University of Vermont Medical Center
Outpatient Surgery Center
TABLE 1
PROJECT COSTS

Construction Costs		
1. New Construction	$	71,708,913
2. Renovation	$	-
3. Site Work	$	-
4. Fixed Equipment	$	4,658,925
5. Design/Bidding Contingency	$	-
6. Construction Contingency	$	14,635,886
7. Construction Manager Fee	$	-
8. Other (please specify)	$	-
Subtotal	$	91,003,724
Related Project Costs		
1. Major Moveable Equipment	$	-
2. Furnishings, Fixtures & Other Equip.	$	19,058,288
3. Architectural/Engineering Fees	$	4,540,051
4. Land Acquisition	$	5,150,158
5. Purchase of Buildings		
6. Administrative Expenses & Permits	$	3,542,586
7. Debt Financing Expenses (see below)		
8. Debt Service Reserve Fund		
9. Working Capital		
10. Other (capitalized interest, non-cash)	$	6,345,897
Subtotal	$	38,636,980
Total Project Costs	**$**	**129,640,703**

Debt Financing Expenses		
1. Capital Interest	$	-
2. Bond Discount or Placement Fee	$	-
3. Misc. Financing Fees & Exp. (issuance costs)	$	-
4. Other	$	-
Subtotal	$	-
Less Interest Earnings on Funds		
1. Debt Service Reserve Funds	$	-
2. Capitalized Interest Account	$	-
3. Construction Fund	$	-
4. Other	$	-
Subtotal	$	-
Total Debt Financing Expenses	**$**	**-**
feeds to line 7 above		

captured in item 10 above

University of Vermont Medical Center

Outpatient Surgery Center

TABLE 2

DEBT FINANCING ARRANGEMENT, SOURCES & USES OF FUNDS

Sources of Funds

1. Financing Instrument	Bond		
a. Interest Rate	5.0%	(estimated)	
b. Loan Period	Oct 2025	To: Sep 2049	
c. Amount Financed	(net proceeds from financing)		$ 100,000,000
2. Equity Contribution			29,640,703
3. Other Sources			
a. Working Capital			-
b. Fundraising			-
c. Grants			-
d. Other			-
Total Required Funds			**$ 129,640,703**

Uses of Funds

Project Costs (feeds from Table 1)	
1. New Construction	$ 71,708,913
2. Renovation	-
3. Site Work	-
4. Fixed Equipment	4,658,925
5. Design/Bidding Contingency	-
6. Construction Contingency	14,635,886
7. Construction Manager Fee	-
8. Major Moveable Equipment	-
9. Furnishings, Fixtures & Other Equip.	19,058,288
10. Architectural/Engineering Fees	4,540,051
11. Land Acquisition	5,150,158
12. Purchase of Buildings	-
13. Administrative Expenses & Permits	3,542,586
14. Debt Financing Expenses	-
15. Debt Service Reserve Fund	-
16. Working Capital	-
17. Other (capitalized interest, non-cash)	6,345,897
Total Uses of Funds	**$ 129,640,703**

Total sources should equal total uses of funds.

