully execute on the regional system of care for Martin County.

3.4.c Required County actions or support

See Section 3.1.c

SECTION 4: QUALITY AND REPUTATION

4.1 Quality Performance Metrics

Delivering safe, reliable, human-centered care close to home for the communities we serve is at the core of all we do, and our ability to define and transparently report the most impactful quality measures is critical to our success. ECU Health's 3-to-5-year quality strategy focuses on improving quality and safety through an integrated approach to advance safety culture with an ultimate goal of zero harm through high reliability in delivery of evidence-based care while advancing health equity, focusing on preventing and optimizing the health of the population we serve. The annual quality plan yields our enterprise quality metrics and is developed within the context of our long-range quality strategy following critical review of the internal and external environments, key services, stakeholder expectations, regulatory standards, and patient and family feedback. The following graphic represents our FY25 ECU Health Board of Directors-approved enterprise quality metrics, which are aligned with our long-term quality strategies.

FY25 ECU Health Board Approved Quality Goals

Quality

Operational Focus - What does excellence look like?

Improve quality and safety through an integrated approach to advance safety culture with an ultimate goal of zero harm through high reliability in delivery of evidence-based care while advancing health equity, focusing on prevention and optimizing the health of the population we serve.

FY25 Goals & Objectives – What does excellence look like *this year*?

Enterprise Goals
• Increase Safety Reporting
• Improve Hospital Acquired Infections (CLABSI[1] & CAUTI[2])
• Improve Patient Safety Indicator 3 Pressure Ulcer Rate
• Reduce Mortality
• Improve Population Health Performance on Annual Wellness Visits & Hypertension Control

[1]Central Line Associated Blood Stream Infection; [2]Catheter Associated Urinary Tract Infection

4.1.a Provide three years of CMS star ratings data for all facilities operated by Respondent

The following table provides ECU Health CMS Overall Hospital Star Ratings for the last three years for all facilities.

CMS Stars	2025	2024	2023
ECU Health Medical Center / Beaufort campus	2	2	2
ECU Health North Hospital	2	1	2
ECU Health Bertie Hospital	5	NA	NA
ECU Health Chowan Hospital	2	2	4
ECU Health Roanoke-Chowan Hospital	2	2	3
ECU Health Duplin Hospital	4	4	4
ECU Health Edgecombe Hospital	2	2	2
The Outer Banks Health Hospital	4	4	5

Note: ECU Health Bertie Hospital met the volume threshold required to be eligible for a star rating in only one year of the three-year period represented. ECU Health Beaufort Hospital is now considered a campus of the ECU Health Medical Center.

4.1.b Provide three years of core quality measures and outcomes for all facilities operated by Respondent

ECU Health tracks and reports core quality measures and outcomes for all its facilities across various programs, including Hospital Acquired Condition Reduction (HAC), Hospital Readmissions Reduction Program (HRRP), and The Hospital Value-Based Purchasing (VBP) program. These measures include indicators of timeliness and effectiveness of care, adherence to evidence-based practice, patient throughput, as well as structural measures and clinical outcomes.

See Appendix F for Hospital Compare data for the last three years for ECU Health hospitals.

4.1.c Provide three years of patient satisfaction scores for all facilities operated by Respondent

See Appendix F for ECU Health Hospital Compare HCAHPS data showing ECU Health patient experience performance. In 2025, ECU Health Bertie Hospital is a 5-star community hospital. We are also proud to have two community hospitals with 4-star patient experience ratings – ECU Health Duplin Hospital and The Outer Banks Health Hospital. These ratings emphasize our commitment to creating positive patient and team member experiences across the health system.

In addition to HCAHPS data, ECU Health is proud to have been recognized by Becker's Hospital Review as a top hospital in the nation for patient experience as ranked by PEP Health based on more than 30 million online reviews of hospitals across the country in 2023.[4] ECU Health's PEP Health performance data reflects our ongoing commitment to compassionate care and patient experience excellence.

[4] https://www.beckershospitalreview.com/rankings-and-ratings/30-best-hospitals-for-patient-experience/

4.1.d Provide three years of other relevant quality indicators for all facilities operated by Respondent

In addition to ECU Health's 3-to-5-year goals, annual enterprise goals and metrics, and core measures, the Office of Quality also conducts enhanced impact analyses to objectively score "measures that matter" by individual hospital and at ECU Health Medical Center by service line. Examples include service-specific measures such as total hip and total knee arthroplasty complications and infections, 30-day revisits for outpatient chemotherapy, population-specific mortality, readmissions, excess days in acute care (EDAC), and severe maternal morbidity rate, among other clinical quality indicators.

4.2 Regulatory Compliance

4.2.a Results of recent CMS surveys, to verify commitment to maintaining high standards

See Appendix B for ECU Health hospitals' accreditation information.

4.2.b State survey results, to verify commitment to maintaining high standards

See Appendix B for ECU Health hospitals' accreditation information.

4.2.c Accreditation survey findings, to verify commitment to maintaining high standards

See Appendix B for ECU Health hospitals' accreditation information.

4.2.d Resolution of any corrective action plans, to verify commitment to maintaining high standards

See Appendix B for ECU Health hospitals' accreditation information.

4.3 Quality Management

4.3.a To illustrate a systematic approach to quality, describe quality management structure and reporting

At ECU Health we consider our pursuit of clinical excellence to be an ongoing journey of continuous performance improvement that enables sustained, highly reliable results over time in alignment with our mission, vision, and values. Our approach to quality management has evolved to support effective enterprise-wide quality data transparency and accountability, a coordinated and collaborative multidisciplinary approach to performance improvement, and a strong emphasis on physician leadership.

ECU Health has a robust structure for overseeing and coordinating a systematic approach to quality reporting and performance improvement. Should the Martin County Board of Commissioners select ECU Health's proposal, the operations of the reopened REH and the proposed new, de novo facility would be integrated into and benefit from the system's quality structure.

The ECU Health Board of Directors has two distinct obligations with respect to patient safety and quality improvement: decision-making and oversight. The ECU Health Board of Directors maintains a Quality Improvement Committee (QIC), which routinely receives reports on patient safety, performance improvement and relevant matters pertaining to clinical practice at ECU Health through two Board-chartered committees: Clinical Excellence Committee (CEC) and Patient Safety and Performance Improvement Committee (PS/PI). The role of CEC is to connect and empower the right people, structures, and decision-making processes to create an environment of excellence in clinical practice and patient care. It is a dyad-led forum co-chaired by the ECU Health Chief Clinical Officer (CCO) and the ECU Health System Chief Nursing Executive (CNE) and chartered to establish ECU Health standards of clinical excellence for approval and adoption by clinical leadership across the system, specifically related to clinical practice guidelines, protocols, and clinical pathways impacting more than one professional group, entity and/or service line. The CEC maintains six sub-committees, including a Quality Assessment Performance Improvement committee (QAPI). Integration of the REH into the quality committee structure, particularly with respect to QAPI, would not only be best practice for ECU Health, but also fulfill CMS's requirement that REHs have a documented QAPI program. *See Appendix G for a copy of the Clinical Excellence Committee structure which includes QAPI.*

Pursuant to governing board motions, the ECU Health Patient Safety and Performance Improvement Committee (PS/PI) was established as a centralized medical review committee responsible for evaluating the quality, safety, cost, and effectiveness of healthcare, and associated performance improvement initiatives at all ECU Health facilities and among all ECU Health providers. The PS/PI Committee is chaired by the ECU Health Chief Quality Officer and membership is multidisciplinary, comprised of acute and ambulatory physician leaders, hospital quality directors, nurse executives and patient care services leaders, informatics, patient experience, allied health services, and operations leaders, among others.

The ECU Health Board of Directors is also engaged in directly promoting our culture of excellence and supporting our annual enterprise quality goals. An example is the annual Board Quality Leadership Awards which recognize teams and projects that quantifiably contribute to our quality goal of zero harm, create exceptional experiences and improve patient outcomes. In 2024, three teams received recognition:

- ECU Health Medical Center *Cutting CAUTIs in the Neurosciences ICU: A Collaborative Approach*
- ECU Health Chowan Hospital – *Catheter Associated Urinary Tract Infection (CAUTI) Prevention in the Inpatient Setting*
- ECU Health Ambulatory – ECU Health Bertie, Family Medicine, Windsor – *Improving Diabetes Management in the Ambulatory Setting*

The ECU Health Office of Quality is led by Dr. Niti Armistead, Chief Clinical Officer and Chief Quality Officer, and is organized to support and drive quality reporting and performance improvement across the system. The office of the CCO/CQO is organized to oversee systemwide acute and ambulatory quality and support performance improvement. The ECU Health Office of Quality ensures the quality plan framework and overall direction and focus areas align with the priorities established by the ECU Health Board of Directors. The system quality office is also responsible for the following functions in support of systemwide quality performance improvement.

- Determining the appropriate level of public reporting of quality indicators.
- Coordination of system-level quality improvement projects and programs.
- Preparing quality metrics and other quality reports, which are routinely shared with QIC, and executive and medical staff leadership.
- Coordinating the work of the PS/PI, QAPI, and Excellence in Clinical Practice (ECP) committees to assure employment of rigorous methods of root cause analysis and performance improvement, and creation of effective action plans to prevent recurrence of events.

4.3.b To illustrate a systematic approach to quality, describe performance improvement methodology

ECU Health leadership assures that processes are examined, opportunities for improvement identified, and necessary changes are made to support quality as defined by internal and external experts. Focused performance improvement efforts are conducted for system service lines – heart and vascular, cancer, neurosciences, orthopedics, behavioral health, primary care, children's health, women's health, and emergency services – and for other ECU Health tertiary services including but not limited to trauma, transplant, children's, cardiac surgery, and bariatrics.

ECU Health uses an integrated approach to performance improvement (PI) as depicted in the ECU Health Integrated PI Model below, which is inclusive of a four-part improvement cycle known as Plan-Do-Study-Act (PDSA). Methods used in PI are selected to best align with the type of problem the project is addressing.

ECU Health Integrated Performance Improvement Model

1. Define the problem and determine alignment with established priorities. 2. Form a team using a charter. 3. Identify problem type and determine appropriate performance improvement approach.		
Problem Type		
Waste, rework, redundancies Poor flow, multiple process steps Non-value added activities Example: ED Throughput	Poor quality and variation Complex and multiple system interactions Example: Reduction of Pressure Ulcers	Poor process Lack of standardization Clinical issues Example: Reduction of CLABSI
Performance Improvement Approach		
LEAN Eliminate waste Improve flow Simplify and mistake proof	**SIX SIGMA** Minimize variation Eliminate defects Establish robust controls to sustain	**Model for Improvement** Testing based on theory Iterative learning Emphasize use of teamwork in improvement
Identify Value Voice of customer, identify value add/non-value add	**Define** Establish problem statement, scope, voice of customer	**Establish Aim** Define what are we trying to accomplish - what by when?
Understand Value Stream Value stream map, observations, visual story boards	**Measure** Identify current performance baseline, validate measurement system, define capability and stability	**Identify Measures** Identify measures that will tell us if the change is resulting in an improvement (process and outcome)
Eliminate Waste Rapid improvement events, 5S	**Analyze** Identify root causes, validate with data and hypothesis testing, density analysis, fishbone	**Identify changes that will lead to improvement** Generate ideas from frontline, research best practices
Establish Flow Patient experience mapping, PDSA cycles	**Improve** Identify improvements based on analysis, PDSA cycles, implement solutions, confirm improvement	**Test chance** PDSA cycles - test ideas on small scale, modify and as cycles proceed, test over wider range
Enable Pull Supplier and customer requirements built into flow/ process	**Control** Ensure systems and processes are in place to sustain new performance	**Implement and Spread** Standardize and make part of day to day operations
Seek Perfection Continuously strive to eliminate all waste		

For 2025 quality planning, ECU Health hospitals and ambulatory practices employed a method to identify "measures that matter" using Vizient's Clinical Database Quality and Accountability (Q&A) tool. This method allows teams to organize, align and focus on measures that are the most meaningful for improving clinical care. Utilizing quality and operational teams to focus on actionable measures that target the greatest areas of opportunity with greatest impact on our patients' outcomes enables us to maximize the benefit to the patients we serve with our available resources. This enables ECU Health's performance to align with national evidence-based measures to improve patient outcomes.

Each hospital's Q&A is reviewed to determine top opportunities based on 1) Vizient's statistical analysis of metrics that will have the greatest improvement impact based on a targeted rank (i.e. rank of 1, or top rank), and 2) greatest z-score variance (the number of standard deviations from benchmark). Quality dashboards are developed in collaboration with ECU Health's Information Services team to measure progress toward established priorities and goals, including regional/national benchmarks where applicable.

4.3.c To illustrate a systematic approach to quality, describe successful quality initiatives and outcomes

Our ability to successfully manage and synthesize large amounts of clinical data to drive timely reporting and successful action plans in a coordinated manner across the system would not be possible without the significant investments in enterprise data and performance analytics tools and resources supported by ECU Health Information Services. In 2020, following the COVID-19 outbreak, our IS and data teams made major advancements in our data capabilities, allowing us to track and trend critical COVID-19 data in real time, such as COVID related hospitalizations, ventilator use, hospital capacity, and vaccinations, among other measures. Our IS and QIC teams partnered to implement Bugsy, an infection control module in Epic that allows for real-time monitoring for patient at risk for infection. This module supports not only clinical care delivery, but also our ability to upload data to the National Healthcare Safety Network (NHSN). ECU Health has continued to build a suite of tools that supports our quality data transparency goals and effective system-wide metric alignment.

The following represents a small snapshot of ECU Health's successful quality initiatives and outcomes in FY24.

- Implementation of systemwide safety event reporting as a safety culture initiative and leading indicator of harm.
- Hospital Acquired Infections (HAIs): CAUTIon: Foley Under Construction (CAUTI-Catheter Associated Urinary Tract Infection) and For the Love of the Line (CLABSI-Central Line Associated Blood Stream Infection) (work ongoing). These HAI initiatives included EHR documentation enhancements, standardization of workflows, auditing measures, and routine demonstrations for Foley/peri care on units.
- Patient Safety Indicator 03 (PSI-03 – Pressure Ulcer Rate); initiatives included development of a Wound Treatment Associate Course, creation of PSI 3 Data Integrity Strategy and Guidance, and enhanced skin swarm documentation to capture Present on Admission (POA) status.
- Patient Safety Indicator 12 (PSI-12Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate); initiatives included introduction of new systems on high-risk units, Failure Mode and Effects Analyses, and an Oral Trach Care initiative.
- Achievement of Mortality Improvement Goal in FY24.
- ECU Health systemwide harmful event reduction.

4.3.d To illustrate a systematic approach to quality, describe approach to quality oversight across facilities

See section 4.3.a for information about ECU Health's approach to quality oversight across facilities. ECU Health anticipates the proposed REH would integrate into the system's overall quality system of management, including QAPI. The facility would participate in regulatory and public reporting programs as required by the REH CoPs, including the REHQRP, and as related to other ECU Health reporting programs and processes as appropriate. In addition, the proposed facility would be eligible for participation in the REH Quality Reporting Program.

4.4 Workforce Development

4.4.a Detail physician and clinical staff recruitment strategies to demonstrate ability to maintain qualified staff

ECU Health Talent Acquisition utilizes "recruitment marketing," which is the process of using marketing strategies to attract, engage and nurture relationships with potential job seekers and positioning the system as an attractive place to work. Recruitment strategies vary across disciplines and communities, allowing targeted use of resources for filling various positions. ECU Health also pays special attention to and engages in strategic partnerships to develop the health professions pipeline in eastern NC, from programs targeting elementary school children through community colleges and four-year universities. ECU Health participates in various school-based educational programs such as the Teddy Bear Hospital program for kindergartners and facility tours and classes for middle school children. For students in high school, the health system offers job fairs and volunteer and internship opportunities for students interested in health sciences. Health Sciences Boot Camps, the Health Science Academy and job shadowing also introduce and expose children, youth, and young adults to health careers.

With multiple community colleges, two state-funded four-year universities as well as private colleges and universities with a presence in the region, ECU Health maintains strong relationships with the institutions of higher learning to develop pipeline programs. In addition to providing faculty and guest speakers for many organizations, hospitals, and practices throughout the system function as host sites for clinical students in nearly all disciplines. Through partnerships with Tradesformers and NC Works, ECU Health acts as an apprenticeship site for more technical professions. In addition to these opportunities with local schools, the Talent Acquisition team participates in virtual and in-person job fairs across the state and country to share ECU Health opportunities with future health professionals. ECU Health and our academic partner, BSOM, have been actively involved in advocating for enhanced support for rural workforce development programs and funding to support our ability to close gaps in the rural workforce.

Other recruitment strategies, which often double as retention strategies and apply to all team members include competitive compensation; various premium pay programs; shift differentials; tuition reimbursement programs; a comprehensive benefits package; professional development opportunities; employee wellness/lifestyle programs; and Employee Assistance Programs. Certain clinical roles may utilize additional strategies to hire the best talent. These enhancements may include sign-on and commitment bonuses. Certain departments also use self-scheduling and allow for remote work, providing flexibility and convenience for employees which support provider and team engagement.

We are proud of our long-standing partnership and clinical integration with BSOM, which is a crucial component of our physician workforce development and retention strategies. With a mission of serving rural communities, graduates from BSOM programs often stay in eastern NC. One of the newer residency programs is the Rural Residency Program, which allows students to work in rural practices in eastern NC. ECU Health also utilizes external recruiting firms for hard-find or hard-to-fill specialties.

In FY2024 ECU Health hired over 180 physicians and advanced practice providers at facilities throughout the region. Specialties include academic medicine services like gynecological oncology, electrophysiology, and transplant as well as community-based services like primary care, emergency services and immediate care.

Additionally, the ECU Health Foundation provides generous gifts to support workforce development efforts. For example, ECU Health is able to offer stipends to residents in return for their commitment to work at ECU Health following training, as a result of the Foundation's support.

4.4.b Detail retention rates and programs to demonstrate ability to maintain qualified staff

ECU Health is committed to providing a culture that supports provider and team member retention. Many of these strategies originate in ECU Health's Office of Well-being, which is led by Dr. Christina Bowen. Dr. Bowen works with organizational and medical staff leadership to identify programs that support team member and provider engagement. See the table below for examples of current retention and engagement related programs.

Audience	Programs
Providers	• *Enhanced Provider Onboarding Program* • *Provider Mentor Program* • *Teachers of Quality Academy*
Nursing	• *Tuition Assistance Program* • *Nurse Residency Program* • *Aspiring Nurse Leader Program* • *Nursing Clinical Ladder Program*
Allied Health	• *Clinical Ladder Program*
Leaders	• *Leadership development training and education offerings*
All Team Members	• *Tuition Assistance* • *Total Rewards* • *Big "E" Initiatives to improve team and patient experience* • *Employee Assistance Program (EAP)*

As the largest portion of the healthcare workforce, retention of nursing staff is of critical importance to ECU Health. ECU Health Medical Center is recognized as a Magnet® hospital for nursing by the American Nurses Credentialing Center and has successfully achieved this designation three times. Magnet® recognition requires a significant focus on supporting nursing practice, autonomy, and professional growth. Nurses at ECU Health participate in Nursing Continuing Professional Development (NCPD) activities to enhance professional role competence and growth. Because ECU Health NCPD is approved as a provider of nursing continuing professional development by the North Carolina Nurses Association, contact hours provided through NCPD activities at ECU Health can be used to meet the continuing competence requirements for license renewal.

In support of nursing practice and autonomy, ECU Health nursing leadership has established a number of nursing specific councils where any ECU Health nurse can apply to join for a two-year term. These councils empower nurses to share in decision making where it pertains to their clinical practice and professional development. Examples include a Nursing Coordinating Council, Nursing Environmental Council, Nurse Executive Council, Nursing Practice Council, Professional Development Council, and Unit Based Councils.
The combined effect of strong recruiting and retention practices has improved workforce engagement at ECU Health and led to improved turnover rates. See the table below for turnover rates for various ECU Health entities and disciplines from February 1, 2024, to January 31, 2025. This includes additional detail for ECU Health Bertie, which is indicative of ECU Health's ability to recruit and retain team members in a rural area.

Entity/Discipline	Turnover Rate
ECU Health: Enterprise-Wide	12.8%
Enterprise-Wide RN	12.6%
ECU Health Bertie Hospital	10.7%
Lab	9.5%
Respiratory	0%
Nursing	2.9%
ECU Health Chowan Hospital	8.4%
ECU Health Duplin Hospital	14.2%
ECU Health Edgecombe Hospital	12.3%
ECU Health Medical Center	15%
ECU Health Physicians Medical Group	8.4%
ECU Health North Hospital	17.3%
ECU Health Roanoke-Chowan Hospital	13.9%

4.4.c Detail experience with such in rural markets similar to Martin County to demonstrate ability to maintain qualified staff

As noted in prior sections, ECU Health Bertie Hospital provides a reasonable proxy for health care operations in Martin County, including recruitment and retention. ECU Health Bertie Hospital benefits from myriad system recruiting and retention resources, particularly relationships with local schools and community colleges. With local participation and system resources at recruitment events, ECU Health Bertie Hospital attracts and engages highly qualified candidates.

ECU Health Bertie Hospital – local recruitment and retention success stories

- ECU Health Family Windsor has a primary care physician who has been retained for roughly 20 years, and a nurse practitioner who has worked for the clinic for roughly 15 years.
- An ED provider who has been with the hospital since FY2013.
- Team members also tend to stay at ECU Health Bertie Hospital, with retirees achieving up to 50 years of service. With team members routinely committing decades of service to the hospital, ECU Health Bertie Hospital has a strong and stable workforce to support the health needs of the community.
- Many team members and clinical leaders are Bertie County natives.
- An active local Team Member Experience Committee that supports team and provider engagement and retention goals.
- Special recognition events and regular expressions of appreciation cultivate a culture of gratitude that makes ECU Health Bertie Hospital a preferred place to work in the area.

ECU Health also has many current team members from Martin County. Many of these team members worked at ECU Health prior to the closure of Martin General Hospital, indicating the system's ability to successfully recruit within Martin County. Following the closure of Martin General Hospital, ECU Health made efforts to assist former employees in finding new positions. Activities included holding job fairs and providing specialized support for applicants to identify positions and complete the application process. The ECU Health Talent Acquisition team made every effort to expedite the recruitment process for applicants impacted by the closure of Martin General Hospital and affiliated practices.

SECTION 5: BREADTH/COMMITMENT TO SERVICES

5.1 Service Implementation Plan

5.1.a Initial services upon reopening

ECU Health envisions reopening the existing facility with all services required by the REH as highlighted in Section 1.3.b and otherwise defined by the REH CoPs. This reopening plan prioritizes REH requirements to ensure timely reestablishment of essential healthcare services in the community.

5.1.b Service additions within the first three years

The footprint available in the portion of the existing facility proposed to be reopened as the REH is limited. Therefore, restoration of essential healthcare services in the existing facility will be ECU Health's priority. The addition of other optional outpatient services in the first three years will be restricted to those that ECU Health can reasonably provide within the proposed REH footprint and would be based on gaps identified in the REH care delivery model or community need. While as of the writing of this proposal ECU Health can only commit to operating the existing facility with required REH services, the health system is committed to the ongoing evaluation of community needs and outpatient access improvements. Following reopening of the facility and stabilization of local access to essential healthcare services, ECU Health will reassess opportunities to expand services to improve access to core outpatient services, including primary care and specialists. Service expansion will consider physician needs and recruitment feasibility and financial sustainability among other critical factors.

5.1.c Long-term service vision in new facility

ECU Health has a deep experience with various community-based models of care, and a long history of evolving facilities and services to meet the needs of the community. Service evolution requires significant analysis, planning, and resource allocation to determine the best way to meet long-term healthcare needs in an equitable and sustainable way. This is particularly true in cases such as this one, where a new facility is contemplated. The size and capabilities of the new facility will influence the services offered. ECU Health concurs with Martin County that a new facility will be required to effectively and efficiently expand local service offerings. The new facility would potentially offer opportunities to expand the REH from the essential healthcare services required by the CoPs to also include optional outpatient services that best meet community need and complement the regional offerings of the health system. This might include integration of primary care, behavioral health services, advanced imaging modalities, telehealth capabilities, specialist access, and high-acuity outpatient surgical services. Of note, ECU Health's long-term vision for the REH is contingent on multiple factors and requires much additional planning to validate community demand and long-term sustainability. ECU Health expects that the parties will continue to come together to develop the long-term plan for sustainable healthcare delivery in Martin County.

5.2 REH Operations Experience

5.2.a Describe experience operating REHs or similar facilities

ECU Health Bertie Hospital is a rural healthcare success story. Though not an REH, as a Critical Access Hospital in neighboring Bertie County it provides a reasonable proxy for ECU Health's operation of an REH in Martin County. Bertie and Martin counties have much in common demographically as detailed in the table below:

Indicator	Bertie	Martin
Total Population	17,240	21,508
<18 years	16.8%	20.1%
>65 years	25.2%	25.8%
% Rural	100.0%	74.9%
Race		
White	34.7%	52.0%
Black	59.9%	41.1%
Latino	2.6%	4.5%
Median Income	$44,400	$44,400
% Children in Poverty	35%	29%
Adult Smoking	23%	21%
Adult Obesity	46%	41%
Physical Inactivity	32%	21%
Excessive Drinking	13%	14%
Uninsured	12%	13%
Primary Care Physicians	3500:1	2420:1
Preventable Hospital Stays	3,865	4,138

Source: County Health Rankings, 2024

Bertie Memorial Hospital opened in 1952 on Sterlingworth Street in the heart of downtown Windsor, NC. Funding sources including Hill-Burton funds, which were designated by Congress to support hospital development following World War II. Originally managed by Bertie County, by the late 1990s changes in healthcare finance and administration encouraged county leadership to seek a local partner to manage their aging facility. As such, then-Mayor Bob Spivey spearheaded negotiations with the Pitt County Memorial Hospital (now ECU Health Medical Center) board and management team to join the new system being developed under the auspices of a new parent corporation. Community hospitals in Ahoskie, Edenton and other small Eastern NC communities were also seeking stability through health system affiliation. This group of hospitals along with various other acquisitions by conveyance or lease eventually grew into the nine-hospital health system now known as ECU Health.

Upon joining the new health system, Bertie Memorial Hospital needed significant facility improvements. Rather than renovating the outdated Sterlingworth facility, a new, modern Critical Access Hospital was built. Construction of ECU Health Bertie Hospital was completed in 2001 and was the first hospital in the country built to Critical Access Standards and designed to align service offerings with the needs of the community in a sustainable manner. Today, services include an Emergency Department (ED), a six-bed inpatient unit, an ambulatory surgery unit (ASU), an outpatient specialty clinic (OSC), a Rural Health Clinic (ECU Health Family Medicine – Windsor), an outpatient behavioral health program and rehabilitation services (physical, occupational and speech therapy). Supporting these units are pharmacy, radiology, laboratory, infection control, respiratory therapy, quality, medical staff support, case management, environmental services, facilities, medical records, and patient access services.

The Emergency Department (ED) at ECU Health Bertie Hospital is an excellent example of how ECU Health plans and manages services to meet community needs and maximize quality. The ED features one triage room, two nursing stations, one trauma room and eight treatment rooms. ED volumes have grown consistently over time, from 6,863 in fiscal year (FY) 2006 to 14,841 in FY24. To accommodate volume growth, the hospital and ED leadership have implemented facility and operational improvements, such as the ED renovations in FY24 to improve patient flow and storage. Growing volumes have led to additions in provider, nursing, and support staff over time. More recently, volume growth and patient acuity demands required adding a 12-hour/day APP shift to augment the 24-hour physician coverage.

Because ECU Health Bertie Hospital has limited inpatient beds and consulting specialists on-site, transfer capabilities to ECU Health Chowan Hospital, ECU Health Roanoke-Chowan Hospital and ECU Health Medical Center are critical and well-managed. ECU Health Bertie Hospital providers work with the ECU Health Transfer Center to identify the appropriate receiving facility for each patient based on distance and acuity. The nursing and discharge planning team collaborate with community transport services and EastCare to ensure patients are transported timely and safely to the most appropriate destination. EastCare operates a satellite location at ECU Health Bertie Hospital with a helicopter based at the hospital. EastCare availability has been a great asset to the entire region as the location in Windsor reduces transport times for patients throughout our northeastern counties.

ECU Health Bertie Hospital includes ECU Health Family Medicine – Windsor, which is designated as a RHC. As a primary care office, ECU Health Family Medicine – Windsor offers traditional primary care including chronic disease management, acute care for illnesses and vaccinations. The clinic has a strong focus on preventative care, with a robust quality dashboard for tracking patient screenings and chronic disease indicators. Another important service at ECU Health Bertie Hospital is the Outpatient Specialty Clinic. ECU Health providers and private providers rotate to the clinic on a regular basis to reduce transportation barriers for patients. Specialties offered have varied over the years, initially including cardiology, general surgery, nephrology and podiatry, and the addition over time of pain management, wound care, gynecology, ENT, and orthopedics to meet patient need.

ECU Health Bertie Hospital has benefitted immensely from the decision to partner with ECU Health. From funding for the new facility in 2001 to managing through Covid-19 in 2020, ECU Health has provided the strategic leadership and corporate support services to foster success. Support functions include finance, billing, purchasing, quality, human resources, information technology and systems, facilities management, planning, and emergency preparedness. Centralizing these services creates meaningful efficiencies for smaller facilities like ECU Health Bertie Hospital, including reductions in purchasing costs and personnel costs. Aside from financial benefits, access to experts in each of the support functions including other corporate shared services allows the hospital to thrive. Similarly, ECU Health Bertie Hospital benefits from integration into the ECU Health Epic EHR, which is often challenging for small stand-alone hospitals due to cost and complexity. From 2001 to present, shared resources between ECU Health Bertie Hospital and ECU Health Chowan Hospital with respect to leadership, finance, quality, human resources, support services, marketing, lab, radiology, rehabilitation, dietary and nursing services has created great value for the individual facilities and the system overall.

ECU Health Bertie Hospital has also been a source of support for the community during difficult times. The response to the Covid-19 pandemic is the most recent response. While continuing to offer traditional ED, inpatient and primary care services, the hospital shifted resources and operations to ensure patient and team member safety. Using a system approach, ECU Health obtained Covid-19 relief funds allowing the hospital to host multiple vaccine clinics at the facility as well as at community sites and provide a no-cost community testing site. This caring and capable response has also been seen during times of disaster such as tornado and flooding events, where the hospital has served as a shelter for local nursing home patients, as well as a base site for an out-of-town swift water rescue crew.

Today, ECU Health Bertie Hospital is financially sound and benefits from cost-based reimbursement from Medicare due to its CAH status. With a positive net operating margin for the past eight of eleven years, the hospital has been able to reinvest in new services, facility improvements and team members.

5.2.b Provide examples of service growth in similar markets

ECU Health has multiple examples of service growth across the system. Of particular interest for this RFP are growth initiatives at ECU Health Bertie Hospital in Windsor NC; ECU Health Chowan Hospital in Edenton NC; and ECU Health Roanoke-Chowan Hospital in Ahoskie NC. The following list includes examples of service growth at these facilities and associated medical group clinics over time to improve local access:

ECU Health Bertie Hospital

- Addition of pain management, wound care, ENT, gynecology, and orthopedics services to Outpatient Specialty Clinic
- Augmentation of ECU Health Family Medicine - Windsor provider staffing from 3.0 FTEs to 4.6 FTEs
- Upgraded mammography services to 3D digital mammography
- Added bone densitometry services with fundraising support from the ECU Health Bertie Hospital Development Council
- Utilized capital funds and community fundraising to construct a chapel and patient/family consultation room

ECU Health Chowan Hospital

- Recent implementation of tele-cardiology service in Outpatient Specialty Clinic
- Opened ECU Health Immediate Care – Edenton
- Established ECU Health Orthopedics – Edenton
- Expansion of Outpatient Specialty Clinic and Rehabilitation Services, including adding a chemotherapy infusion suite and dedicated space for pediatric rehabilitation services; addition of wound care and sleep medicine services to Outpatient Specialty Clinic
- Enhanced obstetrics and gynecology services by adding two providers and acquiring 4D ultrasound for both women's care offices
- Opened ECU Health Family Medicine – Hertford
- Added fixed open bore MRI
- Added "Fast Track" for low acuity ED patients

ECU Health Roanoke-Chowan Hospital

- Opened ECU Health Immediate Care – Ahoskie
- Added neurology services and later augmented solo physician staffing with an advanced practice provider
- Added advanced practice providers to support cardiology and oncology services in the outpatient clinic
- Built freestanding wound care center with hyperbaric oxygen therapy
- Established pulmonology clinic; currently adding capabilities to perform bronchoscopies.
- Added podiatry services in Outpatient Specialty Clinic and Ambulatory Surgery Unit

5.3 Community Needs Assessment

5.3.a To show understanding of local healthcare needs, describe your analysis of community needs

ECU Health has historically supported the Martin County Community Health Needs Assessment, including a contribution of $7,750 to defray expenses from the 2022 report. Because ECU Health was involved with this assessment as a community partner, we support priority needs identified by the Martin County CHNA team and stakeholders: Access to care and transportation; Mental health; Obesity.

ECU Health addresses these priority areas in multiple ways:

- ECU Health Office of Community Health implemented a program to deploy automated external defibrillator devices (AEDs) and compression-only CPR education throughout Martin County, with the goal of improving first responder CPR and AED education in rural eastern NC. By partnering with Compress and Shock Foundation, 33 AEDs have been placed in various locations across eastern NC and 1,190 individuals have been trained in hands-only CPR.
- ECU Health Behavioral Health – Washington is an existing satellite clinic of ECU Health Behavioral Health – Washington located at the Martin-Tyrrell-Washington Health Department in Williamston.
- ECU Health is currently working with Acadia Healthcare to build a behavioral health hospital in Greenville. When this new facility opens in 2025 it will provide a multitude of options for improving access to mental health services in Martin County.
- ECU Health promotes healthy diet and physical activity in all markets to combat obesity and associated health conditions. Historically community benefits grant funding from the ECU Health Bertie Hospital Development Council has supported some of these efforts in the Martin County area. Additionally, ECU Health Bertie Hospital participates in many health-related events in Martin County by offering screenings and/or education. Even the Teddy Bear program for kindergartners addresses healthy eating and physical activity.
- HealThy Neighbor Program – a faith-based program that encourages churches and congregants to establish a healthful church culture including a focus on proper nutrition, regular exercise, and peer support. Currently, there are two churches in Martin County scheduled to join HealThy Neighbors. Funding for this program is available via the ECU Health Bertie Hospital Development Council Community Benefit Grant program.

An initiative that addresses all three Martin County priorities are our community Health Hubs. ECU Health has four health hubs in Martin County with the goal of increasing access to healthcare and employment; removing barriers; and addressing social, economic and environmental causes. Locations for these hubs consider the CDC's Social Vulnerability Index (SVI), which is a place-based index, database, and mapping application designed to identify and quantify communities experiencing social vulnerability. Locations are listed in the table below.

LOCATION	ADDRESS	SVI
Cedar Hill Baptist Church	2131 Rodgers School Rd, Williamston	81%
Macedonia Christian Church	7640 Hwy 17, Williamston	81%
Robersonville Library	119 S Main St, Robersonville	87%
West Martin Community Center	400 S NC Hwy 125, Oak City	77%

In FY25 the Office of Community Health is expanding the Health Hub program in Martin County by adding two new sites for a total of six. Additional locations are determined by analyzing data including social determinants of health (SDOH), Social Vulnerability Index (SVI), and Emergency Room utilization and surveys.

As part of this expansion the Office of Community Health is investigating ways to enhance primary care access. For example, the Health Hub located at West Martin Community Center will offer expanded services. This partnership reduces the transportation barrier often experienced by rural patients and allows them to access care in their own community. By improving access to care, the Health Hubs expect to reduce ED visits, enhance community engagement and trust, address Social Determinants of Health, and create a sustainable model for healthcare delivery in eastern NC.

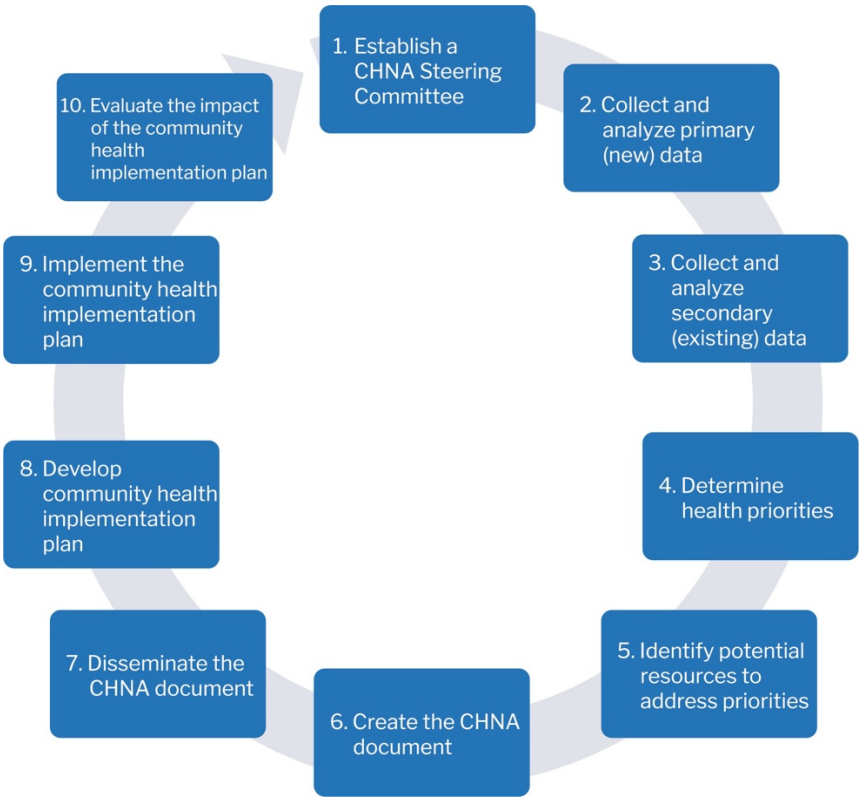
5.3.b To show understanding of local healthcare needs, outline approach to ongoing needs assessment.

ECU Health performs a robust CHNA every three years as required by the Patient Protection Affordable Care Act and IRS regulations. These assessments are performed in collaboration with county health departments, which prevents duplication of efforts in assessing community needs. The collaborative of hospitals and health departments working together to create regional and county CHNAs is called Health ENC. Health ENC serves 35 counties including 34 health departments and 31 hospitals. The CHNA process gathers population health data that county health departments, hospitals, community groups then use to:

- Identify key health needs/issues in eastern NC communities.
- Develop strategies and action plans based upon data to improve the quality of life.
- Collaborate to maximize results by having a collective impact in the region.
- Maintain local control and decision-making about the choice of health priorities and interventions.
- Improve health, partnerships and communication.

ECU Health also seeks grassroots involvement in the CHNA process. This is accomplished by including local health-focused groups such as Three Rivers Healthy Carolinians in Bertie and Chowan counties, as well as inviting local community members and agency leaders to participate. County commissioners, school board members, Department of Social Services representatives and others often have valuable insight into health issues and contributing factors. For the 2022 CHNA, each ECU Health hospital identified representatives from the health system, health department and community at large to review the information gathered, identify priority health needs, and develop strategies to impact those needs.

Once completed, the CHNA includes primary data, secondary data, identified health priorities and resources. This CHNA document is shared with multiple stakeholders including hospital and health system boards, county commissioners, town commissioners, health department boards, school systems and others to inform the development of a Community Health Implementation Plan (CHIP). The CHNA and CHIP documents act as a convening force to organize community efforts and resources to impact the most significant needs. The following graphic provides a visual overview of this process. To see a completed CHNA and CHIP, the 2022 Bertie County Community Health Needs Assessment is available at **https://www.ecuhealth.org/about-us/community/health-needs-assessment/#ECU-Health-Bertie-Hospital**.


1. Establish a CHNA Steering Committee
2. Collect and analyze primary (new) data
3. Collect and analyze secondary (existing) data
4. Determine health priorities
5. Identify potential resources to address priorities
6. Create the CHNA document
7. Disseminate the CHNA document
8. Develop community health implementation plan
9. Implement the community health implementation plan
10. Evaluate the impact of the community health implementation plan

SECTION 6: SYSTEM INTEGRATION

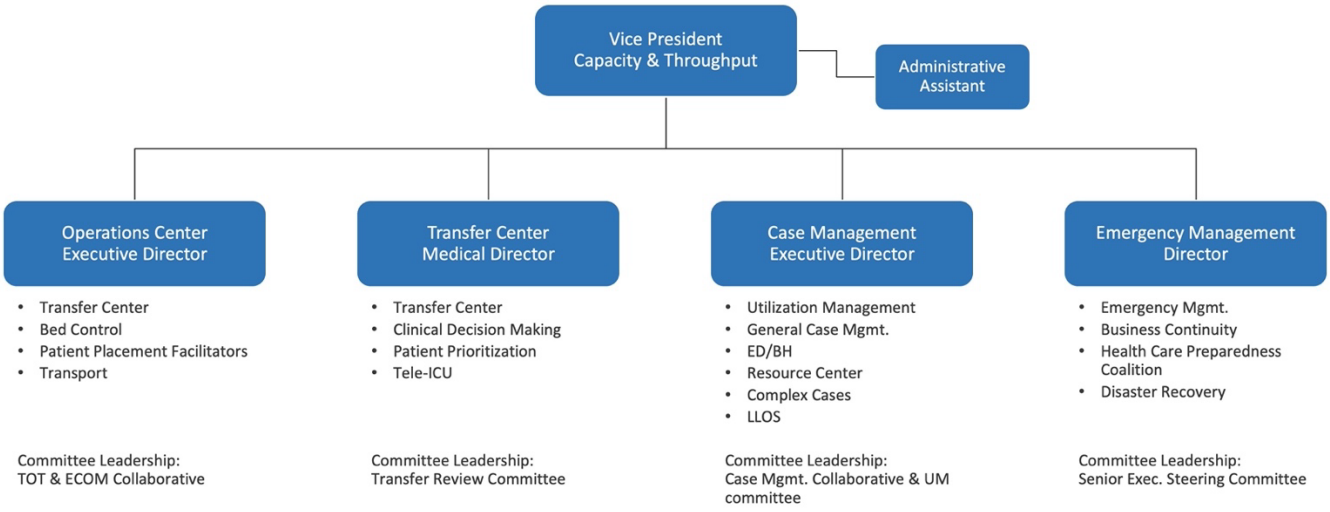
6.1 Care Coordination Infrastructure

6.1.a Describe transfer protocols and agreements to demonstrate ability to provide seamless care delivery

ECU Health Medical Center has a transfer agreement with all ECU Health hospitals, in addition to agreements and relationships with non-ECU Health hospitals in our region. See section 1.4.a.

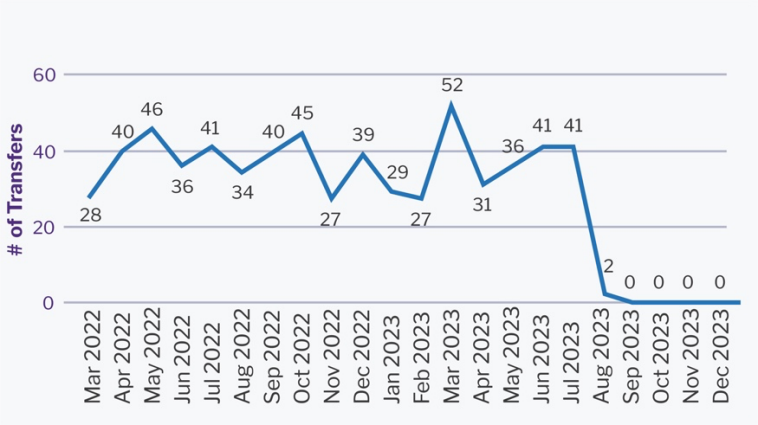
ECU Health acknowledges the unique nature of the proposed REH given the facility will not have an inpatient service. While we envision the REH having a formal relationship with ECU Health Beaufort Hospital for general community acuity inpatient care, ECU Health is prepared to leverage our Transfer Center capabilities to support the REH in the seamless movement of patients to the most appropriate location of care based upon patient need and system capabilities. The following provides a detailed overview of our capabilities to provide seamless patient movement and coordination of care across sites. Our transfer capabilities ensure timeliness of patient transport and care delivery which is critical to saving lives and improving health outcomes.

Patient flow, including transfer processes, across eastern NC is anchored by ECU Health's Operations Center (OC). The OC is physically located in Greenville and provides patient logistics coordination to ensure patients have access to the care they need. This is accomplished in a variety of ways including Transfer Center, Patient Flow Facilitation and Bed Planning. ECU Health Capacity and Throughput leadership oversees the coordination of key functions that support seamless patient movement and operations preparedness.



The Transfer Center serves eastern NC by connecting referring and consulting providers to discuss and determine the most appropriate path forward for patients in terms of optimal service needs and appropriate location. Importantly, the Transfer Center facilitates seamless patient movement both within and outside the ECU Health system, depending on patient need. On any given day, the Transfer Center will field approximately 1,000 telephone calls to facilitate patient movement across eastern NC.

ECU Health is well-positioned to support the patient movement needs of the proposed REH. Martin County can be confident in ECU Health's ability to ensure patients are treated in the right location of care, from community-based services to tertiary and trauma care, and including coordination of quaternary care as needed. Prior to the closure of Martin General Hospital, the Transfer Center worked in partnership with the hospital to safely move patients to the right location of care, including higher levels of care provided by ECU Health Medical Center, based upon patient need. The chart below illustrates the historical transfers from Martin General Hospital to ECU Health prior to the hospital's closure.



6.1.b Describe medical staff integration across facilities to demonstrate ability to provide seamless care delivery

Each ECU Health hospital has a distinct organized medical staff, which is responsible for the quality of care at the facility and reports to the governing body for that facility. ECU Health has a centralized Credentials Verification Office (CVO) to manage the process of gathering and verifying documentation required for granting medical staff membership and/or privileges, as well as a centralized enrollment department to ensure providers are linked to ECU Health locations for billing purposes. ECU Health credentialing and privileging requirements comply with all applicable state and federal laws as well as accrediting agency standards, including DEA licensure.

The Medical Staff Bylaws are developed and maintained by the medical staff at each individual hospital but are generally consistent throughout the system. Private providers, employed providers, locums and independent contractors are subject to the same requirements for receiving credentials and privileges at each facility, ensuring competence of the provider regardless of employment status.

ECU Health has employed a system credentialing model where new applications within certain high-use specialties are evaluated and credentialed for potential appointment, with or without privileges, at all applicable ECU Health acute care facilities. This allows us to deploy providers quickly and easily across the system when there is a staffing need without having to recredential the provider. To facilitate the system credentialing model ECU Health uses standardized privileging request forms for dozens of specialties and disciplines and is in the process of developing standardized privilege request forms for other specialties. The provider must show evidence of clinical competency for certain procedures and treatments, such as conscious sedation. Each specialty has specific privilege lists and competency requirements to ensure providers are acting within their expertise and scope of practice. The CVO ensures each provider submits all required documentation for each entity to which they are requesting privileges. Provider types that require medical staff credentialing include nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, physician assistants, podiatrists, and physicians.

Each medical staff includes a Medical Executive Committee (MEC) as well as pharmacy and therapeutics, peer review, and specialty committees. Other committees may be present in accordance with the medical staff bylaws and hospital needs. The medical staff is led by the MEC, which is elected by the medical staff and typically includes the Chief of Staff, Vice Chief of Staff and Committee Chairs for designated specialties.

Each medical staff has a reappointment process, where providers update their credentials and privileges on a regular basis. This ensures providers remain current with all required licenses and certifications within their specialty. Providers also participate in an ongoing professional practice evaluation (OPPE) process. The OPPE process seeks to continuously assess and monitor provider performance in various metrics to confirm competency and identify opportunities for improvement. All members of the medical staff are subject to reappointment and OPPE processes.

In addition to a centralized CVO and standardized privileging procedures, ECU Health has also implemented Regional Peer Review as needed, which allows cases from smaller facilities with fewer specialists to be included in the peer review process in a confidential manner.
Entity specific medical staff are integrated into the system's quality structure through the CEC, which includes medical staff leadership from hospitals and the medical group. *See 4.3.a for additional details on the CEC.* In addition to the CCQO, other key system leaders for supporting medical staff functions include:

- Senior Vice President, Medical Affairs and Population Health: oversees medical affairs and population health initiatives for the community hospitals and medical group.
- Senior Vice President, Medical Affairs (ECUHMC): oversees medical affairs at ECU Health Medical Center
- Vice President of Medical Affairs Office: oversees other medical staff support functions.

Though each entity maintains its own medical staff, providers across ECU Health use consistent tools to ensure coordination of care. Specifically, the shared EHR allows all providers to access the same information in real-time, fostering collaboration on care decisions. The ECU Health Transfer Center is integral to this collaboration, as it connects providers across the system when a higher level of care is needed. *See sections 6.1.a, 6.1.c, and 6.1.d for more details.*

6.1.c Describe information technology integration across facilities to demonstrate ability to provide seamless care delivery

ECU Health is committed to implementing the best technologies available to extend access into our communities and keep pace with the ever-changing healthcare environment. All ECU Health hospitals are on an integrated IT platform, which includes our Epic electronic health record (EHR)—the core technology component that drives system integration and care coordination. The Epic EHR provides for the ability to share comprehensive patient information across sites, departments and multidisciplinary care teams through a single patient record as well as supporting integration with other business platforms to streamline clinical and administrative functions.

ECU Health was an early adopter of the Epic EHR. Our organization was the first health system in the state to implement Epic, which is now widely considered an industry leader in EHR and interoperability. Our Epic EHR allows providers to access the comprehensive health information needed to make timely, safe, and accurate decisions regarding patient care delivery; facilitate care coordination; and avoid duplication of services – a known driver of unnecessary cost and utilization. Today, ECU Health's Epic platform has been implemented across more than 100 sites, including all our hospitals, ambulatory clinics, and ambulatory surgery center. We have over 1.2 million unique patient records, and more than 1,400 providers in addition to thousands of team members using our Epic platform in the course of delivering care across the region.

We continue to make significant investments in our EHR to improve the end-user experience. We have currently implemented all core Epic modules, with recent implementation of Care Companion, Research, Kaleidoscope for ophthalmology, and plans to implement Cupid for cardiology to improve integration and patient flow as well as replacing an existing QS1 retail pharmacy system with Epic's Willow Ambulatory platform. In 2024, ECU Health implemented enhancements and workflow changes aimed at improving care coordination, patient and provider experience, quality of care, and revenue cycle support. Some of our outcomes include:

- Closure of 250,000 care gaps with external data reducing duplicative care and helping our patients stay healthier, longer.
- Patients took action 190,000 times as a result of campaigns, improving preventive care and patient engagement in their care.
- Nurses and therapists saved 71,000 clicks per day using flowsheet macros. At 1.2 seconds per click, 150 hours were saved each week.
- Clinicians saved 8,300 hours processing medication refills with protocols that automatically present relevant criteria to the clinician.
- Over 22,000 hours saved with revenue cycle automation improving efficiency and freeing up staff to focus on more complex work.
- Providers ordered 8,600 specialty diagnostic tests directly in Epic, saving 860 hours with no faxing or outside portals needed.

Our Epic EHR not only connects providers within ECU Health, but it also connects us with external providers through CareLink and CareEverywhere. CareLink is a web-based platform that allows non-ECU Health providers to view, submit imaging orders and request referrals (see below for a detailed description of CareLink). CareEverywhere allows ECU Health to send and receive patient notes, results, and imaging from other Epic or non-Epic organizations to get the full picture of each patient's current health status. This is accomplished through connectivity to health information exchanges such as NC HealthConnex and the national exchange, The Sequoia Project.

The Epic EHR features a patient portal function, which ECU Health markets as ECU Health MyChart. ECU Health MyChart is an electronic portal that allows patients to access their own health information and promotes timely communication between patients and providers. Patients can share messages, photos and results of at-home testing in a secure electronic format. This can save time and travel as patients may be able to have questions answered without a phone call or visit to the office. Patients can access their medical and billing information including provider notes, request appointments, lab results and current invoices or payment plans. If a person is a caregiver for another patient, they can request proxy access to the patient's account to help better manage their care. This is extremely beneficial for parents, who can have proxy access to their children's charts, and caregivers for the elderly.

Within Epic, clinicians communicate safely and securely via in-basket messaging. In-basket messaging is HIPAA-compliant and allows team members and providers to easily share important messages like refill requests and messages with patients. ECU Health providers, nurses, and clinical support team members also utilize Epic SecureChat, a secure text messaging service on computers or mobile devices. This HIPAA-compliant secure messaging service allows them to communicate in real-time with the patient's care team. That said, Epic is a web-based program and accessible to providers from non-ECU Health locations using multi-factor authentication.

Successful EHR Implementation Experience

We have a wealth of experience extending the reach of our EHR and its capabilities to new sites of care. For example, ECU Health extended its Epic platform to ECU Physicians in 2009 – over a decade *before* our formal clinical integration with BSOM – because we recognized the need for enhanced clinical collaboration with our academic partner. In doing so, ECU Health and ECU Physicians ensure patients have one medical record that reflects the patient's complete health status regardless of where care was delivered across our two organizations. Another example of successful implementation can be found at ECU Health North Hospital (formerly Halifax Regional Hospital). ECU Health invested significant funds to fully implement the Epic EHR platform at ECU Health North, including using data migration processes to transfer data from their previous EHR system. These integration projects enhanced our ability to develop collaborative care models, participate in the AAMC e-consult program, provide remote specialty consultations, evolve our service lines, and ensure seamless coordination of care across all ECU Health sites.

Eastern NC is home to many independent community practices and other provider types that also serve our patients. We recognize the importance of these community partners and their need to access timely patient information and engage with our system in the coordination of care. As such, we implemented Epic CareLink, which is a secure web-based platform that allows independent practices to connect to Epic to view patient information, submit certain orders and referrals, and view real-time updates on care delivered at ECU Health facilities.

Epic CareLink also supports our ability to meet regulatory compliance and accreditation standards (i.e. CMS Meaningful Use-Transitions of Care and Patient-Centered Medical Home recognition). We currently have approximately 7,000 unique users across 960 sites utilizing CareLink in some capacity, including referring provider offices, home health agencies, payors, research sites such as the BSOM, Emergency Services providers, and Pitt County Schools. The largest group of users is our referring provider offices which includes primary care providers, specialists, health departments, other hospitals with outpatient specialty services, concierge medicine clinics, and several Veterans Administration facilities. The following represent examples of the benefits the health system and our partners have experienced as a result of CareLink implementation.

- Several practices have been able to transition almost completely to electronic workflows for referrals and imaging orders placed to ECU Health.
- ECU Health specialists and imaging departments have observed a significant decrease in faxed referrals and radiology orders, which allows for streamlined processes, and a reduction in delays and errors processing appointments.
- Improved coordination among internal departments; referrals submitted via CareLink can easily be redirected as necessary to ensure referrals reach the right department.
- Patient Access Services (PAS) teams require fewer resources to index, scan, and transcribe information into Epic, which allows PAS team members to spend more time connecting with patients and scheduling services.
- Streamlines ECU Health Nurse Advice Line correspondence with external practices served by the program, which enables more accurate communication of patient needs.

Integration of Martin

ECU Health remains committed to building a coordinated and integrated healthcare delivery system, including by ensuring adoption and implementation of the most appropriate tools and technologies available. Therefore, we envision reopening the hospital as an REH that would be integrated into our Epic EHR and other business tools as appropriate, and able to benefit from our enterprise IT governance and shared IT services structures and supports.

6.1.d Describe care navigation support for patients across facilities to demonstrate ability to provide seamless care delivery

ECU Health has multiple layers of care navigation and case management to support patients throughout their experience. For patients with an ECU Health primary care provider, 18 ECU Health primary care offices are recognized as Patient Centered Medical Homes (PCMH). PCMH principles and standards are determined by the National Committee for Quality Assurance (NCQA) and the Agency for Healthcare Research and Quality (AHRQ). The key principles of PCMH designation are providing care that is patient-centered, comprehensive, coordinated, accessible, and safe and high quality. Recognized practices must show evidence of or attest to their compliance with each standard to achieve this prestigious designation. Care navigation is a vital component of providing coordinated, comprehensive care through PCMHs.

The traditional care team includes a primary care provider, nurse, and medical assistant, but in many ECU Health clinics this team is augmented by a RN Health Coach and/or Annual Wellness Visit (AWV) RN. Health coaches provide a multitude of services to assist patients with navigating their care needs. These services include education regarding new onset conditions, chronic care management, follow-up on referrals to specialists, and counseling/support to achieve patient goals. The AWV nurses provide more targeted services to Medicare patients. The AWV nurses see Medicare patients once a year for a complete review of their health including identifying and ordering needed screenings; reviewing current medication list; and establishing advanced care directives if desired. The health coaches and AWV nurses are invaluable assets to ECU Health primary care offices because of their role in care navigation for patients.

PCMH recognition, health coaches and AWV nurses are all ambulatory support functions provided by Access East. Access East (AE) is a 501(c)(3) not-for-profit, controlled affiliate of ECU Health with over 30 years' experience providing high quality care management for eastern NC. This interdisciplinary team provides comprehensive, complex care management for the most vulnerable populations, including Medicare, Medicaid, unhoused, and uninsured patients. AE collaborates with health systems, physician practices, patients/families, and community-based organizations to provide a holistic approach to health and wellness.

AE's complex care management program is accredited through the National Committee of Quality Assurance (NCQA), demonstrating the highest caliber of care for any health status (high risk to low risk). By utilizing evidence-based practices, AE team members engage patients in self-management and assist patients and families in becoming active participants in their care. Care management services include comprehensive assessments of social care needs, medication needs, care plan generation, care gap closures, self-management education, and outcome measure reporting. AE provides care management services to a variety of populations:

- Medicare shared savings participants in the Coastal Plains ACO network
- ECU Health medical plan members and dependents
- Medicaid managed care, and dual eligibles in contracted ECU Health and external practices

AE was selected as a lead pilot agency in the NC Medicaid Healthy Opportunities Pilot (HOP) and recently reported the results of their participation. This funding was provided by NCDHHS to provide additional support for social determinants of health for Medicaid patients in nine eastern NC counties. In FY2024 enrollment in this program grew to 6,777, from 4,279 in FY2023. Through this program, the AE team collaborated with Human Services Organization in the nine participating eastern NC counties to coordinate 83,029 service touchpoints for 5,355 individuals across four domains: food, housing, transportation, and interpersonal violence/toxic stress. Per independent research conducted on behalf of NCDHHS, these interventions resulted in average savings of $85 per member per month across the three HOP networks over the time frame of the pilot.

In addition to care management services, the AE team supports a number of other care navigation needs:

- Transitional Care Coordination: provides a coordinated transition for patients being discharged from inpatient or ED services to home, SNF or other care settings.
- Remote Patient Monitoring: provides patients with equipment to collect their own biometric data such as weight, blood pressure and blood glucose, and share electronically with the care team.
- Nurse Advice Line: provides 24/7/365 nurse triage service utilized by ECU Health hospitals and practices, as well as external offices.
- Health Assist: not-for-profit network of care providers offering primary care, specialty care, dental care, care coordination, and care management services for low-income, uninsured, chronically ill individuals.
- Affordable Care Act Certified Marketplace Navigators: serve the majority of eastern NC counties and assist patients with selecting and enrolling in ACA marketplace plans.

For some services, such as cancer care, specialized navigation services are provided. The ECU Health Cancer Care Navigation Program has been in place since 2018, employing dedicated RN cancer care navigators across the Oncology Service Line with focus on:

- Assessing barriers to care related to physical, psychosocial, emotional, financial, and spiritual factors and planning interventions.
- Advocating for patients to enhance communication with the healthcare team.
- Educating patients on cancer treatments and symptom management.
- Arranging care closer to home when available.
- Coordinating inpatient to outpatient care with Case Management.
- Intervening to help patients/family members cope with diagnosis and connecting with available resources as needed.

Martin County Experience

AE is currently serving Martin County residents in a variety of ways. Following NC's Medicaid expansion, the AE ACA Navigators worked with Martin County residents to enroll eligible patients.

Martin County patients also benefit from AE's Transitional Care Coordination program. In FY2024 the transitional care team completed thousands of contacts with patients discharged from EDs and residing in Martin County. The team also provided support to hundreds of Martin County patients that were discharged from ECU Health hospital inpatient units. AE provides care management services to Medicaid Managed Care members in the Martin County area, which would be expected to continue upon reopening of the REH. AE has a longstanding contractual relationship with the Martin-Tyrrell-Washington Health Department for Advanced Medical Home (AMH) Tier three (T3) care management services.

6.2 Regional Network

6.2.a Detail your existing healthcare operations in the region, to illustrate your capability to provide seamless care delivery across facilities

See sections 1.1.a-b and 2.1.a-b and Appendix A for detailed information about ECU Health's regional integrated system of care.

6.2.b Describe established relationships with tertiary care centers and specialists, to illustrate your capability to provide seamless care delivery across facilities

See sections 1.4 and 6.3.b for information related to relationships with tertiary care centers and specialists.

6.2.c Explain how Martin County services would integrate with your regional network, to illustrate your capability to provide seamless care delivery across facilities

See section 2.1.c-d for information about how Martin County services would integrate with ECU Health's regional network.

6.2.d Outline your approach to coordinating patient care across facilities, to illustrate your capability to provide seamless care delivery across facilities

ECU Health coordinates patient care across facilities in many ways, the most impactful being the Epic Electronic Health Record (EHR). By using Epic, every clinician across ECU Health has access to the same health information for each patient, with real-time updates for labs, imaging, provider notes, and more. For patients with multiple ECU Health providers, the Epic EHR acts as the source of truth for diagnoses, recent activity and demographics. *Refer to Section 6.1.c for detailed information about ECU Health's electronic health record.*

Access East, a controlled affiliate of ECU Health, provides substantial support and infrastructure for care coordination across sites. AE services include ambulatory supports (patient-centered medical home recognition, health coaches, annual wellness visit nurses), care management services, Transitional Care Coordination, Remote Patient Monitoring, Nurse Advice Line, Marketplace ACA Navigators, and Health Assist. *See section 6.1.d for additional information about Access East.*

ECU Health Operations Center includes both the ECU Health Transfer Center and ECU Health Case Management. The Transfer Center works to connect referring and consulting providers with ECU Health specialists to collaborate on the most appropriate care plan patients. *See sections 6.1.a for additional information about ECU Health's Transfer Center.*

ECU Health has a single Case Management function, part of the Operations Center, which was expertly designed to meet the needs of our organization. By having a single function with 5 "centers of excellence," our teams can move patients along their discharge planning process more effectively. This group is focused on length of stay, behavioral health and ED utilization, case management and utilization review. This team works to ensure patients are receiving the right care when they are at ECU Health and have all the needed supports to be successful upon discharge. *See sections 6.1.a for additional information about ECU Health's Transfer Center*.

6.2.e Describe successful examples of care integration in similar markets, to illustrate your capability to provide seamless care delivery across facilities

Examining how services are utilized specifically at ECU Health Bertie Hospital highlights how ECU Health might integrate care at an REH in Martin County. ECU Health Bertie Hospital uses the Epic EHR and encourages patients to use MyChart to promote communication. ECU Health Bertie Hospital departments receive electronic CareLink referrals from local FQHCs such as Bertie County Rural Health Association and Roanoke-Chowan Community Health Center. These FQHCs use OCHIN, an Epic-based ambulatory EHR platform, which means ECU Health providers can pull in notes from their system via CareEverywhere. This promotes efficient and timely sharing of patient information to ensure patients get the right care at the right time.

Access East provides multiple services to ECU Health Bertie Hospital patients. Many of these services are used within ECU Health Family Medicine-Windsor, such as the Nurse Advice Line, Remote Patient Monitoring, and Care Management for various populations. ECU Health Bertie patients also benefit from the Transitional Care Coordination program. In fact, ECU Health Bertie Hospital and ECU Health Chowan Hospital were the first ECU Health hospitals to hire transitional care nurses using grant funds. The program was so successful, it grew into a system-wide service.

ECU Health Bertie Hospital providers utilize the ECU Health Transfer Center, often multiple times a day, to arrange for higher levels of care for patients. Because the hospital does not have full time specialists on-site or on-call, using the ECU Health Transfer Center for ED and inpatients who require a higher level of care is invaluable. The ECU Health Transfer Center uses detailed protocols to identify the closest location with the appropriate services and capacity to meet patient needs.

Some key examples of system-wide care integration strategies are noted below:

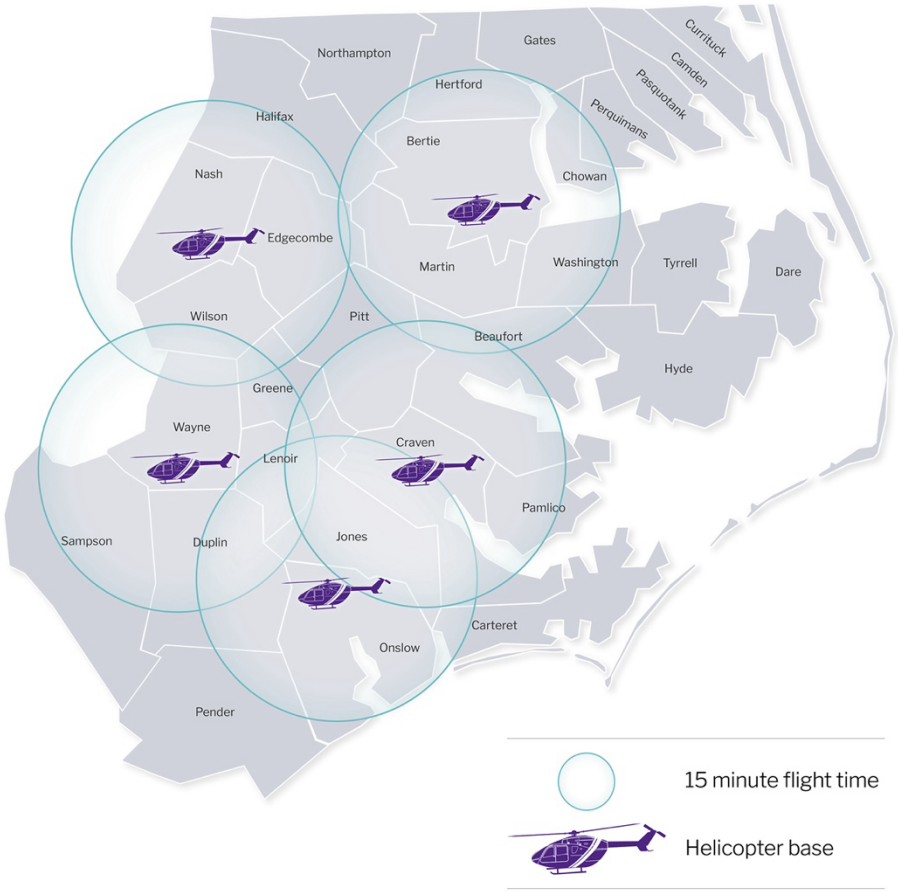
- Centralized radiology reading service covers all system hospitals and clinics.
- Centralized diagnostic reading for electroencephalograms and CardioMEMs.
- Ambulatory specialty care network with hubs, sub-hubs, and clinic sites
    - Cardiology clinics offered in 12 locations with hub in Greenville, sub-hubs in Washington and Roanoke Rapids
    - Fellowship trained spine surgeons in three locations with full time surgeons in Roanoke Rapids and Tarboro
- Acute stroke network *(See Section 6.3.b)*
- Virtual care for inpatient services, including tele-ICU and e-consults.

6.3 Operational Integration

6.3.a Describe emergency medical transport agreements to show how Martin County services will connect to your broader system

ECU Health Medical Center has an existing emergency medical transport program through ECU Health EastCare, which includes air medical and ground transport.

EastCare has been providing critical care air and ground transportation service for all of eastern NC since 1985. Today, EastCare has seven mobile ICU ground ambulances, three basic life support ground ambulances, and five air units currently based in Beaufort, Bertie, Craven, Nash, Onslow, and Wayne counties. One ground transport unit is dedicated to children's transport. The EastCare fleet is positioned to support rapid movement of patients from community hospitals to referral centers. EastCare and Maynard Children's Hospital at ECU Health Medical Center partner to staff a Children's Transport Team, which transports more than 1,700 children each year. All EastCare transport units are staffed and equipped to provide critical services including but not limited to trauma, cardiac, medical, high-risk obstetric, burn, and pediatric care. ECU Health EastCare is nationally recognized for safety, quality, and service, and is the only medical transport service in the region that is accredited by the Commission on Accreditation of Medical Transport Systems. Each year, EastCare covers more than 500,000 air and ground miles transporting more than 11,000 patients.



EastCare air medical and ground operations already cover Martin County, and with existing assets based in counties with existing ECU Health hospitals – Beaufort, Bertie, and Pitt – we are prepared to deploy resources to support the medical transport needs of the proposed REH using existing resources. Additionally, ECU Health has an existing strong presence in the EMS community throughout eastern NC. The system supports the local Martin County EMS system and others in the east through medical directorship services. The EMS Medical Director provides medical oversight and protocol development, education and training, and collaboration on local special EMS projects such as implementation of new technologies or developing innovative approaches to pre-hospital care.

6.3.b Describe specialty consultation arrangements access to show how Martin County services will connect to your broader system

As a national leader in rural healthcare delivery, ECU Health has developed various models to improve access to specialty care in our rural communities. One such model is our connectivity for regional stroke care. Designed to optimize timely clinical decision-making at the local community hospital level, the Tele-Stroke program was established, through a partnership with Sevaro Health, to ensure that patients receive the most appropriate care in the correct location while avoiding the risks, costs, and disruptions associated with unnecessary transfers. By connecting emergency departments in its regional facilities to the Tele-Stroke service, ECU Health and Sevaro can provide stroke care patients closer to home. This program benefits patients by accelerating diagnosis for patients arriving at the ED with symptoms of stroke. Earlier diagnoses allow for treatment, if appropriate in a local ED, and/or transfer to another hospital timely. Time is especially critical in stroke care, and faster treatment can dramatically improve patient outcomes.

ECU Health is also the only health system in North Carolina in which all hospital facilities have achieved accreditations from The Joint Commission, certifying their competency and exceptional standards in delivering evidence-based stroke care that meets or exceeds national benchmarks.

The Joint Commission – Comprehensive Stroke Certification:

- ECU Health Medical Center

The Joint Commission – Primary Stroke Certification:

- ECU Health Beaufort Hospital, a campus of ECU Health Medical Center
- ECU Health Duplin Hospital
- ECU Health Edgecombe Hospital
- ECU Health North Hospital
- ECU Health Roanoke-Chowan Hospital

The Joint Commission – Acute Stroke Ready:

- ECU Health Bertie Hospital
- ECU Health Chowan Hospital
- Outer Banks Health Hospital

ECU Health offers a number of other specialty consult programs, including tele-cardiology, tele-ICU, Infectious Disease Consultative Services, and utilizes NC-STeP services for behavioral health.

6.3.c Describe communication protocols between facilities to show how Martin County services will connect to your broader system

See sections 1.4, 6.1a, and 6.1.c for information about transfer processes, communication protocols and tools across facilities.

SECTION 7: TIMING AND FACILITY COMMITMENT

7.1 Implementation Timeline

7.1.a Provide a detailed reopening timeline with key milestones to document your approach to reopening services

See sections 1.6.a and 7.1 for information about implementation timeline

7.1.b Provide a certifications/accreditations timeline to document your approach to reopening services

See Section 1.2.c for a detailed estimation of the timeline to obtain the appropriate certifications and/or accreditations associated with reopening the existing Martin General Hospital as an REH.

7.1.c Provide services implementation sequencing/timeline to document your approach to reopening services

It is ECU Health's intent to implement and sequence the reestablishment of services in Martin County. ECU Health proposes to develop a detailed reopening implementation plan and timeline during due diligence. Our intent is to reopen the existing facility initially, providing all services required by the REH CoPs, along with programs, policies and procedures that ensure services operate within ECU Health standards that might otherwise exceed regulatory requirements. If ECU Health's proposal is selected, an implementation team comprised of a broad group of clinical and ancillary services and administrative leaders will be established to steer implementation sequencing and timeline development. Execution may be supported by the system's Transformation Execution Office (TEO) as appropriate. ECU Health intends to use its best efforts to reestablish local access to essential healthcare services in a timeframe that is reasonable based on existing considerations at the time. See sections 1.6 and 3.1.c for key contingencies that may impact implementation sequencing/timeline for reopening. We look forward to engaging in further detailed discussions with the County with respect to the reopening process and timeline.

7.2 Facility Development

7.2.a Provide a timeline for new facility planning and development to demonstrate commitment to long-term facility needs

ECU Health intends to use reasonable and best efforts to develop a new, de novo REH facility within the first three to ten years following reopening of the existing facility. In our experience with de novo Critical Access Hospital development, for comparison, the process takes roughly three years from Certificate of Need (CON) submission to facility opening. A key early milestone will be the August 3, 2025 deadline to satisfy notice of intent to reopen the facility under the Legacy Medical Care Facility provisions of N.C.G.S. 131E-176(14f) and N.C.G.S. 131E-84(h) which should also allow for the transition of REH operations to the new proposed facility to be exempt from the CON review process. We anticipate planning and construction of a de novo REH will have lesser complexity as compared to our historical inpatient hospital development projects.

While ECU Health believes a new facility is necessary to support our future-state vision for the Martin County REH and regional system of care objectives, our initial timeline and project plan development focus will be on the timely re-establishment of essential health care services in the existing facility. It is our intent that detailed

timeline development for a new facility that can efficiently support the longer-term health care needs of Martin County and the broader region would commence following successful reopening of the existing facility.

7.2.b Provide financing strategy and capabilities to demonstrate commitment to long-term facility needs

ECU Health is committed to long-term facility development needs and expects the parties will partner to identify and pursue viable capital funding options for the development of long-term facility needs and support of the rural system of care described herein. Viable sources of funding include but may not be limited to existing funds appropriated by the NC General Assembly to support the NC Care initiative. *See sections 1.5.a-d for details about ECU Health's financial performance indicators, including bond ratings and capital capacity, which provide evidence of the system's capabilities to meet long-term facility needs. See section 3.1.c for information describing the key financial considerations associated with ECU Health's commitment to long-term facility needs.*

7.2.c Provide site selection considerations to demonstrate commitment to long-term facility needs

ECU Health Facilities and Properties, a corporate shared service, will perform site visits to evaluate properties and develop potential site recommendations. Data points such as site needs, existing transportation infrastructure and travel patterns, community characteristics and demographics, and site costs are analyzed to produce a short-list of optimal sites. The ECU Health Facilities and Properties team will be responsible for all processes associated with site selection and development, from identification through due diligence and closure of the necessary transaction(s) to secure a site that best meets the needs of the scope of facility to be developed.

7.3 Project Experience

7.3.a Provide examples of similar facility projects to validate capability in facility development

As of the writing of this proposal, it is anticipated that the existing Martin County facility will be the first hospital in the state to operate as a REH. Though ECU Health has not previously developed a new, de novo REH, we are confident the reopening and operation of the existing facility as an REH combined with our past experience developing other facility types with similar regulatory requirements will position us to be successful in development of a future new facility. ECU Health has developed several facilities that can serve as examples of similar facility projects to validate our capability and bring vision to what might constitute a modern Martin County REH:

- ECU Health Bertie Hospital was opened in 2001 as the first hospital in the nation to be constructed to Critical Access Hospital standards. The facility is a 6-bed inpatient hospital with a 24-hour emergency department, operating rooms, and outpatient services that have expanded over time. The facility was designed with community need in mind and is by all accounts an historical success story for how health care services in a community can be transformed into a long-term sustainable model.
- The Outer Banks Health Hospital in Nags Head, NC was developed as a joint venture with Chesapeake Regional Healthcare. *See Appendix A for an overview of Outer Banks Health Hospital.*
- A new ECU Health Behavioral Health Hospital is currently under construction and anticipated to open summer 2025. This project is another example of ECU Health's experience collaborating with other organizations – Acadia Healthcare in this case – to plan and construct facilities that expand health care access.

Other non-hospital projects also validate our facility development capabilities. The ECU Health Healthplex-Wilson is an example of a de novo outpatient facility development that spanned the process from community needs assessment, strategic site selection, development strategy approach, transaction closures, construction, and opening. ECU Health Multispecialty Clinic-Belhaven also offers an example of a state-of-the-art de novo facility specifically designed to meet the unique needs of the Belhaven community and surrounding area.

7.3.b Provide construction management approach to validate capability in facility development

ECU Health's Facilities and Properties division, a corporate shared service, has an in-house design and construction team. Facilities and Properties is fully responsible for all aspects of property and facility development. This includes, but is not limited to, property acquisition and management of outside architectural, engineering and construction firms. Additionally, Facilities and Properties is closely aligned with the health system's Corporate Planning and Quality shared services to support regulatory and licensure activities. Facilities and Properties offers a full-service plant operations, maintenance, planning, and development suite of capabilities, which allows the system to benefit from a coordinated and complete approach to property development.

7.3.c Provide evidence of successful project completion to validate capability in facility development

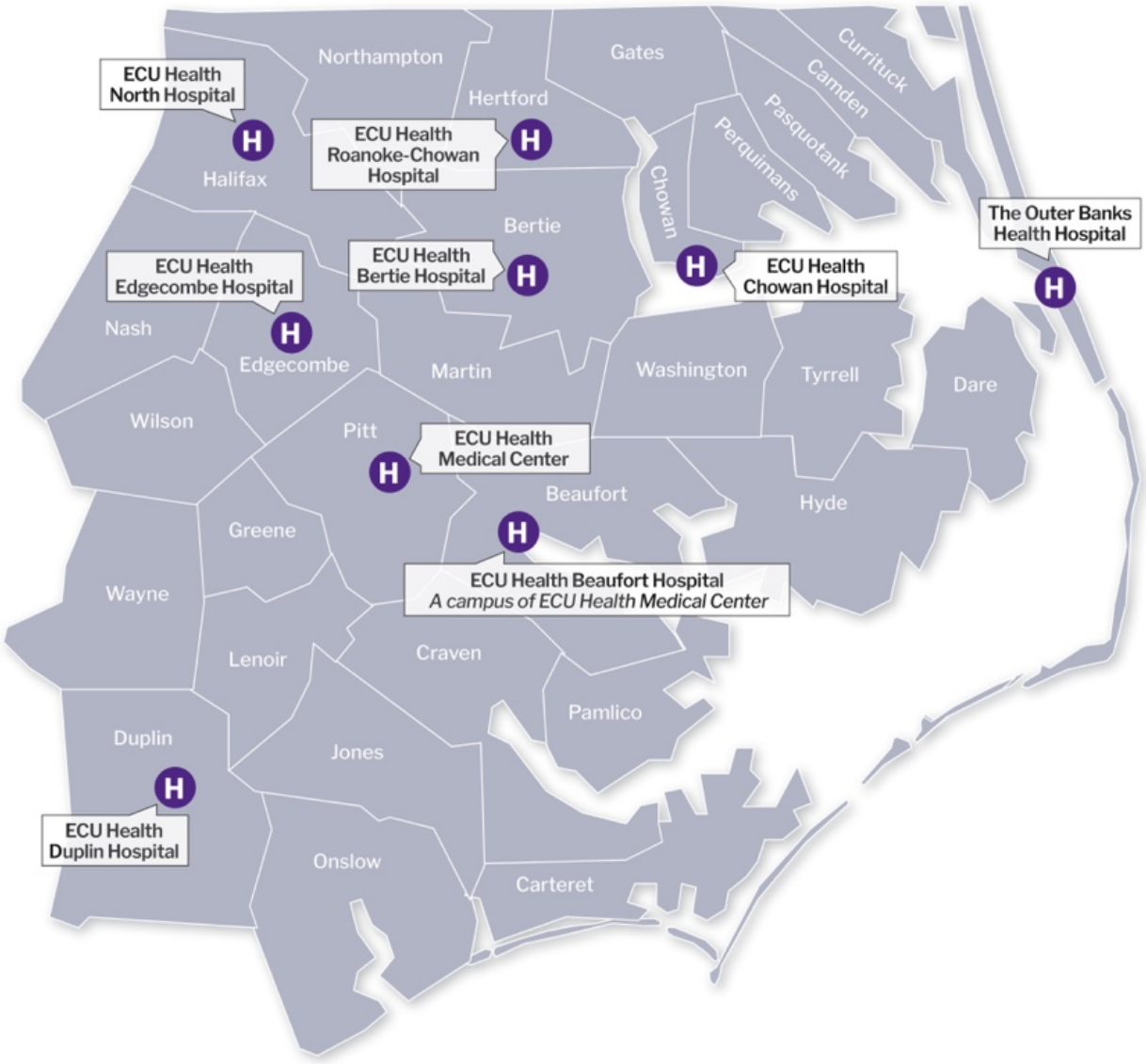
See section 7.3a for evidence of successful project completions that validate ECU Health's capability in facility development.

APPENDIX

Reference	Appendix	Description
Appendix A	A.1	Number, Type and Location of Facilities
Appendix A	A.2	Hospital Overviews
Appendix A	A.3	System Leadership Information
Appendix A	A.4	Board Information
Appendix B	B.1	ECU Health Accreditation Information
Appendix C	C.1	Audited Financials (FY24)
Appendix D	D.1	Financial Assistance-Hospital Billing
Appendix D	D.2	Financial Assistance-Professional Billing
Appendix D	D.3	Self-Pay and Residual Billing and Collection Policy
Appendix E	E.1	Patient Rights and Responsibilities Policy
Appendix F	F.1	ECU Health Medical Center – Hospital Compare Data (Apr. 2023)
Appendix F	F.2	ECU Health Medical Center – Hospital Compare Data (Apr. 2024)
Appendix F	F.3	ECU Health Medical Center – Hospital Compare Data (Mar. 2025)
Appendix G	G.1	Clinical Excellence Committee Structure

A.1

Service Area Map



Hospital Bed Counts

ECU Health Licensed Bed Count by Facility and Type, FY24

		EMC	TOBH	EBEA	EBER	ECHO	EDUP	EEDG	ERCH	ENOR	ECU Health Totals
Acute Care Beds		**847**	**21**	**120**	**6**	**49**	**56**	**101**	**86**	**184**	**1,470**
Intensive Care Units	Cardiac	24									24
	Cardiovascular Surgery	24									24
	Medical/Surgical	76		12		4	9	8	10	16	135
	Neonatal level IV	26									26
	Pediatric	12									12
Other Units	Gynecology					5	6				11
	Medical/Surgical	434	18	105	6	28	32	45	56	158	882
	Neonatal level 111	24						10			34
	Neonatal Level II	21	1			2					24
	Obstetrics	59	2	3		7	9	32	16	10	138
	Oncology	76									76
	Orthopedics	32									32
	Pediatric	39				3		6	4		52
Subacute Care Beds		**127**	**0**	**22**	**0**	**0**	**25**	**16**	**28**	**20**	**238**
	Comprehensive Inpatient Rehabilitation	**75**						**16**			**91**
	Psychiatry	52		22			25		28	20	147
Totals		**974**	**21**	**142**	**6**	**49**	**81**	**117**	**114**	**204**	**1,708**

Note: prior to joining the system, ECU Health was a general community acute care hospital with 49 licensed beds. The hospital was later converted to CAH status and operates only 25 of its licensed beds.

A.2

ECU Health Medical Center

ECU Health Medical Center ('ECUHMC' or 'the medical center') is the flagship teaching hospital for the Brody School of Medicine at East Carolina University and is one of only four academic medical centers in the state. The medical center is home to the region's only Level I Trauma Center and Level I Pediatric Trauma Center, and provides advanced care capabilities in state-of-the-art facilities, including Maynard Children's Hospital, East Carolina Heart Institute at ECU Health Medical Center, and the Eddie and Jo Allison Smith Cancer Center.

ECU Health Medical Center is proud to have been recognized by The American Nurses Credentialing Center as a Magnet® hospital three times, which reinforces our commitment to excellence in nursing care and leadership, quality-driven and evidence-based practice, and a collaborative and engaged culture for nurses and their teams.

The medical center continues to be recognized for its patient- and family-centered approach to care, innovative technologies, award-winning programs, and state-of-the-art facilities, and we are proud of the advancements we continue to make in clinical care delivery. For example, our commitment to improving outcomes for the top leading causes of mortality in eastern North Carolina is evidenced by our neurosciences program. The neurological surgery department exceeds the national benchmark for the American Heart Association's stroke quality measures, and the medical center serves as the leader for a regional stroke system of care. ECU Health Medical Center is a Joint Commission accredited Comprehensive Stroke Center and features the region's only Neuroscience Intensive Care Unit.

ECU Health Medical Center accreditations and key statistics:

- Ventricular Assist Device, The Joint Commission
- Get With The Guidelines Awards for Heart Failure, Mission: Lifeline STEMI & NSTEMI, Stroke, Type II Diabetes and Resuscitation
- Lung Cancer Screening Center of Excellence
- American College of Surgeons Commissoin on Cancer
- MBSAQIP Accredited Bariatric Surgery Center
- SRC Center of Excellence in Robotic Surgery and in Minimally Invasive Surgery
- National Accreditation Program for Breast Centers (NAPBC)

2024 Statistics	
Team members	6,243
Credentialed providers	1,573*
Admissions	44,575
Surgeries	39,670
Births	4,205
ED visits	95,412
Outpatient visits	223,599

*ECU Health Medical Center and ECU Health Beaufort Hospital, a campus of ECU Health Medical Center

ECU Health Beaufort Hospital,
a campus of ECU Health Medical Center

In 2022, ECU Health Beaufort Hospital in Washington, NC, became a campus of ECU Health Medical Center. This transition allowed the health system to expand access to the specialty and tertiary services of ECU Health Medical Center and enhance systemwide capacity to better support the transfer needs of our community hospitals, in support of our rural regional system of care goals. Beaufort is a 142-bed full-service hospital offering a range of inpatient and outpatient services including medical, surgical, intensive care, emergency, pediatrics and women's services. The facility is also home to the Marion L. Shepard Cancer Center which offers leading-edge chemotherapy and radiation therapy locally, among other cancer services.

ECU Health Beaufort Hospital Accreditations and Key Statistics:

- Get With The Guidelines Awards for Stroke and Type II Diabetes
- American College of Surgeons-Commission on Cancer.
- Primary Stroke Center, The Joint Commission

2024 Statistics	
Team members	618
Credentialed providers	1,573*
Admissions	4,887
Surgeries	3,776
Births	314
ED visits	24,182
Outpatient visits	26,188

*ECU Health Medical Center and ECU Health Beaufort Hospital, a campus of ECU Health Medical Center

ECU Health Bertie Hospital

ECU Health Bertie Hospital is a 6-bed critical access hospital (CAH) located in Windsor, NC. ECU Health Bertie offers surgical, emergency, and diagnostic services, and offers access to specialty and primary care clinics. Notably, ECU Health Bertie Hospital was the first facility in the nation to be constructed as a CAH.

ECU Health Bertie Hospital Accreditations and Key Statistics:

- Acute Stroke Ready, The Joint Commission

2024 Statistics	
Team members	122
Credentialed providers	268
Admissions	352
Surgeries	514
ED visits	14,814
Outpatient visits	16,449

ECU Health Chowan Hospital

ECU Health Chowan Hospital is a 25-bed CAH located in Edenton, NC. The hospital serves approximately 110,000 people from across a six-county geography of northeastern NC. ECU Health Chowan offers medical and surgical services, including intensive care, women's services, a multidisciplinary specialty care clinic, and a dedicated outpatient surgery area with endoscopy capability. The hospital has a 7-bed emergency department that serves approximately 15,000 patients annually.

ECU Health Chowan Hospital Accreditations and Key Statistics:

- Get With The Guidelines Awards for Stroke, Type II Diabetes
- Acute Stroke Ready, The Joint Commission

2024 Statistics	
Team members	321
Credentialed providers	396
Admissions	2,004
Surgeries	1,231
Births	400
ED visits	19,223
Outpatient visits	26,704

ECU Health Duplin Hospital

ECU Health Duplin Hospital is an 81-bed general community hospital located in Kenansville, NC. The hospital's renovated emergency department has 15 beds and serves approximately 25,000 patients annually. ECU Health Duplin Hospital offers general medical and surgical services, chemotherapy and other cancer infusion interventions.

ECU Health Duplin Hospital Accreditations and Key Statistics:

- Primary Stroke Center, The Joint Commission

2024 Statistics	
Team members	457
Credentialed providers	357
Admissions	3,047
Surgeries	1,863
Births	419
ED visits	27,279
Outpatient visits	18,075

ECU Health Edgecombe Hospital

ECU Health Edgecombe Hospital is a 117-bed general community acute care hospital located in Tarboro, NC. The hospital offers high quality care general medical and surgical services, rehabilitation, a birthing center, a cancer center, a multispecialty outpatient clinic and various other specialty and primary care services.

ECU Health Edgecombe Hospital Accreditations and Key Statistics:

- Get With The Guidelines Awards for Stroke, Type II Diabetes
- American College of Surgeons-Commission on Cancer
- Primary Stroke Center, The Joint Commission

2024 Statistics	
Team members	502
Credentialed providers	398
Admissions	3,136
Surgeries	2,463
Births	379
ED visits	25,304
Outpatient visits	24,970

ECU Health North Hospital

ECU Health North Hospital is the most recent community hospital to integrate with ECU Health, joining the system in 2019. The facility, located in Roanoke Rapids, NC, is a 204-bed hospital serving a three-county region including Halifax, Northampton and Warren counties. The hospital's service area also reaches into southern Virginia. The hospital offers a broad range of medical and surgical services, advanced diagnostics, as well as specialty and primary care clinics located throughout the area. Inpatient and outpatient services have continued to grow as a result of the hospital's integration into the ECU Health system and subsequent system investments.

2024 Statistics	
Team members	533
Credentialed providers	413
Admissions	4,379
Surgeries	2,615
Births	432
ED visits	26,704
Outpatient visits	35,728

ECU Health North Hospital Accreditations and Key Statistics:

- Get With The Guidelines Awards for Stroke, Type II Diabetes
- American College of Surgeons-Commission on Cancer
- Acute Stroke Ready, The Joint Commission

The Outer Banks Health Hospital

The Outer Banks Health Hospital (OBH) is a full-service CAH located in Nags Head, NC. OBH is a 21-bed facility designed to meet the needs of the coastal community, whose year-round population of approximately 35,000 swells to about 350,000 during the summer season. The campus includes four ORs, a medical/surgical unit, a labor & delivery suite with a dedicated caesarian section OR, a full rehabilitation therapy center, and ED. OBH is a joint venture partnership between ECU Health and Chesapeake Regional Healthcare.

2024 OBH Statistics	
Team members	358
Credentialed providers	396
Admissions	1,635
Surgeries	2,354
Births	288
ED visits	20,284
Outpatient visits	33,623

2024 Statistics OBH Medical Group	
Team members	189
Providers	75
Practices	18

Outer Banks Health Hospital Accreditations and Key Statistics:

- Get With The Guidelines Awards for Stroke, Type II Diabetes
- American College of Surgeons-Commission on Cancer
- National Accreditation Program for Breast Centers
- Acute Stroke Ready, The Joint Commission

ECU Health Roanoke-Chowan Hospital

ECU Health Roanoke-Chowan Hospital (RCH) was the first hospital in the nation to be built using Hill-Burton Act funds for construction in 1948. Today, RCH is a 114-bed general community hospital located in Ahoskie, NC, serving a four-county geography. The facility has a 15-bed emergency department that treats approximately 18,000 patients per year. The hospital provides a wide range of medical and surgical services, radiation oncology, and a host of specialty care clinics. The Wound Healing and Pain Management clinics serve as referral centers for neighboring ECU Health hospitals and providers.

ECU Health Roanoke-Chowan Hospital Accreditations and Key Statistics:

- Get With The Guidelines Awards for Stroke, Type II Diabetes
- American College of Surgeons-Commission on Cancer
- Acute Stroke Ready, The Joint Commission

2024 Statistics	
Team members	518
Credentialed providers	368
Admissions	4,137
Surgeries	1,526
Births	253
ED visits	21,303
Outpatient visits	45,078

System leadership team

Michael Waldrum, MD, MSc, MBA
Chief Executive Officer,
ECU Health

Niti S. Armistead, MD, FACP
Chief Quality Officer and Chief Clinical Officer,
ECU Health

Trish Baise, DNP, RN, NEA-BC
Chief Nursing Executive,
ECU Health

Christina Bowen, MD, ABOIM, DipACLM
Chief Well-being Officer
ECU Health

Jay Briley, MHA, FACHE
President,
ECU Health Medical Center

Daniel Drake, PhD, RN
President,
ECU Health Physicians

Brian Floyd, RN, MBA
Chief Operating Officer,
ECU Health

Jason Foltz, DO
Chief Medical Officer,
ECU Health Physicians

Virginia D. Hardy, PhD
VP and Chief Inclusion and Belonging Officer,
ECU Health

Donette Herring, MBA, RN
Chief Information Officer,
ECU Health

Todd Hickey, MHA, FACHE
Chief Strategy Officer,
ECU Health

Jason Higginson, MD, MA, FAAP
Chief Health Officer,
ECU Health

Julie Kennedy Oehlert, DNP, RN
Chief Experience Officer,
ECU Health

Jenny Markham
Chief Legal Officer
ECU Health

Scott Senatore, EdD, MBA
Chief Philanthropy Officer,
ECU Health Foundation

Van Smith, MBA, MSHA
President,
ECU Health Community Hospitals

Kelly Weatherly, MBA, CEBS, SPHR
Chief Human Resources Officer,
ECU Health

Andy Zukowski, MBA
Chief Financial Officer,
ECU Health

Learn more about our system of care.

ECU HEALTH

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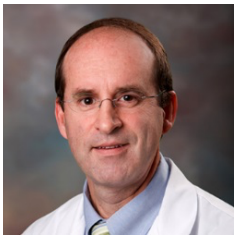

Marcus S. Albernaz, M.D.

Originally from Seattle, Washington, Dr. Marcus Albernaz completed medical school at Northeastern Ohio's College of Medicine in 1984, where he graduated with honors. He completed residencies in General surgery and Ear, Nose and Throat - Head and Neck surgery at the Medical University of South Carolina.

Among his numerous accomplishments, Dr. Albernaz has served as president of the Pitt County Medical Society, president of the Boys and Girls Clubs of the Coastal Plain, chairman of the Greater Greenville Community Foundation, president of the North Carolina Society of Otolaryngology - Head and Neck Surgery. He served on Governor Pat McCrory's Health & Human Services transition team. Additionally, he has been Chief of Staff of ECU Health Medical Center. Dr. Albernaz is certified by the American Board of Otolaryngology- Head and Neck Surgery and is currently a Clinical Professor of Surgery at The Brody School of Medicine of East Carolina University. Dr. Albernaz was inducted into the North Carolina Institute of Medicine.

He and his wife, Lisa, have two children

LaVern (Vern) Davenport

As a Firm Founder and Partner, Mr. Davenport has extensive executive experience in building and transforming healthcare technology and services companies. He is responsible for transaction origination and execution, portfolio company value creation initiatives, and investment policy. Mr. Davenport is a member of the Private Equity investment committee, and most recently served on the East Carolina Board of Trustees, the WakeMed Health and Hospitals Boards, and currently serves on several private company boards.

Before joining QHP Capital (formally NovaQuest Capital), Mr. Davenport was CEO and Board Member at Medfusion.

Prior to Medfusion, Mr. Davenport was Chairman and CEO of Medquist (a public company), a leader in transcription services before and after the privatization of the company. Mr. Davenport rebranded the company to M*Modal and led the take private process, resulting in the sale to One Equity Partners.

Mr. Davenport's previous experience also includes his time as Strategy Consultant to Quintiles, President of Allscripts; CEO, Misys Healthcare; GM & EVP, Kodak Health Group (now Carestream Health), and executive leadership roles at Siemens Medical solutions and Shared Medical Systems. Mr. Davenport started his career at IBM where he spent 11 years in sales, sales leadership, and executive management positions.

Deborah W. Davis

Ms. Deborah Davis has spent more than 47 years in leadership roles in the health care industry. She recently retired as the Chief of Strategic Initiatives, VCU Health System located in Richmond, Virginia. She previously served as the Chief Executive Officer of the VCU Hospitals and Clinics and Vice President for Clinical Services for Virginia Commonwealth University. She was originally recruited to the VCU Health System to serve as the Chief Operating Officer in 2007. Ms. Davis previously served as the President of Pitt County Memorial Hospital (now ECU Health Medical Center) in North Carolina.

She currently serves on the ECU Health Medical Center Board of Trustees and the ECU Health Board of Trustees. In addition, Ms. Davis serves as the Board representative to the Channel Marker Insurance Company, SPC (Captive Board) for ECU Health. Currently, she also serves on the East Carolina University Truist Center for Leadership Board of Directors. She also was a founding member of the East Carolina University Women's Roundtable Board Directors and currently serves in an emeritus status.

Ms. Davis has during her career served on numerous boards at the national, regional and local levels which pertained to healthcare, academics, business and community focus. A few examples include the Vizient University HealthSystem Consortium Board of Managers, the Vizient CEO Executive Board, the Council of Teaching Hospitals Administrative Board as well as the COTH representative to the AAMC Assembly and the COTH representative to the AAMC Group on Diversity and Inclusion. Ms. Davis has also served on various American College of Healthcare Executives committees as well as serving as a Regent-at-Large. Appointed to the East Carolina University Board of Trustees in 2011, she served two terms. She has also served for many years as a preceptor for the Administrative Residency Program at Virginia Commonwealth University and served on the Advisory Committee of the Central Virginia Healthcare Executive Group. While in Virginia, Ms. Davis also served on the Board of Directors for the Valentine Richmond History Center, the American Heart Association of Metro Richmond, the Chamber RVA, the Virginia Hospital and Healthcare Association Board, World Pediatric Project and the Children's Hospital Foundation.

Ms. Davis is a Lifetime Fellow in the American College of Healthcare Executives (LFACHE) and holds B.S.B.A. and M.B.A. degrees from East Carolina University.

Ernest L. (Ernie) Evans

Ernest “Ernie” Evans, a resident of Ahoskie, is the president of ELE Inc., an agribusiness operation in Ahoskie. After graduating from Ahoskie High School, Ernie graduated from Wake Forest College and went on to earn his law degree from Wake Forest University. He spent his first years in law in state government, serving as a research assistant to North Carolina Supreme Court Associate Justice Beverly Lake and as an assistant attorney general with the North Carolina Attorney General’s Office. He later became a partner in the law firm of Cherry, Cherry, Flythe and Evans, based in Ahoskie, became vice president of E.R. Evans and Sons Inc. and went on to become president of ELE Inc.

Ernie has served on numerous business and civic boards, including the Century Mutual Insurance Co., Centura Banks, Roanoke-Chowan Alliance, Roanoke-Chowan Foundation, Ahoskie Housing Authority, Wake Forest Baptist Health, North Carolina Hospital Association, Hertford County Industrial Development and Pollution Control Financing Authority. He also served as a deacon and Sunday school teacher for the First Baptist Church.

He is married to Austine Odom Evans, and they have two children.

Jimmy F. Garris

Jimmy is a graduate from Winterville High School and Bob Jones University with a degree in accounting. He was employed by DuPont Company at the Kinston Plant, where he held various supervisory and managerial positions, until his retirement in 1993. He is an active member of Unity Free Will Baptist Church, where he serves as the church treasurer.

Jimmy was elected Pitt County Commissioner in 2002. He served as the Vice-Chairman in 2005 and 2012. He served as the Chairman in 2006 and 2013.

Jimmy has lived in Pitt County for most of his life and has two children, and five grandsons.

Robert J. (Bob) Greczyn, Jr.

Robert Greczyn is the former president and CEO of Blue Cross and Blue Shield of North Carolina. He also served as president and chief executive officer of Healthsource Health Plans Inc. His expertise includes running both not-for-profit and for-profit entities and running them by focusing on operating successful businesses. Corporate governance experience with a focus on enterprise risk, compliance (Sarbanes-Oxley), ethics and governance standards has been an important part of his leadership style

Mr. Greczyn received his bachelor's degree in psychology from ECU in 1973 and his master's in public health from the University of North Carolina at Chapel Hill in 1981.

He and his wife, Kristen, live in Cary and have four children.

Antoine E. (Tony) Khoury, Sr.

Tony Khoury, CBI, M&AMI is a Senior Business Broker and the Founder/Owner of Transworld Business Advisors of Eastern North Carolina, headquartered in Greenville, NC.

Tony has over 30 years of business ownership experience, with an emphasis on working with privately held businesses within the manufacturing, wholesale/distribution, construction, healthcare, and technology sectors.

He is a member of the International Business Brokers Association, Mergers & Acquisitions Association and Carolina-Virginia Business Brokers Association, where he is recognized as a Certified Business Intermediary and a Mergers & Acquisitions Master Intermediary. In addition, he holds an active Real Estate Broker license in North Carolina.

Tony holds an undergraduate degree in Electrical Engineering from Youngstown State University and a Master of Business Administration degree from Duke University's Fuqua School of Business.

In addition to serving his clients with the confidential acquisition and divestiture of their businesses, Tony has a strong passion for helping the communities of Eastern North Carolina with attracting investment and improving the lives of its residents. He serves on the board of directors the NC East Alliance, a 29-county economic development nonprofit, as well as on the advisory board of the SBTDC (Small Business Technology Development Center).

Tony has been happily married to his wife, Jarma, for over 30 years where together they have three children, Ely, Bryn, and Gabby. Tony's hobbies include traveling, eating good food, cycling and astronomy.

William C. Monk, Jr.

William was born and raised in Farmville, NC. He is a 1986 graduate of the University of North Carolina at Chapel Hill with a BA degree in Economics and received his MBA in 1989 from the Fuqua School of Business at Duke University.

William spent most of his career with his family's international tobacco business serving in numerous positions including Director of Business Planning & Development and Regional Financial Director of the European Region. The company went public in 1992 and is now called Pyxus International.

After his career in the tobacco industry, William engaged in several angel investing networks and eventually co-founded Lunasee in 2005, a startup company with a patented lighting technology for bicycles and motorcycles. William also led a group to acquire and re-open the Greenville Country Club in 2015. In addition, he manages a small family office and philanthropic foundation.

William has served on several boards, including boards of The Oakwood School, the Community Foundation of NC East, St. Mary's School (Raleigh), Vidant Health Foundation, UNC Shuford Program for Entrepreneurship (Chapel Hill), and Vidant Medical Center. Most of his focus on these boards has been in the areas of finance, investment/endowment management, governance and strategic planning.

He is married to Aurelia and enjoys outdoor activities and traveling. He has two children, Will and Relia.

Dr. Philip G. Rogers, Chancellor

Dr. Philip G. Rogers, became the 12th chancellor of East Carolina University on March 15, 2021. Rogers was nominated by UNC President Peter Hans and elected by the Board of Governors on December 17, 2020. Prior to his appointment as Chancellor, Rogers was the Senior Vice President for Learning and Engagement at the American Council on Education. As senior vice president, Rogers helped institutions navigate complex challenges facing the global higher education landscape. He was responsible for ACE's academic, research and innovation strategy, overseeing five separate divisions including advancement and fundraising, education attainment and academic innovation, global engagement and internationalization, leadership and professional learning, and research. The appointment as Chancellor is a homecoming for Rogers, who first came to ECU as a policy analyst in 2007 and served as chief of staff from 2008-2013. As Chief of Staff he was responsible for external relations for the university, including government relations, marketing and communications, public service, and policy development.

As a native North Carolinian, Rogers was raised in Greenville and his family has a long history in the state and with the university. Rogers earned a doctorate degree in higher education management with distinction from the University of Pennsylvania, a master's degree in public administration from the University of North Carolina at Chapel Hill, and a bachelor's degree in communications from Wake Forest University.

He and his wife, Dr. Rebekah P. Rogers, a two-time ECU alumna, have two sons, Grayson and Dean.

Diane N. Taylor

Mrs. Taylor has over seven years of experience in broadcast journalism in television, radio and newspaper mediums. She has a Bachelor's Degree in Broadcast/Journalism from Morgan State University and a Master's in Technical and Professional Communications from East Carolina University.

Mrs. Taylor transitioned to Public Health in 2002 as the Community Outreach Specialist for Carolina Donor Services. She spent five years educating and promoting organ and tissue donation in eastern North Carolina before becoming a certified Substance Abuse Prevention Professional. Mrs. Taylor added author to her repertoire in 2013. Her book A Game of Faith – The Story of Negro League Baseball Player Carl Long was also the beginning of her business Taylor Made Publishing.

Taylor Made Publishing, LLC is a full-service book publishing company that specializes in helping steer authors from manuscript to print. Her focus is diverse children's literature and has garnered much success including featured authors at ESSENCE, Yahoo News, TODAY show online, Huffington Post, Teen Vogue and a host of others. Increasing literacy among young minority readers is at the forefront of everything Taylor Made creates.

In addition to her publishing business, Mrs. Taylor is a community advocate and motivational speaker and volunteers to serve on numerous boards including ECU Health Board of Directors, ECU Health Medical Center Board of Trustees, ECU Health Community Hospitals Board, Pitt Community College Small Business Advisory Committee and Greenville-Pitt County Convention and Visitors Bureau. Her hope is to lend her expertise and create the change she wishes to see in her community.

Anand (Andy) Tewari, MD

Andy Tewari is a board certified anesthesiologist.

Dr. Tewari completed medical school at the University of Manitoba Canada in 1985 after which he entered a surgical residency and fellowship at Stanford University. He completed his anesthesia residency at Yale University and his cardiac anesthesia training at Mercy Hospital of Pittsburgh.

Among his numerous accomplishments, Dr. Tewari has served as Chairman of Anesthesiology at St. Francis Medical Center in Pittsburgh and as Chief of Staff at Vidant Medical Center.

He and his wife have two sons who are both in college in the Triangle.

Entity	Date	Regulatory Agency	Purpose	Requirements for Improvement (RFI)/ Outcome
ECU Health Bertie	05/08 – 05/10/24	TJC	Triennial Survey	RFIs Cited: Yes Outcome: Resolved
ECU Health Bertie	08/13/24	TJC	Acute Stroke Ready Recertification	RFIs Cited: Yes Outcome: Resolved
ECU Health Chowan	05/29 – 05/31/24	TJC	Triennial Survey	RFIs Cited: Yes Outcome: Resolved
ECU Health Chowan	08/26/24	TJC	Acute Stroke Ready Recertification	RFIs Cited: Yes Outcome: Resolved
ECU Health Duplin	03/25 – 03/26/24	TJC	Triennial Survey	RFIs Cited: Yes Outcome: Resolved
ECU Health Duplin	09/27/24	TJC	Primary Stroke Center Recertification	RFIs Cited: Yes Outcome: Resolved
ECU Health Duplin	10/22 – 10/23/24	DHSR	Complaint Survey	RFIs Cited: No Outcome: Closed
ECU Health Edgecombe	03/19 – 03/21/24	TJC	Triennial Survey	RFIs Cited: Yes Outcome: Resolved
ECU Health Edgecombe	08/06 – 08/08/24	DHSR	Complaint Survey	RFIs Cited: No Outcome: Closed
ECU Health Edgecombe	08/20/24	TJC	Primary Stroke Center Recertification	RFIs Cited: Yes Outcome: Resolved
ECU Health Edgecombe	09/20/24	TJC	Office of Quality and Patient Safety Survey	RFIs Cited: No Outcome: Closed
ECU Health Medical Center/Beaufort	02/23 – 02/24/23	TJC	Comprehensive Stroke Center Recertification	RFIs Cited: Yes Outcome: Resolved
ECU Health Medical Center/Beaufort	09/16 – 09/20/24	TJC	Triennial Survey	RFIs Cited: Yes Outcome: Resolved
ECU Health Medical Center/Beaufort	02/28/25	TJC	Office of Quality and Patient Safety Survey	RFIs Cited: Yes Outcome: Resolved

Entity	Date	Regulatory Agency	Purpose	Requirements for Improvement (RFI)/ Outcome
ECU Health Medical Center/Beaufort	03/11 – 03/12/25	DHSR	Complaint Survey	RFIs Cited: No Outcome: Closed
ECU Health North	04/14/23	TJC	Primary Stroke Center Recertification	RFIs Cited: Yes Outcome: Resolved
ECU Health North	06/13/23	TJC	Hip/Knee Recertification	RFIs Cited: Yes Outcome: Resolved
ECU Health North	08/13 – 15/24	TJC	Triennial Survey	RFIs Cited: Yes Outcome: Resolved
ECU Health North	09/24 – 09/27/24	DHSR	Complaint Survey	RFIs Cited: Yes Outcome: Resolved
ECU Health Roanoke-Chowan	03/10/23	TJC	Primary Stroke Center Recertification	RFIs Cited: Yes Outcome: Resolved
ECU Health Roanoke-Chowan	09/12 – 09/14/23	DHSR	Complaint Survey	RFIs Cited: Yes Outcome: Resolved
ECU Health Roanoke-Chowan	07/16 – 07/18/24	TJC	Triennial Survey	RFIs Cited: Yes Outcome: Resolved
ECU Health SurgiCenter	02/05 – 02/06/24	TJC	Triennial Survey	RFIs Cited: Yes Outcome: Resolved
Outer Banks Health	10/10 – 10/12/22	TJC	Triennial Survey	RFIs Cited: Yes Outcome: Resolved
Outer Banks Health	03/14/24	TJC	Acute Stroke Ready Recertification	RFIs Cited: Yes Outcome: Resolved

ECU Health

Financial Statements, Supplementary Information and Reports and Schedules Required by *Government Auditing Standards* and the Requirements of the Single Audit

Year Ended September 30, 2024

ECU Health

Financial Statements, Supplementary Information and Reports and Schedules Required by *Government Auditing Standards* and the Requirements of the Single Audit

Year Ended September 30, 2024

ECU Health

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Tel: 919-754-9370
Fax: 919-754-9369
www.bdo.com

421 Fayetteville Street
Suite 300
Raleigh, NC 27601

Independent Auditor's Report

To the Board of Directors
University Health Systems of Eastern Carolina, Inc.
d/b/a ECU Health
Greenville, North Carolina

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of the business-type activities and the aggregate remaining fund information of University Health Systems of Eastern Carolina, Inc. d/b/a ECU Health (ECU Health) as of and for the year ended September 30, 2024, and the related notes to the financial statements, which collectively comprise ECU Health's basic financial statements, as listed in the table of contents.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the business-type activities and the aggregate remaining fund information of ECU Health as of September 30, 2024, and the respective changes in financial position and where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of ECU Health and to meet our ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about ECU Health's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatements of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of ECU Health's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about ECU Health's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the accompanying Management's Discussion and Analysis (unaudited) and the other required supplementary information (unaudited) as listed on the table of contents, be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited

procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the basic financial statements that collectively comprise ECU Health's basic financial statements. The accompanying supplementary information, as listed in the table of contents, are presented for purposes of additional analysis and are not a required part of the basic financial statements. The accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The consolidating and combining information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating supplementary information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

The combining schedules are prepared by management in accordance with the financial reporting provisions of Article 1 of the Amended and Restated Master Trust Indenture, dated February 1, 2006 (as amended between ECU Health and U.S. Bank National Association), (the MTI), which is a basis of accounting other than the principles generally accepted in the United States of America. In our opinion, the combining information is fairly stated, in all material respects, in accordance with the financial reporting provisions of Article 1 of the MTI, in relation to the basic financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated January 22, 2025 on our consideration of ECU Health's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of ECU Health's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering ECU Health's internal control over financial reporting and compliance.