INCREMENTAL Pro-Forma: Outpatient Surgery Center

	FY25 (Half Year)	FY26	FY27	FY28	FY29	5 Yr. Total
Incremental Volume						
Total Volume [1]	**1,689**	**3,071**	**3,275**	**3,224**	**4,341**	**15,600**
OP Surgical Volume @ OSC	*1,482*	*2,587*	*2,721*	*2,599*	*3,645*	*13,034*
IP Surgical Volume @ Main Campus	*206*	*484*	*554*	*625*	*696*	*2,566*
Incremental Revenue						
OP: Total Net Patient Revenue + FPP [2]	**$ 14,195,742**	**$ 24,860,014**	**$ 26,812,979**	**$ 26,513,468**	**$ 36,780,818**	**$ 129,163,021**
Net Patient Revenue: Facility	*$ 10,965,556*	*$ 19,203,214*	*$ 20,711,789*	*$ 20,480,431*	*$ 28,411,485*	*$ 99,772,475*
Net Patient Revenue: Professional	*$ 3,230,186*	*$ 5,656,800*	*$ 6,101,190*	*$ 6,033,037*	*$ 8,369,333*	*$ 29,390,546*
IP: Total Net Patient Revenue + FPP [2]	**$ 13,006,455**	**$ 30,194,700**	**$ 35,317,756**	**$ 40,594,503**	**$ 46,029,552**	**$ 165,142,966**
Net Patient Revenue: Facility	*$ 12,571,870*	*$ 29,185,803*	*$ 34,137,681*	*$ 39,238,116*	*$ 44,491,564*	*$ 159,625,034*
Net Patient Revenue: Professional	*$ 434,585*	*$ 1,008,897*	*$ 1,180,074*	*$ 1,356,387*	*$ 1,537,988*	*$ 5,517,932*
OP: Reimb. adjustment on current vol. shifted to OSC [3]	**$ (1,636,303)**	**$ (3,338,044)**	**$ (3,512,510)**	**$ (3,692,210)**	**$ (3,877,301)**	**$ (16,056,368)**
Total Operating Revenue	**$ 25,565,894**	**$ 51,716,670**	**$ 58,618,224**	**$ 63,415,761**	**$ 78,933,069**	**$ 278,249,619**
Incremental Expenses						
Salaries/Wages and Other [4]	**$ 4,992,114**	**$ 9,959,665**	**$ 10,251,726**	**$ 10,552,381**	**$ 14,259,707**	**$ 50,015,594**
Physicians	*$ 672,475*	*$ 1,345,750*	*$ 1,379,394*	*$ 1,413,878*	*$ 2,762,152*	*$ 7,573,648*
Staff Direct	*$ 3,741,691*	*$ 7,461,412*	*$ 7,685,255*	*$ 7,915,812*	*$ 10,142,835*	*$ 36,947,005*
Staff Indirect	*$ 577,948*	*$ 1,152,503*	*$ 1,187,078*	*$ 1,222,691*	*$ 1,354,720*	*$ 5,494,941*
Health Care Provider Tax [5]	**$ 1,533,954**	**$ 3,103,000**	**$ 3,517,093**	**$ 3,804,946**	**$ 4,735,984**	**$ 16,694,977**
Provider Tax	*$ 1,533,954*	*$ 3,103,000*	*$ 3,517,093*	*$ 3,804,946*	*$ 4,735,984*	*$ 16,694,977*
Med/Surg/Pharmaceutical Supplies [6]	**$ 1,919,327**	**$ 3,382,994**	**$ 3,725,474**	**$ 3,771,162**	**$ 5,260,721**	**$ 18,059,678**
Medical & Surgical Supplies	*$ 1,670,227*	*$ 2,942,173*	*$ 3,232,755*	*$ 3,263,193*	*$ 4,552,104*	*$ 15,660,451*
Pharmaceuticals	*$ 249,100*	*$ 440,821*	*$ 492,719*	*$ 507,969*	*$ 708,618*	*$ 2,399,227*
Other Dept. Operating Expense [7]	**$ 1,463,494**	**$ 672,394**	**$ 692,566**	**$ 713,343**	**$ 1,090,165**	**$ 4,631,963**
Miscellaneous Other Expense	*$ 309,157*	*$ 618,838*	*$ 637,403*	*$ 656,525*	*$ 841,235*	*$ 3,063,158*
Maintenance	*$ 13,575*	*$ 53,556*	*$ 55,163*	*$ 56,817*	*$ 88,687*	*$ 267,798*
Start-up Costs	*$ 1,140,762*	*$ - *	*$ - *	*$ - *	*$ 160,244*	*$ 1,301,006*
Other non-Dept. Operating Expense [8]	**$ -**	**$ 333,281**	**$ 465,821**	**$ 479,796**	**$ 1,054,961**	**$ 2,333,859**
Miscellaneous non-Dept. Other Expense	*$ - *	*$ 333,281*	*$ 465,821*	*$ 479,796*	*$ 1,054,961*	*$ 2,333,859*
IP Direct Cost [9]	**$ 7,076,153**	**$ 16,427,407**	**$ 19,214,602**	**$ 22,085,413**	**$ 25,042,348**	**$ 89,845,922**
IP direct cost	*$ 7,076,153*	*$ 16,427,407*	*$ 19,214,602*	*$ 22,085,413*	*$ 25,042,348*	*$ 89,845,922*
Total Depreciation and Interest [10]	**$ 8,420,907**	**$ 11,841,815**	**$ 11,841,815**	**$ 11,841,815**	**$ 12,382,816**	**$ 56,329,168**
Depreciation and Amortization	*$ 3,420,907*	*$ 6,841,815*	*$ 6,841,815*	*$ 6,841,815*	*$ 7,382,816*	*$ 31,329,168*
Interest Expense [11]	*$ 5,000,000*	*$ 5,000,000*	*$ 5,000,000*	*$ 5,000,000*	*$ 5,000,000*	*$ 25,000,000*
Total Expenses	**$ 25,405,950**	**$ 45,720,557**	**$ 49,709,097**	**$ 53,248,854**	**$ 63,826,703**	**$ 237,911,160**
Incremental Operating Margin	**$ 159,945**	**$ 5,996,113**	**$ 8,909,127**	**$ 10,166,907**	**$ 15,106,366**	**$ 40,338,458**
EBIDA OPERATING MARGIN [12]	$ 8,580,852	$ 17,837,928	$ 20,750,942	$ 22,008,721	$ 27,489,182	$ 96,667,626

Notes:

General Assumptions:

> All values include cost inflation and revenue inflation to be consistent with assumptions used in the development of our Future Financial Framework.
> Volume estimates are based on OR and surgical volume demand analysis.
> FY25 reflects the April 2025 expected start to operations.
> Estimated cost and revenue not included for additional imaging or other ancillary services.
> There were no estimates built into this pro-forma for revenue opportunities or expense savings for vacated space at the FA campus created by this move.