BDO USA, P.C.

January 22, 2025

Management's Discussion and Analysis (Unaudited)

Annual Financial Report

The discussion and analysis of the University Health Systems of Eastern Carolina, Inc. d/b/a ECU Health, formerly Vidant Health, (the Parent Corporation) financial performance provides an overview of the health system's financial activities for the year ended September 30, 2024. The Parent Corporation, along with its nine component units (the Health System or ECU Health), are nonprofit, tax-exempt corporations. ECU Health consists of the Parent Corporation and its blended component units: Pitt County Memorial Hospital, Inc. d/b/a ECU Health Medical Center (VMC), East Carolina Health, Inc. d/b/a ECU Health Community Hospitals (VCOM), Coastal Plains Network (CPN), Channel Marker Insurance Company, SPC (CMIC), ECU Health Physicians (VMG) which includes Roanoke Valley Health Services, Inc. (RVHS), PCMH Management, Inc. d/b/a ECU Health Properties (VP), Access East, Inc. (Access East), HealthAccess, Inc. (HealthAccess) and Vidant Integrated Care, LLC d/b/a ECU Health Alliance, LLC (VIC). The financial statements of VMC include the activities of ECU Health Medical Center, East Carolina Health-Beaufort, Inc. d/b/a ECU Health Beaufort Hospital—A Campus of ECU Health Medical Center (VBEA), Moye Medical Endoscopy Center, LLC d/b/a ECU Health Endoscopy Center—Greenville (MMEC), SurgiCenter of Eastern Carolina, LLC d/b/a ECU Health SurgiCenter (VSC), and Vidant Radiation Oncology, LLC d/b/a ECU Health Radiation Oncology (VRO). The financial statements of VCOM also include the activities of East Carolina Health-Bertie d/b/a ECU Health Bertie Hospital (BER), East Carolina Health-Chowan d/b/a ECU Health Chowan Hospital (CHO), East Carolina Health-Heritage, Inc. d/b/a ECU Health Edgecombe Hospital (EDG), Duplin General Hospital d/b/a ECU Health Duplin Hospital (DUP), East Carolina Health, Inc. d/b/a ECU Health Roanoke-Chowan Hospital (ROA), Halifax Regional Medical Center, Inc. d/b/a ECU Health North (NOR) and The Outer Banks Hospital, Inc. d/b/a Outer Banks Health (OBH).

ECU Health is a health care delivery system headquartered in Greenville, North Carolina, that provides primarily hospital and other health care–related services to the citizens of eastern North Carolina. As of September 30, 2024, ECU Health has a total of 1,708 licensed beds and is anchored by VMC, a 1,116-bed teaching and tertiary hospital, which is affiliated with the Brody School of Medicine at East Carolina University. As of September 30, 2024, VCOM includes seven hospitals with a total of 592 licensed beds, which are located in communities throughout eastern North Carolina. Please read this information in conjunction with ECU Health's financial statements of its business-type activities, which begin on page 19. The financial statements also include comprehensive notes that describe the Health System, its history and significant accounting policies.

Financial Highlights

- In 2024, ECU Health's admissions and total surgeries increased by 8.7% and 6.2%, respectively, while total patient days and outpatient visits increased 3.7% and 4.3%, respectively. In 2023, ECU Health's admissions and total surgeries increased by 0.5% and 6.3%, respectively, while total patient days and outpatient visits increased 1.9% and 6.3%, respectively.

- ECU Health's income (loss) from operations for the years ended September 30, 2024 and 2023, was $110.5 million and $(0.4) million, respectively. ECU Health's operating margins for 2024 and 2023 were 2.9% and (1.1)%, respectively (the operating margin percentage includes interest expense as an operating expense, but does not include any grant funding from the federal or state government).

- ECU Health's operating cash flow margins (income from operations plus depreciation and amortization divided by total revenues) for the years ended September 30, 2024 and 2023, were 8.0% and 4.3%, respectively (the operating cash flow margin percentage does not include any grant funding from the federal or state government).

- ECU Health's net nonoperating revenue for the years ended September 30, 2024 and 2023, were $71.9 million and $53.7 million, respectively. Investment income for the year ended September 30, 2024, was $110.4 million, consisting of dividends, interest income and realized gains on investments of $42.5 million, plus unrealized gains on investments of $67.9 million. Interest expense on long-term debt was $(26.9) million for the year. Other included an unrealized loss on the interest rate swap of $(1.0) million, gain on equity method investments of $2.2 million, unrestricted contributions received of $5.0 million, and other nonoperating expenses of $(17.8) million.

- ECU Health's increase in net position for the years ended September 30, 2024 and 2023, was $172.7 million and $43.4 million, respectively.

- ECU Health's unrestricted cash and internally designated investments for capital improvements at September 30, 2024 and 2023, totaled $1,003.3 million and $688.8 million, respectively.

Overview of the Financial Statements

ECU Health presents three basic financial statements of its business-type activities: statement of net position; statement of revenues, expenses and changes in net position; and statement of cash flows. The statements and related notes provide information about the financial activity of ECU Health.

The statement of net position presents the financial position on September 30, 2024 and shows the assets and deferred outflows owned by ECU Health and the liabilities owed to others and deferred inflows. The statement of net position includes information that reflects ECU Health's assets and deferred outflows relative to its obligations to bondholders, suppliers, team members and other creditors. The excess of assets and deferred outflows over liabilities and deferred inflows represents ECU Health's net position.

The statement of revenues, expenses and changes in net position reports the financial results from operations during the fiscal year. The statement shows how much ECU Health's net position increased during the past year as a result of operating and nonoperating activities and other changes.

The statement of cash flows describe the flow of cash into and out of ECU Health during the fiscal year. The statement reports cash flows received during the year from operations, management of current assets and liabilities, contributions, investing activities and other sources. The statement also reports how cash was used for investment in capital projects and equipment, contributions and transfers, and other uses, as well as related financing activities.

ECU Health presents a pension trust fund. The statement of fiduciary net position – pension trust fund includes the assets and net position of the Health System's team members' pension plans that are held in a fiduciary capacity. The statement of changes in fiduciary net position reports the additions and deductions to these fiduciary funds during the period. The pension trust fund does

not issue separate financial statements; however, it is included as the aggregate remaining fund information of the Health System.

Nonfinancial factors would also need to be considered in evaluating the overall financial health of ECU Health, including, but not limited to, changes in ECU Health's market share, patient base and the quality of service provided by ECU Health, as well as local, state and national economic and regulatory matters and policy changes.

Summary Financial Statements of The Business-Type Activities of ECU Health

Financial Position

The ECU Health condensed statements of net position are presented below:

Condensed Statements of Net Position
(Dollars in Thousands)

September 30,	**2024**	2023
Current assets	**$ 1,139,356**	$ 964,135
Assets limited as to use—other	**736,304**	629,682
Capital assets, net	**828,511**	817,969
Other assets	**10,217**	33,334
Total assets	**2,714,388**	2,445,120
Deferred outflows	**169,938**	200,278
Total assets and deferred outflows	**$ 2,884,326**	$ 2,645,398
Current liabilities	**$ 555,914**	$ 439,364
Long-term liabilities	**855,425**	936,268
Total liabilities	**1,411,339**	1,375,632
Deferred inflows	**42,251**	11,734
Net investment in capital assets	**259,370**	224,242
Restricted—noncontrolling interests	**51,508**	50,913
Restricted—other	**3,439**	3,186
Unrestricted	**1,116,419**	979,691
Total net position	**1,430,736**	1,258,032
Total liabilities, deferred inflows and net position	**$ 2,884,326**	$ 2,645,398

At September 30, 2024, ECU Health's statement of net position includes total assets and deferred outflows of $2.9 billion and net position of $1.4 billion. From September 30, 2023 to 2024, and from September 30, 2022 to 2023, total assets and deferred outflows increased by $238.9 million and $156.6 million, respectively, while net position increased by $172.7 million and $43.4 million, respectively.

Current assets consist primarily of cash available for operations, patient receivables, other receivables, settlements due from third-party payors, inventories and prepaid expenses. In 2024, current assets were $1,139.4 million and increased by $175.3 million from 2023. Cash and cash equivalents increased by $211.8 million, patient accounts receivable decreased by $34.4 million, other receivables decreased by $3.8 million, and third-party settlements decreased by $11.6 million. In 2024, the increase in cash and cash equivalents was a result of Healthcare Access and Stabilization Program (HASP) receipts, investment gains and operating improvements.

In 2023, current assets were $964.1 million and increased by $208.2 million from 2022. Cash and cash equivalents increased by $16.4 million, patient accounts receivable increased by $51.0 million, other receivables increased by $13.0 million, and third-party settlements increased by $139.6 million. In 2023, the increase in accounts receivable is due in part to timing of payments as volumes continued to increase after the previous decline in volumes related to COVID-19. The increase in third-party settlements was a result of Healthcare Access and Stabilization Program (HASP) funding related to Medicaid expansion which was approved for 2023.

Assets limited as to use consist primarily of investments in equity securities and bonds that are internally designated for future capital improvements and totaled $736.3 million and $629.7 million at September 30, 2024 and 2023, respectively. These funds increased by $106.6 million in 2024 and decreased by $155.6 million in 2023. ECU Health's cash and investment position increased in 2024 due to strong cash flow provided by operating activities and HASP funding and decreased in 2023 due to experiencing operational needs that required using cash reserves.

Capital assets, net of accumulated depreciation and amortization, totaled $828.5 million at September 30, 2024, and increased by $10.5 million in 2024. Capital assets, net of accumulated depreciation, totaled $818.0 million at September 30, 2023, and increased by $44.3 million in 2023. These changes are described on page 16 in the discussion of capital assets.

Other assets include intangible assets, other than goodwill, and other long-term receivables and totaled $10.2 million at September 30, 2024. Other assets include intangible assets, other than goodwill, and other long-term receivables and totaled $33.3 million at September 30, 2023.

Deferred outflows decreased by $30.4 million from adjustments related to deferred losses on various bond refunding transactions, goodwill and deferred assets related to various pension items.

Current liabilities consist primarily of accounts payable, accrued expenses, settlements due to third-party payors, the current portion of reserves established for professional liability losses, current maturities of long-term debt, current portion of lease liability and current portion of subscription software. At September 30, 2024, current liabilities were $555.9 million and increased by $116.5 million from 2023. Accounts payable increased by $30.6 million, estimated settlements due to third-party payors increased by $17.9 million, accrued expenses increased by $60.6 million, current reserves for professional liability losses increased by $1.5 million, current maturities of long-term debt increased by $3.3 million, current lease liability increased by $1.1 million and current subscription software increased by $1.7 million.

At September 30, 2023, current liabilities were $439.4 million and increased by $52.7 million from 2022. Accounts payable decreased by $15.6 million, estimated settlements due to third-party payors increased by $31.3 million, accrued expenses increased by $25.0 million, current reserves for professional liability losses decreased by $5.8 million, current maturities of long-term debt increased by $1.8 million, current lease liability decreased by $0.3 million and current subscription

software increased by $16.1 million due to the first year implementation of GASB Statement 96, *Subscription-Based Information Technology Arrangements (SBITA)*.

Long-term liabilities consist primarily of long-term debt, net pension liability, professional liability losses, long-term lease liability, subscription software, other liabilities and noncontrolling interest. Long-term liabilities were $855.4 million at September 30, 2024, and decreased by $80.9 million. Long-term debt, less current maturities, decreased by $16.2 million, net pension liability decreased by $66.1 million, reserve for professional liability increased by $4.1 million, long-term lease liability, less current maturities, increased by $0.7 million, subscription software, less current maturities, decreased by $1.6 million and other liabilities decreased by $1.7 million. Long-term debt, less current maturities, decreased primarily as a result of the decrease in net pension liability due to investment gains which impacted the value.

Long-term liabilities were $936.3 million at September 30, 2023, and increased by $120.1 million. Long-term debt, less current maturities, decreased by $19.8 million, net pension liability increased by $143.1 million, reserve for professional liability decreased by $10.1 million, long-term lease liability, less current maturities, decreased by $0.4 million, subscription software, less current maturities, increased by $11.8 million and other liabilities decreased by $4.5 million. Long-term debt, less current maturities, increased primarily as a result of the increase in net pension liability due to investment losses which impacted the value and long-term subscription software increased in 2023 as a result of the implementation of GASB Statement 96, *SBITA*.

Changes in Net Position

The ECU Health condensed statements of revenues, expenses and changes in net position are presented below:

Condensed Statements of Revenues, Expenses and Changes in Net Position
(Dollars in Thousands)

Year Ended September 30,	**2024**	2023
Operating Revenues		
Net patient service revenue	**$ 2,695,480**	$ 2,322,581
Other operating revenues	**186,958**	150,825
Total operating revenues	**2,882,438**	2,473,406
Operating Expenses		
Salaries and wages	**1,201,660**	1,058,043
Employee benefits	**308,945**	268,434
Supplies and other	**1,133,895**	1,029,000
Depreciation and amortization	**120,871**	109,538
Lease activity	**6,571**	8,777
Total operating expenses	**2,771,942**	2,473,792
Operating Income (Loss)	**110,496**	(386)

Year Ended September 30,	**2024**	2023
Nonoperating revenues (expenses):		
Interest expense	**(26,866)**	(26,155)
Federal and state grant funds	**-**	378
Investment income (loss), net and other	**98,794**	79,467
Total nonoperating revenues (expenses), net	**71,928**	53,690
Income before noncontrolling interests	**182,424**	53,304
Income applicable to noncontrolling interests	**(13,386)**	(13,232)
Increase in Net Position—ECU Health	**$ 169,038**	$ 40,072
Net position—beginning of year	**$ 1,258,032**	$ 1,214,622
Contributions from members and other, net	**3,666**	3,338
Increase in net position—ECU Health	**169,038**	40,072
Increase in net position	**172,704**	43,410
Net position—end of year	**$ 1,430,736**	$ 1,258,032

Income (loss) from operations for 2024 and 2023 was $110.5 million and $(0.4) million, respectively. The related operating margins for 2024 and 2023 were 2.9% and (1.1)%, respectively. The operating margin percentages include interest expense as an operating expense, but excludes federal and state grant funding.

During 2024, operating revenues were $2.9 billion and increased by 16.5%, while operating expenses increased by 12.1%. Operating revenues increased during 2024 due to increases in inpatient activity of 8.7%, an increase of 8.5% in admissions at VMC and an increase of 9.0% in admissions at VCOM hospitals. Surgical volumes increased 6.2%. Operating revenues for 2024 included $13.2 million of favorable reimbursement settlements and other prior fiscal year adjustments as well as $42.1 million for 3 months of HASP revenue, net of assessments relating to fiscal year 2023.

During 2023, operating revenues were $2.5 billion and increased by 11.0%, while operating expenses increased by 8.8%. Operating revenues increased during 2023 due to increases in inpatient activity of 0.5%, an increase of 2.5% in admissions at VMC and a decrease of 4.4% in admissions at VCOM hospitals. Surgical volumes increased 6.3%. Operating revenues for 2023 included $18.7 million of favorable reimbursement settlements and other prior fiscal year adjustments.

During 2024, salaries and benefits increased by 13.9% to $1.5 billion due to pay for performance, incentives and market salary adjustments and an 29.2% increase in group insurance expense. Supplies and other expense increased by 10.2% to $1.1 billion. Depreciation and amortization expense increased by 11.4% to $120.9 million. Lease activity expense decreased by 25.0% to $6.6 million.

Total net nonoperating revenue is $71.9 million in 2024, as compared to net nonoperating revenue of $53.7 million in 2023. Nonoperating activity consists primarily of investment income, interest expense, gain on interest rate swap and unrestricted contributions. Income from investments was $110.4 million in 2024 and increased by $25.7 million as compared to 2023. ECU Health's 2024 investment income of $110.4 million consisted of unrealized gains on investments of $67.9 million and dividends and interest income and realized gains on investments of $42.5 million. Other income consisted primarily of an unrealized loss on ECU Health's interest rate swap of $1.0 million in addition to $17.8 million of other nonoperating expenses. Investment income was higher in 2024 as compared to 2023 due to overall improvement in financial markets in 2024. In 2024, unrestricted contributions totaled $5.0 million and increased by $2.3 million over 2023 levels. Interest expense on ECU Health's debt totaled $26.9 million, an increase of $0.7 million as compared to 2023. Gain on equity method investments totaled $2.2 million, an increase of $1.3 million as compared to 2023.

Total net nonoperating revenue is $53.7 million in 2023, as compared to net nonoperating expense of $(117.8) million in 2022. Nonoperating activity consists primarily of investment income, interest expense, gain on interest rate swap, federal and state grant funds and unrestricted contributions. Income from investments was $84.7 million in 2023 and increased by $211.9 million as compared to 2022. ECU Health's 2023 investment income of $84.7 million consisted of unrealized gains on investments of $70.4 million and dividends and interest income and realized gains on investments of $14.4 million. Other income consisted primarily of an unrealized gain on ECU Health's interest rate swap of $1.6 million in addition to $10.5 million of other nonoperating expenses. Also included is $0.4 million of federal and state grant funds primarily related to the CARES Act. Investment income was higher in 2023 as compared to 2022 due to overall improvement in financial markets in 2023. In 2023, unrestricted contributions totaled $2.7 million and decreased by $2.1 million over 2022 levels. Interest expense on ECU Health's debt totaled $26.2 million, an increase of $1.4 million as compared to 2022. Gain on equity method investments totaled $0.9 million, a decrease of $0.9 million as compared to 2022.

Income applicable to noncontrolling interests consists of noncontrolling interest due to Chesapeake General Hospital for their 40% ownership in OBH and the noncontrolling interest due to the local physicians for their 45% ownership in VSC. Income applicable to noncontrolling interests for 2024 totaled $13.4 million and increased by $0.2 million as compared to 2023. Income applicable to noncontrolling interests for 2023 totaled $13.2 million and decreased by $1.1 million as compared to 2022.

Cash Flows

The ECU Health condensed statements of cash flows are presented below:

Condensed Statements of Cash Flows
(Dollars in Thousands)

Year Ended September 30,	**2024**	2023
Cash flows:		
Operating activities	**$ 393,321**	$ (42,953)
Noncapital financing activities	**(23,166)**	(17,277)
Capital and related financing activities	**(181,324)**	(168,215)
Investing activities	**22,961**	244,823
Net increase in cash and cash equivalents	**211,792**	16,378
Cash and cash equivalents—beginning of year	**101,009**	84,631
Cash and cash equivalents—end of year	**$ 312,801**	$ 101,009

ECU Health's cash and cash equivalents increased by $211.8 million and $16.4 million in 2024 and 2023, respectively. Cash flows from operating activities were $393.3 million in 2024 and $(43.0) million in 2023, and increased by $436.3 million and $3.7 million in 2024 and 2023, respectively. ECU Health's total cash position at September 30, 2024, was $1,003.3 million, an increase of approximately $314.5 million from September 30, 2023. The 2024 increase in cash was due to strong cash flow provided by operating activities, HASP funding and investment earnings. Days cash on hand, an important metric for ECU Health's bond ratings, increased from 103.4 days at September 30, 2023, to 134.9 days at September 30, 2024.

Net cash outflows for capital and noncapital financing activities were $204.5 million in 2024. In 2024, cash was used to fund capital asset additions of $101.5 million to make principal payments on long-term debt of $66.8 million, and to make interest payments of $22.8 million. In 2023, cash was used to fund capital asset additions of $108.3 million to make principal payments on long-term debt of $48.2 million, and to make interest payments of $22.3 million.

Net cash flow provided by investing activities was $23.0 million in 2024 and $244.8 million in 2023. ECU Health had dividends and interest income and realized gains on investments of $42.5 million and $14.4 million in 2024 and 2023, respectively. Net sales of securities and investments used $40.7 million of cash in 2024, and provided $232.1 million of cash in 2023. During 2024 and 2023, respectively, ECU Health distributed $12.8 million and $9.8 million of earnings to noncontrolling members in joint ventures.

Capital Assets and Administration

Capital Assets

ECU Health's investment in capital assets consisted of the following at:

September 30,	**2024**	2023
Land	**$ 41,294**	$ 40,627
Land improvements	**44,439**	44,481
Buildings and improvements	**1,225,801**	1,184,841
Equipment	**937,216**	893,229
Right-to-use leased assets	**67,272**	53,830
Right-to-use subscription assets	**78,731**	52,060
Construction in progress	**34,028**	48,675
Total Capital Assets	**2,428,781**	2,317,743
Accumulated depreciation and amortization	**(1,600,270)**	(1,499,774)
Capital Assets, Net	**$ 828,511**	$ 817,969

At September 30, 2024 and 2023, ECU Health had $828.5 million and $818.0 million invested in capital assets, respectively. A summary of these assets is presented in Note 7 to the financial statements. During 2024, ECU Health's net investment in capital assets of $133.1 million, excluding accruals and capitalized interest, was higher than its net depreciation and amortization expense of $120.9 million.

In fiscal year 2025, ECU Health expects to invest approximately $153.5 million in capital assets. The Health System expects to spend approximately $18.5 million for information systems, nearly $57.7 million in building renovations, $18.1 million in new buildings, $21.9 million for contingency, and more than $37.3 million in new replacement equipment purchases throughout the region, including VMC and the VCOM hospitals.

Economic Outlook

ECU Health's primary service area covers 29 counties in eastern North Carolina. Greenville is home to East Carolina University (ECU), part of the state of North Carolina pubic university system and a number of community colleges in the state community college system which provide a pipeline for talent. The eastern North Carolina region has a strong collaboration with ECU and community colleges as well as government and industry partners. The population consists of rural areas and a high dependency on government programs.

The HASP program enacted by the State of North Carolina in March 2023 is a federally funded program through CMS to enhance Medicaid reimbursement. HASP provides for increased reimbursements to hospitals like ECU Health. The expansion of Medicaid in North Carolina has expanded Medicaid coverage to additional lives in the service area and also requires hospital assessments to fund the program. The passing of NC Care by the North Carolina General Assembly also provided additional much needed resources to the area to improve access to high quality health care for citizens and communities located in rural areas of North Carolina by establishing outcome

driven regional system of care, beginning in eastern North Carolina. These programs are expected to have a positive impact to ECU Health to allow us to continue to provide the necessary services to the residents of eastern North Carolina.

Contacting Financial Management

If you have questions about this report or need additional information, please contact ECU Health's Chief Financial Officer at ECU Health, 2100 Stantonsburg Road, P.O. Box 6028, Greenville, North Carolina 27835-6028.

Financial Statements

ECU Health

Statement of Net Position

(in $000's)

September 30,		2024
Assets and Deferred Outflows of Resources		
Current Assets		
Cash and cash equivalents	$	312,801
Patient accounts receivable, net		454,236
Other receivables		57,194
Estimated settlements due from third-party payors		206,780
Lease receivable, current portion		281
Inventories		71,370
Prepaid expenses		30,986
Assets limited as to use—professional liability losses, current		5,708
Total Current Assets		1,139,356
Assets Limited as to Use		
Internally designated for capital improvements		666,851
Internally designated for professional liability losses		52,579
Other cash limited as to use		16,874
Total Assets Limited as to Use, Net of Current		736,304
Capital Assets, Net		828,511
Other Noncurrent Assets		
Other intangible assets, net		2,656
Other assets		7,454
Lease receivable, less current portion		107
Total Other Noncurrent Assets		10,217
Total Assets		2,714,388
Deferred Outflows of Resources		169,938
Total Assets and Deferred Outflows of Resources	$	2,884,326

ECU Health

Statement of Net Position (continued)

(in $000's)

September 30,		2024
Liabilities, Deferred Inflows of Resources and Net Position		
Current Liabilities		
Accounts payable	$	141,640
Accrued expenses		277,106
Estimated settlements due to third-party payors		72,174
Current portion of professional liability losses		5,708
Current maturities of long-term debt		30,963
Lease liability, current portion		10,507
Subscription software, current portion		17,816
Total Current Liabilities		555,914
Long-Term Liabilities		
Long-term debt, less current maturities		551,305
Net pension liability		205,596
Professional liability losses, less current portion		28,937
Lease liability, less current portion		26,466
Subscription software, less current portion		10,172
Other liabilities		32,949
Total Liabilities		1,411,339
Deferred Inflows of Resources		42,251
Total Liabilities and Deferred Inflows of Resources		1,453,590
Net Position		
Net investment in capital assets		259,370
Restricted—noncontrolling interests		51,508
Restricted—other		3,439
Unrestricted		1,116,419
Total Net Position		1,430,736
Total Liabilities, Deferred Inflows of Resources and Net Position	$	2,884,326

See accompanying notes to financial statements.

ECU Health

Statement of Revenues, Expenses and Changes in Net Position

(in $000's)

Year Ended September, 30		2024
Operating Revenues		
Net patient service revenue, net of provision of bad debts	$	2,695,480
Other operating revenues		186,958
Total Operating Revenues		2,882,438
Operating Expenses		
Salaries and wages		1,201,660
Employee benefits		308,945
Supplies and other		1,133,895
Depreciation and amortization		120,871
Lease activity		6,571
Total Operating Expenses		2,771,942
Operating Income		110,496
Nonoperating Revenues (Expenses)		
Interest expense		(26,866)
Investment income, net		110,401
Other		(11,607)
Total Nonoperating Revenues, Net		71,928
Income Before Non-Controlling Interests		182,424
Income applicable to noncontrolling interests		(13,386)
Increase in Net Position - ECU Health	$	169,038
Increase in Net Position		
Net Position - Beginning of Year	$	1,258,032
Distributions to noncontrolling interests		(12,790)
Other		3,070
Income before non-controlling interests		182,424
Increase in Net Position		172,704
Net Position - End of Year	$	1,430,736

See accompanying notes to financial statements.

ECU Health

Statement of Cash Flows

(in $000's)

Year ended September 30,	2024
Operating Activities	
Receipts from payments by or on behalf of patients	$ 2,763,058
Receipts from other operations	185,610
Payments to employees for wages and benefits	(1,435,891)
Payments to vendors and suppliers	(1,119,456)
Net Cash Provided by Operating Activities	393,321
Noncapital Financing Activities	
Noncapital grants and contributions received	5,001
Noncapital grants and contributions paid	(9,957)
Distributions to noncontrolling interests	(12,790)
Other nonoperating expense	(4,800)
Intangible asset purchase	(620)
Net Cash Used in Noncapital Financing Activities	(23,166)
Capital and Related Financing Activities	
Capital asset additions	(101,529)
Proceeds from issuance of long-term debt	9,822
Principal payments on long-term debt	(66,802)
Interest paid related to capital financing activities	(22,815)
Net Cash Used in Capital and Related Financing Activities	(181,324)
Investing Activities	
Purchases of investment securities	(1,111,328)
Proceeds from sales and maturities of investment securities	1,070,581
Investment income	43,057
Change in other assets	20,651
Net Cash Provided by Investing Activities	22,961
Net Increase in Cash and Cash Equivalents	211,792
Cash and Cash Equivalents—Beginning of Year	101,009
Cash and Cash Equivalents—End of Year	$ 312,801

ECU Health

Statement of Cash Flows (continued)

(in $000's)

Year Ended September 30,		2024
Reconciliation of Operating Income to Net Cash Provided by Operating Activities		
Operating income	$	110,496
Adjustments to reconcile operating loss to net cash provided by operating activities:		
Depreciation and amortization		120,871
Provision for bad debts		142,726
Loss on disposal of capital assets		333
Changes in operating assets and liabilities:		
Patient accounts receivable		(108,328)
Other receivables		3,708
Inventories		(6,973)
Prepaid expenses		(6,084)
Estimated settlements due from/to third-party payors		29,472
Accounts payable		28,460
Accrued expenses		60,462
Other liabilities		(1,681)
Professional liability losses		5,607
Change in net pension liability, deferred outflows and deferred inflows of resources, net		14,252
Net Cash Provided by Operating Activities	$	393,321
Supplemental Disclosure of Noncash Information		
Accounts payable related to capital asset additions	$	11,900
Amortization of deferred loss on refunding and bond discounts and premiums in interest expense	$	3,900

See accompanying notes to financial statements.

ECU Health

Statement of Fiduciary Net Position—Pension Trust Funds

(in $000's)

September 30,		2024
Assets		
Investments at fair value:		
Mutual funds	$	779,522
Alternative funds		130,855
Cash equivalents		21,646
Equity securities		25,620
Total Investments		957,643
Liabilities		
Accounts payable		366
Total Liabilities		366
Net Position Restrcited for Pension Benefits		957,277
Total Liabilities and Net Position Restricted for Pension Benefits	$	957,643

See accompanying notes to financial statements.

ECU Health

Statement of Changes in Fiduciary Net Position—Pension Trust Funds

(in $000's)

Year ended September 30,		2024
Additions		
Investment earnings:		
Net increase in fair value of investments	$	148,732
Interest and dividends		3,804
Net Investment Earnings		152,536
Employer pension contributions		23,285
Total Additions		175,821
Deductions		
Benefit payments		52,808
Administrative expenses		2,630
Total Deductions		55,438
Net Increase in Fiduciary Net Position		120,383
Net Position Restricted for Pension Benefits Beginning of Year		836,894
End of year	$	957,277

See accompanying notes to financial statements.

1. Organization and Blended Component Units

University Health Systems of Eastern Carolina, Inc. d/b/a ECU Health, formerly Vidant Health, (the Parent Corporation) was incorporated on November 24, 1998, and is a nonprofit, tax-exempt corporation. The Parent Corporation, along with its affiliates (the Health System or ECU Health), is a health care delivery system providing hospital and other health care related services to the citizens of eastern North Carolina. ECU Health is not considered to be a component unit of any governmental organization.

Pitt County Memorial Hospital, Inc. d/b/a ECU Health Medical Center (VMC or the Hospital) is required to pay Pitt County annual payments in lieu of taxes and to partially reimburse Pitt County for its contribution to the North Carolina Medicaid Program. A number of the Hospital's Board of Directors are appointed by the County of Pitt (Pitt County) (see detailed discussion under the nucleus of the reporting entity section below); however, the facilities are not owned by Pitt County. The payment in lieu of taxes to Pitt County was approximately $2.2 million for the year ended September 30, 2024. The Medicaid payment was approximately $0.7 million for the year ended September 30, 2024. Because these payments are considered nonexchange transactions between governmental entities, the annual payments are recognized as components of nonoperating expenses in the statement of revenues, expenses and changes in net position.

Nucleus of the reporting entity: The financial statements of the business-type activities of the Health System present the financial position and results of operations of the Parent Corporation and its affiliates: VMC, which includes the activities of ECU Health Medical Center, East Carolina Health-Beaufort, Inc. d/b/a ECU Health Beaufort Hospital—A Campus of ECU Health Medical Center (VBEA), East Carolina Health, Inc. d/b/a ECU Health Community Hospitals (VCOM), ECU Health Physicians (VMG) which includes Roanoke Valley Health Services, Inc. (RVHS), Coastal Plains Network (CPN), Channel Marker Insurance Company, SPC (CMIC), PCMH Management, Inc. d/b/a ECU Health Properties (VP), Access East, Inc. (Access East), HealthAccess, Inc. (HealthAccess) and Vidant Integrated Care, LLC d/b/a ECU Health Alliance, LLC (VIC). The component units, which are described below, are referred to as affiliates throughout the financial statements. The Parent Corporation has blended the affiliates in a single column with the Parent Corporation in these financial statements based on the interrelationship of these component units and the Parent Corporation. See Note 17 for the presentation of the separate condensed financial information of the Parent Corporation and the major component units.

ECU Health's Board of Directors has certain reserve powers as it relates to VMC's actions. ECU Health's Board of Directors appoints the members of VCOM's Board of Directors. VMC, VCOM and several other component units are obligated in some manner for the debt of the Parent Corporation (see The Combined Group section below). All of the component units operate under substantially the same senior management team, operate to provide services entirely or almost entirely to ECU Health, and ECU Health employs substantially all of the team members of the component units. In addition, the team members are covered under common benefit plans, which are managed by ECU Health.

The Parent Corporation's Board of Directors consists of eleven voting members, six of whom must be current or former Pitt County appointees of VMC's Board of Trustees and five of whom must be current or former University of North Carolina (UNC) appointees of VMC's Board of Trustees. The Vice Chancellor of Health Sciences for East Carolina University also serves ex officio without voting rights. No more than nine current members of VMC's Board of Trustees may serve simultaneously as members of the Parent Corporation's Board of Directors. At all times, a majority, or six members, of the Parent Corporation's Board of Directors must be current members of VMC's Board of Trustees.

Appointments are for terms of three years, and thereafter members may be reappointed for one additional successive term of three years.

ECU Health has determined it has a fiduciary responsibility over three defined benefit pension plans (pension plans) that are offered to some of the team members of the Health System. The pension plans are included in the financial statements as a fiduciary fund.

The business-type activities of the Health System consist of the Parent Corporation and the following entities:

ECU Medical Center: VMC is a tax-exempt 501(c)(3) corporation formed for the purpose of providing health care services to the citizens of eastern North Carolina. VMC is an academic teaching hospital, a regional referral center and a community general hospital. VMC consolidates the financial statements of the Hospital and its affiliates: Moye Medical Endoscopy Center, LLC d/b/a ECU Health Endoscopy Center—Greenville (MMEC), SurgiCenter of Eastern Carolina, LLC d/b/a ECU Health SurgiCenter (VSC), and Vidant Radiation Oncology, LLC d/b/a ECU Health Radiation Oncology (VRO). Effective January 27, 2024, VMC acquired the remaining 50% ownership of VRO becoming the sole member. The purpose of VRO is to direct, operate and maintain radiation therapy centers in eastern North Carolina. VSC's financial statements are consolidated into ECU Health with the 45% interest owned by physicians reported as a noncontrolling interest.

The Hospital is the primary affiliated teaching hospital for the Brody School of Medicine at East Carolina University (Brody School of Medicine), which is physically adjacent to the Hospital. The Hospital and the Brody School of Medicine are committed to providing access to quality medical service to all citizens of Pitt County and eastern North Carolina. See Note 16.

Effective October 1, 2021, BEA became a provider-based department operating as a campus of VMC. ECU Health has a lease agreement with Beaufort County to lease and control Beaufort Regional Health System's assets through September 2041. The initial transaction required an upfront payment by ECU Health to Beaufort County, which approximated the net present value of future lease payments and other expenses. ECU Health recorded the upfront payment as the consideration for the transaction and allocated that consideration to the assets and liabilities acquired. At the end of the lease term, ECU Health is entitled to complete title and ownership of VBEA for a purchase price of $10.0 million.

ECU Community Hospitals: VCOM is a tax-exempt 501(c)(3) corporation formed in 1996 to enhance the quality and management of nonprofit hospitals and health care system services through the operation of community health facilities for the benefit of the residents of eastern North Carolina. VCOM includes the operations of VCOM and its affiliates:

- VCOM owns and operates East Carolina Health, Inc. d/b/a ECU Health Roanoke-Chowan Hospital (ROA), East Carolina Health-Bertie d/b/a ECU Health Bertie Hospital (BER), East Carolina Health-Heritage, Inc. d/b/a ECU Health Edgecombe Hospital (EDG), and Halifax Regional Medical Center, Inc. d/b/a ECU Health North (NOR). NOR was acquired on June 1, 2019, through the execution of a change of control agreement. In consideration for acquiring NOR, ECU Health has committed to providing capital expenditures in the first 10 years for projects and initiatives that ECU Health deems necessary. These entities are component units of VCOM as they provide support exclusively to benefit VCOM.

- VCOM leases East Carolina Health-Chowan d/b/a ECU Health Chowan Hospital (CHO), from Chowan County. At the end of the lease term, November 2, 2028, ownership of the facilities will pass to VCOM, subject to Chowan County's option to buy back the hospital and related facilities for an amount equal to the then fair market value.

- VCOM operates The Outer Banks Hospital, Inc. d/b/a Outer Banks Health (OBH), which is a joint venture between ECU Health (60%) and Chesapeake General Hospital (40%). Chesapeake General Hospital's 40% interest is reported as a noncontrolling interest.

- VCOM operates Duplin General Hospital d/b/a ECU Health Duplin Hospital (DUP) through a lease agreement with Duplin County to lease and control DUP's assets for a 25-year period ending on September 30, 2035. At the end of the lease term, ECU Health is entitled to complete title and ownership of DUP. The transfer of title and ownership is contingent on ECU Health continuing to use the assets for the delivery of health care services.

VCOM recorded the CHO and DUP agreements as capital leases and VMC recorded the BEA agreement as a capital lease. Under the lease agreements, there are no ongoing lease payments required. As of September 30, 2024, the net book value of the assets under these capital leases is approximately $70.5 million.

HealthAccess, Inc.: HealthAccess is a nonprofit, 501(c)(3) tax-exempt corporation formed in 1993 to establish an outreach program for ECU Health by offering support services to other health care providers in eastern North Carolina. HealthAccess offers home health and hospice services (d/b/a ECU Home Health & Hospice). ECU Health appoints all members of the HealthAccess Board.

ECU Health Physicians: VMG provides the capability to lead and manage all aspects of physician organizations. VMG provides a variety of physician services through both stand-alone and hospital-based practice settings. The establishment of VMG has provided strategic alignment and improved the coordination of care throughout the Health System and associated service areas. On June 1, 2019, the operations of RVHS were acquired and are included in the operations of VMG since that date. VMG's financial statements are combined into ECU Health as it is the sole member of VMG.

ECU Health Properties: VP currently owns and operates several office buildings and land in the Health System's service area. The Hospital leases the majority of the office buildings for health system office and clinical services space. VP's financial statements are combined into ECU Health as it is the sole member of VP.

Coastal Plains Network, LLC and Vidant Integrated Care, LLC: CPN and VIC are health care management companies that integrate clinical information and health care services in order to improve value to patients. CPN provides those services primarily for Medicare Shared Savings and VIC provides these services to other payors, including the ECU Health team member plan. These entities are component units of ECU Health as they provide support exclusively to benefit ECU Health.

Channel Marker Insurance Company, SPC: CMIC is a segregated portfolio company and a wholly owned subsidiary of the Parent Corporation, domiciled in the Cayman Islands. CMIC is providing professional liability (PL) and general liability (GL) coverage to ECU Health and its wholly owned subsidiaries effective October 1, 2017, on a claims-made basis, with a retroactive date of October 1, 2001. CMIC is providing coverage to VSC effective October 1, 2017, on a claims-made basis, with retroactive dates of June 10, 2008 (PL) and October 1, 2017 (GL). CMIC provides professional and

general liability coverage to NewCo Cancer Services (wholly owned subsidiary of VMC) effective October 1, 2017, on a claims-made basis, with a retroactive date of June 11, 2011 (PL) and October 1, 2017 (GL). CMIC provides indefinite tail coverage for NewCo Cancer Services effective October 1, 2018. CMIC began providing professional and general liability primary and shared excess coverage to ECU Health's employed and contract physicians effective March 30, 2018, on a claims-made basis. For the primary layer, coverage will correspond to the individual physician's retroactive date. For the shared excess layer, coverage will reflect a retroactive date of March 30, 2011, or the individual physician's retroactive date, whichever is later. Effective October 1, 2019, OBH was added to ECU Health's PL/GL program under CMIC. Effective October 1, 2020, NOR was added to ECU Health's PL/GL program under CMIC. Effective July 1, 2022, a new cell was created for a non-consolidated entity, the Brody School of Medicine and ECU Physicians.

Access East, Inc.: AE is a nonprofit corporation formed in 1995 for the purpose of supporting the delivery of high-quality, low-cost health care to residents of Pitt County and the surrounding region through a Medicaid Care Management demonstration project, the Community Care Plan of Eastern Carolina. Effective July 1, 2021 with the change the Medicaid Managed Care, AE now partners with the Prepaid Health Plans (PHP) to provide similar services for the Medicaid population as well as providing care management and other services to ECU Health.

The Combined Group: The bonds discussed in Note 8 are collateralized by the accounts of the members of the Obligated Group and Restricted Affiliates (Combined Group). Each member of the Obligated Group has covenanted that it will cause each of its Restricted Affiliates to pay, loan or otherwise transfer to such member of the Obligated Group (i) such amounts as are necessary to make payments due under all master obligations or portions thereof, the proceeds of which were loaned or otherwise made available to or benefited such Restricted Affiliate and (ii) such other amounts as are necessary to enable such member of the Obligated Group to make payments due under all master obligations. As of September 30, 2024, the primary members of the Combined Group were the Parent Corporation and its component units: VMC (excluding VSC and VRO), VCOM (excluding OBH), VP and VMG (excluding RVHS).

Separately issued financial statements of The Outer Banks Hospital, Inc. d/b/a Outer Banks Health (a component unit of VCOM) and CMIC can be obtained by writing to University Health Systems of Eastern Carolina, Inc. d/b/a ECU Health, PO Box 6028, Greenville, NC 27835, Attention: Finance Department.

2. Significant Accounting Policies

Basis of Presentation

ECU Health meets the definition of a governmental reporting entity and follows accounting principles generally accepted in the United States of America. The financial statements are prepared in accordance with the GASB. ECU Health utilizes enterprise fund accounting for its business-type activities whereby revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Revenues are recognized when earned, and expenses are recorded when a liability is incurred regardless of the timing of the related cash flows.

The pension trust funds are fiduciary funds used to account for the assets held in trust for the benefit of the team members of the Health System who participate in the three defined benefit pension plans. The pension plans custodians hold the pension plans assets in custody accounts on behalf of the trust.

Use of Estimates in the Preparation of Financial Statements

The preparation of the financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts in the financial statements and the accompanying notes. Actual results could differ from those estimates.

Basis for Consolidation

The financial statements of the business-type activities include the accounts of the Parent Corporation and all of its affiliates as described in Note 1. All significant intercompany accounts and transactions have been eliminated upon consolidation.

Income Taxes

ECU Health and most of its affiliates have been determined to qualify as tax-exempt organizations under section 501(c)(3) of the Internal Revenue Code and are exempt from federal and state income taxes on related income. There was no material amount of income tax expense in 2024.

Patient Accounts Receivable, Net

Patient accounts receivable are reported net of estimated allowances for contractual adjustments and allowances for bad debts and are recorded in the period in which collection is considered doubtful. Estimated allowances for bad debts are approximately $118.3 million as of September 30, 2024.

Net Patient Service Revenue

Net patient service revenue is recorded when services are performed at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and estimated provision for bad debts. Provision for bad debts is included with net patient service revenue. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The provision for uncollectible patient accounts receivable is based on the duration the patient's account has been outstanding, current economic conditions, and historical collection experience. ECU Health provides care to patients who meet certain criteria under its charity care policy. See Note 3.

Investments and Investment Income

Investments in equities, mutual funds, debt and fixed-income equity securities are recorded at fair value and are included in assets limited as to use on the statement of net position. All investment income and losses, net of applicable fees, including changes in realized and unrealized gains and losses on investments and changes in the fair value of derivative instruments, are recognized as nonoperating revenue or nonoperating expense in the statement of revenues, expenses and changes in net position when earned, net of applicable fees.

Assets limited as to use include (1) internally designated assets set aside for capital improvements and to fund professional liability losses, over which the Board retains control and may at its discretion subsequently use for other purposes, except for the portion of professional liability

reserves that are required to be maintained in CMIC, and (2) assets held by a trustee for capital improvements or debt service and the supplemental executive retirement plan. Assets limited as to use consist of cash, cash equivalents and marketable securities.

Operating Revenues and Expenses

The statement of revenues, expenses and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, ECU Health's principal activity. Nonexchange revenues and expenses, including grants, payments to Pitt County and other governmental entities, contributions made to East Carolina University for research and education, and contributions received, are reported as nonoperating revenues and expenses. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

Federal and State Grants and Deferred Revenue

ECU Health recognizes revenue from grants when the expenses have been incurred for the purpose specified by the grantor or in accordance with the terms of the agreement. Payments received in advance are reported as deferred revenue. ECU Health is subject to examination by the funding sources of grants to determine its compliance with grant provisions. In the event that expenditures could be disallowed through such examination or review, repayment of such disallowances could be required.

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with a maturity of three months or less when purchased that are not included in assets limited as to use.

Inventories

Inventories, which consist principally of medical, pharmaceutical and dietary supplies, are stated at the lower of cost (first-in, first-out method) or market.

Capital Assets

Capital assets are stated at cost when acquired, or at acquisition value at date of donation, and are depreciated by the straight-line method over their estimated useful lives, as follows:

Capital Asset Classification	Estimated Useful Lives
Land improvements	5-40 years
Buildings and improvements	5-40 years
Equipment	2-20 years
Right of use assets	2-10 years

Expenditures for repairs and maintenance are charged to expense as incurred. The costs of major renewals and betterments are capitalized and depreciated over their estimated useful lives. Upon disposition, the asset and related accumulated depreciation accounts are relieved, and any related

gain or loss is credited or charged to nonoperating revenues or expenses. The capitalization threshold (the dollar value above which asset acquisitions are added to the capital asset accounts) is primarily $5,000 for most asset classifications and for items with useful lives greater than one year. Capital assets are reviewed for impairment when events or changes in circumstances suggest that the service utility of the capital asset may have significantly and unexpectedly declined.

Leases

Leased assets are included in capital assets, net of accumulated amortization, lease liability is included in lease liability current portion and long-term portion. Leased assets represent the right to use an underlying asset for the lease term, as specified in the contract, in an exchange or exchange-like transaction. Leased assets are recognized at the commencement date based on the initial measurement of the lease liability, adjusted for payments made to the lessor and amortized in a systematic and rational manner over the shorter of the lease term or the useful life of the underlying asset.

Lease liabilities represent the obligation to make lease payments arising from the lease. Lease liabilities are initially recognized at the commencement date based on the present value of the expected lease payments over the lease term. Subsequently, the lease liability is reduced by the principal portion of the lease payments made and interest expense is recognized ratably over the contract term.

The lease term may include options to extend or terminate the lease when it is reasonably certain that the Health System will exercise that option. The Health System has elected to recognize payments for short-term leases with a lease term of 12 months or less as expenses as incurred, and these leases are not included as lease liabilities or capital assets on the statement of net position but as lease activity within operating expenses.

The individual lease contracts do not provide information about the discount rate implicit in the lease; therefore, the Health System has elected to use their incremental borrowing rate to calculate the present value of the expected lease payments.

Lease receivables represent the right to receive lease payments arising from the lease. Lease receivables are included in lease receivable, current portion, lease receivable, long term portion and deferred inflows. Lease receivables are initially recognized at the commencement date based on the present value of the expected lease payments to be received over the lease term. Subsequently, the lease receivable and deferred inflow are reduced by the principal portion of the lease payments received.

Subscription Software

Subscription software assets are included in capital assets, net of accumulated amortization; subscription software liability is in subscription software current portion, subscription software, long term portion. Subscription software assets represent the right to use another party's IT software, alone or in combination with underlying IT assets, for the subscription term, as specified in the contract, in an exchange or exchange-like transaction. Subscription software assets are recognized at the commencement date based on the initial measurement of the subscription software liability, adjusted for payments made to the IT software party and amortized in a systematic and rational manner over the shorter of the subscription term or the useful life of the underlying IT asset.

Subscription software liabilities represent the obligation to make subscription software payments arising from the subscription. Subscription software liabilities are initially recognized at the commencement date based on the present value of the expected subscription software payments over the subscription term. Subsequently, the subscription software liability is reduced by the principal portion of the subscription software payments made and interest expense is recognized ratably over the subscription term.

The subscription term may include options to extend or terminate the software subscription when it is reasonably certain that the Health System will exercise that option. The Health System has elected to recognize payments for short-term software subscriptions with a subscription term of 12 months or less as expenses as incurred, and these software subscriptions are not included as subscription software liabilities or subscription software assets on the statement of net position but as supplies and other in operating expenses.

The individual subscription software contracts do not provide information about the discount rate implicit in the software subscription; therefore, the Health System has elected to use their incremental borrowing rate to calculate the present value of the expected software subscription payments.

Bond Discounts and Premiums

The discounts and premiums associated with the issuance of the long-term debt was amortized using the effective-interest method over the period to maturity of the debt.

Derivative Financial Instruments

ECU Health's derivative financial instruments consist of an interest rate swap, which is utilized by ECU Health to manage net exposure to interest rate changes associated with its variable-rate debt and to lower its overall borrowing costs. ECU Health entered into the floating to fixed interest rate swap agreement to reduce the market risk associated with the changes in interest rates related to certain of ECU Health's variable-rate revenue bonds. Management has evaluated and determined the swap to be an ineffective hedge under the accounting standards, and has recorded its fair value in long-term debt on the statement of net position and includes the gain or loss on the change in the fair value in other nonoperating revenues (expenses) in the statement of revenues, expenses and changes in net position.

Deferred Outflows and Inflows of Resources

In addition to assets, the statement of net position reports a separate section for deferred outflows of resources. This separate financial statement element, deferred outflows, represents a consumption of net position that applies to a future period and so will not be recognized as an expense until then. In addition to liabilities, the statement of net position also reports a separate section for deferred inflows of resources. This separate financial statement element, deferred inflows, represents an acquisition of net position that applies to a future period and so will not be recognized as revenue until then.

(in $000's)

Components of deferred outflows and inflows of resources are as follows:

September 30, 2024	Deferred Outflows of Resources	Deferred Inflows of Resources
Loss on refunding of debt (net of amortization)	$ 41,865	$ -
Pensions and OPEB—difference between projected and actual experience, changes in actuarial assumptions, and net differences between projected and actual investment earnings	67,671	(41,856)
Goodwill, net of amortization	33,567	-
Contributions to pension plans and OPEB after measurement date	26,835	-
Deferred lease receivable	-	(395)
Total	$ 169,938	$ (42,251)

Further discussion of deferred outflows and inflows of resources related to pensions and OPEB are included in Notes 13 and 14, respectively.

Concentration of Credit Risk

ECU Health provides services primarily to the residents of eastern North Carolina without collateral or other proof of ability to pay. Concentrations of credit risk with patients are limited due to the large number of patients served and the formalized agreements with third-party payors. ECU Health has significant patient accounts receivable whose collectability or realizability is dependent upon the performance of certain government programs. The mix of ECU Health's net patient accounts receivable and net patient service revenue at September 30, 2024, is summarized as follows:

	Patient Accounts Receivable, net	Net Patient Service Revenue
Medicare	28%	38%
Medicaid	14%	26%
Significant commercial payor	27%	20%

Net patient service revenue represents the amount of net revenue by primary payor at the time service was performed. Patient accounts receivable, net by payor is based on the primary party who is currently responsible for making payment.

Compensated Absences

ECU Health's team members earn paid time off (PTO) at varying rates depending upon years of service. The maximum amount of PTO that can carry over from one fiscal year is 50 days (400 hours). The liabilities recorded for compensated absences that have been earned and are expected to be paid are included in accrued expenses in the statement of net position.

Prior to December 14, 2014, team members also earned sick time hours. As of December 14, 2014, those hours can only be used for qualified short-term disability events, after 40 hours of PTO is used. Certain team members that have unused accumulated sick time hours at retirement may get paid for a portion of these hours. ECU Health estimates the amounts that will be paid out to the eligible team members upon their future retirement and reports that liability in accrued expenses in the statement of net position.

Net Position

Net position is categorized as net investment in capital assets, restricted or unrestricted. Net investment in capital assets consists of capital assets, net of accumulated depreciation, goodwill and assets whose use is limited from the issuance of bonds and reduced by the balances of any outstanding borrowings used to finance the purchase or construction of those assets as well as the deferred outflows that are attributable to those outstanding borrowings. Restricted—noncontrolling interests includes the minority portion of net position interests in various joint ventures that are owned by unconsolidated partners. Restricted—other includes contributions to be used for operation and capital improvements for the benefit of the ROA and its Wellness Center. The unrestricted component of net position is the net amount of assets, deferred outflows/inflows of resources, and liabilities that is not included in the determination of net investment in capital assets or the restricted components of net position.

The decision to use restricted or unrestricted resources when an expense is incurred is dependent upon the transaction. When both restricted and unrestricted resources are available for use, it is ECU Health's policy to use restricted resources first followed by unrestricted.

Community Benefit

ECU Health furthers its charitable purpose by providing a wide variety of benefits to the community. These services and donations account for a measurable portion of the Health System's costs and serve to promote affordable access to care, health education, community development and healthy lifestyles. See Note 3.

Risk Management

The Health System is exposed to various risks of loss from theft of, damage to and destruction of assets; professional liability; workers' compensation; team member medical expense; and other risk for which ECU Health has self-insured a portion of and purchased commercial insurance coverage for the remaining risks. Settled claims have not exceeded the commercial coverage in either of the two preceding years. See Note 11.

The cost of professional liability losses incurred by ECU Health is accrued in the period the services are rendered. A provision has been made for claims in process of review and for claims incurred but not reported at year-end. The amount of this liability is computed by an independent actuary using historical claims payment experience and industry trends and is recognized on a discounted basis. Liability loss estimates are adjusted based upon changes in experience, and such adjustments are reflected in current operations.

Recently Adopted Accounting and Reporting Pronouncements

In 2022, the GASB issued Statement No. 100, *Accounting Changes for Error Corrections—An Amendment of GASB Statements No. 62*. The primary objective of this Statement is to enhance accounting and financial reporting requirements for accounting changes and error corrections to provide more understandable, reliable, relevant, consistent, and comparable information for making decisions or assessing accountability. GASB Statement No. 100 did not have any impact on ECU Health's financial statements.

Future Accounting and Reporting Pronouncements

In 2022, the GASB issued Statement No. 101, *Compensated Absences*. The objective of this Statement is to better meet the information needs of financial statement users by updating the recognition and measurement guidance for compensated absences. That objective is achieved by aligning the recognition and measurement guidance under a unified model and by amending certain previously required disclosures. The requirements of this Statement are required to be adopted no later than the year ending September 30, 2025. Management is currently evaluating the impacts GASB Statement No. 101 will have on ECU Health's financial statements.

In 2023, the GASB issued Statement No. 102, *Certain Risk Disclosures*. This statement requires governments to disclose essential information about risks related to vulnerabilities due to certain concentrations or constraints. The requirements of this Statement are required to be adopted for fiscal years beginning after June 15, 2024, and all reporting periods thereafter. Management is currently evaluating the impacts GASB Statement No. 102, *Certain Risk Disclosures*, will have on ECU Health's financial statements.

In 2024, the GASB issued Statement No. 103, *Financial Reporting Model Improvements*. The objective of this statement is to improve key components of the financial reporting model to enhance effectiveness in providing information that is essential for decision making and assessing accountability. Certain application issues are also addressed by this statement. The requirements of this Statement are required to be adopted for fiscal years beginning after June 15, 2025, and all reporting periods thereafter. Management is currently evaluating the impacts GASB Statement No. 103 will have on ECU Health's financial statements.

In 2024, the GASB issued Statement No. 104, *Disclosure of Certain Capital Assets*. The objective of this statement is to provide users of financial statements with essential information about certain types of capital assets by requiring certain types of capital assets to be disclosed separately in the capital assets note disclosures required by Statement 34. The requirements of this Statement are required to be adopted for fiscal years beginning after June 15, 2025, and all reporting periods thereafter. Management is currently evaluating the impacts GASB Statement No. 104 will have on ECU Health's financial statements.

3. Charity Care and Community Benefits

Charity Care

ECU Health provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Key elements used to determine eligibility include household income, real property and other assets. ECU Health does not pursue collection of amounts determined to qualify as charity care; therefore, they are not reported as revenue.

ECU Health maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges forgone for services and supplies furnished under its charity care policy and the estimated cost of these services and supplies. ECU Health has a presumptive charity program, which recognizes that there is a segment of the population that should fall within the guidelines of its charity programs, yet do not qualify due to failure to apply or failure to provide income documentation. ECU Health's presumptive charity program seeks to identify and provide financial relief for those patients who would have qualified had their economic situation been known and documented. ECU Health also contracts with an independent third party, which provides assistance in determining which patients qualify for presumptive charity.

ECU Health has estimated its direct and indirect costs of providing charity care under its charity care policy. In order to estimate the cost of providing such care, management calculated a cost-to-charge ratio by comparing the per diem rate from the most recently filed cost report to the Health System's gross bill rate. The cost-to-charge ratio is applied to the charity care charges foregone to calculate the estimated direct and indirect cost of providing charity care. Using the methodology noted above, ECU Health has estimated the costs associated with amounts foregone for patient service revenues of $49.0 million for the year ended September 30, 2024. ECU Health did not receive any funds to subsidize the costs of providing charity care under its charity care policy for the year ended September 30, 2024.

Community Benefits

In addition to providing financial assistance to uninsured patients and in furtherance of its mission, the Health System provides a broad range of benefits and services, including medical education and research opportunities, to the community spanning the geographic region within which ECU Health operates. These community benefits can be measured and categorized as follows:

- Cost of care extended to uninsured and underinsured patients who do not qualify for financial assistance, estimated using applicable cost-to-charge ratios

- Unpaid cost of Medicare and Medicaid services represent the net unreimbursed cost, estimated using the applicable cost-to-charge ratios, of services provided to patients who qualify for federal and/or state government health care benefits

- Community benefit programs include the unreimbursed cost of various medical education programs and costs of various research programs, non-billed medical services, in-kind donations, and other services that meet a community need but do not pay for themselves and would not be provided if based solely on financial considerations alone

4. Net Patient Service Revenue

ECU Health has agreements with third-party payors that provide for payments at amounts different from its established rates. A summary of these arrangements follows:

Medicare: VMC, VMG, HealthAccess and VCOM's inpatient acute care, rehab, psych and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors and cover payment for both operating and capital costs. Direct medical education costs related to Medicare beneficiaries are paid on the basis of reasonable costs. VMC and VCOM are reimbursed for cost-reimbursable items at a tentative rate, with final settlement determined after

submission of annual cost reports by VMC and VCOM and audits thereof by the Medicare Administrative Contractors. BER, CHO and TOBH (the Critical Access Hospitals) have received critical access status, which provides for cost-based reimbursement from the Medicare program. VMC and VCOM's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization. VMC's cost reports have been audited by the Medicare Administrative Contractor through 2017. CHO's and BER's Medicare cost reports have been audited by the Medicare Administrative Contractors through 2011 and 2018, respectively. DUP's and EDG's Medicare cost reports have been audited by the Medicare Administrative Contractor through 2020. TOBH's Medicare cost reports have been audited by the Medicare Administrative Contractor through 2019. BEA's, ROA's and NOR's Medicare cost reports have been audited by the Medicare Administrative Contractor through 2020.

Medicaid: Prior to July 1, 2021, VMC's Medicaid reimbursement is based on the cost for inpatient and outpatient services. VMC was reimbursed at a tentative rate, with final settlement determined after submission of annual cost reports by VMC and audits thereof by the Medicaid fiscal intermediary. VMC's Medicaid cost reports have been audited by the Medicaid fiscal intermediary through 2019.

Prior to July 1, 2021, VCOM's Medicaid reimbursement was based on a payment per discharge system, with case-mix adjustments based on diagnosis-related groups (DRGs) similar to those used in the Medicare program. Outpatient services are paid at a percentage of cost based on the filing of Medicaid cost reports. The Critical Access Hospitals receive cost-based Medicaid reimbursement. VCOM's Medicaid cost reports have been audited by the Medicaid fiscal intermediary through 2018.

VMG and HealthAccess Medicaid reimbursement is based on a payment per discharge system, with case-mix adjustments based on DRGs similar to those used in the Medicare program.

Effective July 1, 2021, North Carolina Department of Health and Human Services (DHHS) converted to Managed Care Medicaid by contracting with select number of Prepaid Health Plans (PHP) to manage the care for most individuals covered by Medicaid. The new base rates were developed by the State of North Carolina to be the equivalent of the amount received (including the supplemental payments) on a per patient basis for fiscal year 2020 plus an inflation factor. As of September 30, 2024, ECU has contracted with the majority of the PHP providers.

ECU Health has historically participated in the voluntary North Carolina Medicaid Reimbursement Initiative Program (the MRI Program). The MRI Program allows the Hospital to receive additional annual Medicaid funding for its disproportionate share costs. ECU Health recognizes the revenues related to the MRI Program as net patient service revenue. In March 2012, the Center for Medicare & Medicaid Services (CMS) approved a new disproportionate share plan for North Carolina. The GAP Assessment Program Plan (the GAP Plan) covers all non—state government hospitals and private hospitals in North Carolina, except for the UNC Health Care System—affiliated hospitals, and is essentially a supplemental upper payment limit plan to the existing MRI Program.

Under the provisions of the GAP Plan, ECU Health is assessed an intergovernmental transfer (IGT Payment) by Medicaid; in return, Medicaid makes an upper payment limit (UPL Plan) payment to ECU Health. When both amounts are reasonably estimable and probable of payment, ECU Health recognizes the revenues related to the UPL Plan as net patient service revenue. The IGT Payment is recorded as an operating expense and classified in supplies and other. Although DHS converted to Managed Care Medicaid effective July 1, 2021, ECU Health can continue to receive funds from these two programs due to the State of North Carolina's reconciliation of the prior plans.

(in $000's)

The following table summarizes the transactions recognized by ECU Health related to these plans:

Year Ended September 30,		**2024**
Medicaid managed care revenue	**$**	**136,760**
HASP revenue		**348,029**
IGT payments		**(31,664)**
Direct pay assessment		**(22,378)**
Expansion assessment		**(21,527)**
HASP assessment		**(86,294)**
Total Medicaid Managed Care	**$**	**322,926**

ECU Health has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

The health care industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and/or allegations concerning possible violations of fraud and abuse statutes and/or regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that ECU Health is in compliance with fraud and abuse as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown and unasserted at this time.

During March 2023, the Healthcare Access and Stabilization Program (HASP) was enacted by the State of North Carolina and is a federally funded program through CMS to enhance Medicaid reimbursement. HASP provides for increased reimbursements to hospitals and increases hospital assessments to fund the program. During September 2023, CMS approved HASP and the increased reimbursements to be made for services provided for the period July 1,2022 to June 30, 2023. For the year ended September 30, 2024, ECU Health recognized $261.7 million as net patient service revenue, net of assessments of approximately $86.3 million, which includes $42.1 million for 3 months of HASP revenue, net of assessments relating to fiscal year 2023.

(in $000's)

Net patient service revenue for the year ended September 30, 2024 is composed of the following:

	2024
Gross charges at established rates	$ 6,656,055
Deductions:	
Medicare adjustments	2,276,603
Medicaid adjustments	551,751
Other contractual adjustments	849,764
Provision for bad debts	142,726
Charges forgone for charity care	139,731
Net patient service revenue	$ 2,695,480

5. Deposits and Investments

Custodial Credit Risk—Deposits

Custodial credit risk is the risk that in the event of a bank failure, ECU Health's deposits may not be returned. ECU Health does not have a deposit policy for custodial credit risk. As of September 30, 2024, $347.5 million of ECU Health's bank balance of $351.6 million was exposed to custodial credit risk, as it exceeded the Federal Deposit Insurance Corporation (FDIC) insurance limit and was not collateralized.

Investments and Assets Limited as to Use

ECU Health requires that its long-term investments be held in a diversified portfolio that has the following maximum allocation guidelines: Long-Term Investment Fund—fixed income 56.5%, equity 63.5% and real assets 18%.

Following is a summary of the fair value of ECU Health's investments. The investments that represent securities are uninsured and unregistered, for which securities are held by the broker or dealer, or by its trust department or agent, but not in ECU Health's name:

September 30,	2024
Investments classified as assets limited as to use:	
Corporate debt and commercial paper	$ 86,396
U.S. Treasury securities	81,062
U.S. government-backed securities	71,290
Fixed-income mutual funds	20,736
Equity and real asset mutual funds	338,536
	598,020

(in $000's)

September 30,	2024
Cash equivalents	141,469
Accrued interest receivable	2,523
	742,012
Less amounts classified as current	5,708
Total assets limited as to use, net of current	$ 736,304

A summary of investment income follows:

Year Ended September 30,	2024
Dividends and interest income	$ 27,879
Net realized gains	14,644
Net unrealized gains	67,878
Investment income, net	$ 110,401

Interest Rate Risk

ECU Health holds investments in a variety of investment funds. In general, investments are exposed to various risks, such as interest rate, credit and overall market volatility risk. Interest rate risk represents the potential volatility of the price of debt securities prior to maturity. Securities with longer maturities have more volatile prices than securities of comparable quality with shorter maturities.

ECU Health does not have a formal policy that dictates the target maturities of its portfolio. As of September 30, 2024, scheduled maturities of debt-type investments classified as limited as to use are as follows:

		Investment Maturities (In Years)			
Investment Type	Fair Value	Less Than 1	1-5	6-10	More Than 10
Corporate debt and commercial paper	$ 86,396	$ 2,864	$ 34,856	$ 29,044	$ 19,632
U.S. Treasury securities	81,062	11,339	51,460	7,570	10,693
U.S. government-backed securities	71,290	14,252	11,819	10,792	34,427
	238,748	$ 28,455	$ 98,135	$ 47,406	$ 64,752
Cash equivalents and accrued interest receivable	143,992				
Fixed-income mutual funds	20,736				
Equity and real asset mutual funds	338,536				
Total assets limited as to use	$ 742,012				

(in $000's)

The cash equivalents in the table above are generally invested in U.S. Treasury securities with original maturity dates of less than 90 days at the time of purchase.

The fair value and durations of the fixed-income mutual funds held were as follows:

September 30, 2024	Fair Value	Duration (Years)
Fund A	$ 11,971	3.85
Fund B	8,764	1.94

Duration is a commonly used measure of the potential volatility of the price of debt securities prior to maturity. Securities with a longer duration have more volatile prices than securities of comparable quality with a shorter duration.

Credit Risk

ECU Health's investment policy objective of short-term investment fund is to generate a rate of return similar to or above short-term money market rate and maintain high liquidity to fund near-term needs for operations and other strategic purposes. The portfolio will be of high quality and well diversified with maturity and duration ranges designed to minimize risk to principal and provide liquidity for withdrawals. The long-term investment fund objective is to maximize returns with reasonable and acceptable levels of risk. To achieve the investment objectives, while assuming acceptable risk levels, the general policy is to diversify investments based on their roles in the funds so as to provide a balance that will enhance total return while avoiding undue risk concentration in any single asset class or investment strategy by investing within specific target asset allocations and rebalancing as needed.

The quality ratings of ECU Health's investments classified as assets limited as to use, based on fair value as of September 30, 2024, are as follows:

		Quality Ratings							
Investment Type	**Total**	**AAA**	**AA**	**A**	**BBB**	**BB**	**B**	**CCC**	**Unrated**
Corporate debt and commercial paper	$ 86,396	$ 1,952	$ 2,642	$18,744	$29,824	$13,349	$ 6,900	$ 1,784	$11,201
U.S. Treasury securities	81,062	37,601	-	-	-	-	-	-	43,461
U.S. government-backed securities	71,290	-	3,926	1,135	6,532	4,233	2,978	1,713	50,773
	238,748	$39,553	$ 6,568	$19,879	$36,356	$17,582	$ 9,878	$ 3,497	$105,435
Cash equivalents and accrued interest receivable	143,992								
Unrated fixed-income mutual funds	20,736								
Equity and real asset mutual funds	338,536								
Total assets limited as to use	$ 742,012								

6. Fair Value Measurements

Accounting guidance provides a framework for measuring fair value of certain assets and liabilities and requires certain disclosures about fair value measurements. As defined in GASB Statement No. 72, *Fair Value Measurement and Application* (GASB No. 72), fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. GASB No. 72 establishes a fair value hierarchy that prioritizes the inputs used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements).

The three levels of the fair value hierarchy defined by GASB No. 72 and description of the valuation methodologies used for instruments measured at fair value are as follows:

Level 1: Inputs are quoted prices (unadjusted) in active markets for identical assets or liabilities as of the reporting date.

Level 2: Pricing inputs are other than quoted prices included in Level 1 that are observable for an asset or liability through corroboration with market data at the measurement date.

Level 3: Pricing inputs include those that are significant to the fair value of the financial asset or liability and are not observable from objective sources. These inputs may be used with internally developed methodologies that result in management's best estimate of fair value.

ECU Health's assets and liability measured at fair value on a recurring basis are limited to investments and certain interest rate swaps.

The fair values of certain investments in mutual funds are estimated using the net asset value (NAV) per share of the investments. As such, they are not included in Level 1, 2 or 3 in the following table. ECU Health may redeem its investments measured at NAV within a stated time period, subject to certain fund availability restrictions. These valuation methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while ECU Health believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

ECU Health has capital commitments to alternative investment funds. At September 30, 2024, the remaining unfunded commitment of $6.5 million will be funded as the managers make capital calls to the funds.

(in $000's)

The following table sets forth, by level within the fair value hierarchy, ECU Health's financial assets and liability measured at fair value on a recurring basis:

		Fair Value Measurements at Reporting Date Using			
September 30, 2024	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Measured Using NAV
Financial assets:					
Equity and mutual funds	$ 323,657	$ 88,558	$ -	$ -	$ 235,099
Venture capital and partnerships	35,615	-	-	-	35,615
Cash equivalents	143,992	143,992	-	-	-
Corporate debt and commercial paper	86,396	7,603	78,793	-	-
U.S. Treasury and government-backed securities	152,352	81,839	70,513	-	-
Total financial assets	$ 742,012	$ 321,992	$ 149,306	$ -	$ 270,714
Financial liabilities:					
Interest rate swap	$ 1,565	$ -	$ -	$ 1,565	$ -

Alternative investments recorded at NAV consisted of the following:

September 30, 2024	Fair Value	Redemption Frequency	Redemption Notice Period
Pimco Priv Inv Grade Corp Sec	$ 11,971	Daily	1 business day
Pimco PAPS Asset Backed Securities	8,765	Daily	1 business day
Dover Street XI Feeder Fund	1,215	*	*
SSGA Russell 2000 R Index	24,308	Daily	1 business day
State Street S&P 500 Index	129,794	Daily	1 business day
SSGA MSCI ACWI EX USA	60,261	Daily	1 business day
Core Plus Fix Income	34,400	Daily	1 business day
	$ 270,714		

*The nature of investing in private investments is such that investors are subject to constraints that limit the ability to withdrawal capital after such investments are made. It is estimated that the underlying assets of the Dover Street XI Feeder Fund would be liquidated over 10-14 years from the final close (2023).

(in $000's)

7. Capital Assets

Capital asset additions, retirements and balances are as follows:

Year Ended September 30, 2024	Beginning of Year	Additions/ Transfers In	Reductions/ Transfers Out	End of Year
Capital Assets at Cost				
Land	$ 40,627	**$ 750**	**$ (83)**	**$ 41,294**
Construction in progress	48,675	**25,352**	**(39,999)**	**34,028**
Total nondepreciable assets	89,302	**26,102**	**(40,082)**	**75,322**
Land improvements	44,481	**406**	**(448)**	**44,439**
Buildings and improvements	1,184,841	**43,655**	**(2,695)**	**1,225,801**
Equipment	893,229	**73,277**	**(29,290)**	**937,216**
Right-to-use leased assets:				
Land	36	**18**	**-**	**54**
Buildings	44,187	**9,733**	**(224)**	**53,696**
Equipment	9,607	**3,925**	**(10)**	**13,522**
Right-to-use subscription assets	52,060	**26,671**	**-**	**78,731**
Total depreciable assets	2,228,441	**157,685**	**(32,667)**	**2,353,459**
Total	2,317,743	**183,787**	**(72,749)**	**2,428,781**
Accumulated Depreciation and Amortization				
Land improvements	35,910	**1,132**	**(340)**	**36,702**
Buildings and improvements	710,602	**50,435**	**(1,532)**	**759,505**
Equipment	717,999	**54,964**	**(39,462)**	**733,501**
Right-to-use leased assets:				
Land	21	**17**	**-**	**38**
Buildings	15,278	**9,284**	**(194)**	**24,368**
Equipment	4,541	**2,943**	**(10)**	**7,474**
Right-to-use subscription assets	15,423	**23,259**	**-**	**38,682**
Total	1,499,774	**142,034**	**(41,538)**	**1,600,270**
Capital Assets, Net	$ 817,969	**$ 41,753**	**$ (31,211)**	**$ 828,511**

(in $000's)

8. Long-Term Obligations

A summary of long-term obligations is as follows:

	September 30, 2023	Additions	Reductions	September 30, 2024	Due Within One Year
Bonds and notes payable:					
Revenue bonds	$ 572,910	$ -	$ (25,775)	$ 547,135	$ 27,270
Notes payable	12,425	15,048	(2,685)	24,788	3,693
	585,335	15,048	(28,460)	571,923	30,963
Interest rate swap agreement	547	1,018	-	1,565	-
Net unamortized discount/premium	9,352	-	(572)	8,780	-
Lease liability	35,245	13,699	(11,971)	36,973	10,507
Subscription software	27,937	26,422	(26,371)	27,988	17,816
Total long-term debt	658,416	56,187	(67,374)	647,229	59,286
Other noncurrent liabilities:					
Estimated professional liability losses	29,038	20,083	(14,476)	34,645	5,708
Other liabilities	37,166	2,271	(4,031)	35,406	2,457
Total other noncurrent liabilities	66,204	22,354	(18,507)	70,051	8,165
Total long-term debt and other noncurrent liabilities	$ 724,620	$ 78,541	$ (85,881)	$ 717,280	$ 67,451

Long-term debt consists of the following:

September 30,	2024
Health Care Facilities Revenue Bonds—Series 2022A, B & C; maturing incrementally through December 2041; principal payable annually June 1 for Series 2022A and December 1 for Series 2022B & C; interest payable monthly at fixed rates for Series 2022A and variable for Series 2022B & C	$ 201,310
Health Care Facilities Revenue Bonds—Series 2021A; maturing incrementally through June 1, 2033; principal payable annually June 1; interest payable monthly at fixed rates	115,825
Health Care Facilities Revenue Bonds—Series 2019B; maturing incrementally through June 1, 2033; principal payable annually June 1; interest payable monthly at fixed rates; 2019A refunded March 3, 2022	46,250
Health Care Facilities Revenue Bonds—Series 2015; maturing incrementally through June 1, 2045, principal payable annually June 1; interest payment semiannually June 1 and December 1 at fixed rates	183,750
Notes payable, payment due monthly through June 2034; fixed interest rates	24,788
	571,923

(in $000's)

September 30,	**2024**
Plus (less):	
Interest rate swap agreement	**1,565**
Net unamortized discount/premium	**8,780**
Current maturities of long-term debt	**(30,963)**
	$ 551,305

Bonds Payable

Series 2022 Bonds: In March 2022, ECU Health issued $94.7 million of Series 2022A tax-exempt revenue refunding bonds (Series 2022A Bonds). Proceeds of the Series 2022A Bonds were used to refund the outstanding balance of the Series 2019A Bonds. As a result, the refunded bonds are considered to be defeased and the liability was removed from the statement of net position in fiscal year 2022. The refunding of the Series 2019A Bonds resulted in a savings of $3.4 million.

In June 2022, ECU Health issued $111.7 million of Series 2022B tax-exempt revenue bonds (Series 2022B Bonds) and $37.4 million of Series 2022C tax-exempt revenue bonds (Series 2022C Bonds). Proceeds of the Series 2022B Bonds were used to refund the outstanding balance of the Series 2013A Bonds and 2013B Bonds. Proceeds of the Series 2022C Bonds were used to refund the outstanding balance of the Series 2011 Bonds. As a result, the refunded bonds are considered to be defeased and the liability was removed from the statement of net position in fiscal year 2022. The refunding of the Series 2013A Bonds, Series 2013B Bonds and Series 2011 Bonds resulted in a savings of $1.6 million in total.

The Series 2022B Bonds will initially bear interest based upon a Daily Secured Overnight Financing Rate (SOFR) index formula, whereas the 2022C Bonds will bear interest based upon a 1-Month Bloomberg Short-term Bank Yield (BSBY) index formula. ECU Health will pay costs of issuance from its own funds. The LIBOR-based swap that hedged the Series 2013A and 2013B Bonds, and will now hedge the 2022B Bonds, will be converted to a Daily SOFR index formula under the ISDA swap protocol, thereby eliminating basis risk between the swap and the 2022B Bonds. The 1-Month BSBY index was chosen as the new index for the 2022C Bonds for diversification purposes, and to permit ECU Health to monitor the relative performance of the two indices. Effective November 1, 2024, the 2022C Bonds will bear interest based upon a Daily SOFR index formula.

***Series 2021A Bonds*:** In March 2021, ECU Health issued $120.9 million of Series 2021A taxable revenue refunding bonds (Series 2021A Bonds). Proceeds of the Series 2021A Bonds were used to advance refund $101.9 million of outstanding Series 2015 Bonds. The Series 2021A Bonds are expected to be refunded and simultaneously redeemed by a tax-exempt fixed rate bond to be issued on June 1, 2025 (or up to 90 days before), the first optional call date for the Refunded Bonds which will constitute a current refunding. As a result, the refunded bonds are considered to be defeased and the liability was removed from the statement of net position in fiscal year 2021.

The Series 2021A Bonds are bank held bonds with a taxable fixed rate of interest of 2.32% through 2033. At the time of conversion, the taxable rate will convert to a tax-exempt rate of 1.83%, which was locked in as of March 25, 2021, the closing date. Principal payments are due annually on June 1, while interest payments are due monthly.

Series 2019 Bonds: In October 2019, ECU Health issued $96.1 million of Series 2019A taxable revenue refunding bonds (Series 2019A Bonds) and $54.1 million of Series 2019B tax-exempt revenue bonds (Series 2019B Bonds) (collectively the Series 2019 Bonds). Proceeds of the Series 2019A Bonds were used to advance refund certain portions of the Series 2012A Bonds totaling $88.0 million. The Series 2019A Bonds were fully refunded as part of the Series 2022A Bonds issued during 2022.

Proceeds of the Series 2019B Bonds were used to refund $33.2 million of the Series 2012A Bonds maturing on June 1, 2033, redeem the outstanding balances of the NOR Series 2011 and Series 2016 bonds and outstanding promissory note together totaling $16.2 million, as well as provide funds of $3.9 million for the purchase of a medical transportation helicopter. The 2019B Bonds are bank-held bonds with a fixed rate of interest of 1.86% through maturity.
In connection with the issuance of the Series 2019 Bonds, effective October 23, 2019, NOR was designated as a restricted affiliate and a member of the Combined Group as defined in the Master Trust Indenture (Amended and Restated) dated February 1, 2006.

Series 2015 Bonds: In April 2015, ECU Health issued Series 2015 tax-exempt revenue bonds (the Series 2015 Bonds). Proceeds of the Series 2015 Bonds were used to advance refund the outstanding balance of the Series 2008D Bonds and pay a portion of the cost of acquiring, constructing and equipping various health care facilities, including the ECU Cancer Care, Eddie and Jo Allison Smith Tower at VMC. The Series 2015 bonds were partially refunded as part of the Series 2021A Bonds issued during 2021.

Covenants and Collateral

The Combined Group is required to comply with certain restrictive covenants relating to its revenue bonds payable. The bonds are collateralized by the accounts receivable of the Combined Group. Certain covenants are measured quarterly.

Notes Payable

Notes payable at September 30, 2024, were $24.8 million. The various notes payable bear interest between 0.09% and 7.91%, and principal amounts are due through 2034. The notes payable are collateralized by certain capital assets.

Swap Agreement

On October 5, 2005, ECU Health entered into a variable to fixed interest rate swap agreement with an effective date of February 16, 2006, and a termination date of December 1, 2028 (the Swap Agreement), for the original purpose of hedging the variable interest rate on the 2006 Refunding Bonds.

The agreement by the counterparty to pay certain amounts to ECU Health pursuant to the Swap Agreement did not alter or affect ECU Health's obligation to pay the principal of, interest on, or redemption price of any of the 2006 Refunding Bonds. Therefore, the Swap Agreement remained in effect upon the refunding of the 2006 Refunding Bonds and refunding of the Series 2013 Bonds. The principal amount and repayment terms of the Series 2013 Bonds did not change significantly from the 2006 Refunding Bonds, other than the interest rate and the principal amount and repayment terms of the Series 2022B Bonds did not change significantly from the Series 2013 Bonds, other than the interest rate. The notional amount of the Swap Agreement at September 30, 2024, was $76.2 million.

(in $000's)

In order to secure ECU Health's payment obligations under the Swap Agreement, ECU Health issued Master Obligation, Series 2006A and 2006B (Derivative Agreement) (the Series Derivative Agreement Master Obligation) to the counterparty. The Series Derivative Agreement Master Obligation was issued under the Master Indenture and Supplemental Master Trust Indenture No. 8, dated February 1, 2006, between ECU Health and the Master Trustee.

Effective June 14, 2012, the interest rate swap was novated from Citibank N.A. to Wells Fargo Bank N.A. with largely the same terms and conditions of the Series 2006A and 2006B Derivative Agreement. The exception to those terms and conditions was the collateral posting requirement; if the estimated fair value of the swap liability is in excess of $20.0 million, Wells Fargo Bank N.A. will require ECU Health to post collateral. No collateral was posted on September 30, 2024, for the interest rate swap.

The estimated fair value of the swap as of September 30, 2024, was a liability of $1.6 million and has been included in long-term debt in the statement of net position. The change in fair value was a loss of $1.0 million for the year ended September 30, 2024 and is included in other nonoperating revenues (expenses) in the statement of revenues, expenses, and changes in net position, as the swap is considered to be an ineffective hedge under the accounting standards.

Interest Rate Risk

ECU Health is exposed to interest rate risk on their interest rate swap. Interest rate risk is a risk that the underlying bond rate (62% of one-month SOFR plus 0.371%) is less than the fixed rate (3.452% per annum) that ECU Health pays the interest rate swap. As underlying bond rates are increasing, the fair value of the interest rate swap is decreasing. Settlements are made on the first Wednesday of each month.

Debt Service Requirements

Scheduled future debt service requirements of long-term debt, for years subsequent to September 30, 2024, are as follows:

September 30,	Series 2015 Bonds	Series 2019 Bonds	Series 2021 Bonds	Series 2022 Bonds	Other	Total Principal	Interest Payments	Total Debt Service
2025	$ 1,510	$ 1,695	$ 1,750	$ 22,315	$ 3,693	$ 30,963	$ 18,487	$ 49,450
2026	1,575	1,730	2,075	23,660	3,875	32,915	17,218	50,133
2027	1,620	5,175	2,110	21,025	3,275	33,205	16,210	49,415
2028	-	4,620	8,705	18,175	3,316	34,816	15,174	49,990
2029	-	4,690	8,955	17,765	2,761	34,171	14,134	48,305
2030-2034	20,000	28,340	92,230	22,285	7,868	170,723	59,474	230,197
2035-2039	41,860	-	-	70,885	-	112,745	39,235	151,980
2040-2044	94,510	-	-	5,200	-	99,710	18,773	118,483
2045	22,675	-	-	-	-	22,675	1,007	23,682
	$ 183,750	$ 46,250	$ 115,825	$ 201,310	$ 24,788	$ 571,923	$ 199,712	$ 771,635

(in $000's)

9. Lease Liabilities

ECU Health utilizes facilities and equipment for various terms under long-term, non-cancelable lease agreements. The leases expire at various dates through 2034 and provide for renewal options. Certain facility leases provide for increases in future minimum annual rental payments based on defined increases in the Consumer Price Index, subject to minimum increases.

The total minimum lease payments for ECU Health under lease agreements are as follows:

	Right of Use Maturity Schedule		
Years ending September 30:	**Principal**	**Interest**	**Total**
2025	$ 10,507	$ 1,228	$ 11,735
2026	8,569	896	9,465
2027	6,495	638	7,133
2028	5,388	415	5,803
2029	3,037	234	3,271
2030-2034	2,977	170	3,147
	36,973	$ 3,581	$ 40,554
Less current maturity of lease liability	(10,507)		
	$ 26,466		

Right of use assets acquired through outstanding leases are shown in Note 7.

10. Subscription Software Right of Use Maturity Schedules

ECU Health utilizes subscription software for various terms under long-term, non-cancelable subscription agreements. The subscriptions expire at various dates through 2028 and provide for renewal options.

The total minimum subscription payments for ECU Health under subscription software agreements are as follows:

	Subscription Software Right of Use Maturity Schedule		
Years ending September 30:	**Principal**	**Interest**	**Total**
2025	$ 17,816	$ 1,023	$ 18,839
2026	7,825	398	8,223
2027	1,736	116	1,852
2028	611	50	661
	27,988	$ 1,587	$ 29,575
Less current maturity of lease liability	(17,816)		
	$ 10,172		

Right of use assets acquired through outstanding software subscriptions are shown in Note 7.

11. Commitments and Contingencies

Medical Malpractice Costs

Effective October 1, 2017, CMIC, ECU Health's wholly owned captive, was formed and provides medical professional liability (PL) and general liability (GL) coverage, on a claims-made basis, to ECU Health's wholly owned hospitals, VSC and NewCo Cancer Services, LLC. In March 2018, CMIC began insuring ECU Health's employed and contract physicians.

ECU Health is self-insured for GL and PL claims up to certain limits for each event and in the annual aggregate, on a claims-made basis. ECU Health also has ten Excess of Loss reinsurance policies through CMIC. Effective October 1, 2019, OBH was added to ECU Health's PL/GL program under CMIC. A prior acts policy for OBH is provided by CMIC with coverage dates of February 4, 2002 through October 1, 2019. Effective October 1, 2020, NOR was added to ECU Health's PL/GL program under CMIC. A prior acts policy for NOR entities and Emergency Department providers is provided by CMIC with coverage dates through October 1, 2020, per endorsement to the policy.

The provision for estimated medical malpractice claims includes estimates of the ultimate costs for reported claims and claims incurred but not reported. The provision is based on actuarially projected estimates of their cost based on historical loss payment patterns as well as current known facts, discounted at 2% for 2024.

Effective October 1, 2020, coverage is provided by a loss portfolio transfer policy between CMIC and ECU Health for the run-off and legacy PL, GL, and Team Member Benefit liabilities for claims reported through September 30, 2017, and for physician run-off and legacy liabilities for claims reported through March 30, 2018.

Workers' Compensation

ECU Health is self-insured for workers' compensation with an occurrence retention of $1.5 million each occurrence. An excess workers' compensation policy, with statutory limits for each team member accident or disease, covers claims above the self-insured retention. In addition, the excess workers' compensation policy provides employer's liability coverage with limits of $1.0 million per occurrence and annual aggregate. Ten Excess of Loss reinsurance liability policies through CMIC provide an annual aggregate limit for employer's liability above the excess workers' compensation policy. The current portion of the liability is included in accrued expenses, and the long-term portion is included in other long-term liabilities.

OBH and VSC were moved into ECU Health's self-insured workers compensation program effective October 1, 2018.

Effective October 1, 2019, the self-insured workers' compensation program moved into CMIC as a deductible buy-down policy.

Effective October 1, 2020, coverage is provided by a loss portfolio transfer policy between ECU Health and CMIC for the run-off and legacy workers' compensation liabilities for claims reported through September 30, 2019.

Cyber Liability

Effective October 1, 2023, CMIC provides cyber liability coverage in two separate ways: 1) a deductible buy-down policy to fund a $1 million cyber liability deductible and 2) A 50% quota share participation with the commercial carriers for the $10 million excess $30 million and $10 million and $10 million excess $40 million layers.

Medical Coverage

ECU Health is self-insured for team members medical and dental coverage with an excess coverage (stop-loss) policy that covers annual medical costs in excess of $450,000 per participant on a claims-made basis. Effective January 1, 2024, CMIC provides stop-loss coverage of $350,000 aggregate deductible above the $450,000 self-insured per participant. Annual costs were approximately $144.0 million for the year ended September 30, 2024, which is included in team member benefits in the statement of revenues, expenses and changes in net position. The medical and dental coverage liability is recorded on the statement of net position in accrued expenses and totaled $24.1 million at September 30, 2024.

Regulatory Matters

Laws and regulations concerning government programs, including Medicare, Medicaid and various research grant programs, are complex and subject to varying interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. As a result of nationwide investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties and potential exclusion from the related programs. ECU Health expects that the level of review and audit to which it is subject will increase.
There can be no assurance that regulatory authorities will not challenge ECU Health's compliance with these laws and regulations, and it is not possible to estimate the impact (if any) such claims or penalties would have on ECU Health. Management believes that ECU Health is in compliance with fraud and abuse as well as other applicable government laws and regulations. Management is monitoring compliance through its Corporate Compliance Program.

CMS implemented a project using recovery auditors as part of CMS's further efforts to assure accurate payments. The project uses the recovery auditors to search for potentially inaccurate Medicare payments that may have been made to health care providers and that were not detected through existing CMS program integrity efforts. Once a recovery auditor identifies a claim believed to be inaccurate, the recovery auditor makes a deduction from or addition to the provider's Medicare reimbursement in an amount estimated to equal the overpayment or underpayment.

Litigation

ECU Health is party to a number of pending or threatened lawsuits arising out of, or incidental to, the ordinary course of business for which it carries professional and general liability coverage and other insurance coverages. In the opinion of management, upon consultation with legal counsel, all of the pending or threatened lawsuits that are determined to result in a probable loss to ECU Health have been properly recorded within the financial statements.

Construction Commitment

ECU Health entered into contracts for various construction projects. ECU Health's outstanding commitments for signed contracts totaled approximately $21.8 million as of September 30, 2024, primarily related to renovations of existing buildings and equipment upgrades.

Leases

ECU Health has a total of $3.5 million of future minimum lease payments under non-cancelable leases for buildings and equipment that do not meet the right of use asset criteria at September 30, 2024. These agreements expire at various times through 2029.

12. Defined Contribution Retirement Plan

ECU Health sponsors a defined contribution retirement plan, with a matching component of 50%, 75% or 100% of the team member's contribution, up to 5% of the team member's salary, for team members who have met the eligibility and years of service requirements of the plan. During 2024, ECU Health contributed approximately $26.8 million to the defined contribution retirement plan, which is included in salaries and wages in the statement of revenues, expenses and changes in net position.

13. Defined Benefit Pension Plans

Defined benefit pension plans disclosures, as required by the Plan sponsor (GASB Statement No. 68):

Plan Description

ECU Health maintains a noncontributory defined benefit pension plan (the Plan) covering some of the team members of ECU Health. Plan participants are now fully vested with over 10 years of service as the Plan was frozen to new team members hired on or after January 1, 2010. The Plan is funded annually by ECU Health and its affiliates in amounts at least equal to the actuarially determined contribution (pension cost). The Plan is considered a governmental entity under section 401(a) of the Internal Revenue Code of 1954. The Plan year is January 1 to December 31. Team members hired after this date are eligible to participate in the defined contribution retirement plan described in Note 12.

(in $000's)

Team Members Covered by Benefit Terms

The pension liability at September 30, 2024, is computed using a measurement date as of October 1, 2023 and was determined by an actuarial valuation date of January 1, 2023 rolled forward to September 30, 2024 to calculate the net pension liability as of that date. The participant data utilized in the actuarial computation is as of January 1, 2023, which is rolled forward to the measurement dates using the standard methodology.

Following is the team member participant data utilized:

	VMC	NOR	DUP	Consolidated
Participant data as of January 1:				
Active participants	2,939	175	104	3,218
Inactives with deferred benefits	3,147	214	146	3,507
Inactives receiving payment	3,549	418	177	4,144
Total	9,635	807	427	10,869

Contributions

Actuarially determined contributions are calculated as of October 1, one year prior to the end of the fiscal year in which contributions are reported. ECU Health's funding policy is to make contributions to at least meet the minimum funding requirements for the current year as determined by an independent actuary. ECU Health contributed 100% of the actuarially determined contributions for the year ended September 30, 2024, which approximated $25.4 million, which is recorded as a deferred outflow.

Summary of Significant Accounting Policies

The pension plan is accounted for using the flow of economic resources measurement focus and the accrual basis of accounting. Benefit payments are recognized when due and payable in accordance with benefit terms.

Investment Management Agreement

In March 2020, the plan sponsor and investment fiduciary committee delegated certain authority to an investment consultant in an arrangement referred to as Outsourced Chief Investment Officer (OCIO). The OCIO provides services with respect to investment program review, investment strategy, asset allocation, selection and monitoring of sub-advisors and investments, investment in advised funds, reporting and investment communication and custody and registration of plan assets.

(in $000's)

Actuarial Assumptions

The annual required contribution and the net pension liability recorded on the statement of net position at September 30, 2024, were computed as part of an actuarial valuation performed using the measurement date of October 1, 2023. Significant actuarial assumptions used in that actuarial valuation of the Plan include the following:

Rate of return on plan assets	7.50%
Mortality	Pri-2012 Mortality Table, Scale MP-2021
Projected salary increases	3.00%
Inflation rate	2.50%
Measurement date	October 1, 2023

These assumptions were selected by management at the measurement date.

The long-term expected rate of return on pension plan investments was determined using a building block method in which best-estimate ranges of expected real rates of return (expected returns, net of plan investment expenses and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and adding expected inflation. The target allocation and best estimates of arithmetic real rates of return for each major asset class are summarized in the following table:

Asset Class	Total Allocation	Real Rate of Return
International equity	**45.0%**	**4.78%**
Core U.S. fixed income	**17.0%**	**1.56%**
Hedge funds	**8.0%**	**3.32%**
Real estate	**10.0%**	**4.05%**
Private equity	**10.0%**	**7.12%**
Private debt	**2.5%**	**5.07%**
Multi-asset credit	**7.5%**	**4.29%**
Total	**100.0%**	

The discount rate used to measure the total pension liability as of September 30, 2024 was 7.50%. The projection of cash flows used to determine the discount rate assumed that employer contributions will be made in amounts equal to the actuarially determined contributions. Based on that assumption, the Plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive team members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

There are six investments in the pension plan that make up $648.4 million and 77.4% of the total investments at September 30, 2023.

(in $000's)

The following table sets forth, by level within the fair value hierarchy, ECU Health, NOR and DUP's pension plan financial assets measured at fair value on a recurring basis at the measurement date of September 30, 2023:

		Fair Value Measurements at Measurement Date Using			
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level2)	Significant Unobservable Inputs (Level 3)	Measured Using NAV
Financial Assets:					
Mutual funds	$ 689,379	$ -	$ -	$ -	$ 689,379
Alternative funds	103,121	-	-	-	103,121
Cash equivalents	23,430	23,430	-	-	-
Equity securities	20,965	20,965	-	-	-
Total financial assets	$ 836,895	$ 44,395	$ -	$ -	$ 792,500

At September 30, 2023, the pension plans alternative investments recorded at NAV consisted of the following:

	Fair Value	Redemption Frequency	Redemption Notice Period
Trumbull Property	$ 8,030	Quarterly	60 Days
MFO Aon Collective Investment Formerly Aon Hew Large Cap Equity Index	11,889	Daily	1 Business Day
MRO Aon Collective Investment Formerly Aon Hew Small Cap Equity Index	1,834	Daily	1 Business Day
Aon Core Real Estate	3,071	Quarterly	105 Days
MFO AGT Non-US Active EQ	136,767	Daily	1 Business Day
Russell Small Cap	10,544	Daily	1 Business Day
S&P 500 ® Index	201,135	Daily	1 Business Day
AGT Global Real Estate	4,812	Daily	1 Business Day
Aon Core Real Estate	974	Quarterly	105 Days
Aon Collective Investment Formerly Aon New Bond	119,436	Daily	1 Business Day
AHGT High Yield Plus Bond	6,183	Daily	1 Business Day
Aon Multi-Asset Credit Fund	65,109	Monthly	10 Days
Aon Return Enhancing Alternatives	70,320	Biannual (June 30, December 31)	95 Days
AON Core Real Estate	55,619	Quarterly	105 Days
Aon Return Enhancing Alternatives	1,687	Biannual (June 30, December 31)	95 Days
Dover Street IX Cayman Fund LP	30,319	N/A	N/A
Aon Opportunistic Credit Portfolio LP	11,449	N/A	N/A

(in $000's)

	Fair Value	Redemption Frequency	Redemption Notice Period
Oaktree Real Estate Opportunities Fund III, LP	**10,256**	N/A	N/A
FTV VII, L.P	**4,013**	N/A	N/A
One Rock Capital Partners III, LP	**8,298**	N/A	N/A
Trive Capital Fund IV, L.P.	**4,544**	N/A	N/A
Level Equity Growth Partners V, L.P.	**3,661**	N/A	N/A
The Veritas Capital Vantage Fund, L.P.	**3,528**	N/A	N/A
Stepstone Secondaries Fund V, L.P.	**2,811**	N/A	N/A
GTCR Fund XIIIB LP	**2,299**	N/A	N/A
Diversis Capital Partners II, L.P.	**2,231**	N/A	N/A
GTCR Fund XIIIA LP	**1,734**	N/A	N/A
Stepstone Global Partners XI (Cayman) LP	**784**	N/A	N/A
Arlington Capital Partners VI, LP	**2,356**	N/A	N/A
Aon PRVT CR OPPS FD II-SUB	**6,807**	N/A	N/A
	$ 792,500		

Sensitivity of the Net Pension Liability to Changes in the Discount Rate

The following presents ECU Health's net pension liability calculated using the discount rate of 7.50% at September 30, 2024, as well as the net pension liability using a discount rate that is 1% lower and 1% higher:

	1% Decrease 6.50%	Current Rate 7.50%	1% Increase 8.50%
Net pension liability, September 30, 2024	**$ 327,170**	**$ 205,596**	**$ 103,748**

Pension Liabilities, Pension Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions

For the year ended September 30, 2024, ECU Health recognized pension expense of $40.7 million. Pension expense is included in salaries and wages in the statement of revenues, expenses and changes in net position.

(in $000's)

Changes in the net pension liability are summarized in the following table:

	Increase (Decrease)		
	Total Pension Liability (a)	Plan Fiduciary Net Position (b)	Net Pension Liability (Asset) (a) - (b)
Balances at September 30, 2023	$ 1,042,807	$ 771,111	$ 271,696
Changes for the year:			
Service cost	**7,016**	**-**	**7,016**
Interest	**71,822**	**-**	**71,822**
Difference between expected and actual experience	**13,330**	**18,078**	**(4,748)**
Changes in assumptions	**(58,040)**	**-**	**(58,040)**
Employer contributions	**-**	**28,845**	**(28,845)**
Net investment income	**-**	**53,305**	**(53,305)**
Benefit payments	**(48,388)**	**(48,388)**	**-**
Net changes	**(14,260)**	**51,840**	**(66,100)**
Balances at September 30, 2024	**$ 1,028,547**	**$ 822,951**	**$ 205,596**

As of October 1, 2023, the most recent actuarial date, the Plan was 80.0% funded.

At September 30, 2024, ECU Health reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

September 30, 2024	Deferred Outflows of Resources	Deferred Inflows of Resources
Difference between actual and expected experience	**$ 13,037**	**$ (39)**
Changes in actuarial assumptions	**5,054**	**(39,546)**
Net differences between projected and actual earnings on pension plan investments	**48,196**	**-**
Contributions made after the measurement date, not yet recognized in the net pension liability	**25,379**	**-**
Total	**$ 91,666**	**$ (39,585)**

(in $000's)

At September 30, 2024, amounts reported as deferred outflows and inflows of resources related to defined benefit pension, excluding the contributions made after the measurement date, will be recognized in pension expense as follows:

Years ending September 30:	
2025	**$ 6,381**
2026	**(4,729)**
2027	**28,720**
2028	**(3,670)**
	$ 26,702

Effective October 1, 2010, ECU Health assumed sponsorship of and full financial responsibility for the DUP defined benefit pension plan (DUP Plan). Effective September 30, 2010, the DUP Plan was amended to freeze the DUP Plan. No participant shall accrue any additional benefits, and each participant's accrued benefit shall be determined based on their average annual compensation and number of years of service at September 30, 2010. DUP made an additional $2.4 million contribution on September 27, 2010, to the DUP Plan in connection with this amendment to fund any unfunded amounts at that time. As of September 30, 2024, the fair value of the plan assets exceeded the gross pension liability, resulting in a net pension asset of $2.5 million, reflected on the statement of net position in prepaid expenses.

Effective June 1, 2019, ECU Health assumed sponsorship of and full financial responsibility for the NOR defined benefit pension plan (NOR Plan). During 2005, the NOR Plan was amended to freeze the NOR Plan. No participant shall accrue any additional benefits, and each participant's accrued benefit shall be determined based on their average annual compensation and number of years of service at 2005. NOR makes annual contributions to the NOR Plan based on actuarial calculations using the projected unit credit actuarial cost model. As of September 30, 2024, the fair value of the plan assets were less than the gross pension liability, resulting in a net pension liability of $2.4 million reflected on the statement of net position in net pension liability.

Defined Benefit Pension Plans Disclosures, as Required by the Plan (GASB Statement No. 67)

The net pension liability of the Plan as of September 30, 2024, to be reported as the net pension liability of the Health System as of September 30, 2025, was measured as of September 30, 2024. The total pension liability as of September 30, 2024, is based on the liability determined on January 1, 2024, census data and a January 1, 2024, valuation date using update procedures to roll forward to the measurement date of September 30, 2024.

(in $000's)

The components of the net pension liability of the pension plans (the Plan, NOR Plan and DUP Plan) at September 30, 2024, were are follows:

	2024
Total pension liability	$ 1,105,323
Plan fiduciary assets	957,643
Net pension liability	$ 147,680
Plan fiduciary net position as a percentage of the total pension liability	86.6%

The following presents the sensitivity of the net pension liability calculated using a 1.0% increase and a 1.0% decrease in the discount rate used to measure the net pension liability and asset:

September 30, 2024	1% Decrease 6.50%	Current Rate 7.50%	1% Increase 8.50%
Net pension liability - the Plan	$ 279,265	$ 153,299	$ 47,714
Net pension liability (asset) - NOR Plan	$ 1,018	$ (1,349)	$ (3,394)

	1% Decrease 5.25%	Current Rate 6.25%	1% Increase 7.25%
Net pension asset – DUP Plan	$ (3,161)	$ (4,270)	$ (5,209)
Net	$ 277,122	$ 147,680	$ 39,111

There were no changes in assumptions for the measurement date for the year ended September 30, 2024.

(in $000's)

Best estimates of arithmetic real rates of return (expected returns, net of pension plan investment expense and inflation) for major asset classes included in the pension plans asset allocations as of September 30, 2024, are summarized in the following table:

Asset Class	Long-term Expected Real Rate of Return
International equity	**4.5%**
Core U.S. fixed income	**2.2%**
Hedge funds	**4.5%**
Real estate	**4.1%**
Private equity	**6.7%**
Multi-asset credit	**5.4%**
Private debt	**4.7%**

Investment Capital Commitment

The ECU Health noncontributory defined benefit pension plan has capital commitments to alternative investment funds in the pension plan. At September 30, 2024, the remaining unfunded commitment of $91.4 million will be funded as the managers make capital calls to the funds.

The tables below present the fair value leveling of the pension plans investments as of September 30, 2024 in accordance with GASB Statement No. 72:

September 30, 2024	**Level 1**	**Level 2**	**Level 3**	**NAV**	**Total**
Mutual funds	**$ -**	**$ -**	**$ -**	**$ 779,522**	**$ 779,522**
Alternative funds	**-**	**-**	**-**	**130,855**	**130,855**
Cash equivalents and accrued interest receivable	**21,646**	**-**	**-**	**-**	**21,646**
Equity securities	**25,620**	**-**	**-**	**-**	**25,620**
	$ 47,266	**$ -**	**$ -**	**$ 910,377**	**$ 957,643**

Interest rate risk exposure is managed by limiting investment maturities in accordance with parameters in the Plan's investment policy. At September 30, 2024, the pension plans had no stated investment maturities and credit ratings.

Supplemental Executive Retirement Plan

ECU Health has also established a noncontributory, nonvesting supplemental executive retirement plan (SERP). For the year ended September 30, 2024, ECU Health recognized expense of approximately $0.7 million. SERP had a net pension obligation of approximately $13.8 million at September 30, 2024.

The SERP is not a qualified plan, and as a result, ECU Health is unable to net the plan's liability against assets held for the plan. ECU Health had funds set aside of approximately $16.9 million at

(in $000's)

September 30, 2024, in relation to this plan. The liability associated with this plan is recorded in other long-term liabilities, and the assets associated with this plan are recorded in assets limited as to use, other restricted cash.

Effective January 1, 2010, ECU Health froze the plan to new entrants. On November 20, 2012, the ECU Health Board of Directors froze plan benefits of existing participants beginning January 1, 2013. This was replaced by a cash balance plan on that date. There are 33 inactive participants in the plan who are receiving payments and no active participants in the plan.

Contributions

ECU Health's funding policy is to make contributions to meet the minimum funding requirements for the current year as determined by an independent actuary. ECU Health contributed payments to the plan for the year ended September 30, 2024, of approximately $1.1 million.

Actuarial Assumptions

The annual required contribution and the net pension liability recorded on the statement of net position at September 30, 2024, were computed as part of an actuarial valuation performed as of October 1, 2023, which is also the measurement date. Significant actuarial assumptions used in the actuarial valuation of the plan include a discount rate of 4.09% in 2024 and mortality rates using the Pri-2012 Mortality Table and generationally projected with Scale MP-2021.

Sensitivity of the Net Pension Liability to Changes in the Discount Rate

The following presents ECU Health's net pension liability calculated using the discount rate of 4.09% in 2024, as well as the net pension liability using a discount rate that is 1% lower and 1% higher:

	1% Decrease 3.09%	Current Rate 4.09%	1% Increase 5.09%
Net pension liability, September 30, 2024	**$ 15,077**	**$ 13,770**	**$ 12,648**

(in $000's)

Changes in the net SERP pension liability for the year ended September 30, 2024, are summarized in the following table:

	Increase (Decrease)		
	Total Pension Liability (a)	Plan Fiduciary Net Position (b)	Net Pension Liability (Asset) (a) - (b)
Balances at September 30, 2023	$ 14,269	$ -	$ 14,269
Changes for the year:			
Interest	**551**	**-**	**551**
Difference between expected and actual experience	**177**	**-**	**177**
Changes in assumptions	**(85)**	**-**	**(85)**
Benefit payments	**(1,142)**	**-**	**(1,142)**
Net changes	**(499)**	**-**	**(499)**
Balances at September 30, 2024	**$ 13,770**	**$ -**	**$ 13,770**

At September 30, 2024, ECU Health reported deferred outflows of resources and deferred inflows of sources related to the SERP from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions made after the measurement date, not yet recognized in the net pension liability	**$ 1,142**	**$ -**
Total	**$ 1,142**	**$ -**

At September 30, 2024, amounts reported as deferred outflows of resources related to the SERP, excluding the contributions made after the measurement date, will be recognized in pension expense in the year ending September 30, 2024.

14. Other Postemployment Benefits

Plan Description

ECU Health sponsors a postretirement health care benefit program (referred to as the Retiree Medical Plan) for all team members hired before July 1, 2008, that satisfies the criteria for receiving retirement benefits under the plan. The Retiree Medical Plan includes eligible retirees, spouses and spouse survivors. All eligible members pay a portion of the expense. Effective July 1, 2008, ECU Health froze the plan to new entrants. The Retiree Medical Plan does not issue stand-alone financial reports.

(in $000's)

Membership of the Retiree Medical Plan consisted of the following at October 1, 2023, the date of the latest actuarial valuation:

Retirees eligible for benefits (including eligible spouses)	$	64
Active plan members (including eligible spouses)		2,420
Total	$	2,484

Funding Policy

ECU Health has chosen to fund the Retiree Medical Plan on a pay-as-you-go basis. Contributions are not expressed as a percentage of covered payroll, since benefits provided are not payroll related. ECU Health has outsourced the processing of their health claims for the Retiree Medical Plan through a third-party administrator. ECU Health's contributions were $0.3 million as of September 30, 2024 and were 100% of the benefits paid in the plan.

Summary of Significant Accounting Policies

The other postemployment benefits (OPEB) are accounted for using the flow of economic resources measurement focus and the accrual basis of accounting. Postemployment benefit expenses are made from ECU Health's operating assets. No funds are set aside to pay benefits or administration costs. Benefit and administration expenses are recognized in the accounting period in which the benefits are provided. No assets are accumulated in a trust to fund the plan. The net OPEB liability is recorded in other liabilities within the statement of net position.

Actuarial Assumptions

The annual expense and the net OPEB liability recorded on the statement of net position at September 30, 2024, were computed as part of an actuarial valuation performed as of October 1, 2023. Significant actuarial assumptions used in the actuarial valuation of the plan for the year ended September 30, 2024, include the following:

Discount rate	4.09%
Mortality	Pri-2012 Table
Health care participation rate	10.00%
Health care cost trend rate	7.02%
Valuation date	October 1, 2022
Measurement date	October 1, 2023

Health care claims development were based on the average pre-65 claims costs of a blend of retiree and active claim experience based on three years of data and adjusted for population, health care trends and paid-to-incurred basis.

Actuarial methods and assumptions: Projections of benefits for financial reporting purposes are based on the substantive plan (the plan as understood by the employer and the plan members) and include the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit cost between the employer and plan members at that point.

(in $000's)

Sensitivity of the net OPEB liability to changes in the discount rate and health care cost trend rate: The following presents ECU Health's net OPEB liability calculated using the discount rate of 4.09% in 2024, as well as the net OPEB liability using a discount rate that is 1% lower and 1% higher:

	1% Decrease 3.09%	Current Rate 4.09%	1% Increase 5.09%
Net OPEB liability, September 30, 2024	**$ 6,196**	**$ 5,772**	**$ 5,384**

The following presents ECU Health's net OPEB liability calculated using a health care cost trend rate that is 1% lower and 1% higher than the current health care trend rate:

	1% Decrease 6.02%	Current Rate 7.02%	1% Increase 8.02%
Net OPEB liability, September 30, 2024	**$ 5,263**	**$ 5,772**	**$ 6,349**

Changes in the net OPEB liability for the year ended September 30, 2024, are summarized in the following table:

	Increase (Decrease) in Total Net OPEB Liability
Balance at beginning of year, October 1	**$ 4,881**
Changes for the year:	
Service cost	**74**
Interest	**192**
Differences between expected and actual experience	**803**
Change in assumptions	**199**
Benefit payments	**(377)**
Net changes	**891**
Balance at end of year, September 30	**$ 5,772**

(in $000's)

At September 30, 2024, ECU Health reported deferred outflows of resources and deferred inflows of sources related to the OPEB from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Difference between actual and expected experience	$ 1,080	$ (1,780)
Changes in actuarial assumptions	304	(491)
Contributions made after the measurement date, not yet recognized in the net OPEB liability	314	-
Total	$ 1,698	$ (2,271)

At September 30, 2024, amounts reported as deferred inflows of resources related to the OPEB, excluding the contributions made after the measurement date, will be recognized in benefit expense as follows:

Years ending September 30:	
2025	$ (540)
2026	(340)
2027	(102)
2028	95
	$ (887)

15. Other Nonoperating Revenues and Expenses

Other nonoperating revenues and expenses on the statement of revenues, expenses and changes in net position are composed of the following:

Year Ended September 30,	2024
Mark to market loss on interest rate swap	$ (1,018)
Foundation expenses	(3,254)
Payments to Pitt County:	
Payment in lieu of taxes	(2,196)
Medicaid funding	(741)
Investment expense	(1,679)
Contributions made	(9,957)
Unrestricted contributions received	5,001
Gain on equity method investments	2,237
	$ (11,607)

16. Related Parties

East Carolina University and the Brody School of Medicine: The Hospital is the primary affiliated teaching hospital for the Brody School of Medicine through a formal agreement originally executed on December 17, 1975, and most recently renewed on August 8, 2013, for an additional 20-year period. The Brody School of Medicine reimburses the Hospital for costs associated with the utilization of Hospital facilities. The Hospital reimburses the Brody School of Medicine for any third-party reimbursement resulting from any of the school's costs being included in the Hospital's Medicare and Medicaid cost-reimbursement reports.

The Hospital has recorded receivables of approximately $4.1 million and payables of approximately $0.8 million as of September 30, 2024, with the Brody School of Medicine, which are settled in the normal course of business. These receivables and payables are recorded in other receivables and accrued expenses within the statement of net position, respectively.

Operating expenses recognized related to services received from East Carolina University (ECU) were $65.1 million for the year ended September 30, 2024. Other revenues earned from services provided to ECU were $15.5 million for the year ended September 30, 2024. These revenues and expenses are recorded in other revenue and supplies and other expenses within the statement of revenues, expenses and changes in net position, respectively.

Joint Operating Agreement: Effective January 1, 2022, ECU Health and Brody School of Medicine entered into a joint operating agreement (JOA) to move toward greater clinical integration. The JOA will create closer alignment between ECU Health and Brody School of Medicine and support the combined vision of creating a premier, rural academic health system that cares for 1.4 million people throughout eastern North Carolina.

Under the JOA, ECU Health and the Brody School of Medicine will retain their separate legal entities and continue to report to their respective Boards but will operate as a single clinical enterprise with an integrated system of care under a new, shared brand known as ECU Health. Most ECU Health entities and ECU physicians will operate under the new brand while the Brody School of Medicine's name will not change. There are no changes to the employment status or benefits of current team members and no assets will be exchanged as a result of the JOA; however, the JOA will operate under the single leadership of the CEO/Dean who fills both the role of the CEO of ECU Health and the Dean of the Brody School of Medicine. The role of CEO/Dean began on July 1, 2021 and is jointly employed by both organizations.

A joint operation committee (JOC) of nine members was formed and serve as a non-fiduciary, oversight and advisory committee responsible for providing advice, guidance and oversight to the CEO/Dean regarding management and oversight of ECU Health. The JOC will be responsible for approving and overseeing strategic planning and budgeting and will be responsible for but not limited to operations, finances, reporting of information, advising on matters of integrated leadership, making recommendations to respective Boards, overseeing reports on performance, growth and direction, stewardship, quality, performance, care delivery models, board liaisons, execution of milestones, providing input on the performance of the CEO/Dean and reviewing risk management and compliance plans and concerns of ECU Health.

ECU Health Foundation: University Health Systems of Eastern Carolina Foundation, Inc. d/b/a ECU Health Foundation (the Foundation) was organized to receive gifts, donations, income and funds for the promotion of health and wellness to the general public and community in eastern North Carolina

(in $000's)

and all areas served by ECU Health. The Foundation provides these services directly to the Development Councils for BEA, BER, CHO, EDG, NOR and OBH. VMC provides management services, supplies and labor to the Foundation. VCOM hospitals also provide some administrative services. The Foundation is not required to reimburse VMC or the VCOM hospitals for the cost of these expenses; however, the Foundation recognizes the value of those expenses paid on their behalf as contributed services expense along with corresponding contributed services, or in-kind, revenue in their financial statements.

At September 30, 2024, consolidated assets of the Foundation were approximately $58.9 million and liabilities were approximately $20.8 million. The assets that were restricted for use for the benefit of other entities, primarily ECU Health, were $19.5 million at September 30, 2024. The consolidated net assets of the Foundation had an increase of approximately $7.4 million for the year ended September 30, 2024.

ECU Health Foundation is not included in the financial statements of ECU Health as it does not meet the criteria used that would require consolidation since there is no control by ECU Health. A separate audit of the ECU Health Foundation is issued.

17. Condensed Financial Information

Following is the condensed statement of net position, and the related condensed statement of revenues, expenses and changes in net position and cash flows for the Parent Corporation (primary government) and its significant blended component units:

Condensed Statement of Net Position:

September 30, 2024	Parent Corporation	VMC	VCOM	Eliminations and Other	Total ECU Health
Current assets	$ 60,323	$ 759,246	$ 288,984	$ 30,803	$ 1,139,356
Assets limited as to use-other	265,924	370,233	32,361	67,786	736,304
Capital assets, net of accumulated depreciation	109,586	458,688	177,586	82,651	828,511
Other assets	6,863	1,775	1,559	20	10,217
Total assets	442,696	1,589,942	500,490	181,260	2,714,388
Deferred outflows	58,194	75,986	28,088	7,670	169,938
Total assets and deferred outflows	$ 500,890	$ 1,665,928	$ 528,578	$ 188,930	$ 2,884,326
Current liabilities	$ 162,210	$ 229,215	$ 108,410	$ 56,079	$ 555,914
Long-term liabilities	584,340	167,291	48,983	54,811	855,425
Total liabilities	746,550	396,506	157,393	110,890	1,411,339
Deferred inflows	7,030	24,369	7,399	3,453	42,251
Net investment in capital assets	(434,864)	452,414	179,713	62,107	259,370
Restricted-noncontrolling interests	-	4,905	46,603	-	51,508
Restricted-other	-	-	3,439	-	3,439
Unrestricted (deficit)	182,174	787,734	134,031	12,480	1,116,419
Total net position (deficit)	(252,690)	1,245,053	363,786	74,587	1,430,736
Total liabilities, deferred inflows and net position	$ 500,890	$ 1,665,928	$ 528,578	$ 188,930	$ 2,884,326

(in $000's)

Condensed Statement of Revenues, Expenses and Changes in Net Position:

Year Ended September 30, 2024	Parent Corporation	VMC	VCOM	Eliminations and Other	Total ECU Health
Operating revenues	$ 359,707	$ 1,934,171	$ 648,857	$ (60,297)	$ 2,882,438
Operating expenses:					
Salaries and wages	145,151	536,940	217,138	302,431	1,201,660
Team member benefits	53,937	143,901	60,785	50,322	308,945
Supplies and other	160,710	936,723	305,986	(269,524)	1,133,895
Depreciation and amortization	40,739	49,561	18,488	12,083	120,871
Lease activity	2,914	8,445	2,648	(7,436)	6,571
Total operating expenses	403,451	1,675,570	605,045	87,876	2,771,942
Income (loss) from operations	(43,744)	258,601	43,812	(148,173)	110,496
Nonoperating revenues (expenses):					
Interest expense	(24,581)	(25,608)	(3,351)	26,674	(26,866)
Investment gain (loss) and other	99,838	15,114	4,501	(20,659)	98,794
Total nonoperating revenues (expenses), net	75,257	(10,494)	1,150	6,015	71,928
Income (loss) before non-controlling interests	31,513	248,107	44,962	(142,158)	182,424
Income applicable to noncontrolling interest	-	(9,028)	(4,358)	-	(13,386)
Increase (decrease) in net position	$ 31,513	$ 239,079	$ 40,604	$ (142,158)	$ 169,038

Condensed Statement of Cash Flows:

Year Ended September 30, 2024	Parent Corporation	VMC	VCOM	Eliminations and Other	Total ECU Health
Cash flows:					
Operating activities	$ 11,307	$ 387,591	$ 111,752	$ (117,329)	$ 393,321
Capital and noncapital financing activities	(86,608)	(90,072)	(26,870)	(940)	(204,490)
Investing activities	40,514	(136,989)	(239)	119,675	22,961
Net increase (decrease) in cash and cash equivalents	(34,787)	160,530	84,643	1,406	211,792
Cash and cash equivalents-beginning of year	34,787	15,646	40,998	9,578	101,009
Cash and cash equivalents-end of year	$ -	$ 176,176	$ 125,641	$ 10,984	$ 312,801

18. Subsequent Events

The System has evaluated subsequent events from September 30, 2024 through January 22, 2025 (the date of the audit report and the date the financial statements were ready to be issued). No material recognizable events were identified.

Required Supplementary Information (Unaudited)

ECU Health

Required Supplementary Information - Schedule of Changes in the Net Pension Liability and Related Ratios (Unaudited)

(in $000's)

	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
Total Pension Liability										
Service cost	**$ 7,016**	$ 7,297	$ 7,520	$ 8,033	$ 8,422	$ 9,831	$ 9,809	$ 11,385	$ 11,685	$ 12,452
Interest	**71,822**	69,044	67,085	65,025	61,447	58,279	55,756	52,511	50,456	47,259
Plan changes**	**-**	-	-	-	-	3,752	-	-	-	-
Assumption changes	**(58,040)**	2,197	25,982	(2,970)	(2,085)	(3,970)	17,238	6,745	(7,194)	-
Differences between expected and actual experience	**13,330**	8,527	4,991	(297)	(1,279)	(361)	6,517	209	(5,456)	60
Benefit payments	**(48,388)**	(45,831)	(42,850)	(38,940)	(34,392)	(30,254)	(27,577)	(24,492)	(19,200)	(13,890)
Net Change in Total Pension Liability	**(14,260)**	41,234	62,728	30,851	32,113	37,277	61,743	46,358	30,291	45,881
Total Pension Liability - Beginning of Year	**1,042,807**	1,001,573	938,845	907,994	875,881	808,882	747,139	700,781	670,490	624,609
Addition of VNOR liability	**-**	-	-	-	-	29,722	-	-	-	-
Total Pension Liability - End of Year (a)	**1,028,547**	1,042,807	1,001,573	938,845	907,994	875,881	808,882	747,139	700,781	670,490
Plan Fiduciary Net Position										
Employer contributions	**28,845**	43,041	33,028	27,591	34,200	29,463	27,303	28,571	26,809	30,370
Net investment income	**53,305**	61,010	52,826	51,496	48,513	45,158	41,605	38,283	38,545	34,514
Differences between expected and actual experience	**18,078**	(160,053)	96,478	(22,550)	(20,781)	(7,861)	27,055	4,065	(47,920)	7,267
Benefit payments	**(48,388)**	(45,831)	(42,850)	(38,940)	(34,392)	(30,254)	(27,577)	(24,492)	(19,200)	(13,890)
Net Change in Plan Fiduciary Net Position	**51,840**	(101,833)	139,482	17,597	27,540	36,506	68,386	46,427	(1,766)	58,261
Plan Fiduciary Net Position—Beginning of Year	**771,111**	872,944	733,462	715,865	688,325	623,250	554,864	508,437	510,203	451,942
Addition of VNOR net position	**-**	-	-	-	-	28,569	-	-	-	-
Plan Fiduciary Net Position—End of Year (b)	**822,951**	771,111	872,944	733,462	715,865	688,325	623,250	554,864	508,437	510,203
Net Pension Liability—End of Year (a) - (b)	**$ 205,596**	$ 271,696	$ 128,629	$ 205,383	$ 192,129	$ 187,556	$ 185,632	$ 192,275	$ 192,344	$ 160,287
Plan Fiduciary Net Position as a Percentage of Total Pension Liability	**80.0%**	73.9%	87.2%	78.1%	78.8%	78.6%	77.1%	74.3%	72.6%	76.1%
Covered Employee Payroll	**$ 247,101**	$ 249,743	$ 254,173	$ 261,364	$ 271,681	$ 281,572	$ 296,700	$ 309,816	$ 333,405	$ 351,483
Net Pension Liability as a Percentage of Covered Employee Payroll	**83.2%**	108.8%	50.6%	78.6%	70.7%	66.6%	61.0%	62.1%	57.7%	45.6%

The amounts presented for each fiscal year were determined as of the calendar year-end that occurred within the fiscal year.

** The plan was amended on May 3, 2019, so that ad hoc additional accrued benefit adjustments were added for select participants effective December 31, 2018.

ECU Health

Required Supplementary Information - Schedule of Employer Contributions (Unaudited)

(in '000's)

Year Ended September 30,	**2024**	2023	2022	2021	2020	2019	2018	2017	2016	2015
Actuarially determined contribution	**$ 25,379**	$ 28,845	$ 27,665	$ 27,012	$ 26,906	$ 27,525	$ 28,456	$ 26,011	$ 26,186	$ 26,842
Contributions in relation to the actuarially determined contribution	**25,379**	28,845	43,041	33,028	27,591	34,200	29,462	27,301	28,571	26,842
Contribution excess	**$ -**	$ -	$ (15,376)	$ (6,016)	$ (685)	$ (6,675)	$ (1,006)	$ (1,290)	$ (2,385)	$ -
Covered employee payroll	**$ 247,101**	$ 249,743	$ 254,173	$ 261,364	$ 271,681	$ 281,572	$ 304,497	$ 309,816	$ 333,405	$ 351,483
Contributions recognized as a percentage of actuarially determined contribution	**100.0%**	100.0%	155.6%	122.3%	102.5%	124.3%	103.5%	105.0%	109.1%	100.0%
Contributions as a percentage of covered employee payroll	**10.3%**	11.5%	16.9%	12.6%	10.2%	12.1%	9.7%	8.8%	8.6%	7.6%

The amounts presented for each fiscal year were determined as of the calendar year-end that occurred within the fiscal year.

Notes to Required Supplementary Information (Unaudited)

Valuation date: October 1, 2023
Actuarial cost method: Projected Unit Credit
Asset valuation method: Five-year smoothing
Inflation: 2.5%
Salary increases: 3.0%
Investment rate of return: 7.50% in 2024. 7.00% in 2022 through 2023 (was 7.25% beginning 2018 through 2021), including inflation, previously 7.5% prior to 2018.
Retirement age: Varies by age and service
Mortality: In 2024 and 2023 Pri-2012 aggregate benefits-weighted table adjusted to 2012 and generationally projected with Scale MP-2021. In 2022 Pri-2012 aggregate benefits-weighted table adjusted to 2012 and generationally projected with Scale MP-2020. In 2021 Pri-2012 aggregate benefits-weighted table adjusted to 2012 and generationally projected with Scale MP-2019. RP-2014 Table for Employees and Healthy Annuitants, Generationally Projected with Scale MP-2014 for 2015, MP-2015 for 2016 and 2017, MP-2016 for 2018, MP-2017 for 2019, MP-2018 for 2020.
Changes in assumptions: In 2024, change in discount rate and investment rate return. In 2023, no substantive changes. In 2022, change in discount rate and investment reutrn. In 2021, change in discount rate and investment rate return. In 2018, change in investment rate return and discount rate. In 2017, changes in the expected retirement rate and termination rate for active employees and change in mortality assumption. In 2020 and prior years, no substantive changes.
The North pension plan liability and net position was acquired as of June 1, 2019.

ECU Health

Required Supplementary Information - Schedule of Changes in the Net SERP Liability and Related Ratios (Unaudited)

(in '$000s)

	2024	2023	2022	2021	2020	2019	2018	2017	2016**
Total Pension Liability									
Interest	$ 551	$ 381	$ 391	$ 473	$ 649	$ 847	$ 810	$ 862	$ 903
Plan changes***	-	-	-	-	-	(7,085)	-	-	-
Differences between expected and actual experience	177	195	169	(50)	109	876	(462)	72	-
Changes in assumptions	(85)	(2,571)	(283)	620	2,680	(1,048)	(2,030)	-	-
Benefit payments	(1,142)	(1,142)	(1,142)	(1,115)	(1,115)	(1,534)	(2,710)	(2,532)	(2,085)
Net Change in Total Pension Liability	(499)	(3,137)	(865)	(72)	2,323	(7,944)	(4,392)	(1,598)	(1,182)
Total Pension Liability - Beginning of Year	14,269	17,406	18,271	18,343	16,020	23,964	28,356	29,954	31,136
Total Pension Liabilty - End of Year (a)	13,770	14,269	17,406	18,271	18,343	16,020	23,964	28,356	29,954
Plan Fiduciary Net Position—Beginning of Year*	-	-	-	-	-	-	-	-	-
Plan Fiduciary Net Position—End of Year (b)*	-	-	-	-	-	-	-	-	-
Net Pension Liability—End of Year (a) - (b)	$ 13,770	$ 14,269	$ 17,406	$ 18,271	$ 18,343	$ 16,020	$ 23,964	$ 28,356	$ 29,954
Covered Employee Payroll	***	***	***	***	***	***	$ 3,427	$ 3,343	$ 3,210
Net Pension Liability as a Percentage of Covered Employee Payroll	***	***	***	***	***	***	699.3%	848.2%	933.1%
Actuarially Determined Contribution	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 271	$ 2,085
Contributions in Relation to the Actuarially Determined Contribution	1,142	1,142	1,142	1,115	1,115	1,534	2,710	2,532	2,085
Contribution excess	$ 1,142	$ 1,142	$ 1,142	$ 1,115	$ 1,115	$ 1,534	$ 2,710	$ 2,261	$ -
Contributions Recognized as a Percentage of Actuarially Determined Contribution	NA	NA	NA	NA	NA	NA	NA	934.3%	100.0%
Contributions as a Percentage of Covered Employee Payroll	***	***	***	***	***	***	79.1%	75.7%	65.0%

Notes to Required Supplementary Information (Unaudited)

Valuation date: January 1, 2023
Actuarial cost method: Entry Age Normal
Discount rate: 3% in 2016 and 2017; 3.65% in 2018; 4.20 in 2019; 2.66% in 2020; 2.21% in 2021; 2.26% in 2022; 4.02% in 2023; 4.09 in 2024.
Salary increases: NA
Investment rate of return: NA
Retirement age: NA. All inactives.
Mortality: In 2024 and 2023 Pri-2012 aggregate benefits-weighted table adjusted to 2012 and generationally projected with Scale MP-2021. RP-2014 Table for Employees and Healthy Annuitants, Generationally Projected with Scale MP-2015 for 2016 and 2017, MP-2016 for 2018, MP-2017 for 2019, MP-2018 for 2020. In 2021 Pri-2012 aggregate benefits-weighted table adjusted to 2012 and generationally projected with Scale MP-2019. In 2022 Pri-2012 aggregate benefits-weighted table adjusted to 2012 and generationally projected with Scale MP-2020.
Changes in assumptions: In 2018, 2019, 2020, 2021, 2022, 2023 and 2024 change in discount rate. In prior years, no substantive changes.

* Although assets are not included to reduce the net pension liability, ECU Health does have assets set aside to fund this liability. See Note 13 to the financial statements.
** Certain information prior to 2016 is not available.
*** All participants that had not yet reached age 62 were impacted by the plan changes during 2019; therefore, there is no longer covered payroll associated with this plan. The financial accounting valuation reflects an ad hoc adjustment for certain participants to reduce the accrued benefit under the plan.

ECU Health

Schedule of Changes in the Net OPEB Liability and Related Ratios (Unaudited)

($000's)

	2024	2023	2022	2021	2020	2019	2018	2017*
Total OPEB liability:								
Service cost	**$ 74**	$ 154	$ 141	$ 165	$ 130	$ 171	$ 187	$ 221
Interest	**192**	188	145	293	347	329	304	305
Differences between expected and actual experience	**803**	(2,590)	1,467	(3,512)	1,374	(572)	-	-
Changes in assumptions	**199**	(664)	478	(1,239)	1,249	724	(496)	-
Benefit payments	**(377)**	(721)	(232)	(67)	(698)	(1,999)	(221)	(814)
Net change in total OPEB liability	**891**	(3,633)	1,999	(4,360)	2,402	(1,347)	(226)	(288)
Total OPEB liability—beginning	**4,881**	8,514	6,515	10,875	8,473	9,820	10,046	10,334
Total OPEB liability—ending	**$ 5,772**	$ 4,881	$ 8,514	$ 6,515	$ 10,875	$ 8,473	$ 9,820	$ 10,046

Methods and assumptions used to determine contribution rates:

Valuation date: October 1, 2022
Actuarial cost method: Entry Age Normal
Discount rate: 4.09% in 2024, 4.02% in 2023, 2.26% in 2022; 2.21% in 2021; 2.66% in 2020; 4.20% in 2019; 3.65% in 2018; 3.00% in 2017
Salary increases: 3.00% in 2024, 2023, 2022 and 2021. 0.00% in other years
Health care participation rate: 10% in 2024, 2023, 2022, 2021, 2020 and 2019, 15% in other years
Retirement rates: Age 55 to 57—5% with progressive increases to 100% at age 65
Mortality: In 2024 and 2023 Pri-2012 aggregate benefits-weighted table adjusted to 2012 generationally projected with Scale MP-2021. In 2022 Pri-2012 aggregate benefits-weighted table adjusted to 2012 and generationally projected with Scale MP-2020. In 2021 Pri-2012 aggregate benefits-weighted table adjusted to 2012 and generationally projected with Scale MP-2019. RP-2014 Table for Employees and Healthy Annuitants, Generationally Projected with Scale MP-2015 for 2017, MP-2016 for 2018, MP-2017 for 2019, MP-2018 for 2020.
Changes in assumptions: In 2024, change in discount rate. In 2023, change in discount rate. In 2022, change in discount rate. In 2021, change in discount rate and change in the salary scale. In 2020, change in discount rate. In 2019, change in discount rate, change in the retirement age to better reflect past and expended future plan experiences and change in the future retirees health care participation rate from 15% to 10% to better reflect recent plan experience. In 2018, change in discount rate. In 2017, no substantive changes.
Change in benefit terms: There were no changes to benefit terms.

*Certain information prior to 2017 is not available.

Supplementary Information

ECU Health

Consolidating Schedule of Net Position

(in $000's)

September 30, 2024	Consolidated	Eliminations	ECU Health	ECU Health Medical Center	ECU Health Community Hospitals	ECU Health Alliance	Coastal Plains Network	Channel Marker	ECU Health Physicians	ECU Health Properties	Access East, Inc.	HealthAccess, Inc.
Assets and Deferred Outflows of Resources												
Current Assets												
Cash and cash equivalents	$ 312,801	$ -	$ -	$ 176,176	$ 125,641	$ 42	$ 457	$ 3,312	$ -	$ 4,622	$ 2,479	$ 72
Patient accounts receivable, net	454,236	-	518	325,839	97,026	-	-	-	27,336	-	-	3,517
Other receivables	57,194	(47,612)	42,650	28,607	7,433	-	1	8,427	14,437	703	2,506	42
Estimated settlements due from third-party payors	206,780	-	-	165,867	40,956	-	-	-	(43)	-	-	-
Lease receivable, current portion	281	-	-	52	122	-	-	-	-	107	-	-
Inventories	71,370	-	3,233	49,442	14,575	-	-	-	4,102	1	-	17
Prepaid expenses	30,986	-	13,922	13,263	3,231	-	-	24	404	42	51	49
Assets limited as to use—professional liability losses, current	5,708	-	-	-	-	-	-	5,708	-	-	-	-
Total Current Assets	1,139,356	(47,612)	60,323	759,246	288,984	42	458	17,471	46,236	5,475	5,036	3,697
Assets Limited as to Use												
Internally designated for capital improvements	666,851	-	265,924	353,359	32,361	-	-	-	-	-	15,207	-
Internally designated for professional liability losses	52,579	-	-	-	-	-	-	52,579	-	-	-	-
Other cash limited as to use	16,874	-	-	16,874	-	-	-	-	-	-	-	-
Total Assets Limited as to Use, Net of Current	736,304	-	265,924	370,233	32,361	-	-	52,579	-	-	15,207	-
Capital Assets, Net	828,511	-	109,586	458,688	177,586	-	-	-	40,177	40,796	1,405	273
Other Noncurrent Assets												
Other intangible assets, net	2,656	-	890	1,746	-	-	-	-	-	-	-	20
Other assets	7,454	-	5,973	-	1,481	-	-	-	-	-	-	-
Lease receivable, less current portion	107	-	-	29	78	-	-	-	-	-	-	-
Total Other Noncurrent Assets	10,217	-	6,863	1,775	1,559	-	-	-	-	-	-	20
Total Assets	2,714,388	(47,612)	442,696	1,589,942	500,490	42	458	70,050	86,413	46,271	21,648	3,990
Deferred Outflows of Resources	169,938	-	58,194	75,986	28,088	-	-	-	4,897	-	1,487	1,286
Total Assets and Deferred Outflows of Resources	$ 2,884,326	$ (47,612)	$ 500,890	$ 1,665,928	$ 528,578	$ 42	$ 458	$ 70,050	$ 91,310	$ 46,271	$ 23,135	$ 5,276

ECU Health

Consolidating Schedule of Net Position (continued)

(in $000's)

September 30, 2024	Consolidated	Eliminations	ECU Health	ECU Health Medical Center	ECU Health Community Hospitals	ECU Health Alliance	Coastal Plains Network	Channel Marker	ECU Health Physicians	ECU Health Properties	Access East, Inc.	HealthAccess, Inc.
Liabilities, Deferred Inflows of Resources and Net Position												
Current Liabilities												
Accounts payable	$ 141,640	$ (45,388)	$ 56,556	$ 64,392	$ 38,170	$ 85	$ 171	$ 1,050	$ 23,539	$ 304	$ 1,394	$ 1,367
Accrued expenses	277,106	(2,224)	60,380	110,417	44,215	-	-	6,202	44,219	5	11,636	2,256
Estimated settlements due to third-party payors	72,174	-	-	48,349	23,825	-	-	-	-	-	-	-
Current portion of professional liability losses	5,708	-	-	-	-	-	-	5,708	-	-	-	-
Current maturities of long-term debt	30,963	-	27,270	3,094	480	-	-	-	119	-	-	-
Lease liability, current portion	10,507	-	943	2,208	1,720	-	-	-	5,457	-	84	95
Subscription software, current portion	17,816	-	17,061	755	-	-	-	-	-	-	-	-
Total Current Liabilities	555,914	(47,612)	162,210	229,215	108,410	85	171	12,960	73,334	309	13,114	3,718
Long-Term Liabilities												
Long-term debt, less current maturities	551,305	-	530,210	17,769	2,870	-	-	-	456	-	-	-
Net pension liability	205,596	-	34,949	117,934	39,466	-	-	-	8,893	-	1,883	2,471
Professional liability losses, less current portion	28,937	-	6,269	-	269	-	-	18,958	3,441	-	-	-
Lease liability, less current portion	26,466	-	2,150	4,263	5,688	-	-	-	14,088	-	235	42
Subscription software, less current portion	10,172	-	9,571	601	-	-	-	-	-	-	-	-
Other liabilities	32,949	-	1,191	26,724	690	-	-	4,343	1	-	-	-
Total Liabilities	1,411,339	(47,612)	746,550	396,506	157,393	85	171	36,261	100,213	309	15,232	6,231
Deferred Inflows of Resources	42,251	-	7,030	24,369	7,399	-	-	-	2,078	116	680	579
Total Liabilities and Deferred Inflows of Resources	1,453,590	(47,612)	753,580	420,875	164,792	85	171	36,261	102,291	425	15,912	6,810
Net Position												
Net investment in capital assets	259,370	-	(434,864)	452,414	179,713	-	-	-	20,069	40,796	1,086	156
Restricted—noncontrolling interests	51,508	-	-	4,905	46,603	-	-	-	-	-	-	-
Restricted—other	3,439	-	-	-	3,439	-	-	-	-	-	-	-
Unrestricted (deficit)	1,116,419	-	182,174	787,734	134,031	(43)	287	33,789	(31,050)	5,050	6,137	(1,690)
Total Net Position (Deficit)	1,430,736	-	(252,690)	1,245,053	363,786	(43)	287	33,789	(10,981)	45,846	7,223	(1,534)
Total Liabilities, Deferred Inflows of Resources and Net Position	$ 2,884,326	$ (47,612)	$ 500,890	$ 1,665,928	$ 528,578	$ 42	$ 458	$ 70,050	$ 91,310	$ 46,271	$ 23,135	$ 5,276

ECU Health

Consolidating Schedule of Revenues and Expenses

(in '000's)

Year Ended September 30, 2024	Consolidated	Eliminations	ECU Health	ECU Health Medical Center	ECU Health Community Hospitals	ECU Health Alliance	Coastal Plains Network	Channel Marker	ECU Health Physicians	ECU Health Properties	Access East, Inc.	HealthAccess, Inc.
Operating Revenues												
Net patient service revenue, net of provision for bad debts	$ 2,695,480	$ -	$ (131)	$ 1,842,451	$ 626,329	$ -	$ -	$ -	$ 217,296	$ -	$ -	$ 9,535
Other operating revenues	186,958	(459,114)	359,838	91,720	22,528	-	-	28,352	108,341	8,317	26,868	108
Total Operating Revenues	2,882,438	(459,114)	359,707	1,934,171	648,857	-	-	28,352	325,637	8,317	26,868	9,643
Operating Expenses												
Salaries and wages	1,201,660	-	145,151	536,940	217,138	-	-	-	274,022	-	16,804	11,605
Employee benefits	308,945	(6,643)	53,937	143,901	60,785	-	-	1,431	45,672	-	5,957	3,905
Supplies and other	1,133,895	(442,837)	160,710	936,723	305,986	2,511	3,213	17,592	137,114	2,822	6,239	3,822
Depreciation and amortization	120,871	-	40,739	49,561	18,488	-	-	-	8,797	2,997	175	114
Lease activity	6,571	(9,634)	2,914	8,445	2,648	-	-	-	1,467	-	90	641
Total Operating Expenses	2,771,942	(459,114)	403,451	1,675,570	605,045	2,511	3,213	19,023	467,072	5,819	29,265	20,087
Operating Income (Loss)	110,496	-	(43,744)	258,601	43,812	(2,511)	(3,213)	9,329	(141,435)	2,498	(2,397)	(10,444)
Nonoperating Revenues (Expenses)												
Interest expense	(26,866)	27,561	(24,581)	(25,608)	(3,351)	-	-	-	(865)	-	(15)	(7)
Investment loss, net	110,401	-	78,105	23,811	2,709	-	9	5,375	29	21	337	5
Other	(11,607)	(27,561)	21,733	(8,697)	1,792	-	-	(33)	(159)	53	-	1,265
Total Nonoperating Revenues (Expenses), Net	71,928	-	75,257	(10,494)	1,150	-	9	5,342	(995)	74	322	1,263
Income (Loss) Before Non-Controlling Interests	182,424	-	31,513	248,107	44,962	(2,511)	(3,204)	14,671	(142,430)	2,572	(2,075)	(9,181)
Income applicable to noncontrolling interests	(13,386)	-	-	(9,028)	(4,358)	-	-	-	-	-	-	-
Increase (Decrease) in Net Position - ECU Health	$ 169,038	$ -	$ 31,513	$ 239,079	$ 40,604	$ (2,511)	$ (3,204)	$ 14,671	$ (142,430)	$ 2,572	$ (2,075)	$ (9,181)

ECU Health Medical Center

Consolidating Schedule of Net Position

(in $000's)

Year ended September 30, 2024	Consolidated	Eliminations and Noncontrolling Interests	ECU Health* Medical Center	ECU Health SurgiCenter	ECU Health Radiation Oncology
Assets and Deferred Outflows of Resources					
Current Assets					
Cash and cash equivalents	$ 176,176	$ -	$ 167,386	$ 4,012	$ 4,778
Patient accounts receivable, net	325,839	-	312,597	8,652	4,590
Other receivables	28,607	(1,235)	28,914	417	511
Estimated settlements due from third-party payors	165,867	-	165,867	-	-
Lease receivable, current portion	52	-	52	-	-
Inventories	49,442	-	48,233	1,209	-
Prepaid expenses	13,263	-	12,587	129	547
Total Current Assets	759,246	(1,235)	735,636	14,419	10,426
Assets Limited as to Use					
Internally designated for capital improvements	353,359	-	353,359	-	-
Other cash limited as to use	16,874	-	16,874	-	-
Total Assets Limited as to Use, Net of Current	370,233	-	370,233	-	-
Capital Assets, Net	458,688	-	445,411	6,174	7,103
Other Noncurrent Assets					
Other intangible assets, net	1,746	-	1,126	-	620
Other assets	-	(6,223)	6,223	-	-
Lease receivable, less current portion	29	-	29	-	-
Total Other Noncurrent Assets	1,775	(6,223)	7,378	-	620
Total Assets	1,589,942	(7,458)	1,558,658	20,593	18,149
Deferred Outflows of Resources	75,986	-	56,416	1,196	18,374
Total Assets and Deferred Outflows of Resources	$ 1,665,928	$ (7,458)	$ 1,615,074	$ 21,789	$ 36,523

*Includes activity of MMEC and BEA

ECU Health Medical Center

Consolidating Schedule of Net Position (continued)

(in $000's)

Year ended September 30, 2024	Consolidated	Eliminations and Noncontrolling Interests	ECU Health* Medical Center	ECU Health SurgiCenter	ECU Health Radiation Oncology
Liabilities, Deferred Inflows of Resources and Net Position					
Current Liabilities					
Accounts payable	$ 64,392	$ (1,235)	$ 60,853	$ 3,281	$ 1,493
Accrued expenses	110,417	-	105,703	2,202	2,512
Estimated settlements due to third-party payors	48,349	-	48,349	-	-
Current maturities of long-term debt	3,094	-	3,094	-	-
Lease liability, current portion	2,208	-	1,628	-	580
Subscription software, current portion	755	-	314	-	441
Total Current Liabilities	229,215	(1,235)	219,941	5,483	5,026
Long-Term Liabilities					
Long-term debt, less current maturities	17,769	-	17,769	-	-
Net pension liability	117,934	-	115,176	2,758	-
Lease liability, less current portion	4,263	-	3,325	-	938
Subscription software, less current portion	601	-	601	-	-
Other liabilities	26,724	-	26,453	271	-
Total Liabilities	396,506	(1,235)	383,265	8,512	5,964
Deferred Inflows of Resources	24,369	-	23,940	429	-
Total Liabilities and Deferred Inflows of Resources	420,875	(1,235)	407,205	8,941	5,964
Net Position					
Net investment in capital assets	452,414	-	421,919	6,357	24,138
Restricted—noncontrolling interests	4,905	4,905	-	-	-
Unrestricted	787,734	(11,128)	785,950	6,491	6,421
Total Net Position	1,245,053	(6,223)	1,207,869	12,848	30,559
Total Liabilities, Deferred Inflows of Resources and Net Position	$ 1,665,928	$ (7,458)	$ 1,615,074	$ 21,789	$ 36,523

*Includes activity of MMEC and BEA

ECU Health Medical Center

Consolidating Schedule of Revenues and Expenses

(in $000's)

Year ended September 30, 2024	Consolidated	Eliminations and Noncontrolling Interests	ECU Health* Medical Center	ECU Health SurgiCenter	ECU Health Radiation Oncology
Operating Revenues					
Net patient service revenue, net of provision for bad debts	$ 1,842,451	$ -	$ 1,772,139	$ 54,102	$ 16,210
Other operating revenues	91,720	(2,997)	93,989	325	403
Total Operating Revenues	1,934,171	(2,997)	1,866,128	54,427	16,613
Operating Expenses					
Salaries and wages	536,940	-	523,266	8,081	5,593
Employee benefits	143,901	-	140,752	2,705	444
Supplies and other	936,723	(2,997)	912,161	21,338	6,221
Depreciation and amortization	49,561	-	46,490	933	2,138
Lease activity	8,445	-	5,477	1,631	1,337
Total Operating Expenses	1,675,570	(2,997)	1,628,146	34,688	15,733
Operating Income	258,601	-	237,982	19,739	880
Nonoperating Revenues (Expenses)					
Interest expense	(25,608)	-	(25,568)	-	(40)
Investment income	23,811	-	23,445	323	43
Other	(8,697)	(11,034)	2,337	-	-
Total Nonoperating Revenues (Expenses), Net	(10,494)	(11,034)	214	323	3
Income before Non-Controlling Interests	248,107	(11,034)	238,196	20,062	883
Income applicable to noncontrolling interest	(9,028)	(9,028)	-	-	-
Increase in Net Position—ECU Health Medical Center	$ 239,079	$ (20,062)	$ 238,196	$ 20,062	$ 883

*Includes activity of MMEC and BEA

ECU Health Community Hospitals

Consolidating Schedule of Net Position

(in $000's)

September 30, 2024	Consolidated	Eliminations and Noncontrolling Interests	Outer Banks Health	ECU Health Roanoke-Chowan Hospital	ECU Health Bertie Hospital	ECU Health Edgecombe Hospital	ECU Health Chowan Hospital	ECU Health Duplin Hospital	ECU Health Beaufort Hospital	ECU Health North
Assets and Deferred Outflows of Resources										
Current Assets										
Cash	$ 125,641	$ -	$ 28,499	$ 9,009	$ 20,135	$ 20,054	$ 26,869	$ 11,385	$ 1,756	$ 7,934
Patient accounts receivable, net	97,026	-	18,353	15,734	4,203	17,920	12,148	10,926	(196)	17,938
Other receivables	7,433	(100)	2,973	696	243	1,020	567	665	22	1,347
Estimated settlements due from third-party payors	40,956	-	3,709	6,544	1,717	7,107	5,401	8,367	642	7,469
Lease receivable, current portion	122	-	117	-	-	-	-	-	-	5
Inventories	14,575	-	2,094	3,142	441	2,505	2,056	1,373	-	2,964
Prepaid expenses	3,231	-	230	124	52	32	40	2,557	-	196
Total Current Assets	288,984	(100)	55,975	35,249	26,791	48,638	47,081	35,273	2,224	37,853
Assets Limited as to Use										
Internally designated for capital improvements	32,361	-	31,855	-	-	-	-	-	-	506
Capital Assets, Net	177,586	-	57,042	22,107	5,375	19,881	19,294	22,177	-	31,710
Other Noncurrent Assets										
Other assets	1,481	-	-	564	-	-	-	-	-	917
Lease receivable, less current portion	78	-	66	-	-	-	-	-	-	12
Total Other Noncurrent Assets	1,559	-	66	564	-	-	-	-	-	929
Total Assets	500,490	(100)	144,938	57,920	32,166	68,519	66,375	57,450	2,224	70,998
Deferred Outflows of Resources	28,088	-	-	4,996	-	16,237	3,335	2,165	-	1,355
Total Assets and Deferred Outflows of Resources	$ 528,578	$ (100)	$ 144,938	$ 62,916	$ 32,166	$ 84,756	$ 69,710	$ 59,615	$ 2,224	$ 72,353

ECU Health Community Hospitals

Consolidating Schedule of Net Position (Continued)

(in $000's)

September 30, 2024	Consolidated	Eliminations and Noncontrolling Interests	Outer Banks Health	ECU Health Roanoke-Chowan Hospital	ECU Health Bertie Hospital	ECU Health Edgecombe Hospital	ECU Health Chowan Hospital	ECU Health Duplin Hospital	ECU Health Beaufort Hospital	ECU Health North
Liabilities, Deferred Inflows of Resources and Net Position										
Current Liabilities										
Accounts payable	$ 38,170	$ (100)	$ 8,923	$ 5,303	$ 1,494	$ 5,790	$ 3,227	$ 4,149	$ -	$ 9,384
Accrued expenses	44,215	-	8,932	7,882	2,084	7,429	5,143	5,298	95	7,352
Estimated settlements due to third-party payors	23,825	-	3,186	2,148	2,147	2,718	6,834	1,595	2,495	2,702
Current maturities of long-term debt	480	-	108	43	-	105	-	24	-	200
Lease liability, current portion	1,720	-	1,134	90	1	87	6	257	-	145
Total Current Liabilities	108,410	(100)	22,283	15,466	5,726	16,129	15,210	11,323	2,590	19,783
Long-Term Liabilities										
Long-term debt, less current maturities	2,870	-	479	167	163	452	754	165	-	690
Net pension liability	39,466	-	-	14,631	-	9,179	10,749	2,339	-	2,568
Professional liability losses, less current portion	269	-	269	-	-	-	-	-	-	-
Lease liability, less current portion	5,688		5,202	44	3	49	2	196	-	192
Other liabilities	690	-	44	108	44	140	63	43	-	248
Total Liabilities	157,393	(100)	28,277	30,416	5,936	25,949	26,778	14,066	2,590	23,481
Deferred Inflows of Resources	7,399	-	183	2,218	-	1,565	1,484	1,097	-	852
Total Liabilities and Deferred Inflows of Resources	164,792	(100)	28,460	32,634	5,936	27,514	28,262	15,163	2,590	24,333
Net Position										
Net investment in capital assets	179,713	-	50,119	21,779	5,208	31,847	18,532	21,745	-	30,483
Restricted—noncontrolling interests	46,603	46,603	-	-	-	-	-	-	-	-
Restricted—other	3,439	-	-	3,434	5	-	-	-	-	-
Unrestricted	134,031	(46,603)	66,359	5,069	21,017	25,395	22,916	22,707	(366)	17,537
Total Net Position	363,786	-	116,478	30,282	26,230	57,242	41,448	44,452	(366)	48,020
Total Liabilities, Deferred Inflows of Resources and Net Position	$ 528,578	$ (100)	$ 144,938	$ 62,916	$ 32,166	$ 84,756	$ 69,710	$ 59,615	$ 2,224	$ 72,353

ECU Health Community Hospitals

Consolidating Schedule of Revenues and Expenses

(in $000's)

Year Ended September 30, 2024	Consolidated	Eliminations and Noncontrolling Interests	Outer Banks Health	ECU Health Roanoke-Chowan Hospital	ECU Health Bertie Hospital	ECU Health Edgecombe Hospital	ECU Health Chowan Hospital	ECU Health Duplin Hospital	ECU Health Beaufort Hospital	ECU Health North
Operating Revenues										
Net patient service revenue, net of provision for bad debts	$ 626,329	$ -	$ 125,417	$ 92,345	$ 32,405	$ 109,511	$ 84,798	$ 75,748	$ 2,080	$ 104,025
Other operating revenues	22,528	(294)	4,762	4,505	240	6,779	2,202	1,309	-	3,025
Total Operating Revenues	648,857	(294)	130,179	96,850	32,645	116,290	87,000	77,057	2,080	107,050
Operating Expenses										
Salaries and wages	217,138	-	49,625	34,192	10,404	35,889	21,221	28,199	-	37,608
Employee benefits	60,785	-	10,435	10,901	2,344	10,505	6,646	8,486	-	11,468
Supplies and other	305,986	(294)	59,332	49,090	10,504	53,713	33,151	30,164	224	70,102
Depreciation and amortization	18,488	-	4,351	1,850	560	3,716	1,815	2,918	-	3,278
Lease activity	2,648	-	331	601	112	484	414	406	-	300
Total Operating Expenses	605,045	(294)	124,074	96,634	23,924	104,307	63,247	70,173	224	122,756
Operating Income (Loss)	43,812	-	6,105	216	8,721	11,983	23,753	6,884	1,856	(15,706)
Nonoperating Revenues (Expenses)										
Interest expense	(3,351)	-	(264)	(340)	(7)	(2,129)	(140)	(52)	-	(419)
Investment income	2,709	-	2,162	158	29	154	56	33	5	112
Other	1,792	-	2,893	(151)	(186)	(175)	(284)	(70)	-	(235)
Total Nonoperating Revenues (Expenses), Net	1,150	-	4,791	(333)	(164)	(2,150)	(368)	(89)	5	(542)
Income (Loss) Before Non-Controlling Interests	44,962	-	10,896	(117)	8,557	9,833	23,385	6,795	1,861	(16,248)
Income applicable to noncontrolling interest	(4,358)	(4,358)	-	-	-	-	-	-	-	-
Increase (Decrease) in Net Position - ECU Health Community Hospitals	$ 40,604	$ (4,358)	$ 10,896	$ (117)	$ 8,557	$ 9,833	$ 23,385	$ 6,795	$ 1,861	$ (16,248)

ECU Health (Combined Group)

Consolidating Schedule of Net Position

(in '$000s)

September 30, 2024	Consolidated	Eliminations and Noncontrolling Interests	Combined Group	Unrestricted Affiliates
Assets and Deferred Outflows of Resources				
Current Assets				
Cash and cash equivalents	$ 312,801	$ -	$ 266,771	$ 46,030
Patient accounts receivable, net	454,236	-	418,758	35,478
Other receivables	57,194	(9,205)	51,498	14,901
Estimated settlements due from third-party payors	206,780	-	203,114	3,666
Lease receivable, current portion	281	-	164	117
Inventories	71,370	-	68,018	3,352
Prepaid expenses	30,986	-	29,956	1,030
Assets limited as to use—professional liability losses, current	5,708	-	-	5,708
Total Current Assets	1,139,356	(9,205)	1,038,279	110,282
Assets Limited as to Use				
Internally designated for capital improvements	666,851	-	619,789	47,062
Internally designated for professional liability losses	52,579	-	-	52,579
Other cash limited as to use	16,874	-	16,874	-
Total Assets Limited as to Use, Net of Current	736,304	-	636,663	99,641
Capital Assets, Net	828,511	-	756,509	72,002
Other Noncurrent Assets				
Intangible assets, net	2,656	-	2,016	640
Other assets	7,454	(584)	8,038	-
Lease receivable, less current portion	107	-	41	66
Total Other Noncurrent Assets	10,217	(584)	10,095	706
Deferred Outflows of Resources	169,938	-	147,595	22,343
Total Assets and Deferred Outflows of Resources	$ 2,884,326	$ (9,789)	$ 2,589,141	$ 304,974

ECU Health (Combined Group)

Consolidating Schedule of Net Position (Continued)

(in $000's)

September 30, 2024	Consolidated	Eliminations and Noncontrolling Interests	Combined Group	Unrestricted Affiliates
Liabilities, Deferred Inflows of Resources and Net Position				
Current Liabilities				
Accounts payable	$ 141,640	$ (9,205)	$ 132,552	$ 18,293
Accrued expenses	277,106	-	242,998	34,108
Estimated settlements due to third-party payors	72,174	-	68,988	3,186
Current reserve for professional liability losses	5,708	-	-	5,708
Current maturities of long-term debt	30,963	-	30,855	108
Lease liability, current portion	10,507	-	8,614	1,893
Subscription software, current portion	17,816	-	17,375	441
Total Current Liabilities	555,914	(9,205)	501,382	63,737
Long-Term Liabilities				
Long-term debt, less current maturities	551,305	-	550,826	479
Net pension liability	205,596	-	198,484	7,112
Professional liability losses, less current portion	28,937	-	9,710	19,227
Lease liability, less current portion	26,466	-	20,049	6,417
Subscription software, less current portion	10,172	-	10,172	-
Other liabilities	32,949	(584)	28,875	4,658
Total Long-Term Liabilities	855,425	(584)	818,116	37,893
Total Liabilities	1,411,339	(9,789)	1,319,498	101,630
Deferred Inflows of Resources	42,251	-	40,380	1,871
Total Liabilities and Deferred Inflows of Resources	1,453,590	(9,789)	1,359,878	103,501
Net Position				
Net investment in capital assets	259,370	-	177,509	81,861
Restricted—noncontrolling interests	51,508	-	51,508	-
Restricted—other	3,439	-	3,439	-
Unrestricted	1,116,419	-	996,807	119,612
Total Net Position	1,430,736	-	1,229,263	201,473
Total Liabilities, Deferred Inflows of Resources and Net Position	$ 2,884,326	$ (9,789)	$ 2,589,141	$ 304,974

ECU Health (Combined Group)

Consolidating Schedule of Revenues and Expenses

(in $000's)

Year Ended September 30, 2024	Consolidated	Eliminations and Noncontrolling Interests	Combined Group	Unrestricted Affiliates
Operating Revenues				
Other operating revenues	$ 2,695,480	$ -	$ 2,487,149	$ 208,331
Other revenue	186,958	(33,696)	159,716	60,938
Total Operating Revenues	2,882,438	(33,696)	2,646,865	269,269
Operating Expenses				
Salaries and wages	1,201,660	-	1,106,861	94,799
Employee benefits	308,945	-	283,283	25,662
Supplies and other	1,133,895	(32,065)	1,044,865	121,095
Depreciation and amortization	120,871	-	113,159	7,712
Lease activity	6,571	(1,631)	3,972	4,230
Total Operating Expenses	2,771,942	(33,696)	2,552,140	253,498
Operating Income	110,496	-	94,725	15,771
Nonoperating Revenues (Expenses)				
Interest expense	(26,866)	-	(26,540)	(326)
Investment loss, net	110,401	-	102,141	8,260
Income applicable to noncontrolling interest	(13,386)	(13,386)	-	-
Other	(11,607)	-	(15,732)	4,125
Total Nonoperating Revenues (Expenses), Net	58,542	(13,386)	59,869	12,059
Increase in Net Position—ECU Health	$ 169,038	$ (13,386)	$ 154,594	$ 27,830

Reports and Schedules Required by *Government Auditing Standards* and the Uniform Guidance

Tel: 919-754-9370
Fax: 919-754-9369
www.bdo.com

421 Fayetteville Street,
Suite 300
Raleigh, NC 27601

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of Directors
University Health Systems of Eastern Carolina, Inc.
d/b/a ECU Health
Greenville, North Carolina

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the business-type activities and the aggregate remaining fund information of University Health Systems of Eastern Carolina, Inc. d/b/a ECU Health (ECU Health), as of and for the year ended September 30, 2024, and the related notes to the financial statements, which collectively comprise ECU Health's basic financial statements, and have issued our report thereon dated January 22, 2025.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered ECU Health's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of ECU Health's internal control. Accordingly, we do not express an opinion on the effectiveness of ECU Health's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or team members, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. *A significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that have not been identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether ECU Health's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering ECU Health's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

BDO USA, P.C.

January 22, 2025

Tel: 919-754-9370
Fax: 919-754-9369
www.bdo.com

421 Fayetteville Street,
Suite 300
Raleigh, NC 27601

Independent Auditor's Report on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance

To the Board of Directors
University Health Systems of Eastern Carolina, Inc.
d/b/a ECU Health
Greenville, North Carolina

Report on Compliance for Each Major Federal Program

Opinion on Each Major Federal Program

We have audited University Health Systems of Eastern Carolina, Inc.'s d/b/a ECU Health (ECU Health), compliance with the types of compliance requirements identified as subject to audit in the OMB *Compliance Supplement* that could have a direct and material effect on each of ECU Health's major federal programs for the year ended September 30, 2024. ECU Health's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

In our opinion, ECU Health complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on its major federal programs for the year ended September 30, 2024.

Basis for Opinion on Each Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of ECU Health and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for each major federal program. Our audit does not provide a legal determination of ECU Health's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules, and provisions of contracts or grant agreements applicable to ECU Health's federal programs.

Auditor's Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on ECU Health's compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about ECU Health's compliance with the requirements of each major federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding ECU Health's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.
- Obtain an understanding of ECU Health's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of ECU Health's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Report on Internal Control Over Compliance

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or team members, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. *A material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. *A significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations, during our audit we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses or significant deficiencies in internal control over compliance may exist that were not identified.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

BDO USA, P.C.

January 22, 2025

ECU Health

Schedule of Expenditures of Federal Awards

Year Ended September 30, 2024

Federal Grantor/Pass-Through Agency/Program Title	Assistance Listing Number	Agency or Pass-Through Grantor's Number	Provided to Subrecipients	Total Federal Expenditures
Federal Awards				
U.S. Department of Health and Human Services				
Health Resources and Services Administration (HRSA)				
Direct awards:				
Rural Health Care Services Outreach, Rural Health Network Development and Small Health Care Provider Quality Improvement	93.912			450,522
Pass-through awards from North Carolina Healthcare Quality Alliance, Inc.:				
Rural Health Care Services Outreach, Rural Health Network Development and Small Health Care Provider Quality Improvement	93.912	GA1RH39580		55
Pass-through awards from NC Department of Health and Human Services, Office of				
Rural Health: COVID-19, Rural Health Research Centers	93.155	H3L42219		195,736
Center for Medicare and Medicaid Services (CMS)				
Pass-through awards form Legal Aid of North Carolina, Inc.:				
Cooperative Agreement to Support Navigators in Federally-facilitated Exchanges	93.332	NAVCA210405-03-00 NAVCMS240463-01-00		364,557
Administration for Community Living (ACL)				
Pass-through awards from North Carolina Department of Insurance:				
State Health Insurance Assistance Program	93.324	90SAPG0099-03-00 90SAPG0099-04-00		2,599
Special Programs for the Aging, Title IV, and Title II, Discretionary Projects	93.048	90MPPG0074-01-00		1,986
Centers for Disease Control and Prevention (CDC)				
Pass-through awards from NC Department of Health and Human Services, Division of Public Health: Paul Coverdell Acute Stroke Program National Center for Chronic Disease Prevention and Health Promotion	93.810	NU58DP006944		43,798
Injury Prevention and Control Research and State and Community Based Programs	93.136	NU50CE002591		75,646
Activities to Support State, Tribal, Local and Territorial (STLT) Health Department Response to Public Health or Healthcare Crises	93.391	NH75OT000028		60,000
Pass-through awards from University of North Carolina at Chapel Hill:				
Cancer Center Supports Grants	93.397	5P30CA016086-46/47		3,194
Total U.S. Department of Health and Human Services				**1,198,093**
Total Expenditures of Federal Awards			$ -	**$ 1,198,093**

See notes to schedule of expenditures of federal awards.

Note 1. Basis of Presentation

The accompanying schedule of expenditures of federal awards (the Schedule) includes the federal award activity of University Health Systems of Eastern Carolina, Inc. d/b/a ECU Health (ECU Health) for the year ended September 30, 2024. The information in the Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200*, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Because the Schedule presents only a selected portion of the operations of ECU Health, it is not intended to and does not present the financial position, changes in net position, or cash flows of ECU Health.

Note 2. Summary of Significant Accounting Policies

Expenditures reported on the Schedule are recognized under the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement.

Note 3. Indirect Cost Rate

ECU Health has elected to use the 10% de minimis indirect cost rate as allowed under the Uniform Guidance.

ECU Health

Schedule of Findings and Questioned Costs
Year Ended September 30, 2024

I. Summary of Auditor's Results

Financial Statements

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP: Unmodified

Internal control over financial reporting:

- Material weakness(es) identified? ___ Yes ___x___ No
- Significant deficiency(ies) identified? ___ Yes ___x___ None Reported

Noncompliance material to financial statements noted? ___ Yes ___x___ No

Federal Awards

Internal control over major federal programs

- Material weakness(es) identified? ___ Yes ___x___ No
- Significant deficiency(ies) identified? ___ Yes ___x___ None Reported

Type of auditor's report issued on compliance for major federal programs: Unmodified

Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)? ____ Yes ___x___ No

Identification of federal major programs:

Assistance Listing Number(s)	Name of Federal Program or Cluster
93.912	Rural Health Care Services Outreach, Rural Health Network and Small Health Care Provider Quality Improvement

Dollar threshold used to distinguish between type A and type B programs: $750,000

Auditee qualified as low-risk auditee? ___x___ Yes ____ No

II. Financial Statement Findings

There are no matters to report.

III. Federal Award Findings and Questioned Costs

There are no audit findings to be reported under 2 CFR 200.516(a).

ECU HEALTH

Summary Schedule of Prior Audit Findings

Status of Prior Year Findings

2023-001 – *Estimation / Reconciliation of Medicaid Directed Payment Receivable / IGT Assessment Liability*

Prior Year Finding:

Beginning July 1, 2021, Medicaid moved to a managed care model for care in North Carolina. As part of the reimbursement modeling, Pitt County Memorial Hospital, Inc. d/b/a ECU Health Medical Center (VMC) was one of two entities (UNC owning the other) that were provided an additional add-on payment as a result of being an academic teaching facility to account for previous adjustments to reimbursement that were being accomplished through the cost report. The Directed Payment model created for VMC and UNC was a simple reimbursement model that would be paid quarterly (in arrears), computed by a contracted rate per discharge to be applied to all "paid" claims during the quarter. The rate is not impacted by any other factor, but rather is simply a per discharge amount set annually by the State.

As a result of this reimbursement change, the ECU Health reimbursement team began recording a receivable each month, calculated as the total discharges during the month times the Directed Payment rate. In addition, the reimbursement team would apply an assessment expense factor to that total receivable to account for the expected Intergovernmental Transfer (IGT), which is the process by which funds are transferred for the purpose of the federal match to the State.

During fiscal year 2023, the Medicaid Directed Payment receivable and related IGT assessment liability continued to grow. It was determined that the receivable and related assessment liability was never discounted for potential denials based on experience.

As a result, the reimbursement team performed a complete review and reconciliation matching up payments received by quarter which resulted in a net overstatement of the receivable and related assessment liability of $14.1 million with $8.7 million of the net overstatement related to fiscal year 2022 and prior.

We recommend that ECU Health reconcile the receivable and related assessment liability on a timely basis going forward ensuring to continually challenge the critical factors in this estimation which includes updating for the discount related to actual denial experience.

Current Year Status:

This finding has been corrected in the current year.

2100 Stantonsburg Road
Greenville, NC 27834-2818
PO Box 6028
Greenville, NC 27835-6028
252.847.4100
ECUHealth.org

Status **Active** PolicyStat ID **17735538**

Origination	12/2024
Last Approved	03/2025
Effective	03/2025
Last Revised	03/2025
Next Review	03/2026
Owner	Sabrina Sims: VP, Revenue Cycle
Document Area	ECU Health Financial Services
Applicability	ECU Health System-Wide

Financial Assistance- Hospital Billing

Applicability

This policy applies ECU Health Medical Center, Outer Banks Health Hospital, ECU Health Beaufort Hospital, a campus of ECU Health Medical Center, ECU Health Bertie Hospital, ECU Health Chowan Hospital, ECU Health Duplin Hospital, ECU Health Edgecombe Hospital, ECU Health Roanoke-Chowan Hospital, ECU Health North Hospital, and ECU Health Home Health and Hospice.

Additionally, this policy applies to North Carolina and non-North Carolina residents related to the hospital-based charges that they incur from services received at ECU Health.

Summary of Changes:	
12/2024	New policy

Policy

The Central Business Office (CBO) for ECU Health will engage in the evaluation of patients' accounts for Financial Assistance eligibility. If you receive help from the Financial Assistance Program (FAP), we will not charge more than the amounts generally billed to patients who have insurance for emergency or other medically necessary care. ECU Health uses a look back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to our hospital during the prior 12-month period to determine the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care. (See Attachment B for exclusions)

Definitions

Plain Language Summary means a written statement that notifies an Individual(s) that ECU Health offers financial assistance under the FAP for services and contains the information required to be

included in such statement under the FAP.

Completion Deadline means the date after which ECU Health or collection agency may initiate or resume an ECA against an Individual(s) who has submitted an incomplete FAP if that Individual(s) has not provided the missing information and/or documentation necessary to complete the application or denied application. The Completion Deadline must be specified in a written notice and must be no earlier than the later of (1) 30 days after ECU Health provides the Individual(s) with this notice; or (2) the last day of the Application Period.

Federal Poverty Level (FPL) is a measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for financial assistance and charity allocations.

ECU Health maintains three (3) types of financial assistance:

A. Charity Care
B. Payment Plans
C. Medicaid Screening

Charity Care

There are two (2) types of Charity Care: Income-based and Non-income based. Patients qualify for Charity Care based on the following:

1. **Income-based**
    a. **Presumptive eligibility process**
        - The balance is written-off at or after day 160 based on income less than or equal to 200% FPL.

    b. **Application-based process**
        - Utilized by individuals who would like to request that all or a portion of their balance be written-off based on income and family size. They can retrieve an application on the ECU Health website or they can contact the Customer Service department to obtain an application via mail or secure email.
        - ECU Health requires patients to submit documentation or verification that they meet the eligibility criteria.
        - The following ranges are applied for evaluating applications and adjusting accounts:
            - Discount of 100% for individuals with incomes below 200% FPL.
            - Discount of at least 75% for individuals with incomes between 200% – 250% FPL.
            - Discount of at least 50% for individuals with incomes between 251% - 300% FPL.

- ECU Health discounts must be applied to the amount the patient owes (i.e. accounting for contractual allowances and insurance payments, if applicable) or the “amount generally billed” for uninsured individuals.
- ECU Health will consistently apply discounts to uninsured and insured individuals.

2. **Non-income based**
    a. **Presumptive eligibility process**

- ECU Health will deem patients presumptively eligible for financial assistance based on the following non-income criteria and documentation will not be required : (patients must meet at least one)
    - Homelessness
    - Mental incapacitation with no one to act on the patient’s behalf
    - Enrollment in Medicaid of patient or a child in their household
    - Enrollment in another means-tested public assistance program (including, but not limited to Women, Infants and Children Nutrition Program, Supplemental Nutrition Assistance Program)
- ECU Health will screen patients for non-income based presumptive eligibility and notify patients of results based on the following timeline:
    - Non-emergency department services:
      A. Screening: Prior to or at check in.
      B. Notification: Prior to discharge.
    - Emergency department services:
      A. Screening: As soon as possible and prior to discharge if feasible.
      B. Notification: Prior to issuing bill to patient.

Payment Plans

- ECU Health manages a patient payment plan program as outlined in Payment Plans.
- For individuals with incomes between 200 - 300% FPL, ECU Health will offer a payment plan that does not exceed a duration of 36 months with monthly payments no greater than 5% of monthly household income.
- ECU Health will offer alternative payment plans that exceed 36 months, but the aggregate amount collected from the patient will not exceed what would have been collected under the 36 month/5% income plan.

Medicaid Screening

- ECU Health manages a Medicaid screening process as outlined in Financial Counseling.

Attachments

Attachment A 2024 FEDERAL POVERTY GUIDELINES.docx

Attachment B Exclusions.docx

Approval Signatures

Step Description	Approver	Date
Legal Review	Vicki Haddock: VP, Office of Gen Counsel	03/2025
Associate General Counsel	Caroline Henderson: Associate General Counsel	03/2025
SVP, Financial Services	Bobby Dunn: SVP, Financial Services	03/2025
VP, Revenue Cycle	Sabrina Sims: VP, Revenue Cycle	03/2025
Legal Review 1	Melissa Anderson: Coord, ECU Hlth Policy Managmt	03/2025
Policy Owner	Sabrina Sims: VP, Revenue Cycle	03/2025

Applicability

ECU Health Duplin Hospital, ECU Health Beaufort Hospital-a Campus of EMC, ECU Health Bertie Hospital, ECU Health Chowan Hospital, ECU Health Corporate, ECU Health Edgecombe Hospital, ECU Health Endoscopy Center, ECU Health Home Health & Hospice, ECU Health Medical Center, ECU Health North Hospital, ECU Health Physicians, ECU Health Roanoke-Chowan Hospital, ECU Health SurgiCenter, Outer Banks Health, Population Health Management

Status **Active** PolicyStat ID **17251575**

Origination	12/2024	Owner	Sabrina Sims: VP, Revenue Cycle
Last Approved	12/2024	Document Area	ECU Health Financial Services
Effective	01/2025	Applicability	ECU Health System-Wide
Last Revised	12/2024		
Next Review	12/2025		

Financial Assistance- Professional Billing

Applicability

This policy applies to ECU Health Medical Center, Outer Banks Health Hospital, ECU Health Beaufort Hospital, a campus of ECU Health Medical Center, ECU Health Bertie Hospital, ECU Health Chowan Hospital, ECU Health Duplin Hospital, ECU Health Edgecombe Hospital, ECU Health Roanoke-Chowan Hospital, ECU Health North Hospital, ECU Health Surgicenter, ECU Health Physicians-Community, ECU Health Home Health and Hospice, and ECU Health Physicians-Academic.

Additionally, this policy applies to North Carolina and non-North Carolina residents related to the professional charges that they incur from services received at ECU Health.

Summary of Changes:	
12/2024	New policy

Policy

The Central Business Office (CBO) for ECU Health will engage in the evaluation of patients' accounts for Financial Assistance eligibility. If you receive help from the Financial Assistance Program (FAP), we will not charge more than the amounts generally billed to patients who have insurance for emergency or other medically necessary care. ECU Health uses a look back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to our hospital during the prior 12-month period to determine the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care. (See Attachment B for exclusions)

Definitions

Federal Poverty Level (FPL) is a measure of income issued every year by the Department of Health and

Human Services (HHS). Federal poverty levels are used to determine eligibility for financial assistance and charity allocations.

Plain Language Summary means a written statement that notifies an Individual(s) that ECU Health offers financial assistance under the FAP for services and contains the information required to be included in such statement under the FAP.

Completion Deadline means the date after which ECU Health or collection agency may initiate or resume an ECA against an Individual(s) who has submitted an incomplete FAP if that Individual(s) has not provided the missing information and/or documentation necessary to complete the application or denied application. The Completion Deadline must be specified in a written notice and must be no earlier than the later of (1) 30 days after ECU Health provides the Individual(s) with this notice; or (2) the last day of the Application Period.

ECU Health maintains three (3) types of financial assistance:

A. Charity Care
B. Payment Plans
C. Medicaid Screening

Charity Care

There are two (2) types of Charity Care: Income-based and Non-income based. Patients qualify for Charity Care based on the following:

1. **Income-based**
    A. **Presumptive eligibility process**
        - The balance is written-off at or after day 160 based on income less than or equal to 200% FPL.

    B. **Application-based process**
        - Utilized by individuals who would like to request that all or a portion of their balance be written-off based on income and family size. They can retrieve an application on the ECU Health website or they can contact the Customer Service department to obtain an application via mail or secure email.
        - ECU Health requires patients to submit documentation or verification that they meet the eligibility criteria.
        - The following ranges are applied for evaluating applications and adjusting accounts:
            - Discount of 100% for individuals with incomes below 200% FPL.
            - Patients with an income ranging from 201% to 300% of the FPL are eligible for Financial Assistance, with their household patient responsibility limited to 2% of the household income.
            - Patients with an income ranging from 301% to 400% of the FPL

are eligible for Financial Assistance, with their household patient responsibility limited to 3% of the household income.

- ECU Health discounts must be applied to the amount the patient owes (i.e. accounting for contractual allowances and insurance payments, if applicable) or the "amount generally billed" for uninsured individuals.
- ECU Health will consistently apply discounts to uninsured and insured individuals.

2. **Non-income Based**

   A. **Presumptive eligibility process**

- There are occasions in which a patient may appear eligible for charity care consideration, but there is no financial assistance information available to support the determination.
- Some patients are presumed eligible for charity care based on individual life circumstances (e.g., homelessness, patients with minimal or no income and no assets, etc.).
- Balances are adjusted on the accounts deemed eligible for presumptive charity, and the remaining accounts are referred to an outside collection agency.
- Once the agency has had the accounts for six months and has deemed them uncollectible, accounts with balances of $1,580.00 and less will be returned. Accounts with balances greater than $1,580.00 will remain with the agency and will remain on the patients' credit files.
- Accounts returned as uncollectible will be placed in a unique financial class and will not be pursued for collections.

Although guidelines are herein previously outlined, accounts will be evaluated on an individual basis.

Payment Plans

- ECU Health manages a patient payment plan program as outlined in Payment Plans.

Medicaid Screening

- ECU Health manages a Medicaid screening process as outlined in Financial Counseling.

Attachments

Attachment A 2024 FEDERAL POVERTY GUIDELINES.docx

Attachment B Exclusions.docx

Approval Signatures

Step Description	Approver	Date
Legal Review	Vicki Haddock: VP, Office of Gen Counsel	12/2024
Associate General Counsel	Caroline Henderson: Associate General Counsel	12/2024
SVP, Financial Services	Bobby Dunn: SVP, Financial Services	12/2024
VP, Revenue Cycle	Sabrina Sims: VP, Revenue Cycle	12/2024
Legal Review 1	Melissa Anderson: Coord, ECU Hlth Policy Managmt	12/2024
Policy Owner	Sabrina Sims: VP, Revenue Cycle	12/2024

Applicability

ECU Health Duplin Hospital, ECU Health Beaufort Hospital-a Campus of EMC, ECU Health Bertie Hospital, ECU Health Chowan Hospital, ECU Health Corporate, ECU Health Edgecombe Hospital, ECU Health Endoscopy Center, ECU Health Home Health & Hospice, ECU Health Medical Center, ECU Health North Hospital, ECU Health Physicians, ECU Health Roanoke-Chowan Hospital, ECU Health SurgiCenter, Outer Banks Health, Population Health Management

Status **Active** PolicyStat ID **17094668**

Origination	12/2024
Last Approved	12/2024
Effective	01/2025
Last Revised	12/2024
Next Review	12/2025
Owner	Sabrina Sims: VP, Revenue Cycle
Document Area	ECU Health Financial Services
Applicability	ECU Health System-Wide

Self-Pay & Residual Billing and Collection Policy

Applicability

This policy applies to ECU Health Beaufort Hospital-A Campus of ECU Health Medical Center, ECU Health Bertie Hospital, ECU Health Chowan Hospital, ECU Health Duplin Hospital, ECU Health Edgecombe Hospital, ECU Health Medical Center, ECU Health Physicians, ECU Health Corporate, ECU Health North Hospital, ECU Health Roanoke Chowan Hospital, Outer Banks Health Hospital, ECU Health Home Health and Hospice, Access East, ECU Health Surgicenter, and ECU Health Endoscopy Center.

Summary of Changes:	
11/2024	New policy

Policy

ECU Health facilities are private not for profit entities that treat all patients regardless of ability to pay. However, ECU Health also recognizes that in order to continue providing medical services to the region in the future, the organization must pursue collections from all available resources.

Unresolved balances will become eligible for collection agency referral. Patients or responsible parties will be sent written notice of intent prior to referral of an account that is deemed delinquent to a collection agency. The collection agency's first written communication to the debtor will advise that ECU Health has a charity program for which they may qualify and will include a contact number for ECU Health's Central Business Office. ECU Health contractually requires that a collection agency, entity, or other assignee obtain written consent from the facility prior to initiating litigation against the patient or responsible party.

Definitions

Billing Deadline means the date after which ECU Health or collection agency may initiate an Extraordinary Collection Action (ECA) against a Responsible Individual(s) who has failed to submit an application for financial assistance under the Financial Assistance Policy (FAP). The Billing Deadline must be specified in a written notice to the Responsible Individual(s) provided at least 30 days prior to such deadline, but no earlier than 120 days after the first post discharge statement.

Extraordinary Collection Action (ECA) means any action against an Individual(s) responsible for a bill related to obtaining payment of a Self-Pay Account that requires a legal or judicial process or reporting adverse information about the Responsible Individual(s) to consumer credit reporting agencies/credit bureaus.

Financial Assistance Policy (FAP) means ECU Health's Financial Assistance Program for Underinsured and Uninsured Patients Policy, which includes eligibility criteria, the basis for calculating charges, the method for applying the policy, and the measures to publicize the policy, and sets forth the financial assistance program.

Responsible Individual(s) means the patient and any other Individual(s) having financial responsibility for a Self-Pay Account. There may be more than one Responsible Individual(s).

Self-Pay Account means that portion of a patient account that is the Individual(s) responsibility of the patient or other Responsible Individual(s), net of the application of payments made by any available healthcare insurance or other third-party payer (including co-payments, co-insurance and deductibles), and net of any reduction or write off made with respect to such patient account after application of an Assistance Program, as applicable.

Procedure

A. Subject to compliance with the provisions of this policy, ECU Health may take any and all legal actions, including ECA, to obtain payment for medical services provided.

B. ECU Health will not engage in ECAs, either directly or by any debt collection agency or other party to which the hospital has referred the patient's debt, before reasonable efforts are made to determine whether a Responsible Individual(s) is eligible for assistance under the FAP.

C. All patients can ask for a Plain Language Summary and an application form for financial assistance under the FAP as part of the discharge or intake process from a hospital.

D. Multiple separate statements as described in Statement Cycle above, for collection of Self Pay Accounts shall be mailed or emailed to the last known address of each responsible Individual(s); provided, however, that no additional statements need be sent after a Responsible Individual(s) account has been paid in-full. If a patient submits a complete application for financial assistance under the FAP, the patient will continue to receive statements until it has been determined if patient is eligible for the FAP. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made. All Single Patient Account statements of Self-Pay Accounts will include but not limited to:

1. The amount required to be paid by the Responsible Individual(s).
2. A conspicuous written notice that notifies and informs the Responsible Individual(s) about the availability of Financial Assistance under the hospital FAP including the telephone number of the department and direct website address where copies of documents may be obtained.

E. At least one of the statements mailed or emailed will include written notice that informs the Responsible Individual(s) about the ECAs that are intended to be taken if the Responsible Individual(s) does not apply for financial assistance under the FAP or pay the amount due by the Billing Deadline. Such statement must be provided to the Responsible Individual(s) at least 30 days before the deadline specified in the statement.

F. ECAs may be commenced as follows:

If any Responsible Individual(s) fail to apply for financial assistance under the FAP by 150 days after the first post discharge statement, and the Responsible Parties have received a statement with a Billing Deadline described in Section E above, then ECU Health or collection agency may initiate ECA.

Statement Cycle:

The Statement Cycle will be measure from the first statement sent to the patient (date sent).

Subsequent statements sent to the patient/guarantor in 30-day increments. Final Notice will be sent 30 days prior to referral to Collection Agency.

Exclusions:

Hospital account balances for NC residents who qualify for Medical Debt relief are excluded from this policy.

Approval Signatures

Step Description	Approver	Date
Legal Review	Vicki Haddock: VP, Office of Gen Counsel	12/2024
Associate General Counsel	Caroline Henderson: Associate General Counsel	12/2024
SVP, Financial Services	Bobby Dunn: SVP, Financial Services	12/2024
VP, Revenue Cycle	Sabrina Sims: VP, Revenue Cycle	12/2024

Legal Review 1	Melissa Anderson: Coord, ECU Hlth Policy Managmt	12/2024
Policy Owner	Sabrina Sims: VP, Revenue Cycle	12/2024

Applicability

ECU Health Duplin Hospital, ECU Health Beaufort Hospital-a Campus of EMC, ECU Health Bertie Hospital, ECU Health Chowan Hospital, ECU Health Corporate, ECU Health Edgecombe Hospital, ECU Health Endoscopy Center, ECU Health Home Health & Hospice, ECU Health Medical Center, ECU Health North Hospital, ECU Health Physicians, ECU Health Roanoke-Chowan Hospital, ECU Health SurgiCenter, Outer Banks Health, Population Health Management

Status **Active** PolicyStat ID **15129086**

Origination	05/2015
Last Approved	02/2024
Effective	02/2024
Last Revised	02/2024
Next Review	02/2025

Owner	Donna Montana-Rhodes: VP, Experience
Document Area	ECU Health Patient Family Experience
Applicability	ECU Health System-Wide
References	ECU Health Home Infusion, VMC Specialty Pharmacy

Patient Rights and Responsibilities, ECUH – PFE7

Applicability

This policy is applicable to AccessEast, ECU Health Beaufort Hospital-a Campus of ECU Health Medical Center, ECU Health Bertie Hospital, ECU Health Chowan Hospital, ECU Health Duplin Hospital, ECU Health Edgecombe Hospital, ECU Health Medical Center, ECU Health Roanoke-Chowan Hospital, Outer Banks Health Hospital, ECU Health Home Health and Hospice, ECU Health Physicians, ECU Health SurgiCenter, and ECU Health Endoscopy Center-Greenville.

Purpose

This policy addresses patient rights and the responsibilities of patients. All team members, medical team members and contracted agency team members shall observe these patient rights. Printed patient rights documents also contain responsibilities of the patient (examples include patient handbooks, welcome packets for ECU Health Cancer Care Pharmacy).

ECU Health recognizes that it serves a diverse population that includes persons of different races, religions, national origins, sexual orientation, gender identities, genders, education levels, citizenship or immigration status, and levels of proficiency in English. ECU Health is committed to recognizing, respecting and protecting the rights of patients and other persons. ECU Health is committed to providing safe, timely, effective, efficient, and equitable patient centered care.

Policy

ECU Health team members and medical team shall recognize and respect patient rights as outlined in this policy. Our goal is to inform you of your rights and responsibilities as a patient at the earliest reasonable time in the course of your care.

A. Section A- Rights that apply to all patients (including ambulatory services)
B. Section B- Patient Responsibilities
C. Section C- Additional rights of disabled patients
D. Section D- Additional rights of child patients and their parents
E. Section E- Additional rights of mental health patients
F. Section F- Rights of Home Health and Hospice patients

Section A - Rights that apply to all patients (including ambulatory services)

Our first priority is to provide you the care you need, when you need it, with skill, compassion and respect. Please tell us if you have concerns about your care of if you have pain.

As an adult patient, you have the right to:

High quality care, *You have the right to…*

A. Considerate and respectful care in a safe setting that supports your individual dignity and is respectful of your culture, personal values and beliefs.
B. Quality care given by competent teams and high professional standards that are continually maintained and reviewed.
C. Treatment without discrimination based on age, ethnicity, race, color, religion, culture, language, national origin, sex, gender identity or expression, sexual orientation, physical or mental disability, socioeconomic status, or source of payment
D. Know the name of the provider responsible for coordinating your care and the names and roles of people involved in your care.
E. Be told who to contact to report a complaint or grievance, and expect a prompt response or resolution without fear of retaliation or negative consequences.
F. Have a family member and your provider notified of your admission, if you wish.
G. Decide who your designated medical representative is.
H. Be informed (or have your representative informed) about the outcome of your care, including unanticipated outcomes.
I. Emergency procedures started without unnecessary delay
J. Be free from repeated medical procedures unless they are medically necessary.
K. Medical and nursing treatment that avoids unnecessary physical and mental

discomfort.Comfort and also information about managing pain. You can access teams who are committed to pain relief.

L. Exercise your rights without being subject to discrimination, punishment or reprisal.

M. Communication and information you can understand. Information will be appropriate to your age, understanding, and language. If you have vision, speech, hearing, and/or other impairments, you will receive help (if needed) to ensure your care needs are met.

N. Interpreter services for sign language and spoken language (for patients with Limited English Proficiency) as needed at no cost.

A clean and safe environment, *You have the right to…*

A. Freedom from abuse or harassment.

B. Know what rules and regulations of the organization apply to your behavior as a patient.

C. Obtain information about any professional relationships among individuals who are treating you.

D. To be woken up only if necessary for medical care.

E. Be restrained or put in seclusion only if necessary for your safety or the safety of others.

F. Ask to move to a different room if another patient or visitors in the room are unreasonably disturbing you.

Involvement in your care, *You have the right to…*

A. Participate in your plan of care.

B. Receive from your provider all information necessary to give or refuse informed consent before the start of any procedure and/or treatment, except in emergencies. The information includes the specific procedure or treatment, the medically significant risks involved and the probable amount of time to recover. Your provider should also tell you about significant medical alternatives or other ways to treat your medical condition. If you are unable to receive or understand this information, your provider can also tell your designated representative.

C. Get complete and current information in easily understood language from your provider about your medical condition, diagnosis, treatment and prognosis (expected outcome). If it is not possible or medically advisable to give the information to you, the information will be available to the person you choose or appoint.

D. Refuse any drug, treatment or procedure to the extent permitted by law and be informed of the medical consequences of your action.

E. Decide who your family members are and how you would like them to be involved in your care. These can be people who are related to you by genetic, legal or emotional relationships.

F. Decide which people should have the same visitation rights as immediate family (even if they are not related to you.)

G. Have your family or support person with you unless that person's presence is not appropriate for therapeutic or medical reasons, or violates privacy or safety.

    1. Any alterations from safety, regulatory and/or governmental authorities that impact this provision will be communicated by multiple venues to keep you and your family

informed (ie: pandemic response).

H. Be informed about potential participation in a research study or in an organ or tissue donor program. You have the right to refuse participation in such programs and may withdraw from them at any time.

I. Consult with another doctor or provider at your own request and expense. Medical or nursing team will help arrange a consultation if requested

J. Receive spiritual and emotional support and care by a religious official. Your religious practices will be supported as much as possible.

K. Make advance directives to guide your health care if you become unable to speak for yourself. The team will follow your valid advance directives.

L. Ask for help with ethical issues and difficult decisions regarding your care.

M. Access all information in your medical record. When it is not possible or medically advisable to give the information to you, the information will be available to an appropriate person on your behalf within a reasonable time frame.

Protection of your privacy, *You have the right to…*

A. Confidentiality in all communications and records about your care.

B. Privacy about your medical care program. Case discussions, consultations, examinations and treatments are confidential and should be as private as possible.

C. Personal privacy during medical or nursing treatments, and during activities like dressing, bathing and using the bathroom. People who are not directly involved in your care must have your permission to be present.

D. Personal privacy and privacy about your health care information following HIPAA regulations (Health Insurance Portability and Accountability Act) and ECU Health policies related to privacy.

E. Request a list of certain disclosures of your personal health information.

F. Request an amendment to clinical, billing or other records containing personal health information.

Help when leaving the hospital/ discharging to another care setting, *You have the right to…*

A. Expect reasonable continuity of care. You have the right to know about your continuing health care needs after discharge and how to meet them.

B. A complete explanation of the reasons for a transfer to another facility and the alternatives to that transfer. The facility you are going to must accept you before you are transferred.

Help with your bill and filing insurance claims, *You have the right to…*

A. See your bill and receive an explanation of charges regardless of who is paying the bill.

B. Information about financial resources that may help you pay for your care.

Behavioral Health patients may have additional rights per North Carolina statutes.

Section B- Patient Responsibilities

As a patient, you are responsible for:

A. Providing, to the best of your knowledge, accurate and complete information about your current health condition, past illnesses, hospitalizations, medicines and other matters about your health.

B. Telling your caregiver if you think you will have problems following the prescribed treatment.

C. Speaking up and asking questions if you do not understand your treatment plan and what you need to do.

D. Following the treatment plan recommended by the provider who is responsible for your care.

E. Making informed decisions about your care.

F. Making sure that we have a copy of your written advance directive if you have one.

G. Asking about pain management, including what to expect and options for pain relief. You should let us know if your pain continues. You should take an active part in your pain management plan and ask for relief when you first feel pain.

H. Making reasonable efforts to cooperate with other patients, the needs of the medical center, medical team and team members.

I. Providing necessary information for insurance claims and working with us to make payment arrangements as promptly as possible.

J. Recognizing that your lifestyle and behaviors affect your health.

K. Keeping appointments that are arranged for your continuing care.

L. Accepting responsibility for the medical results if you refuse treatment and do not follow your health providers' instructions.

M. Behaving in a way that respects the rights of other patients, team members and medical center property.

Section C - Additional rights of patients with disabilities

In addition to the rights listed in Section A of this policy, patients with disabilities have the following rights:

A. Qualified patients with disabilities have a right to freedom from discrimination on the basis of their disability in admission to, access to, or operation of ECU Health programs, services, or activities, in accordance with the Americans with Disabilities Act of 1990 (ADA) and subsequent amendments, 2008.

B. Qualified individuals with disabilities who are in need of auxiliary aids for effective communication or who would like to participate in ECU Health programs and services have a right to make their needs and preferences known to the ADA Director, Office of Audit and Compliance.

Procedure

A. If a patient with disabilities has questions, concerns or complaints, or would like additional information regarding the Americans with Disabilities Act, VH team member should encourage the patient to contact the ADA Director. A VH team member may also contact the ADA Director on patient's behalf.

B. VH team members are encouraged to direct any questions about disability related access and accommodations to the ADA Director.

C. Notices regarding the rights of individuals with disabilities may be available in alternate formats upon request by contacting ADA@ecuhealth.org.

Section D- Additional rights of child patients and their parents

Rights for children and teens, You and your family have a right to:

Respect and personal dignity

A. You are important. We want to get to know you better.

B. We will tell you who we are, and we will call you by your name

C. We will take time to listen to you.

D. We will honor your privacy.

Care that supports you and your family

A. You and your family are important. We will work together to make you feel as safe and comfortable as possible.

B. All families are different. We want to learn about what is important to you and your family.

C. You, your family and caregivers will plan how the important people in your life can visit you.

1. Any alterations from safety, regulatory and/or governmental authorities that impact this provision will be communicated by multiple venues to keep you and your family informed (ie: pandemic response).

Information you can understand

A. We will explain things to you. We will speak in ways that you can understand. You can ask about what is happening to you and why.

B. Someone who speaks your language will help explain things to you.

C. Someone from your family can be with you when people are explaining things to you.

Quality health care

A. You will be taken care of by providers, nurses and other people who know how to take care of children and teenagers.

B. You have the right to know all of the people who take care of you. You and your family can

meet with them to plan what is best for you.

C. We will work together with you and your family to make your stay as short and comfortable as possible.

Emotional support

A. You might feel scared, mad, lonely or sad. You can let people know how you feel. It is okay to cry or complain.

B. You can have your family with you as much as possible. When this is not possible, the other people caring for you will explain why.

C. We can help you meet other children and families who have had similar experiences to yours.

D. You can wear your own clothing most of the time and keep your special things with you.

E. You can talk or play with people who know how to help when you have questions or problems.

F. You can ask to be moved to another room if you are uncomfortable or unhappy, and we can try to make this happen if we can.

Care that respects your need to grow, play and learn

A. We will consider all your interests and needs, not just those related to your illness or hospitalization.

B. You have the right to rest, to play and to learn. We will make sure that you have places and times for the things children your age need to grow and learn.

Make choices and decisions

A. Your ideas and feelings about how you want to be cared for are important.

B. You can tell us how we can help you feel more comfortable.

C. You can tell us how you want to take part in your care.

D. You can make choices whenever possible.

Family responsibilities

You have the responsibility to:

Provide information

A. You have important information about your child's health. We need to know about symptoms, treatment, medicines and other illness.

B. You should tell us what you want for your child.

C. It is important for you to tell us how you want to take part in your child's care.

D. You should tell us if you don't understand something about your child's care.

E. If you are not satisfied with your child's care, please tell us.

Provide appropriate care

A. You and the other members of the health care team work together to plan your child's care.

B. You are responsible for doing the things you agreed to do in this plan of care. If you cannot follow the plan, please tell us.

Meet financial obligations

A. You are responsible for your child's bill.

B. You must provide necessary information for insurance claims and work with us to make payment arrangements as promptly as possible.

C. Notify us if you need financial counseling.

Respect and consider the rights of others

A. Respect their privacy.

B. Keep noise low, including voices, TV, radio and video games.

C. Do not smoke in any ECU Health building or on ECU Health property.

D. Do not bring or use adult entertainment items, such as R-rated movies, adult magazines or adult websites.

Section E - Additional rights of mental health patients

Our first priority is to provide you the care you need, when you need it, with skill, compassion and respect. Please tell us if you have concerns about your care or if you are in pain.

Important facts about your rights while you are a patient

A. You have all civil rights, benefits and privileges guaranteed by law.

B. You have the right to be fully informed about your patient rights.

C. You have the right to be fully informed about all guidelines and rules about your conduct as a patient in this facility as soon as possible after you are admitted to the hospital.

D. You are considered legally competent unless a court decides that you are incompetent.

As an adult patient, you have the right to:

High quality care, You have the right …

A. To considerate and respectful care in a safe setting.

B. To quality care given by competent team and high professional standards that are continually maintained and reviewed.

C. To treatment without discrimination based on age, ethnicity, race, color, religion, creed, culture, language, national origin, gender, gender identity or expression, sexual orientation, physical or mental disability, socioeconomic status, or source of payment.

D. To know the name of your provider, the names of all other providers directly participating in your care, provider responsible for coordinating your care and the names and functions of other health care team with whom you have direct contact.

E. To express opinions, recommendations and grievances about the policies and services offered by this hospital without fear of interference, coercion, discrimination or reprisal.

F. To have a family member and your provider notified of your admission, if you wish.

G. To have emergency procedures started without unnecessary delay.

H. To be free from repeated medical or nursing procedures unless they are medically necessary.

I. To treatment that avoids unnecessary physical and mental discomfort.

J. To information about pain management and relief, and a prompt assessment of your reports about pain by appropriate clinical team.

K. To communication and information you can understand. Information will be appropriate to your age, understanding, and language. If you have vision, speech, hearing, and/or other impairments, or if you do not speak English, you will receive help (if needed) to ensure your care needs are met.

A clean and safe environment, You have the right …

A. To expect to be safe and secure. In order to assure a safe environment, team may search you, your room and personal items if there is a report or reasonable suspicion that you have a weapon, drugs or anything that could cause harm.

B. To be free from restrictive interventions except in emergency situations. Restrictive interventions such as seclusion, chemical restraints or physical restraints are limited to emergency situations in order to maintain your safety or the safety of others. Your designated representative will be notified in the event of restrictive interventions.

Involvement in your care, You have the right …

A. To an individualized, written treatment plan that you participate in developing. You may request a copy of you treatment plan.

B. To receive from your provider all information necessary to give informed consent before the start of any procedure and/or treatment, except in emergencies. The information includes the specific procedure or treatment, and the medically significant risks. Your provider should also tell you about alternative treatments. If you are unable to receive or understand this information, your provider can also tell your designated representative.

C. To have the purpose of all prescribed medications explained to you, including the reason for the medication and the most common side effects. You have the right to be free from unnecessary or excessive medication. Medication will not be used for punishment, discipline or team convenience.

D. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of your action. You may withdraw consent at any time.

E. To be informed about potential participation in a research study or in an organ or tissue donor program. You have the right to refuse participation in such programs and may withdraw from them at any time.

F. To give or withhold consent for treatment involving electroconvulsive therapy (ECT), the use of experimental drugs, procedures or surgery (other than emergency surgery). You may withdraw consent at any time.

G. To carry out your religious beliefs and receive spiritual and emotional support and care by a religious official. You may request a visit from your clergy or ask for a Chaplain.

H. To make advance directives for mental health treatment, medical treatment or end-of-life care.

I. To access information in your medical record. When it is not possible or medically advisable to give the information to you, the information will be available to an appropriate person on your behalf within a reasonable time frame.

Protection of your privacy, You have the right …

A. To confidentiality in all communications and records about your care, according to law.

B. To privacy about your medical care program. Case discussions, consultations, examinations and treatments are confidential and should be as private as possible.

C. To personal privacy during medical or nursing treatments, and during activities like dressing, bathing and using the bathroom.

D. To personal privacy and privacy about your health care information following HIPAA regulations *(Health Insurance Portability and Accountability Act)* and hospital policies related to privacy.

Communication with others, You have the right …

A. To send and receive unopened mail, have access to writing material and stamps, and receive any help you need with correspondence.

B. To contact and consult, at your own expense: lawyers, doctors, and/or private professionals of your choice (mental health, developmental disabilities, substance abuse, and behavioral health).

C. To make and receive private telephone calls.

D. To have visitors during established visiting hours. Visiting must not interfere with your therapies. Specific visitors may be restricted at your request and/or if the provider feels certain people are interfering with your treatment progress. Visitation may be restricted by the treatment team.

    1. Any alterations from safety, regulatory and/or governmental authorities that impact this provision will be communicated by multiple venues to keep you and your family informed (ie: pandemic response).

Personal Rights, You have the right …

A. To environmental breaks and access to recreational activity.

B. To keep personal items and clothing except when prohibited by law and/or unit policies for your safety or the safety of others. You will have access to individual safe storage space for your personal belongings.

C. To keep a reasonable amount of money (such as $5.00-$10.00) and to manage your personal affairs.

D. To keep a driver's license, unless not allowed by law.

Help when leaving the hospital, You have the right …

A. To an individualized, written discharge plan or continuing care plan that you participate in developing. You will be made aware of continuing health requirements when you are discharged.

B. To a complete explanation of the reasons for a transfer to another facility and the alternatives to that transfer. The facility you are going to must accept you before you are transferred.

Help with your bill and filing insurance claims, You have the right …

A. To see your bill and receive an explanation of charges (regardless of who is paying the bill). You have the right to communicate with a patient account representative.

B. To timely notice before your eligibility for reimbursement for the cost of care by any third party payor ends.

We encourage you to discuss any concerns or questions regarding your rights with any team member. If you think your rights have been violated, you may file a grievance with any team member, your nursing team, your doctor or provider, or a member of the Behavioral Health leadership team.

Section F- Rights of Home Health and Hospice patients

As a Patient, You Have the Right to:

High Quality Care

A. Be advised of the agency or facility's policies regarding the patient's rights and responsibilities.

B. Considerate, dignified and respectful care and provision of services in a safe setting in which your individual, physical, spiritual, emotional and social needs are met.

C. Quality care given by competent team members and high professional standards that are continually maintained and reviewed and a health care team that is able to perform procedures and deliver care at the level of experience and skill required. You have the right to reasonable continuity of care and services by all team.

D. Treatment without discrimination based on age, ethnicity, race, color, religion, culture, language, national origin, sex, gender identity or expression, sexual orientation, physical or mental disability, socioeconomic status or source of payment.

E. Be given the name and title of all persons who are providing care and services to you.

F. Interact with all persons involved in your care, including your physician or other members of your health care team, as appropriate.

G. Be told who to contact to report a complaint or grievance, and expect a prompt response or resolution.

H. Have a family member and your provider notified of your admission, if you wish.

I. Decide who your designated medical representative is.

J. Be informed (or have your representative informed) about the outcome of your care, including unanticipated outcomes. An unanticipated outcome is a result that is significantly different from what was expected from a treatment or procedure.

K. Emergency procedures started without unnecessary delay.

L. Be free from repeated medical procedures unless they are medically necessary.

M. Medical and nursing treatment that avoids unnecessary physical and mental discomfort.

N. A complete explanation of all care and services provided upon entry into care, resumption of care, at discharge as well as continually throughout your care. You have the right to be informed of, in advance, of the disciplines that will provide the care and services, and the proposed visit frequency.

O. Comfort, and also information about managing pain. You can access team that is committed to pain relief.

P. Exercise your rights without being subject to discrimination, punishment or reprisal.

Q. Communication and information you can understand. Information will be appropriate to your age, understanding, and language. If you have vision, speech, hearing, and/or other impairments, you will receive help (if needed) to ensure your care needs are met.

R. Receive appropriate instructions and education that you can understand regarding the plan of treatment and care plan.

S. Interpreter services for sign language and foreign language as needed and/or requested at no cost.

T. To be informed of the agency's "on-call" service and be provided information on how teams may be reached at all hours of the day for emergency purposes.

U. A copy of the agency or facility's policies regarding client responsibility as it relates to safety and care plan compliance.

A Clean and Safe Environment / *You have the right to…*

A. Have your personal property respected.

B. Be free of mental and physical abuse, neglect or exploitation or harassment.

C. Know what rules and regulations of the organization apply to your behavior as a patient.

D. Obtain information about any professional relationships among individuals who are treating you.

E. Be disturbed from sleep only if necessary for medical care.

F. Be notified within ten (10) days when the agency's licensure has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.

G. Obtain information on the relationship of an agency or facility to other healthcare providers and other institutions insofar as your care is concerned.

Involvement in your Care / *You have the right to…*

A. Be informed and participate in your plan of care and any changes made to it, as well as to be provided with informed education and health teaching in a language that you or your authorized representative, can reasonably understand.

B. Receive from your healthcare team, all information necessary to give competent and voluntary informed consent before the start of any procedure and/or treatment, except in emergencies.

The information includes the nature of the specific procedure or treatment, the medically significant risks and benefits involved and the probable amount of time to recover. Your provider should also tell you about significant medical alternatives or other ways to treat your medical condition. If you are unable to receive or understand this information, your authorized representative will be provided this information on your behalf.

C. Get complete and current information from your provider about your medical condition, diagnosis, treatment and prognosis (expected outcome). If it is not possible or medically advisable to give the information to you, the information will be available to the person you choose or appoint.

D. Refuse any drug, treatment or procedure, to the extent permitted by law and to be informed of the medical consequences of your action. If you refuse, or your legal representative prevents the provision of appropriate care in accordance with professional standards, the relationship between this organization and you may be terminated.

E. Decide who your family members are and how you would like them to be involved in your care. These can be people who are related to you by genetics, legal or emotional relationships.

F. Decide which people should have the same visitation rights as immediate family (even if they are not related to you).

G. Have your family or support person with you unless that person's presence is not appropriate for therapeutic or medical reasons, or violates privacy or safety.

H. Be informed about potential participation in an organ or tissue donor program. You have the right to refuse participation in such programs and may withdraw from them at any time.

I. Consult with another provider at your own request and expense. Medical or nursing team will help arrange a consultation if requested.

J. A complete explanation of the reasons for a transfer to another organization, agency or facility and the alternatives to that transfer. The agency or facility you are going to must accept you before you are transferred. Financial benefits to our agency from making any such transfer must be discussed with you as well. You must also be informed at least three (3) days prior to discharge of any healthcare requirements/care following discharge.

K. Be advised of the agency or facility's procedure for discharge.

L. Be informed of the agency or facility's grounds for termination of services and to seek assistance in finding and transferring provision of care and services.

M. Receive spiritual and emotional support and care by a religious official. Your religious practices will be supported as much as possible.

N. Make Advance Directives to guide your health care if you become unable to speak for yourself. The team will follow your valid Advance Directives, according to local, state and federal law; and there will be no fear by you of discrimination or differentiation of care and services.

O. Ask for help with ethical issues and difficult decisions regarding your care.

P. Be allowed to exercise your right as a patient and to have your designee, as selected by you or applicable local, state or federal law, exercise that right as well.

Q. Access all information in your medical record. When it is not possible or medically advisable to give the information to you, the information will be available to your authorized designee on your behalf within a reasonable time frame.

R. Be given a copy of your plan of care.

Protection of your Privacy/ *You have the right to…*

A. Confidentiality, privacy and individuality with regards to communication and records of care and services. Case discussions, consultations, examinations and treatments are confidential and should be as private as possible as it relates to your social, religious, psychological well-being, medical care programs, records and communications.

B. Personal privacy during medical or nursing treatments, and during activities like dressing, bathing and using the bathroom. People who are not directly involved in your care must have your permission to be present.

C. Personal privacy and privacy about your health care information following HIPAA regulations (Health Insurance Portability and Accountability Act) and ECU Health Home Health & Hospice policies related to privacy.

D. Request a list of certain disclosures of your personal health information.

E. Request and examine all information being maintained by the agency or facility including your patient chart and financial records. This includes but is not limited to information regarding your diagnosis, prognosis, and treatment, provision of care and services and related costs attributed to them.

F. Request an amendment to clinical, billing or other records containing personal health information.

G. Not disclosing any of your personal privacy or privacy about your health care information without the appropriate written consent of you or your designee.

Help with Financial Matters/ *You have the right to…*

A. Information about financial resources that may help you pay for your care.

B. Be informed, orally and in writing, prior to care being initiated or at the time of, to the extent to which payment may be expected from health insurance, Medicare, Medicaid or any other federally funded or aided programs or known payer.

C. Be informed of the charges that will not be covered by Medicare or other payer.

D. Be informed and receive a written statement of services provided by the agency and of the charges that you may be liable responsible for paying.

E. Be informed of the process for acceptance and continuance of services and eligibility determination, as well as to accept or refuse service.

F. Receive this information, orally and in writing, before care is initiated and within thirty (30) calendar days of the date the agency becomes aware of any changes or potential eligibility reasons for termination.

G. See your bill(s) for services provided and request and receive an itemized explanation of charges regardless of who is paying the bill (out-of-pocket or by another party).

As a Patient, you are responsible for:

A. Providing, to the best of your ability and knowledge, accurate and complete information about your current health condition, past illnesses, hospitalizations, medicines and other matters

about your health.

B. Assisting in developing and maintaining a safe environment by making care providers aware of any special mobility needs you may have.

C. Telling your caregiver if you think you will have problems following the prescribed treatment.

D. Participating in the planning of your care and following the plan of treatment and care ordered by your care provider/physician and explained to you by a member of the healthcare team.

E. Speaking up and asking questions if you do not understand your treatment plan and what you need to do to.

F. Following the treatment plan recommended by the provider who is responsible for your care.

G. Making informed decisions about your care.

H. Reporting any unexpected changes in your condition to your care provider including any change in the way you "feel" or changes in your symptoms.

I. Reporting any change in address, telephone number or home caregiver.

J. Making sure that we have a copy of your written advance directive if you have one.

K. Asking about pain management, including what to expect and options for pain relief. You should let us know if your pain continues. You should take an active part in your pain management plan and ask for relief when you first feel pain.

L. Making reasonable efforts to cooperate with and respectfully treat other patients, the needs of the agency, medical team and team members.

M. Providing necessary information for insurance claims and for working with us to make financial arrangements as promptly as possible.

N. Assuring that financial obligations are fulfilled as promptly as possible according to any financial agreements.

O. Recognizing that your lifestyle and behaviors affect your personal health.

P. Keeping appointments that are arranged for your continuing care.

Q. Accepting responsibility for the medical results and understanding the consequences if you refuse treatment and do not follow your health providers' instructions.

R. Behaving in a way that respects the rights of other patients, team members and home health and hospice property.

S. Reporting unexpected changes in your condition.

When You Have Concerns or Complaints Regarding Care or Services

As a patient, you have a right to...

A. Expect and receive care in a timely manner, appropriate to your needs and accurate and reasonable responses to your requests and questions within a reasonable time frame.

B. Be actively involved in resolving ethical issues about care or service.

C. Give information regarding concerns and problems to a team member or other member of the care team or relay them the Leadership.

D. Be informed of a supervisor's accessibility and availability.

E. Discuss problems, voice grievances and suggest changes regarding your care, services provided and/or the team without fear of retaliation, discrimination by the agency or facility in action or verbally.

F. Be advised of the telephone number and address for additional information, questions or complaints about home health care and hospice services provided by our agency.

G. The addresses and telephone numbers are as follows:

1. ECU Health Home Health & Hospice
   1005 WH Smith Boulevard
   Post Office Box 8125
   Greenville, North Carolina 27835-8125
   (252)847-7830 or (800)227-3894

2. Service League-Inpatient Hospice Facility
   920 Wellness Drive
   Greenville, North Carolina 27835
   (252)847-1241 direct line / (252)847-1230 main number

H. Be advised that the Acute and Home Care Licensure and Certification Section at the Division of Health Sciences Regulation (DHSR) is responsible for enforcing state statutes for home health and hospice care agencies. Questions and requests for information would also be handled by this Section. The agency's address and phone number are as follows:

1. Acute and Home Care Licensure and Certification Section/Division of Health Service Regulation
   2712 Mail Service Center
   Raleigh, North Carolina 27699
   (919)855-4620

I. Be advised there are also additional resources for reporting concerns, complaints or requesting more information. These are as follows:

1. The Joint Commission
   Office of Quality Monitoring
   One Renaissance Boulevard
   Oakbrook Terrace, Illinois 60181
   Complaint@jointcommission.org
   (800)994-6610 / (630)792-5636 fax

2. Long Term Care Regional Ombudsman
   (NC Division of Aging and Adult Services)
   (252) 974-1838
   NC State Hotline for Complaints
   North Carolina Department of Health and Human Services
   Division of Health Service Regulation
   Complaint Intake Unit
   1-800-624-3004 (North Carolina only) / (919) 855-4500 (All other areas)

Procedure

The Registered Nurse or other professional performing the admission assessment will be responsible for reviewing the Patient's Rights and Responsibilities with the patient or authorized representative in a language that is understandable to the recipient of the information

References

A. **North Carolina's Hospital Licensure Act's Bill of Rights** North Carolina's hospital licensure act also includes a Bill of Rights, (10A NCAC 13B .3302 MINIMUM PROVISIONS OF PATIENT'S BILL OF RIGHTS). Readopted :04/01/2020

B. **American Hospital Association** "The Patient Care Partnership," 2003. http://www.aha.org/content/00-10/pcp_english_030730.pdf and http://www.aha.org/advocacy-issues/communicatingpts/pt-care-partnership.shtml

C. **Conditions of Participation for Hospitals,** Subchapter D, Part 482 http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr482_main_02.tpl 42 CFR 482.13 (Conditions of Participation – Patient's Rights).

D. **TJC RI.02.01.01 Patient Responsibilities/** JCAHO 2007. RI1.1.30 - 2.50. Effective date07/01/2020

E. **NCHA Patient Bill of Rights** https://www.ncha.org/issues/legal/patient-bill-of-rights

F. North Carolina Mental Health, Developmental Disabilities and Substance Abuse Laws, G.S.122C-51 - G.S. 122C-68.

G. **10A NCAC 27E.0102** Prohibited Procedures.

H. **Magnet Standards** 11 and 13, 2003

I. 45 CFR § 160.101 through § 160.532. Health Insurance Portability and Accountability Act of 1996.

J. **ACHC Standards**: DRX2-1A, DRX2-2A, DRX2-2A.01, DRX2-2B, DRX2-3A, DRX2-4A, DRX2-5A, DRX2-6A, DRX3-4B, DRX5-4A,

K. **URAC Standards**: PHARM Core 37, CSCD 1, PM 12

L. **N.C. General Statute §131E-79.3**

Approval Signatures

Step Description	Approver	Date
Legal	Vicki Haddock: VP, Office of Gen Counsel	02/2024

Chief Experience Officer	Julie Oehlert: Chief Experience Officer	02/2024
Director, Accreditation	Michael Carter: Dir, Quality-Corporate	02/2024
VP, Experience	Donna Montana-Rhodes: VP, Experience	02/2024
Legal Review 1	Becky Davis: Coord, ECU Hlth Policy Managmt	01/2024
Policy Owner	Donna Montana-Rhodes: VP, Experience	01/2024

Applicability

ECU Health Duplin Hospital, ECU Health Beaufort Hospital-a Campus of EMC, ECU Health Bertie Hospital, ECU Health Chowan Hospital, ECU Health Corporate, ECU Health Edgecombe Hospital, ECU Health Endoscopy Center, ECU Health Home Health & Hospice, ECU Health Medical Center, ECU Health North Hospital, ECU Health Physicians, ECU Health Roanoke-Chowan Hospital, ECU Health SurgiCenter, Outer Banks Health, Population Health Management

Hospital Compare Preview Report

ECU HEALTH MEDICAL CENTER

2100 STANTONSBURG RD
GREENVILLE, NC 27834

CCN-340040
(252) 847-4100

Facility Type:	Short-term
Ownership Type:	Voluntary non-profit - Private
Emergency Service:	Yes

Survey of Patients' Experience

Attention: Individual question scores appear only in the Preview Report and downloadable databases. Individual question scores are presented for informational purposes only; they are not official HCAHPS measures. A simple average of the individual questions that comprises a composite measure may not always match the composite score.

HCAHPS individual question scores based on fewer than 50 completed surveys **will not** be reported in the downloadable database.

HCAHPS Summary Star Rating

Completed Surveys	1,766
Survey Response Rate	16%

Star Rating:

More stars are better
"For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org"

*When HCAHPS scores are based on fewer than 25 completed surveys, scores WILL NOT be reported on Hospital Compare.

Communication with Nurses

Q3 (2021) - Q2 (2022)

Linear Score (1 - 100): 90

Composite (Q1 - Q3)	Facility	State	National
Always Patients who reported that their	77%	79%	79%

Communication with Nurses

Q3 (2021) - Q2 (2022)

★★★★★ Linear Score (1 - 100): 90

nurses 'Always' communicated well			
Usually Patients who reported that their nurses 'Usually' communicated well	17%	16%	16%
Sometimes/Never Patients who reported that their nurses 'Sometimes' or 'Never' communicated well	6%	5%	5%
Nurse Courtesy & Respect (Q1)	Facility	State	National
Always Patients who reported that their nurses "Always" treated them with courtesy and respect	84%	85%	86%
Usually Patients who reported that their nurses "Usually" treated them with courtesy and respect	12%	11%	11%
Sometimes/Never Patients who reported that their nurses "Sometimes" or "Never" treated them with courtesy and respect	4%	4%	3%
Nurse Listen (Q2)	Facility	State	National
Always Patients who reported that their nurses "Always" listened carefully to them	75%	76%	76%

Communication with Nurses

Q3 (2021) - Q2 (2022)

Usually Patients who reported that their nurses "Usually" listened carefully to them	19%	18%	19%
Sometimes/Never Patients who reported that their nurses "Sometimes" or "Never" listened carefully to them	6%	6%	5%
Nurse Explain (Q3)	Facility	State	National
Always Patients who reported that their nurses "Always" explained things in a way they could understand	73%	75%	75%
Usually Patients who reported that their nurses "Usually" explained things in a way they could understand	20%	18%	19%
Sometimes/Never Patients who reported that their nurses "Sometimes" or "Never" explained things in a way they could understand	7%	7%	6%

Star Rating:

More stars are better
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Communication with Doctors

Q3 (2021) - Q2 (2022)

Composite (Q5 - Q7)	Facility	State	National

Communication with Doctors

Q3 (2021) - Q2 (2022)

Always Patients who reported that their doctors 'Always' communicated well	79%	80%	80%
Usually Patients who reported that their doctors 'Usually' communicated well	16%	15%	15%
Sometimes/Never Patients who reported that their doctors 'Sometimes' or 'Never' communicated well	5%	5%	5%
Doctor Courtesy & Respect (Q5)	Facility	State	National
Always Patients who reported that their doctors "Always" treated them with courtesy and respect	86%	86%	86%
Usually Patients who reported that their doctors "Usually" treated them with courtesy and respect	10%	10%	10%
Sometimes/Never Patients who reported that their doctors "Sometimes" or "Never" treated them with courtesy and respect	4%	4%	4%
Doctor Listen (Q6)	Facility	State	National
Always Patients who reported that their doctors "Always" listened	78%	79%	78%

Communication with Doctors

Q3 (2021) - Q2 (2022)

★★★★★ Linear Score (1 - 100): 91

carefully to them			
Usually Patients who reported that their doctors "Usually" listened carefully to them	16%	15%	16%
Sometimes/Never Patients who reported that their doctors "Sometimes" or "Never" listened carefully to them	6%	6%	6%
Doctor Explain (Q7)	Facility	State	National
Always Patients who reported that their doctors "Always" explained things in a way they could understand	74%	76%	75%
Usually Patients who reported that their doctors "Usually" explained things in a way they could understand	20%	18%	18%
Sometimes/Never Patients who reported that their doctors "Sometimes" or "Never" explained things in a way they could understand	6%	6%	7%

Star Rating:

More stars are better

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Responsiveness of Hospital Staff

Q3 (2021) - Q2 (2022)

Composite (Q4 & Q11)	Facility	State	National
Always Patients who reported that they 'Always' received help as soon as they wanted	57%	63%	66%
Usually Patients who reported that they 'Usually' received help as soon as they wanted	29%	25%	23%
Sometimes/Never Patients who reported that they 'Sometimes' or 'Never' received help as soon as they wanted	14%	12%	11%
Call Button (Q4)	Facility	State	National
Always Patients who reported that they "Always" received help after using the call button as soon as they wanted	57%	62%	64%
Usually Patients who reported that they "Usually" received help after using the call button as soon as they wanted	30%	27%	26%
Sometimes/Never Patients who reported that they "Sometimes" or "Never" received help after using the call button as soon as they wanted	13%	11%	10%
Bathroom Help (Q11)	Facility	State	National

Responsiveness of Hospital Staff

Q3 (2021) - Q2 (2022)

★★★★★ Linear Score (1 - 100): 80

	Facility	State	National
Always Patients who reported that they "Always" received bathroom help as soon as they wanted	58%	63%	66%
Usually Patients who reported that they "Usually" received bathroom help as soon as they wanted	26%	24%	23%
Sometimes/Never Patients who reported that they "Sometimes" or "Never" received bathroom help as soon as they wanted	16%	13%	11%

Star Rating:

More stars are better

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Communication About Medicines

Q3 (2021) - Q2 (2022)

★★★★★ Linear Score (1 - 100): 73

Composite (Q13 - Q14)	Facility	State	National
Always Patients who reported that staff 'Always' explained about medicines before giving it to them	55%	62%	62%
Usually Patients who reported that staff 'Usually' explained about medicines before giving it to	21%	17%	18%

Communication About Medicines

Q3 (2021) - Q2 (2022)

them			
Sometimes/Never Patients who reported that staff 'Sometimes' or 'Never' explained about medicines before giving it to them	24%	21%	20%
Medicine Explain (Q13)	Facility	State	National
Always Patients who reported that when receiving new medication the staff "Always" communicated what the medication was for	69%	75%	75%
Usually Patients who reported that when receiving new medication the staff "Usually" communicated what the medication was for	20%	16%	15%
Sometimes/Never Patients who reported that when receiving new medication the staff "Sometimes" or "Never" communicated what the medication was for	11%	9%	10%
Side Effects (Q14)	Facility	State	National
Always Patients who reported that when receiving new medication the staff "Always" discussed possible side effects	41%	48%	48%
Usually Patients who reported that when	21%	20%	21%

Communication About Medicines

Q3 (2021) - Q2 (2022)

★★★☆☆ Linear Score (1 - 100): 73

	Facility	State	National
receiving new medication the staff "Usually" discussed possible side effects			
Sometimes/Never Patients who reported that when receiving new medication the staff "Sometimes" or "Never" discussed possible side effects	38%	32%	31%

Star Rating:

More stars are better

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Cleanliness of Hospital Environment

Q3 (2021) - Q2 (2022)

★★☆☆☆ Linear Score (1 - 100): 81

	Facility	State	National
Always Patients who reported that their room and bathroom were 'Always' clean	62%	69%	72%
Usually Patients who reported that their room and bathroom were 'Usually' clean	24%	19%	18%
Sometimes/Never Patients who reported that their room and bathroom were 'Sometimes' or 'Never' clean	14%	12%	10%

Star Rating:

More stars are better

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Quietness of Hospital

Q3 (2021) - Q2 (2022)


Linear Score (1 - 100): 81

	Facility	State	National
Always Patients who reported that the area around their room was 'Always' quiet at night	57%	61%	62%
Usually Patients who reported that the area around their room was 'Usually' quiet at night	33%	29%	28%
Sometimes/Never Patients who reported that the area around their room was 'Sometimes' or 'Never' quiet at night	10%	10%	10%

Star Rating:

More stars are better

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Discharge Information

Q3 (2021) - Q2 (2022)


Linear Score (1 - 100): 86

Composite (Q16 - Q17)	Facility	State	National
Yes Patients who reported that YES, they were given information about what to do during their recovery at home	86%	86%	86%

Discharge Information

Q3 (2021) - Q2 (2022)

★★★★☆ Linear Score (1 - 100): 86

No Patients who reported that NO, they were not given information about what to do during their recovery at home	14%	14%	14%
Help After Discharge (Q16)	Facility	State	National
Yes Patients who reported that YES, they did discuss whether they would need help after discharge	85%	84%	84%
No Patients who reported that NO, they did not discuss whether they would need help after discharge	15%	16%	16%
Symptoms (Q17)	Facility	State	National
Yes Patients who reported that YES, they did receive written information about possible symptoms to look out for after discharge	88%	88%	87%
No Patients who reported that NO, they did not receive written information about possible symptoms to look out for after discharge	12%	12%	13%

Star Rating:

More stars are better

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Care Transition

Q3 (2021) - Q2 (2022)

Composite (Q20 - Q22)	Facility	State	National
Strongly Agree Patients who 'Strongly Agree' they understood their care when they left the hospital	48%	50%	51%
Agree Patients who 'Agree' they understood their care when they left the hospital	46%	44%	43%
Disagree/Strongly Disagree Patients who 'Disagree' or 'Strongly Disagree' they understood their care when they left the hospital	6%	6%	6%
Preference (Q20)	**Facility**	**State**	**National**
Strongly Agree Patients who "Strongly Agree" that the staff took my preferences into account when determining their health care needs	41%	44%	44%
Agree Patients who "Agree" that the staff took my preferences into account when determining my health care their needs	51%	48%	48%
Disagree/Strongly Disagree Patients who "Disagree" or "Strongly Disagree" that the staff	8%	8%	8%

Care Transition

Q3 (2021) - Q2 (2022)

Linear Score (1 - 100): 80

took my preferences into account when determining their health care needs

Understanding (Q21)	Facility	State	National
Strongly Agree Patients who "Strongly Agree" that they understood their responsiblities in managing their health	48%	50%	51%
Agree Patients who "Agree" that they understood their responsiblities in managing their health	46%	44%	43%
Disagree/Strongly Disagree Patients who "Disagree" or "Strongly Disagree" that they understood their responsiblities in managing their health	6%	6%	6%

Medicine Purpose (Q22)	Facility	State	National
Strongly Agree Patients who "Strongly Agree" that they understood the purposes of their medications when leaving the hospital	55%	57%	58%
Agree Patients who "Agree" that they understood the purposes of their medications when leaving the hospital	39%	38%	37%
Disagree/Strongly	6%	5%	5%

Care Transition

Q3 (2021) - Q2 (2022)

★★★☆☆ Linear Score (1 - 100): 80

Disagree
Patients who "Disagree" or "Strongly Disagree" that they understood the purposes of their medications when leaving the hospital

Star Rating:

More stars are better
"For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org"

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Overall Hospital Rating

Q3 (2021) - Q2 (2022)

★★★☆☆ Linear Score (1 - 100): 87

	Facility	State	National
0-6 Rating Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)	10%	10%	9%
7-8 Rating Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)	22%	22%	20%
9-10 Rating Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	68%	68%	71%

Star Rating:

More stars are better
"For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org"

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Willingness to Recommend this Hospital

Q3 (2021) - Q2 (2022)

	Facility	State	National
Definitely Yes Patients who reported YES, they would definitely recommend the hospital	72%	67%	69%
Probably Patients who reported YES, they would probably recommend the hospital	22%	26%	25%
Definitely No Patients who reported NO, they would probably not or definitely not recommend the hospital	6%	7%	6%

Star Rating:

More stars are better

"For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org"

*When HCAHPS scores are based on fewer than 25 completed surveys, scores WILL NOT be reported on Hospital Compare.

Timely and Effective Care

Sepsis

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SEP-1 Q3 (2021) - Q2 (2022) Severe Sepsis and Septic Shock	49%(2)	122(2)	56%(25,26)	58%(25,26)	78%(25,26)
SEV-SEP-3HR Q3 (2021) - Q2 (2022) Severe Sepsis 3-Hour Bundle	75%(2)	122(2)	77%(25,26)	78%(25,26)	92%(25,26)
SEV-SEP-6HR Q3 (2021) - Q2 (2022) Severe Sepsis 6-Hour Bundle	89%(2)	61(2)	90%(25,26)	89%(25,26)	100%(25,26)
SEP-SH-3HR Q3 (2021) - Q2 (2022) Septic Shock 3-Hour Bundle	54%(2)	48(2)	66%(25,26)	65%(25,26)	93%(25,26)
SEP-SH-6HR Q3 (2021) - Q2 (2022) Septic Shock 6-Hour Bundle	95%(2)	20(2)	82%(25,26)	84%(25,26)	100%(25,26)

Footnotes:

2. Data submitted were based on a sample of cases/patients.
25. State and national averages include Veterans Health Administration (VHA) hospital data.
26. State and national averages include Department of Defense (DoD) hospital data.

Emergency Department Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%

Emergency Department Care

		Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-18b Q3 (2021) - Q2 (2022) Median Time from ED Arrival to ED Departure for Discharged ED Patients An EDV-1 indicator will be shown in the volume category row of your facility.		305 mins.	385	171 mins.(25,26)	160 mins.(25,26)	101 mins.(25,26)
	Low Volume	-	-	172 mins.(25,26)	127 mins.(25,26)	-
	Medium Volume	-	-	188 mins.(25,26)	171 mins.(25,26)	-
	High Volume	EDV-1	-	197 mins.(25,26)	204 mins.(25,26)	-
	Very High Volume	-	-	174 mins.(25,26)	190 mins.(25,26)	-
OP-18c Q3 (2021) - Q2 (2022) Median Time from ED Arrival to ED Departure for Discharged ED Patients - Psychiatric/Mental Health Patients An EDV-1 indicator will be shown in the volume category row of your facility.		606 mins.	15	299 mins.(25)	266 mins.(25)	131 mins.(25)
	Low Volume	-	-	405 mins.(25)	204 mins.(25)	-
	Medium Volume	-	-	340 mins.(25)	271 mins.(25)	-
	High Volume	EDV-1	-	485 mins.(25)	345 mins.(25)	-
	Very High Volume	-	-	281 mins.(25)	333 mins.(25)	-
OP-22 Q1 (2021) - Q4 (2021) Left Without Being Seen		11%	57,315	4%(25,26)	3%(25,26)	0%(25,26)
OP-23 Q3 (2021) - Q2 (2022) Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival		45%	22	70%(25)	69%(25)	100%(25)

Emergency Department Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
ED-2-Strata-1 Q1 (2021) - Q4 (2021) Admit Decision Time to ED Departure Time for Admitted Patients - non psychiatric/ mental health disorders	N/A(5)	N/A(5)	124 mins.	138 mins.	20 mins.
ED-2-Strata-2 Q1 (2021) - Q4 (2021) Admit Decision Time to ED Departure Time for Admitted Patients – psychiatric/mental health disorders	N/A(5)	N/A(5)	133 mins.	108 mins.	31 mins.

Footnotes:

5. Results are not available for this reporting period.
25. State and national averages include Veterans Health Administration (VHA) hospital data.
26. State and national averages include Department of Defense (DoD) hospital data.

Healthcare Personnel Vaccination

	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
IMM-3 Q4 (2021) - Q1 (2022) Influenza Vaccination Coverage among Healthcare Personnel	99%	92%	80%
HCP_COVID-19 Q2 (2022) - Q2 (2022) COVID-19 Vaccination Coverage Among Healthcare Personnel	94.6%	88.9%	90%
IPFQR-HCP_COVID-19	96.1%	92.4%	89.2%

Healthcare Personnel Vaccination

	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
Q2 (2022) - Q2 (2022) COVID-19 Vaccination Coverage Among Healthcare Personnel			

Perinatal Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
PC-01 Q3 (2021) - Q2 (2022) Elective Delivery	6%(2)	53(2)	2%(26)	2%(26)	0%(26)
PC-05 Q1 (2021) - Q4 (2021) Exclusive Breast Milk Feeding	46%	1,361	41%	53%	85%

Footnotes:

2. Data submitted were based on a sample of cases/patients.
26. State and national averages include Department of Defense (DoD) hospital data.

Cardiac Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-2 Q3 (2021) - Q2 (2022) Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	N/A(5)	N/A(5)	56%(26)	51%(26)	100%(26)
OP-3b Q3 (2021) - Q2 (2022) Median Time to Transfer to Another Facility for Acute Coronary Intervention -	N/A(5)	N/A(5)	54 mins.(26)	63 mins.(26)	41 mins.(26)

Cardiac Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
Reporting Rate					

Footnotes:

5. Results are not available for this reporting period.
26. State and national averages include Department of Defense (DoD) hospital data.

Cataracts

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-31 Q1 (2021) - Q4 (2021) Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	N/A(5)	N/A(5)	N/A(5)	99%	100%

Footnotes:

5. Results are not available for this reporting period.

Colonoscopy

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-29 Q1 (2021) - Q4 (2021) Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	95%	79	92%(25,26)	91%(25,26)	100%(25,26)

Footnotes:

25. State and national averages include Veterans Health Administration (VHA) hospital data.
26. State and national averages include Department of Defense (DoD) hospital data.

Opioid Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
Safe Use of Opioids Q1 (2021) - Q4 (2021) Safe Use of Opioids – Concurrent Prescribing	17%	5,685	19%	17%	9%

Venous Thromboembolism

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
VTE-1 Q1 (2021) - Q4 (2021) Venous Thromboembolism Prophylaxis	N/A(5)	N/A(5)	92%	90%	99%
VTE-2 Q1 (2021) - Q4 (2021) Intensive Care Unit Venous Thromboembolism Prophylaxis	N/A(5)	N/A(5)	96%	96%	100%

Footnotes:

5. Results are not available for this reporting period.

Stroke Care

	Facility Rate	Patients/Days	State Rate	National Rate	Top 10%
STK-02 Q1 (2021) - Q4 (2021) Discharged on Antithrombotic Therapy	99%	211	97%	95%	100%
STK-03 Q1 (2021) - Q4 (2021) Anticoagulation Therapy for	N/A(5)	N/A(5)	73%	72%	100%

Stroke Care

	Facility Rate	Patients/Days	State Rate	National Rate	Top 10%
Atrial Fibrillation/Flutter					
STK-05 Q1 (2021) - Q4 (2021) Antithrombotic Therapy by End of Hospital Day 2	N/A(5)	N/A(5)	91%	90%	100%
STK-06 Q1 (2021) - Q4 (2021) Discharged on Statin Medication	96%	211	95%	94%	100%

Footnotes:

5. Results are not available for this reporting period.

Structural Measures

Structural Measures

	Measure Response
SM-7 Q4 (2021) - Q4 (2021) Maternal Morbidity Structural Measure	Yes

Complications & Deaths

30 Day Death Rates

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
MORT-30-AMI Q3 (2018) - Q2 (2021) Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	818	13.7% (11.7%, 15.9%)	12.4%	SAME	State	0	59	1	40
					Nation	19	2,014	14	1,917
MORT-30-HF Q3 (2018) - Q2 (2021) Heart Failure (HF) 30-Day Mortality Rate	1,252	10.8% (9.1%, 12.5%)	11.3%	SAME	State	4	85	3	14
					Nation	195	2,988	109	1,285
MORT-30-PN Q3 (2018) - Q2 (2021) Pneumonia 30-Day Mortality Rate	662	18.3% (15.8%, 21.1%)	16.6%	SAME	State	4	88	9	5
					Nation	232	3,415	169	839
MORT-30-STK Q3 (2018) - Q2 (2021) Acute Ischemic Stroke (STK) 30-Day Mortality Rate	811	16.6% (14.5%, 18.8%)	13.6%	WORSE	State	0	76	3	20
					Nation	79	2,075	53	1,912
MORT-30-COPD Q3 (2018) - Q2 (2021) Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	297	7.7% (5.8%, 10.3%)	8.4%	SAME	State	0	90	0	16
					Nation	25	2,956	38	1,539
MORT-30-CABG Q3 (2018) - Q2 (2021) 30-Day All-Cause Mortality Following Coronary Artery	408	2% (1.2%, 3.2%)	2.9%	SAME	State	0	22	0	0
					Nation	7	903	12	206

30 Day Death Rates

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages			
					Better	Same	Worse	Too Few
Bypass Graft (CABG) Surgery								

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate/ Value (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
PSI-3 Q3 (2019) - Q2 (2021) Pressure Ulcer Rate	14,349	1.46 (1.06, 1.87)	0.62	WORSE	State	1	82	6	0
					Nation	27	3,015	229	59
PSI-4 Q3 (2019) - Q2 (2021) Death among surgical inpatients with serious treatable complications Rate	318	151.37 (128.35, 174.39)	143.04	SAME	State	0	34	0	43
					Nation	27	1,381	28	1,201
PSI-6 Q3 (2019) - Q2 (2021) Iatrogenic pneumothorax, adult Rate	15,997	0.19 (0.08, 0.31)	0.19	SAME	State	0	89	0	1
					Nation	1	3,293	4	44
PSI-8 Q3 (2019) - Q2 (2021) In-Hospital Fall With Hip Fracture Rate	17,454	0.12 (0.02, 0.21)	0.07	SAME	State	0	89	0	1
					Nation	0	3,271	26	45
PSI-9 Q3 (2019) - Q2 (2021) Perioperative Hemorrhage	4,924	3.08 (2.14, 4.02)	2.39	SAME	State	0	83	0	3
					Nation	1	2,949	30	173

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate/ Value (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
or Hematoma Rate									
PSI-10 Q3 (2019) - Q2 (2021) Postoperative Acute Kidney Injury Requiring Dialysis Rate	2,154	0.81 (0.19, 1.43)	0.92	SAME	State	0	76	0	7
					Nation	1	2,624	33	342
PSI-11 Q3 (2019) - Q2 (2021) Postoperative Respiratory Failure Rate	2,045	6.07 (3.51, 8.62)	6.47	SAME	State	0	77	0	6
					Nation	45	2,484	129	343
PSI-12 Q3 (2019) - Q2 (2021) Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate	5,346	3.24 (1.95, 4.52)	3.41	SAME	State	0	82	1	3
					Nation	12	2,912	62	167
PSI-13 Q3 (2019) - Q2 (2021) Postoperative Sepsis Rate	2,185	4.05 (2.34, 5.76)	4.09	SAME	State	0	75	0	7
					Nation	17	2,565	38	355
PSI-14 Q3 (2019) - Q2 (2021) Postoperative Wound Dehiscence Rate	1,809	1.98 (1.25, 2.7)	0.82	WORSE	State	0	80	1	3
					Nation	0	2,670	7	396
PSI-15 Q3 (2019) - Q2 (2021) Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate	3,925	1.19 (0.43, 1.95)	1.04	SAME	State	0	82	1	3
					Nation	1	2,899	42	219
	Not Applicable	1.13	1.00	SAME	State	4	81	0	N/A(5)

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate/ Value (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages			
					Better	Same	Worse	Too Few
PSI-90 Q3 (2019) - Q2 (2021) Patient Safety and Adverse Events Composite		(0.96, 1.3)			Nation	105	2,899	102	N/A(5)

Footnotes:

5. Results are not available for this reporting period.

Infections

	Predicted	Reported	Days / Procedure	Facility Ratio (95% conf. int.)	State Ratio (95% conf. int.)	National Ratio	National Compare
HAI-1 Q3 (2021) - Q2 (2022) Central Line Associated Bloodstream Infection (ICU + select Wards)	44.008	50	40,762	1.136 (0.852, 1.486)	1.245 (1.164, 1.330)	0.965	SAME
HAI-2 Q3 (2021) - Q2 (2022) Catheter Associated Urinary Tract Infections (ICU + select Wards)	38.059	49	25,387	1.287 (0.963, 1.688)	0.876 (0.812, 0.944)	0.755	SAME
HAI-3 Q3 (2021) - Q2 (2022) SSI - Colon Surgery	13.635	21	459	1.540 (0.979, 2.314)	0.900 (0.799, 1.011)	0.862	SAME
HAI-4	3.715	2	404	0.538	1.018	0.963	SAME

Infections

	Predicted	Reported	Days / Procedure	Facility Ratio (95% conf. int.)	State Ratio (95% conf. int.)	National Ratio	National Compare
Q3 (2021) - Q2 (2022) SSI - Abdominal Hysterectomy				(0.090, 1.779)	(0.808, 1.267)		
HAI-5 Q3 (2021) - Q2 (2022) MRSA Bacteremia	27.976	31	262,453	1.108 (0.766, 1.554)	1.114 (1.017, 1.217)	1.059	SAME
HAI-6 Q3 (2021) - Q2 (2022) Clostridium Difficile (C.Diff)	136.368	65	245,611	0.477 (0.371, 0.604)	0.401 (0.380, 0.424)	0.487	BETTER

Surgical Complications

	Eligible Discharges	Complication Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
COMP-HIP-KNEE Q2 (2018) - Q1 (2021) HIP/Knee Complication Rate (RSCR) following Total Hip/ Knee Arthroplasty	565	2.1% (1.4%, 3.3%)	2.4%	SAME	State	3	75	1	10
					Nation	28	2,478	24	915

Unplanned Hospital Visits

Condition Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-AMI Q3 (2018) - Q2 (2021) Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	893	14.8% (13.0%, 16.8%)	15%	SAME	State	1	50	0	49
					Nation	4	1,864	13	1,903
READM-30-HF Q3 (2018) - Q2 (2021) Heart Failure (HF) 30-day Readmission Rate	1,559	21.8% (20.0%, 23.7%)	21.3%	SAME	State	3	91	1	11
					Nation	66	3,225	85	1,208
READM-30-PN Q3 (2018) - Q2 (2021) Pneumonia (PN) 30-day Readmission Rate	698	18.3% (16.2%, 20.5%)	17%	SAME	State	2	98	0	6
					Nation	11	3,742	56	843
READM-30-COPD Q3 (2018) - Q2 (2021) Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate	346	21.1% (18.4%, 24.3%)	19.8%	SAME	State	0	93	0	13
					Nation	7	3,063	21	1,472

Procedure Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages			
					Better	Same	Worse	Too Few

Procedure Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-CABG Q3 (2018) - Q2 (2021) Hospital-Level 30-day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft Surgery (CABG)	395	11.9% (9.5%, 14.7%)	11.9%	SAME	State	0	22	0	0
					Nation	4	902	7	213
READM-30-HIP-KNEE Q3 (2018) - Q2 (2021) 30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	541	4.7% (3.4%, 6.3%)	4.1%	SAME	State	0	75	3	11
					Nation	19	2,509	12	893

Hospital Wide Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-HOSPWIDE Q3 (2020) - Q2 (2021) 30-Day Hospital-Wide All-Cause Unplanned Readmission Rate	6,938	16.3% (15.2%, 17.0%)	15%	WORSE	State	6	96	6	1
					Nation	169	3,985	259	289

Inpatient Psychiatric Facility (IPF)- Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-IPF Q3 (2019) - Q2 (2021) Rate of readmission after discharge from hospital	295	21.1% (17.4%, 25.5%)	20.1%	SAME	State	3	38	1	3
					Nation	44	1,345	94	134

Procedure Specific Outcomes

	Eligible Discharges	Facility Rate/ Ratio	National Rate/ Ratio	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
OP-32 Q1 (2019) - Q4 (2021) Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy	404	15.6 (11.4, 20.9)	14.2	SAME	State	0	89	0	7
					Nation	12	3,291	2	480
OP-35_ADM Q1 (2021) - Q4 (2021) Admissions (ADM) for Patients Receiving Outpatient Chemotherapy	484	12.1 (9.9, 14.5)	10.2	SAME	State	1	47	1	36
					Nation	12	1,446	95	1,788
OP-35_ED Q1 (2021) - Q4 (2021) Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	484	5.3 (4, 7)	5.4	SAME	State	0	49	0	36
					Nation	29	1,502	22	1,788
OP-36 Q1 (2021) - Q4 (2021)	1,224	0.8 (0.6, 0.9)	Not Applicable	BETTER	State	5	80	0	11
					Nation	84	2,631	88	979

Procedure Specific Outcomes

	Eligible Discharges	Facility Rate/ Ratio	National Rate/ Ratio	National Compare	Facility Compared to Averages			
					Better	Same	Worse	Too Few
Hospital Visits after Hospital Outpatient Surgery								

Excess Days in Acute Care

	Eligible Discharges	Patients Included	Returned to a Hospital	Measr. Days (95% int. limits)	Compare	Facility Compared to Averages (Days)				
							Fewer	Same	More	Too Few
EDAC-30-AMI Q3 (2018) - Q2 (2021) Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	893	858	240	11.7 (0.4, 23.3)	WORSE	State	5	40	6	49
						Nation	183	1,318	380	1,903
EDAC-30-HF Q3 (2018) - Q2 (2021) Excess Days in Acute Care after Hospitalization for Heart Failure	1,559	1,244	449	30 (17.9, 43)	WORSE	State	6	72	17	11
						Nation	383	2,336	657	1,208
EDAC-30-PN Q3 (2018) - Q2 (2021) Excess Days in Acute Care after Hospitalization for Pneumonia	698	648	198	58.3 (39.9, 78.6)	WORSE	State	14	65	21	6
						Nation	442	2,465	902	843

Payment & Value of Care

Payment

	Eligible Discharges	Facility Payment (95% conf. int.)	National Average Payment	National Compare	Facility Compared to Averages				
						Greater	Same	Less	Too Few
PAYM-30-AMI Q3 (2018) - Q2 (2021) Risk-Standardized Payment Associated with a 30-Day AMI Episode-of-Care for Acute Myocardial Infarction	798	$27,143 ($25,671, $28,566)	$26,800	SAME	State	0	53	5	38
					Nation	144	1,690	103	1,859
					Value of Care	Average Mortality and Average Payment			
PAYM-30-HF Q3 (2018) - Q2 (2021) Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure	1,233	$16,993 ($16,385, $17,627)	$18,280	BETTER	State	1	51	36	14
					Nation	362	2,458	305	1,320
					Value of Care	Average Mortality and Lower Payment			
PAYM-30-PN Q3 (2018) - Q2 (2021) Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia	624	$18,145 ($17,974, $19,469)	$19,490	BETTER	State	1	66	29	6
					Nation	471	2,699	465	885
					Value of Care	Average Mortality and Lower Payment			
PAYM-90-HIP-KNEE Q2 (2018) - Q1 (2021) Risk-Standardized Payment Associated with a 90-Day Episode of Care for THA/ TKA	562	$18,291 ($17,736, $18,855)	$20,793	BETTER	State	6	38	32	10
					Nation	409	1,236	789	914
					Value of Care	Average Complications and Lower Payment			

Medicare Spending per Beneficiary

	Facility Rate	State Rate	National Rate	National Median Amount
MSPB-1 Q1 (2021) - Q4 (2021) Spending per hospital patient with Medicare	1.00	0.95	0.99	$24,299.69

Note:

A MSPB performance of greater than one indicates that your hospital's MSPB Amount is more expensive than the U.S. National Median MSPB Amount.
A MSPB performance of less than one indicates that your hospital's MSPB Amount is less expensive than the National Median Amount.

Follow-Up Care

Transition Records

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
TR1 Q1 (2021) - Q4 (2021) Transition Record with Specified Elements	67%	634	60%	67%	100%
TR2 Q1 (2021) - Q4 (2021) Timely Transmission of Transition Record	64%	634	51%	57%	99%

Hospital-Based Inpatient Psychiatric Services

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
HBIPS-5 Q1 (2021) - Q4 (2021) Patients discharged on multiple antipsychotic medications with appropriate justification	91%	32	69%	62%	100%

Follow-up After Hospitalization for Mental Illness

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
FUH-7 Q3 (2020) - Q2 (2021) Follow-up after Hospitalization for Mental Illness 7-Days	35.7%	143	24.5%	28.6%	45.3%
FUH-30 Q3 (2020) - Q2 (2021)	59.4%	143	47%	51.7%	71.4%

Follow-up After Hospitalization for Mental Illness

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
Follow-up after Hospitalization for Mental Illness 30-Days					

Medication Continuation Following Inpatient Psychiatric Discharge

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
MedCont Q3 (2019) - Q2 (2021) Medication Continuation Following Inpatient Psychiatric Discharge	79%	238	72.9%	73.1%	83.1%

Substance Use Treatment

Substance Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SUB-2 Q1 (2021) - Q4 (2021) Alcohol Use Brief Intervention Provided or Offered	88%	86	79%	65%	100%
SUB-2a Q1 (2021) - Q4 (2021) Alcohol Use Brief Intervention	89%	85	79%	76%	100%
SUB-3 Q1 (2021) - Q4 (2021) Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge	97%	223	88%	75%	100%
SUB-3a Q1 (2021) - Q4 (2021) Alcohol and other Drug Use Disorder Treatment Provided at Discharge	97%	223	82%	62%	100%

Tobacco Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
TOB-2 Q1 (2021) - Q4 (2021) Tobacco Use Treatment Provided or Offered	79%	306	80%	72%	99%
TOB-2a Q1 (2021) - Q4 (2021)	72%	294	49%	42%	88%

Tobacco Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
Tobacco Use Treatment (during the hospital stay)					
TOB-3 Q1 (2021) - Q4 (2021) Tobacco Use Treatment Provided or Offered at Discharge	86%	288	70%	57%	99%
TOB-3a Q1 (2021) - Q4 (2021) Tobacco Use Treatment at Discharge	82%	288	30%	18%	81%

Patient Safety

Hospital-Based Inpatient Psychiatric Services

		Rate	Hours	Days
HBIPS-2 Q1 (2021) - Q4 (2021) Hours of physical-restraint use	Facility	2.04	711.75	14,522
	State	0.15	2,789.88	760,904
	National	0.38	246,415.88	26,725,748
HBIPS-3 Q1 (2021) - Q4 (2021) Hours of seclusion	Facility	0.91	318.83	14,522
	State	0.23	4,150.46	760,904
	National	0.36	230,351.11	26,725,748

Preventive Care and Screening

Screening

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SMD Q1 (2021) - Q4 (2021) Screening for Metabolic Disorders	99%	345	88%	77%	100%

Immunization

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
IPFQR-IMM-2 Q4 (2021) - Q1 (2022) Influenza Immunization	96%	310	85%	77%	99%

Use of Medical Imaging

Imaging Efficiency

	Number of Patients	Facility Rate	State Rate	National Rate
OP-8 Q3 (2020) - Q2 (2021) MRI Lumbar Spine for Low Back Pain	41	51.2%	45.2%	45.2%
OP-10 Q3 (2020) - Q2 (2021) Abdomen CT - Use of Contrast Material	1,263	1.7%	5%	6.3%
OP-13 Q3 (2020) - Q2 (2021) Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	N/A(1)	N/A(1)	3.4%	3.8%
OP-39 Q3 (2020) - Q2 (2021) Breast Cancer Screening Recall Rates	104	7.7%	7.6%	9.4%

Footnotes:

1. The number of cases/patients is too few to report.

Hospital Compare Preview Report
ECU HEALTH MEDICAL CENTER

2100 STANTONSBURG RD
GREENVILLE, NC 27834

CCN-340040
(252) 847-4100

Facility Type:	Short-term
Ownership Type:	Voluntary non-profit - Private
Emergency Service:	Yes

Survey of Patients' Experience

Attention: Individual question scores appear only in the Preview Report and downloadable databases. Individual question scores are presented for informational purposes only; they are not official HCAHPS measures. A simple average of the individual questions that comprises a composite measure may not always match the composite score.

HCAHPS individual question scores based on fewer than 50 completed surveys **will not** be reported in the downloadable database.

HCAHPS Summary Star Rating

Completed Surveys	2,119
Survey Response Rate	18%

Star Rating:

More stars are better
"For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org"

*When HCAHPS scores are based on fewer than 25 completed surveys, scores WILL NOT be reported on Hospital Compare.

Communication with Nurses

Q3 (2022) - Q2 (2023)

Linear Score (1 - 100): 90

Composite (Q1 - Q3)	Facility	State	National
Always Patients who reported that their	76%	79%	79%

Communication with Nurses

Q3 (2022) - Q2 (2023)

★★★★★ Linear Score (1 - 100): 90

nurses 'Always' communicated well			
Usually Patients who reported that their nurses 'Usually' communicated well	18%	16%	16%
Sometimes/Never Patients who reported that their nurses 'Sometimes' or 'Never' communicated well	6%	5%	5%
Nurse Courtesy & Respect (Q1)	Facility	State	National
Always Patients who reported that their nurses "Always" treated them with courtesy and respect	84%	86%	86%
Usually Patients who reported that their nurses "Usually" treated them with courtesy and respect	12%	11%	11%
Sometimes/Never Patients who reported that their nurses "Sometimes" or "Never" treated them with courtesy and respect	4%	3%	3%
Nurse Listen (Q2)	Facility	State	National
Always Patients who reported that their nurses "Always" listened carefully to them	73%	77%	76%

Communication with Nurses

Q3 (2022) - Q2 (2023)

Usually Patients who reported that their nurses "Usually" listened carefully to them	21%	18%	19%
Sometimes/Never Patients who reported that their nurses "Sometimes" or "Never" listened carefully to them	6%	5%	5%
Nurse Explain (Q3)	Facility	State	National
Always Patients who reported that their nurses "Always" explained things in a way they could understand	72%	75%	75%
Usually Patients who reported that their nurses "Usually" explained things in a way they could understand	22%	19%	19%
Sometimes/Never Patients who reported that their nurses "Sometimes" or "Never" explained things in a way they could understand	6%	6%	6%

Star Rating:

More stars are better
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Communication with Doctors

Q3 (2022) - Q2 (2023)

Composite (Q5 - Q7)	Facility	State	National

Communication with Doctors

Q3 (2022) - Q2 (2023)

Always Patients who reported that their doctors 'Always' communicated well	79%	81%	80%
Usually Patients who reported that their doctors 'Usually' communicated well	16%	14%	15%
Sometimes/Never Patients who reported that their doctors 'Sometimes' or 'Never' communicated well	5%	5%	5%
Doctor Courtesy & Respect (Q5)	Facility	State	National
Always Patients who reported that their doctors "Always" treated them with courtesy and respect	86%	87%	86%
Usually Patients who reported that their doctors "Usually" treated them with courtesy and respect	11%	10%	10%
Sometimes/Never Patients who reported that their doctors "Sometimes" or "Never" treated them with courtesy and respect	3%	3%	4%
Doctor Listen (Q6)	Facility	State	National
Always Patients who reported that their doctors "Always" listened	78%	79%	78%

Communication with Doctors

Q3 (2022) - Q2 (2023)

★★★★★ Linear Score (1 - 100): 91

carefully to them			
Usually Patients who reported that their doctors "Usually" listened carefully to them	16%	16%	16%
Sometimes/Never Patients who reported that their doctors "Sometimes" or "Never" listened carefully to them	6%	5%	6%
Doctor Explain (Q7)	Facility	State	National
Always Patients who reported that their doctors "Always" explained things in a way they could understand	72%	76%	75%
Usually Patients who reported that their doctors "Usually" explained things in a way they could understand	22%	18%	19%
Sometimes/Never Patients who reported that their doctors "Sometimes" or "Never" explained things in a way they could understand	6%	6%	6%

Star Rating:

More stars are better

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Responsiveness of Hospital Staff

Q3 (2022) - Q2 (2023)

Composite (Q4 & Q11)	Facility	State	National
Always Patients who reported that they 'Always' received help as soon as they wanted	59%	63%	66%
Usually Patients who reported that they 'Usually' received help as soon as they wanted	28%	26%	24%
Sometimes/Never Patients who reported that they 'Sometimes' or 'Never' received help as soon as they wanted	13%	11%	10%
Call Button (Q4)	Facility	State	National
Always Patients who reported that they "Always" received help after using the call button as soon as they wanted	58%	63%	65%
Usually Patients who reported that they "Usually" received help after using the call button as soon as they wanted	30%	26%	25%
Sometimes/Never Patients who reported that they "Sometimes" or "Never" received help after using the call button as soon as they wanted	12%	11%	10%
Bathroom Help (Q11)	Facility	State	National

Responsiveness of Hospital Staff

Q3 (2022) - Q2 (2023)

Always Patients who reported that they "Always" received bathroom help as soon as they wanted	60%	63%	67%
Usually Patients who reported that they "Usually" received bathroom help as soon as they wanted	27%	25%	22%
Sometimes/Never Patients who reported that they "Sometimes" or "Never" received bathroom help as soon as they wanted	13%	12%	11%

Star Rating:

More stars are better

"For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org"

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Communication About Medicines

Q3 (2022) - Q2 (2023)

Composite (Q13 - Q14)	Facility	State	National
Always Patients who reported that staff 'Always' explained about medicines before giving it to them	56%	62%	62%
Usually Patients who reported that staff 'Usually' explained about medicines before giving it to	21%	18%	18%

Communication About Medicines

Q3 (2022) - Q2 (2023)

them			
Sometimes/Never Patients who reported that staff 'Sometimes' or 'Never' explained about medicines before giving it to them	23%	20%	20%
Medicine Explain (Q13)	Facility	State	National
Always Patients who reported that when receiving new medication the staff "Always" communicated what the medication was for	71%	75%	75%
Usually Patients who reported that when receiving new medication the staff "Usually" communicated what the medication was for	18%	16%	15%
Sometimes/Never Patients who reported that when receiving new medication the staff "Sometimes" or "Never" communicated what the medication was for	11%	9%	10%
Side Effects (Q14)	Facility	State	National
Always Patients who reported that when receiving new medication the staff "Always" discussed possible side effects	42%	48%	48%
Usually Patients who reported that when	24%	21%	22%

Communication About Medicines

Q3 (2022) - Q2 (2023)

★★★☆☆ Linear Score (1 - 100): 74

	Facility	State	National
receiving new medication the staff "Usually" discussed possible side effects			
Sometimes/Never Patients who reported that when receiving new medication the staff "Sometimes" or "Never" discussed possible side effects	34%	31%	30%

Star Rating:

More stars are better

"For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org"

*When HCAHPS scores are based on fewer than 25 completed surveys, scores WILL NOT be reported on Hospital Compare.

Cleanliness of Hospital Environment

Q3 (2022) - Q2 (2023)

★★☆☆☆ Linear Score (1 - 100): 83

	Facility	State	National
Always Patients who reported that their room and bathroom were 'Always' clean	64%	69%	73%
Usually Patients who reported that their room and bathroom were 'Usually' clean	23%	20%	18%
Sometimes/Never Patients who reported that their room and bathroom were 'Sometimes' or 'Never' clean	13%	11%	9%

Star Rating:

More stars are better

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Quietness of Hospital

Q3 (2022) - Q2 (2023)

Linear Score (1 - 100): 82

	Facility	State	National
Always Patients who reported that the area around their room was 'Always' quiet at night	59%	61%	62%
Usually Patients who reported that the area around their room was 'Usually' quiet at night	31%	30%	28%
Sometimes/Never Patients who reported that the area around their room was 'Sometimes' or 'Never' quiet at night	10%	9%	10%

Star Rating:

More stars are better

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Discharge Information

Q3 (2022) - Q2 (2023)

Linear Score (1 - 100): 86

Composite (Q16 - Q17)	Facility	State	National
Yes Patients who reported that YES, they were given information about what to do during their recovery at home	86%	87%	86%

Discharge Information

Q3 (2022) - Q2 (2023)

★★★★★ Linear Score (1 - 100): 86

No Patients who reported that NO, they were not given information about what to do during their recovery at home	14%	13%	14%
Help After Discharge (Q16)	Facility	State	National
Yes Patients who reported that YES, they did discuss whether they would need help after discharge	85%	86%	84%
No Patients who reported that NO, they did not discuss whether they would need help after discharge	15%	14%	16%
Symptoms (Q17)	Facility	State	National
Yes Patients who reported that YES, they did receive written information about possible symptoms to look out for after discharge	86%	88%	87%
No Patients who reported that NO, they did not receive written information about possible symptoms to look out for after discharge	14%	12%	13%

Star Rating:

More stars are better

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Care Transition

Q3 (2022) - Q2 (2023)

Composite (Q20 - Q22)	Facility	State	National
Strongly Agree Patients who 'Strongly Agree' they understood their care when they left the hospital	49%	52%	52%
Agree Patients who 'Agree' they understood their care when they left the hospital	45%	42%	42%
Disagree/Strongly Disagree Patients who 'Disagree' or 'Strongly Disagree' they understood their care when they left the hospital	6%	6%	6%
Preference (Q20)	**Facility**	**State**	**National**
Strongly Agree Patients who "Strongly Agree" that the staff took my preferences into account when determining their health care needs	43%	45%	45%
Agree Patients who "Agree" that the staff took my preferences into account when determining my health care their needs	50%	48%	48%
Disagree/Strongly Disagree Patients who "Disagree" or "Strongly Disagree" that the staff	7%	7%	7%

Care Transition

Q3 (2022) - Q2 (2023)

★★★★★ Linear Score (1 - 100): 80

took my preferences into account when determining their health care needs

Understanding (Q21)	Facility	State	National
Strongly Agree Patients who "Strongly Agree" that they understood their responsiblities in managing their health	48%	50%	51%
Agree Patients who "Agree" that they understood their responsiblities in managing their health	46%	45%	44%
Disagree/Strongly Disagree Patients who "Disagree" or "Strongly Disagree" that they understood their responsiblities in managing their health	6%	5%	5%

Medicine Purpose (Q22)	Facility	State	National
Strongly Agree Patients who "Strongly Agree" that they understood the purposes of their medications when leaving the hospital	57%	59%	58%
Agree Patients who "Agree" that they understood the purposes of their medications when leaving the hospital	37%	36%	37%
Disagree/Strongly	6%	5%	5%

Care Transition

Q3 (2022) - Q2 (2023)


Linear Score (1 - 100): 80

Disagree
Patients who "Disagree" or "Strongly Disagree" that they understood the purposes of their medications when leaving the hospital

Star Rating:

More stars are better
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Overall Hospital Rating

Q3 (2022) - Q2 (2023)


Linear Score (1 - 100): 88

	Facility	State	National
0-6 Rating Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)	9%	9%	9%
7-8 Rating Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)	22%	22%	20%
9-10 Rating Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	69%	69%	71%

Star Rating:

More stars are better
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Willingness to Recommend this Hospital

Q3 (2022) - Q2 (2023)

	Facility	State	National
Definitely Yes Patients who reported YES, they would definitely recommend the hospital	69%	67%	69%
Probably Patients who reported YES, they would probably recommend the hospital	26%	27%	25%
Definitely No Patients who reported NO, they would probably not or definitely not recommend the hospital	5%	6%	6%

Star Rating:

More stars are better

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*When HCAHPS scores are based on fewer than 25 completed surveys, scores WILL NOT be reported on Hospital Compare.

Timely and Effective Care

Sepsis

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SEP-1 Q3 (2022) - Q2 (2023) Severe Sepsis and Septic Shock	34%(2)	120(2)	58%(25,26)	60%(25,26)	81%(25,26)
SEV-SEP-3HR Q3 (2022) - Q2 (2023) Severe Sepsis 3-Hour Bundle	59%(2)	121(2)	77%(25,26)	79%(25,26)	92%(25,26)
SEV-SEP-6HR Q3 (2022) - Q2 (2023) Severe Sepsis 6-Hour Bundle	96%(2)	46(2)	92%(25,26)	90%(25,26)	100%(25,26)
SEP-SH-3HR Q3 (2022) - Q2 (2023) Septic Shock 3-Hour Bundle	24%(2)	29(2)	68%(25,26)	69%(25,26)	96%(25,26)
SEP-SH-6HR Q3 (2022) - Q2 (2023) Septic Shock 6-Hour Bundle	43%(1,2)	7(1,2)	85%(25,26)	85%(25,26)	100%(25,26)

Footnotes:

1. The number of cases/patients is too few to report.
2. Data submitted were based on a sample of cases/patients.
25. State and national averages include Veterans Health Administration (VHA) hospital data.
26. State and national averages include Department of Defense (DoD) hospital data.

Emergency Department Care

		Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-18b Q3 (2022) - Q2 (2023) Median Time from ED Arrival to ED Departure for Discharged ED Patients An EDV-1 indicator will be shown in the volume category row of your facility.		305 mins.	384	182 mins.(25,26)	162 mins.(25,26)	101 mins.(25,26)
	Low Volume	-	-	155 mins.(25,26)	125 mins.(25,26)	-
	Medium Volume	-	-	190 mins.(25,26)	171 mins.(25,26)	-
	High Volume	-	-	198 mins.(25,26)	212 mins.(25,26)	-
	Very High Volume	EDV-1	-	192 mins.(25,26)	194 mins.(25,26)	-
OP-18c Q3 (2022) - Q2 (2023) Median Time from ED Arrival to ED Departure for Discharged ED Patients - Psychiatric/Mental Health Patients An EDV-1 indicator will be shown in the volume category row of your facility.		621 mins.	15	310 mins.(25)	268 mins.(25)	130 mins.(25)
	Low Volume	-	-	268 mins.(25)	202 mins.(25)	-
	Medium Volume	-	-	306 mins.(25)	269 mins.(25)	-
	High Volume	-	-	337 mins.(25)	349 mins.(25)	-
	Very High Volume	EDV-1	-	316 mins.(25)	333 mins.(25)	-
OP-22 Q1 (2022) - Q4 (2022) Left Without Being Seen		6%	127,287	4%(25,26)	3%(25,26)	0%(25,26)
OP-23 Q3 (2022) - Q2 (2023) Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival		52%	33	70%(25)	69%(25)	100%(25)

Emergency Department Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
ED-2-Strata-1 Q1 (2022) - Q4 (2022) Admit Decision Time to ED Departure Time for Admitted Patients - non psychiatric/ mental health disorders	N/A(5)	N/A(5)	133 mins.	135 mins.	18 mins.
ED-2-Strata-2 Q1 (2022) - Q4 (2022) Admit Decision Time to ED Departure Time for Admitted Patients – psychiatric/mental health disorders	N/A(5)	N/A(5)	133 mins.	121 mins.	24 mins.

Footnotes:

5. Results are not available for this reporting period.
25. State and national averages include Veterans Health Administration (VHA) hospital data.
26. State and national averages include Department of Defense (DoD) hospital data.

Healthcare Personnel Vaccination

	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
IMM-3 Q4 (2022) - Q1 (2023) Influenza Vaccination Coverage among Healthcare Personnel	98%	92%	81%
HCP_COVID-19 Q2 (2023) - Q2 (2023) COVID-19 Vaccination Coverage Among Healthcare Personnel	92.8%	89.8%	90.5%
IPFQR-HCP_COVID-19	95.7%	90.3%	89.7%

Healthcare Personnel Vaccination

	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
Q2 (2023) - Q2 (2023) COVID-19 Vaccination Coverage Among Healthcare Personnel			

Perinatal Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
PC-01 Q3 (2022) - Q2 (2023) Elective Delivery	2%(2)	50(2)	2%(26)	2%(26)	0%(26)
PC-05 Q1 (2022) - Q4 (2022) Exclusive Breast Milk Feeding	N/A(5)	N/A(5)	N/A(5)	55%	85%

Footnotes:

2. Data submitted were based on a sample of cases/patients.
5. Results are not available for this reporting period.
26. State and national averages include Department of Defense (DoD) hospital data.

Cataracts

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-31 Q1 (2022) - Q4 (2022) Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	N/A(5)	N/A(5)	N/A(5)	97%	100%

Footnotes:

5. Results are not available for this reporting period.

Colonoscopy

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-29 Q1 (2022) - Q4 (2022) Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	92%	173	92%(25,26)	92%(25,26)	100%(25,26)

Footnotes:

25. State and national averages include Veterans Health Administration (VHA) hospital data.
26. State and national averages include Department of Defense (DoD) hospital data.

Opioid Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
Safe Use of Opioids Q1 (2022) - Q4 (2022) Safe Use of Opioids – Concurrent Prescribing	14%	7,073	16%	15%	8%

Venous Thromboembolism

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
VTE-1 Q1 (2022) - Q4 (2022) Venous Thromboembolism Prophylaxis	N/A(5)	N/A(5)	91%(25)	89%(25)	99%(25)
VTE-2 Q1 (2022) - Q4 (2022) Intensive Care Unit Venous Thromboembolism Prophylaxis	N/A(5)	N/A(5)	94%(25)	95%(25)	100%(25)

Footnotes:

5. Results are not available for this reporting period.
25. State and national averages include Veterans Health Administration (VHA) hospital data.

Stroke Care

	Facility Rate	Patients/Days	State Rate	National Rate	Top 10%
STK-02 Q1 (2022) - Q4 (2022) Discharged on Antithrombotic Therapy	96%	327	92%(25)	96%(25)	100%(25)
STK-03 Q1 (2022) - Q4 (2022) Anticoagulation Therapy for Atrial Fibrillation/Flutter	N/A(5)	N/A(5)	70%	75%	100%
STK-05 Q1 (2022) - Q4 (2022) Antithrombotic Therapy by End of Hospital Day 2	90%	500	93%	92%	100%
STK-06 Q1 (2022) - Q4 (2022) Discharged on Statin Medication	96%	321	96%(25)	95%(25)	100%(25)

Footnotes:

5. Results are not available for this reporting period.
25. State and national averages include Veterans Health Administration (VHA) hospital data.

Structural Measures

Structural Measures

	Measure Response
SM-7 Q1 (2022) - Q4 (2022) Maternal Morbidity Structural Measure	Yes

Complications & Deaths

30 Day Death Rates

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
MORT-30-AMI Q3 (2019) - Q2 (2022) Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	800	14.4% (12.4%, 16.6%)	12.6%	SAME	State	2	52	1	46
					Nation	22	1,929	14	1,981
MORT-30-HF Q3 (2019) - Q2 (2022) Heart Failure (HF) 30-Day Mortality Rate	1,080	13.7% (11.9%, 15.8%)	11.8%	WORSE	State	3	87	3	13
					Nation	215	2,808	97	1,398
MORT-30-PN Q3 (2019) - Q2 (2022) Pneumonia 30-Day Mortality Rate	507	20% (17.0%, 23.2%)	18.2%	SAME	State	4	84	9	9
					Nation	219	3,240	135	1,008
MORT-30-STK Q3 (2019) - Q2 (2022) Acute Ischemic Stroke (STK) 30-Day Mortality Rate	699	14.9% (12.8%, 17.1%)	13.9%	SAME	State	1	75	2	19
					Nation	76	2,035	43	1,901
MORT-30-COPD Q3 (2019) - Q2 (2022) Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	239	9.5% (7.0%, 12.6%)	9.2%	SAME	State	0	83	2	20
					Nation	24	2,569	20	1,885
MORT-30-CABG Q3 (2019) - Q2 (2022) 30-Day All-Cause Mortality Following Coronary Artery	337	2.1% (1.3%, 3.6%)	2.9%	SAME	State	0	21	0	1
					Nation	2	880	6	209

30 Day Death Rates

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages			
					Better	Same	Worse	Too Few
Bypass Graft (CABG) Surgery								

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate/ Value (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
PSI-3 Q3 (2020) - Q2 (2022) Pressure Ulcer Rate	17,893	0.96 (0.66, 1.25)	0.59	WORSE	State	2	81	5	0
					Nation	70	2,973	206	56
PSI-4 Q3 (2020) - Q2 (2022) Death rate among surgical inpatients with serious treatable complications	348	163.59 (138.57, 188.61)	167.87	SAME	State	0	43	2	33
					Nation	62	1,510	45	1,059
PSI-6 Q3 (2020) - Q2 (2022) Iatrogenic pneumothorax rate	19,662	0.20 (0.06, 0.34)	0.25	SAME	State	0	88	0	0
					Nation	1	3,267	8	32
PSI-8 Q3 (2020) - Q2 (2022) In-Hospital Fall With Hip Fracture Rate	21,386	0.11 (0.05, 0.16)	0.09	SAME	State	0	88	0	0
					Nation	0	3,277	0	31
PSI-9 Q3 (2020) - Q2 (2022) Postoperative Hemorrhage	5,465	2.70 (1.69, 3.71)	2.52	SAME	State	1	84	0	0
					Nation	14	2,928	45	137

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate/ Value (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
or Hematoma Rate									
PSI-10 Q3 (2020) - Q2 (2022) Postoperative Acute Kidney Injury Requiring Dialysis Rate	2,273	1.04 (0.04, 2.04)	1.57	SAME	State	0	76	0	7
					Nation	4	2,608	25	340
PSI-11 Q3 (2020) - Q2 (2022) Postoperative Respiratory Failure Rate	2,165	6.82 (3.79, 9.85)	8.86	SAME	State	2	75	0	6
					Nation	57	2,482	111	327
PSI-12 Q3 (2020) - Q2 (2022) Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate	6,002	3.65 (2.40, 4.89)	3.63	SAME	State	1	83	1	0
					Nation	16	2,902	74	135
PSI-13 Q3 (2020) - Q2 (2022) Postoperative Sepsis Rate	2,279	4.52 (2.39, 6.65)	5.28	SAME	State	0	73	0	10
					Nation	15	2,540	37	348
PSI-14 Q3 (2020) - Q2 (2022) Postoperative Wound Dehiscence Rate	1,304	4.37 (2.82, 5.93)	2.01	WORSE	State	0	76	2	6
					Nation	0	2,614	9	397
PSI-15 Q3 (2020) - Q2 (2022) Abdominopelvic Accidental Puncture or Laceration Rate	4,614	1.34 (0.62, 2.06)	1.10	SAME	State	0	83	0	2
					Nation	3	2,931	34	181
PSI-90	Not Applicable	1.01	1.00	SAME	State	3	81	1	N/A(5)

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate/ Value (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages			
					Better	Same	Worse	Too Few
Q3 (2020) - Q2 (2022) Patient Safety and Adverse Events Composite		(0.84, 1.18)			Nation	77	2,837	160	N/A(5)

Footnotes:

5. Results are not available for this reporting period.

Infections

	Predicted	Reported	Days / Procedure	Facility Ratio (95% conf. int.)	State Ratio (95% conf. int.)	National Ratio	National Compare
HAI-1 Q3 (2022) - Q2 (2023) Central Line Associated Bloodstream Infection (ICU + select Wards)	39.720	34	36,817	0.856 (0.602, 1.183)	0.974 (0.900, 1.052)	0.772	SAME
HAI-2 Q3 (2022) - Q2 (2023) Catheter Associated Urinary Tract Infections (ICU + select Wards)	35.164	33	24,366	0.938 (0.657, 1.303)	0.743 (0.681, 0.808)	0.610	SAME
HAI-3 Q3 (2022) - Q2 (2023) SSI - Colon Surgery	14.678	22	499	1.499 (0.963, 2.232)	1.050 (0.942, 1.166)	0.893	SAME
HAI-4 Q3 (2022) - Q2 (2023)	3.741	1	403	0.267 (0.013, 1.318)	0.858 (0.662, 1.095)	0.966	SAME

Infections

	Predicted	Reported	Days / Procedure	Facility Ratio (95% conf. int.)	State Ratio (95% conf. int.)	National Ratio	National Compare
SSI - Abdominal Hysterectomy							
HAI-5 Q3 (2022) - Q2 (2023) MRSA Bacteremia	29.601	18	283,798	0.608 (0.372, 0.942)	0.821 (0.738, 0.912)	0.800	BETTER
HAI-6 Q3 (2022) - Q2 (2023) Clostridium Difficile (C.Diff)	145.791	73	262,678	0.501 (0.395, 0.626)	0.366 (0.345, 0.388)	0.448	BETTER

Surgical Complications

	Eligible Discharges	Complication Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
COMP-HIP-KNEE Q2 (2019) - Q1 (2022) HIP/Knee Complication Rate (RSCR) following Total Hip/ Knee Arthroplasty	286	3.5% (2.3%, 5.4%)	3.2%	SAME	State	1	60	1	27
					Nation	24	2,102	7	1,225

Unplanned Hospital Visits

Condition Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-AMI Q3 (2019) - Q2 (2022) Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	851	14.5% (12.6%, 16.6%)	14%	SAME	State	1	47	0	49
					Nation	6	1,798	12	1,936
READM-30-HF Q3 (2019) - Q2 (2022) Heart Failure (HF) 30-day Readmission Rate	1,312	21.9% (20.0%, 24.0%)	20.2%	SAME	State	2	87	4	13
					Nation	58	3,066	63	1,334
READM-30-PN Q3 (2019) - Q2 (2022) Pneumonia (PN) 30-day Readmission Rate	517	17.7% (15.5%, 20.4%)	16.9%	SAME	State	0	97	0	9
					Nation	10	3,544	39	1,016
READM-30-COPD Q3 (2019) - Q2 (2022) Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate	273	18.5% (15.6%, 21.7%)	19.3%	SAME	State	0	85	0	20
					Nation	2	2,645	17	1,836

Procedure Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few

Procedure Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-CABG Q3 (2019) - Q2 (2022) Hospital-Level 30-day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft Surgery (CABG)	324	11.7% (9.4%, 14.6%)	11%	SAME	State	0	21	0	1
					Nation	0	878	4	215
READM-30-HIP-KNEE Q3 (2019) - Q2 (2022) 30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	252	4.5% (3.1%, 6.5%)	4.3%	SAME	State	0	62	0	26
					Nation	21	2,085	4	1,234

Hospital Wide Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-HOSPWIDE Q3 (2021) - Q2 (2022) 30-Day Hospital-Wide All-Cause Unplanned Readmission Rate	6,828	16.2% (14.9%, 16.9%)	14.6%	WORSE	State	10	95	2	1
					Nation	185	4,027	195	268

Inpatient Psychiatric Facility (IPF)- Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-IPF Q3 (2020) - Q2 (2022) Rate of readmission after discharge from hospital	349	20.9% (17.3%, 25.2%)	19.6%	SAME	State	2	38	0	4
					Nation	49	1,285	108	126

Procedure Specific Outcomes

	Eligible Discharges	Facility Rate/ Ratio	National Rate/ Ratio	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
OP-32 Q1 (2020) - Q4 (2022) Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy	597	14.4 (10.7, 19.6)	13.2	SAME	State	0	92	0	5
					Nation	11	3,254	5	505
OP-35_ADM Q1 (2022) - Q4 (2022) Admissions (ADM) for Patients Receiving Outpatient Chemotherapy	460	13.2 (10.9, 15.8)	10.3	WORSE	State	0	48	2	34
					Nation	14	1,447	61	1,825
OP-35_ED Q1 (2022) - Q4 (2022) Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	460	5.7 (4.3, 7.5)	5.4	SAME	State	0	50	0	34
					Nation	26	1,475	21	1,825
OP-36 Q1 (2022) - Q4 (2022)	1,463	0.7 (0.5, 0.8)	Not Applicable	BETTER	State	8	69	7	14
					Nation	211	2,438	228	941

Procedure Specific Outcomes

	Eligible Discharges	Facility Rate/ Ratio	National Rate/ Ratio	National Compare	Facility Compared to Averages			
					Better	Same	Worse	Too Few
Hospital Visits after Hospital Outpatient Surgery								

Excess Days in Acute Care

	Eligible Discharges	Patients Included	Returned to a Hospital	Measr. Days (95% int. limits)	Compare	Facility Compared to Averages (Days)				
							Fewer	Same	More	Too Few
EDAC-30-AMI Q3 (2019) - Q2 (2022) Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	851	816	221	17.8 (6.2, 30.2)	WORSE	State	4	30	5	58
						Nation	142	1,066	314	2,230
EDAC-30-HF Q3 (2019) - Q2 (2022) Excess Days in Acute Care after Hospitalization for Heart Failure	1,312	1,055	359	41.7 (27.3, 56.7)	WORSE	State	6	70	17	13
						Nation	338	2,243	606	1,334
EDAC-30-PN Q3 (2019) - Q2 (2022) Excess Days in Acute Care after Hospitalization for Pneumonia	517	477	136	31.2 (14.2, 50.4)	WORSE	State	14	62	21	9
						Nation	415	2,336	842	1,016

Payment & Value of Care

Payment

	Eligible Discharges	Facility Payment (95% conf. int.)	National Average Payment	National Compare	Facility Compared to Averages				
						Greater	Same	Less	Too Few
PAYM-30-AMI Q3 (2019) - Q2 (2022) Risk-Standardized Payment Associated with a 30-Day AMI Episode-of-Care for Acute Myocardial Infarction	780	$26,048 ($24,750, $27,468)	$27,314	SAME	State	0	50	3	42
					Nation	129	1,644	75	1,917
					Value of Care	Average Mortality and Average Payment			
PAYM-30-HF Q3 (2019) - Q2 (2022) Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure	1,040	$17,938 ($17,238, $18,688)	$18,764	BETTER	State	1	56	31	14
					Nation	346	2,334	275	1,431
					Value of Care	Worse Mortality and Lower Payment			
PAYM-30-PN Q3 (2019) - Q2 (2022) Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia	482	$18,907 ($17,899, $19,862)	$20,362	BETTER	State	0	61	32	9
					Nation	444	2,502	462	1,066
					Value of Care	Average Mortality and Lower Payment			
PAYM-90-HIP-KNEE Q2 (2019) - Q1 (2022) Risk-Standardized Payment Associated with a 90-Day Episode of Care for THA/ TKA	283	$20,125 ($19,188, $21,111)	$21,247	BETTER	State	2	35	23	26
					Nation	261	1,247	536	1,216
					Value of Care	Average Complications and Lower Payment			

Medicare Spending per Beneficiary

	Facility Rate	State Rate	National Rate	National Median Amount
MSPB-1 Q1 (2022) - Q4 (2022) Spending per hospital patient with Medicare	0.98	0.95	0.99	$25,753.96

Note:

A MSPB performance of greater than one indicates that your hospital's MSPB Amount is more expensive than the U.S. National Median MSPB Amount.
A MSPB performance of less than one indicates that your hospital's MSPB Amount is less expensive than the National Median Amount.

Follow-Up Care

Transition Records

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
TR1 Q1 (2022) - Q4 (2022) Transition Record with Specified Elements	63%	636	64%	62%	99%

Hospital-Based Inpatient Psychiatric Services

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
HBIPS-5 Q1 (2022) - Q4 (2022) Patients discharged on multiple antipsychotic medications with appropriate justification	75%	44	66%	58%	100%

Follow-up After Psychiatric Hospitalization

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
FAPH-7 Q3 (2021) - Q2 (2022) Follow-up after psychiatric hospitalization (7 days)	43.8%	146	34.1%	36.2%	54%
FAPH-30 Q3 (2021) - Q2 (2022) Follow-up after psychiatric hospitalization (30 days)	65.8%	146	58.1%	60%	77.9%

Medication Continuation Following Inpatient Psychiatric Discharge

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
MedCont Q3 (2020) - Q2 (2022) Medication Continuation Following Inpatient Psychiatric Discharge	81%	279	76%	76.3%	87%

Substance Use Treatment

Substance Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SUB-2 Q1 (2022) - Q4 (2022) Alcohol Use Brief Intervention Provided or Offered	76%	75	71%	61%	100%
SUB-2a Q1 (2022) - Q4 (2022) Alcohol Use Brief Intervention	76%	75	82%	77%	100%
SUB-3 Q1 (2022) - Q4 (2022) Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge	97%	215	88%	72%	100%
SUB-3a Q1 (2022) - Q4 (2022) Alcohol and other Drug Use Disorder Treatment Provided at Discharge	96%	215	79%	61%	99%

Tobacco Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
TOB-2 Q1 (2022) - Q4 (2022) Tobacco Use Treatment Provided or Offered	42%	284	78%	71%	99%
TOB-2a Q1 (2022) - Q4 (2022)	47%	230	50%	40%	87%

Tobacco Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
Tobacco Use Treatment (during the hospital stay)					
TOB-3 Q1 (2022) - Q4 (2022) Tobacco Use Treatment Provided or Offered at Discharge	73%	220	70%	58%	98%
TOB-3a Q1 (2022) - Q4 (2022) Tobacco Use Treatment at Discharge	69%	220	27%	16%	78%

Patient Safety

Hospital-Based Inpatient Psychiatric Services

		Rate	Hours	Days
HBIPS-2 Q1 (2022) - Q4 (2022) Hours of physical-restraint use	Facility	0.49	165.18	13,998
	State	0.40	6,834	703,527
	National	0.32	194,177.80	25,042,403
HBIPS-3 Q1 (2022) - Q4 (2022) Hours of seclusion	Facility	1.06	356.98	13,998
	State	0.15	2,614.86	703,527
	National	0.34	206,741.69	25,042,403

Preventive Care and Screening

Screening

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SMD Q1 (2022) - Q4 (2022) Screening for Metabolic Disorders	97%	340	87%	79%	100%

Immunization

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
IPFQR-IMM-2 Q4 (2022) - Q1 (2023) Influenza Immunization	95%	304	84%	77%	99%

Use of Medical Imaging

Imaging Efficiency

	Number of Patients	Facility Rate	State Rate	National Rate
OP-8 Q3 (2021) - Q2 (2022) MRI Lumbar Spine for Low Back Pain	66	27.3%	35.1%	37.1%
OP-10 Q3 (2021) - Q2 (2022) Abdomen CT - Use of Contrast Material	1,554	2.1%	5.1%	6%
OP-13 Q3 (2021) - Q2 (2022) Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	71	2.8%	3.4%	3.8%
OP-39 Q3 (2021) - Q2 (2022) Breast Cancer Screening Recall Rates	106	10.4%	7.4%	9.2%

Hospital Compare Preview Report
ECU HEALTH MEDICAL CENTER

2100 STANTONSBURG RD
GREENVILLE, NC 27834

CCN-340040
(252) 847-4100

Facility Type:	Short-term
Ownership Type:	Voluntary non-profit - Private
Emergency Service:	Yes

Survey of Patients' Experience

Attention: Individual question scores appear only in the Preview Report and downloadable databases. Individual question scores are presented for informational purposes only; they are not official HCAHPS measures. A simple average of the individual questions that comprises a composite measure may not always match the composite score.

HCAHPS individual question scores based on fewer than 50 completed surveys **will not** be reported in the downloadable database.

HCAHPS Summary Star Rating

Completed Surveys	2,175
Survey Response Rate	17%

Star Rating:

More stars are better
"For more information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org"

*When HCAHPS scores are based on fewer than 25 completed surveys, scores WILL NOT be reported on Hospital Compare.

Communication with Nurses

Q3 (2023) - Q2 (2024)

Linear Score (1 - 100): 90

Composite (Q1 - Q3)	Facility	State	National
Always Patients who reported that their	77%	80%	80%

Communication with Nurses

Q3 (2023) - Q2 (2024)

★★★★★ Linear Score (1 - 100): 90

nurses 'Always' communicated well			
Usually Patients who reported that their nurses 'Usually' communicated well	18%	16%	16%
Sometimes/Never Patients who reported that their nurses 'Sometimes' or 'Never' communicated well	5%	4%	4%
Nurse Courtesy & Respect (Q1)	Facility	State	National
Always Patients who reported that their nurses "Always" treated them with courtesy and respect	84%	86%	87%
Usually Patients who reported that their nurses "Usually" treated them with courtesy and respect	12%	11%	10%
Sometimes/Never Patients who reported that their nurses "Sometimes" or "Never" treated them with courtesy and respect	4%	3%	3%
Nurse Listen (Q2)	Facility	State	National
Always Patients who reported that their nurses "Always" listened carefully to them	74%	78%	77%

Communication with Nurses

Q3 (2023) - Q2 (2024)

★★★★★ Linear Score (1 - 100): 90

Usually Patients who reported that their nurses "Usually" listened carefully to them	21%	17%	18%
Sometimes/Never Patients who reported that their nurses "Sometimes" or "Never" listened carefully to them	5%	5%	5%
Nurse Explain (Q3)	Facility	State	National
Always Patients who reported that their nurses "Always" explained things in a way they could understand	74%	76%	75%
Usually Patients who reported that their nurses "Usually" explained things in a way they could understand	20%	19%	20%
Sometimes/Never Patients who reported that their nurses "Sometimes" or "Never" explained things in a way they could understand	6%	5%	5%

Star Rating:

More stars are better
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Communication with Doctors

Q3 (2023) - Q2 (2024)

★★★★★ Linear Score (1 - 100): 91

Composite (Q5 - Q7)	Facility	State	National

Communication with Doctors

Q3 (2023) - Q2 (2024)

Always Patients who reported that their doctors 'Always' communicated well	78%	81%	80%
Usually Patients who reported that their doctors 'Usually' communicated well	17%	14%	15%
Sometimes/Never Patients who reported that their doctors 'Sometimes' or 'Never' communicated well	5%	5%	5%
Doctor Courtesy & Respect (Q5)	Facility	State	National
Always Patients who reported that their doctors "Always" treated them with courtesy and respect	84%	87%	86%
Usually Patients who reported that their doctors "Usually" treated them with courtesy and respect	12%	10%	11%
Sometimes/Never Patients who reported that their doctors "Sometimes" or "Never" treated them with courtesy and respect	4%	3%	3%
Doctor Listen (Q6)	Facility	State	National
Always Patients who reported that their doctors "Always" listened	77%	80%	79%

Communication with Doctors

Q3 (2023) - Q2 (2024)

carefully to them			
Usually Patients who reported that their doctors "Usually" listened carefully to them	17%	15%	16%
Sometimes/Never Patients who reported that their doctors "Sometimes" or "Never" listened carefully to them	6%	5%	5%
Doctor Explain (Q7)	Facility	State	National
Always Patients who reported that their doctors "Always" explained things in a way they could understand	74%	76%	75%
Usually Patients who reported that their doctors "Usually" explained things in a way they could understand	20%	18%	19%
Sometimes/Never Patients who reported that their doctors "Sometimes" or "Never" explained things in a way they could understand	6%	6%	6%

Star Rating:

More stars are better

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Responsiveness of Hospital Staff

Q3 (2023) - Q2 (2024)

Composite (Q4 & Q11)	Facility	State	National
Always Patients who reported that they 'Always' received help as soon as they wanted	58%	64%	67%
Usually Patients who reported that they 'Usually' received help as soon as they wanted	28%	25%	24%
Sometimes/Never Patients who reported that they 'Sometimes' or 'Never' received help as soon as they wanted	14%	11%	9%
Call Button (Q4)	Facility	State	National
Always Patients who reported that they "Always" received help after using the call button as soon as they wanted	58%	63%	65%
Usually Patients who reported that they "Usually" received help after using the call button as soon as they wanted	29%	27%	26%
Sometimes/Never Patients who reported that they "Sometimes" or "Never" received help after using the call button as soon as they wanted	13%	10%	9%
Bathroom Help (Q11)	Facility	State	National

Responsiveness of Hospital Staff

Q3 (2023) - Q2 (2024)

Always Patients who reported that they "Always" received bathroom help as soon as they wanted	59%	64%	67%
Usually Patients who reported that they "Usually" received bathroom help as soon as they wanted	26%	24%	23%
Sometimes/Never Patients who reported that they "Sometimes" or "Never" received bathroom help as soon as they wanted	15%	12%	10%

Star Rating:

More stars are better

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Communication About Medicines

Q3 (2023) - Q2 (2024)

Composite (Q13 - Q14)	Facility	State	National
Always Patients who reported that staff 'Always' explained about medicines before giving it to them	59%	61%	62%
Usually Patients who reported that staff 'Usually' explained about medicines before giving it to	19%	19%	19%

Communication About Medicines

Q3 (2023) - Q2 (2024)

them			
Sometimes/Never Patients who reported that staff 'Sometimes' or 'Never' explained about medicines before giving it to them	22%	20%	19%
Medicine Explain (Q13)	Facility	State	National
Always Patients who reported that when receiving new medication the staff "Always" communicated what the medication was for	73%	75%	75%
Usually Patients who reported that when receiving new medication the staff "Usually" communicated what the medication was for	16%	16%	16%
Sometimes/Never Patients who reported that when receiving new medication the staff "Sometimes" or "Never" communicated what the medication was for	11%	9%	9%
Side Effects (Q14)	Facility	State	National
Always Patients who reported that when receiving new medication the staff "Always" discussed possible side effects	46%	47%	48%
Usually Patients who reported that when	21%	22%	23%

Communication About Medicines

Q3 (2023) - Q2 (2024)

★★★☆☆ Linear Score (1 - 100): 76

	Facility	State	National
receiving new medication the staff "Usually" discussed possible side effects			
Sometimes/Never Patients who reported that when receiving new medication the staff "Sometimes" or "Never" discussed possible side effects	33%	31%	29%

Star Rating:

More stars are better

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Cleanliness of Hospital Environment

Q3 (2023) - Q2 (2024)

★★☆☆☆ Linear Score (1 - 100): 81

	Facility	State	National
Always Patients who reported that their room and bathroom were 'Always' clean	61%	71%	74%
Usually Patients who reported that their room and bathroom were 'Usually' clean	23%	18%	17%
Sometimes/Never Patients who reported that their room and bathroom were 'Sometimes' or 'Never' clean	16%	11%	9%

Star Rating:

More stars are better

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Quietness of Hospital

Q3 (2023) - Q2 (2024)

Linear Score (1 - 100): 82

	Facility	State	National
Always Patients who reported that the area around their room was 'Always' quiet at night	58%	62%	62%
Usually Patients who reported that the area around their room was 'Usually' quiet at night	31%	29%	29%
Sometimes/Never Patients who reported that the area around their room was 'Sometimes' or 'Never' quiet at night	11%	9%	9%

Star Rating:

More stars are better

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Discharge Information

Q3 (2023) - Q2 (2024)

Linear Score (1 - 100): 85

Composite (Q16 - Q17)	Facility	State	National
Yes Patients who reported that YES, they were given information about what to do during their recovery at home	85%	87%	86%

Discharge Information

Q3 (2023) - Q2 (2024)

★★★★★ Linear Score (1 - 100): 85

No Patients who reported that NO, they were not given information about what to do during their recovery at home	15%	13%	14%
Help After Discharge (Q16)	Facility	State	National
Yes Patients who reported that YES, they did discuss whether they would need help after discharge	85%	86%	85%
No Patients who reported that NO, they did not discuss whether they would need help after discharge	15%	14%	15%
Symptoms (Q17)	Facility	State	National
Yes Patients who reported that YES, they did receive written information about possible symptoms to look out for after discharge	86%	87%	88%
No Patients who reported that NO, they did not receive written information about possible symptoms to look out for after discharge	14%	13%	12%

Star Rating:

More stars are better

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Care Transition

Q3 (2023) - Q2 (2024)

Composite (Q20 - Q22)	Facility	State	National
Strongly Agree Patients who 'Strongly Agree' they understood their care when they left the hospital	50%	52%	52%
Agree Patients who 'Agree' they understood their care when they left the hospital	44%	42%	42%
Disagree/Strongly Disagree Patients who 'Disagree' or 'Strongly Disagree' they understood their care when they left the hospital	6%	6%	6%
Preference (Q20)	**Facility**	**State**	**National**
Strongly Agree Patients who "Strongly Agree" that the staff took my preferences into account when determining their health care needs	44%	46%	46%
Agree Patients who "Agree" that the staff took my preferences into account when determining my health care their needs	49%	47%	47%
Disagree/Strongly Disagree Patients who "Disagree" or "Strongly Disagree" that the staff	7%	7%	7%

Care Transition

Q3 (2023) - Q2 (2024)

took my preferences into account when determining their health care needs

Understanding (Q21)	Facility	State	National
Strongly Agree Patients who "Strongly Agree" that they understood their responsiblities in managing their health	50%	51%	52%
Agree Patients who "Agree" that they understood their responsiblities in managing their health	44%	44%	43%
Disagree/Strongly Disagree Patients who "Disagree" or "Strongly Disagree" that they understood their responsiblities in managing their health	6%	5%	5%

Medicine Purpose (Q22)	Facility	State	National
Strongly Agree Patients who "Strongly Agree" that they understood the purposes of their medications when leaving the hospital	55%	59%	59%
Agree Patients who "Agree" that they understood the purposes of their medications when leaving the hospital	38%	36%	36%
Disagree/Strongly	7%	5%	5%

Care Transition

Q3 (2023) - Q2 (2024)

★★★☆☆ Linear Score (1 - 100): 80

Disagree
Patients who "Disagree" or "Strongly Disagree" that they understood the purposes of their medications when leaving the hospital

Star Rating:

More stars are better
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Overall Hospital Rating

Q3 (2023) - Q2 (2024)

★★★☆☆ Linear Score (1 - 100): 87

	Facility	State	National
0-6 Rating Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)	9%	8%	8%
7-8 Rating Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)	22%	21%	20%
9-10 Rating Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	69%	71%	72%

Star Rating:

More stars are better
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Willingness to Recommend this Hospital

Q3 (2023) - Q2 (2024)

	Facility	State	National
Definitely Yes Patients who reported YES, they would definitely recommend the hospital	69%	69%	70%
Probably Patients who reported YES, they would probably recommend the hospital	25%	25%	24%
Definitely No Patients who reported NO, they would probably not or definitely not recommend the hospital	6%	6%	6%

Star Rating:

More stars are better

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Timely and Effective Care

Sepsis

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SEP-1 Q3 (2023) - Q2 (2024) Severe Sepsis and Septic Shock	42%(2)	99(2)	62%(25,26)	63%(25,26)	84%(25,26)
SEV-SEP-3HR Q3 (2023) - Q2 (2024) Severe Sepsis 3-Hour Bundle	63%(2)	99(2)	80%(25,26)	81%(25,26)	93%(25,26)
SEV-SEP-6HR Q3 (2023) - Q2 (2024) Severe Sepsis 6-Hour Bundle	98%(2)	42(2)	93%(25,26)	91%(25,26)	100%(25,26)
SEP-SH-3HR Q3 (2023) - Q2 (2024) Septic Shock 3-Hour Bundle	45%(2)	31(2)	71%(25,26)	71%(25,26)	96%(25,26)
SEP-SH-6HR Q3 (2023) - Q2 (2024) Septic Shock 6-Hour Bundle	91%(2)	11(2)	84%(25,26)	85%(25,26)	100%(25,26)

Footnotes:

2. Data submitted were based on a sample of cases/patients.
25. State and national averages include Veterans Health Administration (VHA) hospital data.
26. State and national averages include Department of Defense (DoD) hospital data.

Emergency Department Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%

Emergency Department Care

		Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-18b Q3 (2023) - Q2 (2024) Median Time from ED Arrival to ED Departure for Discharged ED Patients An EDV-1 indicator will be shown in the volume category row of your facility.		268 mins.	389	195 mins.(25,26)	163 mins.(25,26)	100 mins.(25,26)
	Low Volume	-	-	146 mins.(25,26)	122 mins.(25,26)	-
	Medium Volume	-	-	180 mins.(25,26)	175 mins.(25,26)	-
	High Volume	-	-	189 mins.(25,26)	215 mins.(25,26)	-
	Very High Volume	EDV-1	-	211 mins.(25,26)	193 mins.(25,26)	-
OP-18c Q3 (2023) - Q2 (2024) Median Time from ED Arrival to ED Departure for Discharged ED Patients - Psychiatric/Mental Health Patients An EDV-1 indicator will be shown in the volume category row of your facility.		540 mins.	11	315 mins.(25)	267 mins.(25)	131 mins.(25)
	Low Volume	-	-	292 mins.(25)	195 mins.(25)	-
	Medium Volume	-	-	340 mins.(25)	272 mins.(25)	-
	High Volume	-	-	383 mins.(25)	359 mins.(25)	-
	Very High Volume	EDV-1	-	316 mins.(25)	320 mins.(25)	-
OP-22 Q1 (2023) - Q4 (2023) Left Without Being Seen		5%	130,071	3%(25,26)	2%(25,26)	0%(25,26)
OP-23 Q3 (2023) - Q2 (2024) Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival		30%	20	71%(25)	70%(25)	100%(25)

Emergency Department Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
ED-2-Strata-1 Q1 (2023) - Q4 (2023) Admit Decision Time to ED Departure Time for Admitted Patients - non psychiatric/ mental health disorders	N/A(5)	N/A(5)	149 mins.	114 mins.	15 mins.
ED-2-Strata-2 Q1 (2023) - Q4 (2023) Admit Decision Time to ED Departure Time for Admitted Patients – psychiatric/mental health disorders	N/A(5)	N/A(5)	254 mins.	108 mins.	19 mins.

Footnotes:

5. Results are not available for this reporting period.
25. State and national averages include Veterans Health Administration (VHA) hospital data.
26. State and national averages include Department of Defense (DoD) hospital data.

Healthcare Personnel Vaccination

	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
IMM-3 Q4 (2023) - Q1 (2024) Influenza Vaccination Coverage among Healthcare Personnel	97%	91%	80%
HCP_COVID-19 Q2 (2024) - Q2 (2024) COVID-19 Vaccination Coverage Among Healthcare Personnel	2.9%	9.9%	12.4%
IPFQR-HCP_COVID-19	3.2%	3.7%	14.2%

Healthcare Personnel Vaccination

	Facility's Adherence Rate	State Adherence Rate	National Adherence Rate
Q2 (2024) - Q2 (2024) COVID-19 Vaccination Coverage Among Healthcare Personnel			

Cardiac Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-40 Q1 (2023) - Q4 (2023) ST-Segment Elevation Myocardial Infarction (STEMI)	N/A(5)	N/A(5)	32%	46%	69%

Footnotes:

5. Results are not available for this reporting period.

Cataracts

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-31 Q1 (2023) - Q4 (2023) Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	N/A(5)	N/A(5)	N/A(5)	98%	100%

Footnotes:

5. Results are not available for this reporting period.

Colonoscopy

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
OP-29 Q1 (2023) - Q4 (2023) Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	94%	188	94%(25,26)	92%(25,26)	100%(25,26)

Footnotes:

25. State and national averages include Veterans Health Administration (VHA) hospital data.
26. State and national averages include Department of Defense (DoD) hospital data.

Opioid Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
Safe Use of Opioids Q1 (2023) - Q4 (2023) Safe Use of Opioids – Concurrent Prescribing	17%	10,642	16%	15%	8%

Venous Thromboembolism

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
VTE-1 Q1 (2023) - Q4 (2023) Venous Thromboembolism Prophylaxis	N/A(5)	N/A(5)	90%(25)	88%(25)	99%(25)
VTE-2 Q1 (2023) - Q4 (2023) Intensive Care Unit Venous Thromboembolism Prophylaxis	N/A(5)	N/A(5)	95%(25)	94%(25)	100%(25)

Footnotes:

5. Results are not available for this reporting period.
25. State and national averages include Veterans Health Administration (VHA) hospital data.

Stroke Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
STK-02 Q1 (2023) - Q4 (2023) Discharged on Antithrombotic Therapy	97%	574	98%(25)	96%(25)	100%(25)
STK-03 Q1 (2023) - Q4 (2023) Anticoagulation Therapy for Atrial Fibrillation/Flutter	N/A(5)	N/A(5)	73%	74%	100%
STK-05 Q1 (2023) - Q4 (2023) Antithrombotic Therapy by End of Hospital Day 2	N/A(5)	N/A(5)	94%	92%	100%
STK-06 Q1 (2023) - Q4 (2023) Discharged on Statin Medication	N/A(5)	N/A(5)	96%(25)	95%(25)	100%(25)

Footnotes:

5. Results are not available for this reporting period.
25. State and national averages include Veterans Health Administration (VHA) hospital data.

Hospital Harm

	Facility Rate	Patients/Days	State Rate	National Rate	Top 10%
HH-01 Q1 (2023) - Q4 (2023) Hospital Harm - Severe Hypoglycemia	N/A(5)	N/A(5)	1%	1%	0%

Hospital Harm

	Facility Rate	Patients/Days	State Rate	National Rate	Top 10%
HH-02 Q1 (2023) - Q4 (2023) Hospital Harm - Severe Hyperglycemia	N/A(5)	N/A(5)	4%	7%	0%

Footnotes:

5. Results are not available for this reporting period.

Maternal Health

Structural Measures

	Measure Response
SM-7 Q1 (2023) - Q4 (2023) Maternal Morbidity Structural Measure	Yes

Perinatal Care

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
PC-05 Q1 (2023) - Q4 (2023) Exclusive Breast Milk Feeding	N/A(5)	N/A(5)	25%	53%	84%
ePC-02 Q1 (2023) - Q4 (2023) Cesarean Birth	26%	1,217	25%	26%	14%
	Facility Risk-Adjusted Rate (per 10,000)	Number of Patients	State Rate (per 10,000)	National Rate (per 10,000)	Top 10% (per 10,000)
ePC-07a Q1 (2023) - Q4 (2023) Risk Adjusted Severe Obstetric Complications (All)	322	3,981	337	237	80
ePC-07b Q1 (2023) - Q4 (2023) Risk Adjusted Severe Obstetric Complications (excluding blood-transfusion-only cases)	80	3,981	61	57	33

Footnotes:

5. Results are not available for this reporting period.

Health Equity

Hospital Commitment to Health Equity

Total facility score: 5 out of 5 points

Score	0 of 5	1 of 5	2 of 5	3 of 5	4 of 5	5 of 5
State	0/100 (0%)	0/100 (0%)	4/100 (4%)	3/100 (3%)	5/100 (5%)	87/100 (87%)
National	2/100 (2%)	4/100 (4%)	4/100 (4%)	6/100 (6%)	10/100 (10%)	74/100 (74%)

Domain 1: Equity is a strategic priority	Facility	State	National
Earned Point?	Yes	95%	87%

Our strategic plan...	Facility	State (% yes)	National (% yes)
...identifies priority populations who currently experience health disparities.	Yes	95%	92%
...identifies healthcare equity goals and discrete action steps to achieving these goals.	Yes	95%	90%
	Yes	95%	90%

Our strategic plan...	Facility	State (% yes)	National (% yes)
...outlines specific resources which have been dedicated to achieving our equity goals.			
...describes our approach for engaging key stakeholders, such as community-based organizations.	Yes	95%	89%

Domain 2: Data collection	Facility	State	National
Earned Point?	Yes	95%	91%

Our hospital...	Facility	State (% yes)	National (% yes)
...collects demographic information (such as self-reported race, national origin, primary language, and ethnicity data) and/or social determinant of health information on the majority of our patients.	Yes	100%	99%
...has training for staff in culturally sensitive collection of demographic and/or	Yes	95%	93%

Our hospital...	Facility	State (% yes)	National (% yes)
social determinant of health information.			
...inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.	Yes	100%	97%

Domain 3: Data analysis	Facility	State	National
Earned Point?	Yes	97%	85%

Our hospital...	Facility	State (% yes)	National (% yes)
...stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.	Yes	97%	85%

Domain 4: Quality improvement	Facility	State	National
	Yes	100%	95%

Domain 4: Quality improvement	Facility	State	National
Earned Point?			

Our hospital...	Facility	State (% yes)	National (% yes)
...participates in local, regional, or national quality improvement activities focused on reducing health disparities.	Yes	100%	95%

Domain 5: Leadership engagement	Facility	State	National
Earned Point?	Yes	89%	82%

Our hospital senior leadership, including chief executives and the entire hospital board of trustees...	Facility	State (% yes)	National (% yes)
...annually reviews our strategic plan for achieving health equity.	Yes	95%	87%
...annually reviews key performance indicators stratified by demographic and/or social factors.	Yes	93%	83%

Complications & Deaths

30 Day Death Rates

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
MORT-30-AMI Q3 (2020) - Q2 (2023) Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	897	14.3% (12.4%, 16.5%)	12.6%	SAME	State	2	54	1	45
					Nation	29	1,966	28	1,929
MORT-30-HF Q3 (2020) - Q2 (2023) Heart Failure (HF) 30-Day Mortality Rate	1,278	13.3% (11.6%, 15.2%)	11.9%	SAME	State	4	86	3	12
					Nation	288	2,809	126	1,276
MORT-30-PN Q3 (2020) - Q2 (2023) Pneumonia 30-Day Mortality Rate	628	19.9% (17.1%, 23.1%)	17.9%	SAME	State	8	80	11	6
					Nation	326	3,235	185	819
MORT-30-STK Q3 (2020) - Q2 (2023) Acute Ischemic Stroke (STK) 30-Day Mortality Rate	759	14.9% (13.0%, 17.2%)	13.9%	SAME	State	2	78	0	18
					Nation	99	2,104	47	1,817
MORT-30-COPD Q3 (2020) - Q2 (2023) Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	292	10.3% (7.9%, 13.5%)	9.4%	SAME	State	0	84	1	20
					Nation	46	2,620	32	1,771
MORT-30-CABG Q3 (2020) - Q2 (2023) 30-Day All-Cause Mortality Following Coronary Artery	404	2.2% (1.4%, 3.7%)	2.8%	SAME	State	0	19	1	2
					Nation	10	872	14	188

30 Day Death Rates

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages			
					Better	Same	Worse	Too Few
Bypass Graft (CABG) Surgery								

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate/ Value (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
PSI 03 Q3 (2021) - Q2 (2023) Pressure ulcer rate	17,196	1.21 (0.86, 1.56)	0.65	WORSE	State	2	79	7	0
					Nation	55	2,939	213	55
PSI 04 Q3 (2021) - Q2 (2023) Death rate among surgical inpatients with serious treatable complications	294	169.74 (138.88, 200.61)	176.55	SAME	State	1	38	3	34
					Nation	48	1,484	46	1,043
PSI 06 Q3 (2021) - Q2 (2023) Iatrogenic pneumothorax rate	18,765	0.30 (0.14, 0.47)	0.25	SAME	State	0	88	0	0
					Nation	0	3,223	14	30
PSI 08 Q3 (2021) - Q2 (2023) In-hospital fall-associated fracture rate	19,524	0.42 (0.26, 0.58)	0.29	SAME	State	0	88	0	0
					Nation	0	3,233	4	30
PSI 09 Q3 (2021) - Q2 (2023) Postoperative hemorrhage	4,850	1.47 (0.34, 2.59)	2.44	SAME	State	1	83	0	1
					Nation	15	2,874	44	145

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate/ Value (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
or hematoma rate									
PSI 10 Q3 (2021) - Q2 (2023) Postoperative acute kidney injury requiring dialysis rate	1,990	0.74 (0, 1.81)	1.69	SAME	State	0	72	0	12
					Nation	3	2,534	19	370
PSI 11 Q3 (2021) - Q2 (2023) Postoperative respiratory failure rate	1,945	2.91 (0, 6.5)	10.26	BETTER	State	2	69	1	11
					Nation	49	2,422	103	361
PSI 12 Q3 (2021) - Q2 (2023) Perioperative pulmonary embolism or deep vein thrombosis rate	5,510	4.93 (3.55, 6.32)	3.91	SAME	State	0	83	1	1
					Nation	16	2,848	78	139
PSI 13 Q3 (2021) - Q2 (2023) Postoperative sepsis rate	1,983	2.81 (0.41, 5.2)	5.58	BETTER	State	1	68	0	13
					Nation	14	2,450	36	388
PSI 14 Q3 (2021) - Q2 (2023) Postoperative wound dehiscence rate	1,193	2.63 (1.22, 4.04)	1.87	SAME	State	0	76	0	7
					Nation	0	2,563	4	415
PSI 15 Q3 (2021) - Q2 (2023) Abdominopelvic accidental puncture or laceration rate	4,263	1.01 (0.4, 1.61)	0.89	SAME	State	0	84	0	1
					Nation	1	2,904	22	185
PSI 90 Q3 (2021) - Q2 (2023)	Not Applicable	0.90 (0.72, 1.07)	1.00	SAME	State	2	80	3	N/A(5)
					Nation	85	2,772	171	N/A(5)

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate/ Value (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages			
					Better	Same	Worse	Too Few
CMS Medicare PSI 90: Patient safety and adverse events composite								

Footnotes:

5. Results are not available for this reporting period.

Infections

	Predicted	Reported	Days / Procedure	Facility Ratio (95% conf. int.)	State Ratio (95% conf. int.)	National Ratio	National Compare
HAI-1 Q3 (2023) - Q2 (2024) Central Line Associated Bloodstream Infection (ICU + select Wards)	29.073	20	28,621	0.688 (0.432, 1.044)	0.843 (0.773, 0.917)	0.685	SAME
HAI-2 Q3 (2023) - Q2 (2024) Catheter Associated Urinary Tract Infections (ICU + select Wards)	25.506	19	20,506	0.745 (0.462, 1.142)	0.597 (0.541, 0.656)	0.553	SAME
HAI-3 Q3 (2023) - Q2 (2024) SSI - Colon Surgery	14.807	17	514	1.148 (0.691, 1.801)	0.918 (0.818, 1.028)	0.873	SAME
HAI-4 Q3 (2023) - Q2 (2024) SSI - Abdominal	3.979	4	425	1.005 (0.319, 2.425)	1.037 (0.813, 1.304)	1.110	SAME

Infections

	Predicted	Reported	Days / Procedure	Facility Ratio (95% conf. int.)	State Ratio (95% conf. int.)	National Ratio	National Compare
Hysterectomy							
HAI-5 Q3 (2023) - Q2 (2024) MRSA Bacteremia	25.307	19	289,221	0.751 (0.465, 1.151)	0.770 (0.690, 0.857)	0.731	SAME
HAI-6 Q3 (2023) - Q2 (2024) Clostridium Difficile (C.Diff)	146.394	35	265,933	0.239 (0.169, 0.329)	0.338 (0.318, 0.359)	0.400	BETTER

Surgical Complications

	Eligible Discharges	Complication Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
COMP-HIP-KNEE Q3 (2020) - Q1 (2023) HIP/Knee Complication Rate (RSCR) following Total Hip/ Knee Arthroplasty	175	5.4% (3.4%, 8.2%)	3.5%	SAME	State	2	53	0	31
					Nation	27	1,723	8	1,498

Unplanned Hospital Visits

Condition Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-AMI Q3 (2020) - Q2 (2023) Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	943	13.7% (11.9%, 15.5%)	13.7%	SAME	State	1	48	0	50
					Nation	8	1,853	13	1,895
READM-30-HF Q3 (2020) - Q2 (2023) Heart Failure (HF) 30-day Readmission Rate	1,523	21.5% (19.7%, 23.4%)	19.8%	SAME	State	3	91	1	10
					Nation	63	3,157	56	1,234
READM-30-PN Q3 (2020) - Q2 (2023) Pneumonia (PN) 30-day Readmission Rate	631	17.4% (15.1%, 19.9%)	16.4%	SAME	State	1	99	0	5
					Nation	23	3,664	55	825
READM-30-COPD Q3 (2020) - Q2 (2023) Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate	348	18.2% (15.6%, 21.0%)	18.5%	SAME	State	0	86	0	19
					Nation	1	2,721	17	1,733

Procedure Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few

Procedure Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-CABG Q3 (2020) - Q2 (2023) Hospital-Level 30-day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft Surgery (CABG)	388	10.8% (8.7%, 13.3%)	10.7%	SAME	State	0	20	0	2
					Nation	2	888	3	189
READM-30-HIP-KNEE Q3 (2020) - Q2 (2023) 30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	194	6.2% (4.4%, 9.0%)	4.5%	SAME	State	1	55	0	30
					Nation	29	1,793	5	1,438

Hospital Wide Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-HOSPWIDE Q3 (2022) - Q2 (2023) 30-Day Hospital-Wide All-Cause Unplanned Readmission Rate	6,798	15.5% (14.7%, 16.1%)	14.6%	WORSE	State	7	94	4	2
					Nation	116	4,062	188	287

Inpatient Psychiatric Facility (IPF)- Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate/ Value	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
READM-30-IPF Q3 (2021) - Q2 (2023) Rate of readmission after discharge from hospital	276	16.5% (13.0%, 20.7%)	19.4%	SAME	State	1	39	0	3
					Nation	45	1,261	98	143

Procedure Specific Outcomes

	Eligible Discharges	Facility Rate/ Ratio	National Rate/ Ratio	National Compare	Facility Compared to Averages				
						Better	Same	Worse	Too Few
OP-32 Q1 (2021) - Q4 (2023) Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy	803	14.3 (10.9, 18.5)	13	SAME	State	0	91	0	6
					Nation	10	3,299	2	483
OP-35_ADM Q1 (2023) - Q4 (2023) Admissions (ADM) for Patients Receiving Outpatient Chemotherapy	433	13.5 (11.2, 16.3)	10.6	WORSE	State	1	46	1	38
					Nation	18	1,433	73	1,821
OP-35_ED Q1 (2023) - Q4 (2023) Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	433	5.3 (4, 7.1)	5.5	SAME	State	3	45	0	38
					Nation	32	1,471	21	1,821
OP-36 Q1 (2023) - Q4 (2023)	1,621	0.7 (0.5, 0.8)	Not Applicable	BETTER	State	10	65	9	13
					Nation	318	2,196	297	937

Procedure Specific Outcomes

	Eligible Discharges	Facility Rate/ Ratio	National Rate/ Ratio	National Compare	Facility Compared to Averages			
					Better	Same	Worse	Too Few
Hospital Visits after Hospital Outpatient Surgery								

Excess Days in Acute Care

	Eligible Discharges	Patients Included	Returned to a Hospital	Measr. Days (95% int. limits)	Compare	Facility Compared to Averages (Days)				
							Fewer	Same	More	Too Few
EDAC-30-AMI Q3 (2020) - Q2 (2023) Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	943	905	233	11.7 (0, 24.5)	SAME	State	2	34	3	60
						Nation	126	1,248	223	2,172
EDAC-30-HF Q3 (2020) - Q2 (2023) Excess Days in Acute Care after Hospitalization for Heart Failure	1,523	1,201	405	41.9 (27.9, 56.7)	WORSE	State	9	69	17	10
						Nation	300	2,481	495	1,234
EDAC-30-PN Q3 (2020) - Q2 (2023) Excess Days in Acute Care after Hospitalization for Pneumonia	631	573	152	22.5 (6.2, 40.1)	WORSE	State	14	67	19	5
						Nation	393	2,649	700	825

Payment & Value of Care

Payment

	Eligible Discharges	Facility Payment (95% conf. int.)	National Average Payment	National Compare	Facility Compared to Averages				
						Greater	Same	Less	Too Few
PAYM-30-AMI Q3 (2020) - Q2 (2023) Risk-Standardized Payment Associated with a 30-Day AMI Episode-of-Care for Acute Myocardial Infarction	870	$27,871 ($26,538, $29,350)	$28,355	SAME	State	2	46	5	44
					Nation	157	1,647	106	1,876
					Value of Care	Average Mortality and Average Payment			
PAYM-30-HF Q3 (2020) - Q2 (2023) Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure	1,227	$18,579 ($17,888, $19,287)	$19,602	BETTER	State	1	50	37	13
					Nation	419	2,284	341	1,328
					Value of Care	Average Mortality and Lower Payment			
PAYM-30-PN Q3 (2020) - Q2 (2023) Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia	587	$19,884 ($18,924, $20,860)	$21,120	BETTER	State	0	54	40	7
					Nation	500	2,467	598	873
					Value of Care	Average Mortality and Lower Payment			
PAYM-90-HIP-KNEE Q3 (2020) - Q1 (2023) Risk-Standardized Payment Associated with a 90-Day Episode of Care for THA/TKA	170	$23,087 ($21,543, $24,693)	$22,530	SAME	State	0	30	23	30
					Nation	198	996	473	1,491
					Value of Care	Average Complications and Average Payment			

Medicare Spending per Beneficiary

	Facility Rate	State Rate	National Rate	National Median Amount
MSPB-1 Q1 (2023) - Q4 (2023) Spending per hospital patient with Medicare	0.98	0.95	0.99	$26,516.28

Note:

A MSPB performance of greater than one indicates that your hospital's MSPB Amount is more expensive than the U.S. National Median MSPB Amount.
A MSPB performance of less than one indicates that your hospital's MSPB Amount is less expensive than the National Median Amount.

Follow-Up Care

Transition Records

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
TR1 Q1 (2023) - Q4 (2023) Transition Record with Specified Elements	70%	635	54%	63%	99%

Follow-up After Psychiatric Hospitalization

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
FAPH-7 Q3 (2022) - Q2 (2023) Follow-up after psychiatric hospitalization (7 days)	56.7%	104	33.3%	35.7%	53.8%
FAPH-30 Q3 (2022) - Q2 (2023) Follow-up after psychiatric hospitalization (30 days)	74%	104	58.2%	59.5%	76.9%

Medication Continuation Following Inpatient Psychiatric Discharge

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
MedCont Q3 (2021) - Q2 (2023) Medication Continuation Following Inpatient Psychiatric Discharge	85.9%	206	78.6%	77.8%	88.4%

Substance Use Treatment

Substance Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SUB-2 Q1 (2023) - Q4 (2023) Alcohol Use Brief Intervention Provided or Offered	91%	82	65%	58%	100%
SUB-2a Q1 (2023) - Q4 (2023) Alcohol Use Brief Intervention	93%	81	83%	76%	100%
SUB-3 Q1 (2023) - Q4 (2023) Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge	97%	237	86%	71%	100%
SUB-3a Q1 (2023) - Q4 (2023) Alcohol and other Drug Use Disorder Treatment Provided at Discharge	97%	237	79%	59%	99%

Tobacco Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
TOB-3 Q1 (2023) - Q4 (2023) Tobacco Use Treatment Provided or Offered at Discharge	46%	213	65%	56%	97%
TOB-3a	41%	213	27%	16%	80%

Tobacco Use

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
Q1 (2023) - Q4 (2023) Tobacco Use Treatment at Discharge					

Patient Safety

Hospital-Based Inpatient Psychiatric Services

		Rate	Hours	Days
HBIPS-2 Q1 (2023) - Q4 (2023) Hours of physical-restraint use	Facility	0.53	193.58	15,196
	State	0.23	4,806.78	875,799
	National	0.30	203,763.35	28,001,996
HBIPS-3 Q1 (2023) - Q4 (2023) Hours of seclusion	Facility	0.78	285.77	15,196
	State	0.11	2,411.63	875,799
	National	0.36	241,512.98	27,995,707

Preventive Care and Screening

Screening

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
SMD Q1 (2023) - Q4 (2023) Screening for Metabolic Disorders	95%	394	83%	80%	100%

Immunization

	Facility Rate	Number of Patients	State Rate	National Rate	Top 10%
IPFQR-IMM-2 Q4 (2023) - Q1 (2024) Influenza Immunization	97%	302	77%	76%	99%

Use of Medical Imaging

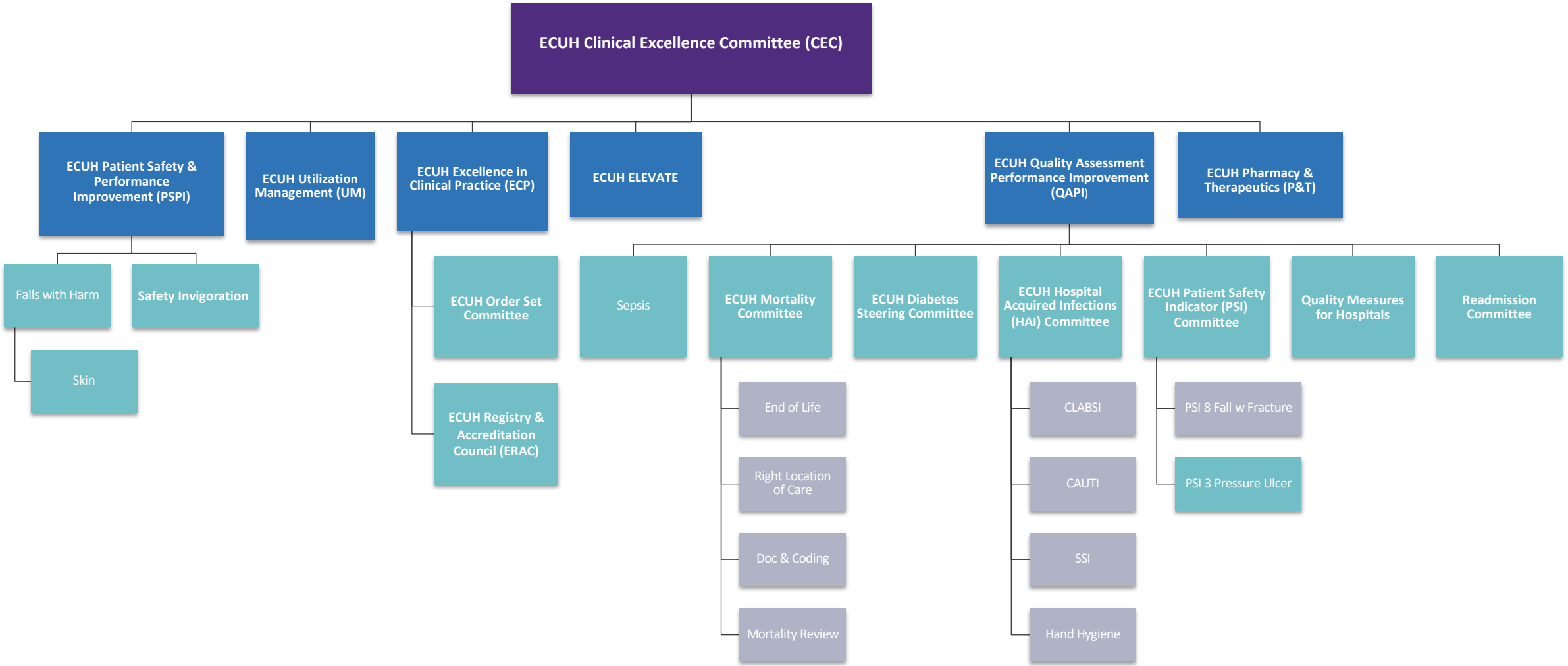
Imaging Efficiency

	Number of Patients	Facility Rate	State Rate	National Rate
OP-8 Q3 (2022) - Q2 (2023) MRI Lumbar Spine for Low Back Pain	69	31.9%	35.3%	36.2%
OP-10 Q3 (2022) - Q2 (2023) Abdomen CT - Use of Contrast Material	1,553	1.5%	5.2%	5.8%
OP-13 Q3 (2022) - Q2 (2023) Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	77	5.2%	3.2%	3.7%
OP-39 Q3 (2022) - Q2 (2023) Breast Cancer Screening Recall Rates	116	6%	7.7%	9%

Patient-Reported Outcomes

Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Measure	Completed Surveys	Eligible Patients	Response Rate
THA/TKA Inpatient Pre-operative surveys only (Voluntary) Q1 (2023) - Q2 (2023) Hospital-Level Total Hip Arthroplasty/Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure	0	26	0%



Ad hoc groups could be formed based on identified PI needs

ECU HEALTH