Specific Assumptions:

1: Volume based on OR cases. Incremental OP and IP cases due to this project.
2: Revenue based on average reimbursement per case per specialty, recommended by Stroudwater Associates.
3: Reduced reimbursement from HOPD rates for current OP cases moving to the new OSC. Reimbursement for OP cases adjusted down from current state to Stoudwater recommended rates.
4: Salaries for incremental providers and staff based on FY22 averages. 20% of physician salary added as benefits. 33.1% of staff salary added as benefits, then adjusted for cost inflation.
5: Calculated at 6% of Total NPR + FPP.
6: Cost based on FY22 avg. supply cost per case and applied to incremental OP OSC volume then adjusted for cost inflation.
7: Incremental costs based on operating budget for the new OSC plus one time operating start-up cost incurred from FY21-FY25.
8: Incremental non-salary expenses assigned to the future OSC cost center. Based on cost accounting analysis.
9: Incremental IP direct costs for incremental IP cases.
10: Capital depreciation for project and Interest expense on a loan to fund this project. Includes additional depreciation for $8.8M fit-up costs for shelled spaces starting in FY29.
11: $5M represents 12 months of interest. $100M debt issuance expected in October FY25 - Interest only payments for first 5 years.
12: Earnings before interest, depreciation and amortization.

Incremental Cash Flow: Outpatient Surgery Center

	FY25 (Half Year)	FY26	FY27	FY28	FY29	5 Yr. Total
Margin from Operations	$ 159,945	$ 5,996,113	$ 8,909,127	$ 10,166,907	$ 15,106,366	***$ 40,338,458***
Depreciation	$ 3,420,907	$ 6,841,815	$ 6,841,815	$ 6,841,815	$ 7,382,816	***$ 31,329,168***
Cap Interest (non-cash, add back as in Total Project Cost)	$ 6,345,897					***$ 6,345,897***
Total Project Cost - this CON Application	$ (129,640,703)					***$ (129,640,703)***
Estimated fit-up cost of Additional 4 OR rooms - Future CON (TBD)					$ 8,756,748	***$ 8,756,748***
Debt Proceeds	$ 100,000,000					***$ 100,000,000***
Debt Principle payments (intest only first 5 years)	$ -	$ -	$ -	$ -	$ -	***$ -***
Annual Cash Flow	**$ (19,713,954)**	**$ 12,837,928**	**$ 15,750,942**	**$ 17,008,721**	**$ 31,245,930**	***$ 57,129,568***
Project Aggregate Cash Flow @ End of Each Yr	**$ (19,713,954)**	**$ (6,876,026)**	**$ 8,874,916**	**$ 25,883,637**	**$ 57,129,568**	
5 Yr NPV @ 5%	$44,950,562					

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Outpatient Surgery Center

INCOME STATEMENT

Table 3A

WITHOUT PROJECT

	2021	2022		2022		2023		2025		2026		2027		2028		2029	
	Actual	Budget	% change	Actual	% change	Budget	% change		% change		% change		% change		% change		% change
REVENUES																	
INPATIENT CARE REVENUE	1,040,515,780	1,140,061,944	9.6%	1,181,255,119	3.6%	1,275,210,726	8.0%	1,389,979,691	9.0%	1,445,578,879	4.0%	1,488,946,245	3.0%	1,533,614,633	3.0%	1,579,623,072	3.0%
OUTPATIENT CARE REVENUE	1,423,273,080	1,616,166,040	13.6%	1,692,993,784	4.8%	1,871,814,603	10.6%	2,040,277,917	9.0%	2,121,889,034	4.0%	2,185,545,705	3.0%	2,251,112,076	3.0%	2,318,645,438	3.0%
OUTPATIENT CARE REVENUE - PHYSICIAN	601,148,188	703,860,927	17.1%	687,368,255	-2.3%	803,021,428	16.8%	875,293,356	9.0%	910,305,090	4.0%	937,614,243	3.0%	965,742,670	3.0%	994,714,950	3.0%
CHRONIC/SNF PT CARE REVENUE	18,811,357	35,107,205	86.6%	21,736,148	-38.1%	23,733,230	9.2%	25,869,221	9.0%	26,903,990	4.0%	27,711,110	3.0%	28,542,443	3.0%	29,398,716	3.0%
SWING BEDS PT CARE REVENUE	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
GROSS PATIENT CARE REVENUE	3,083,748,404	3,495,196,116	13.3%	3,583,353,306	2.5%	3,973,779,987	10.9%	4,331,420,186	9.0%	4,504,676,993	4.0%	4,639,817,303	3.0%	4,779,011,822	3.0%	4,922,382,176	3.0%
DISPROPORTIONATE SHARE PAYMENTS	11,231,758	11,214,283	-0.2%	20,245,439	80.5%	23,019,801	13.7%	25,091,583	9.0%	26,095,246	4.0%	26,878,104	3.0%	27,684,447	3.0%	28,514,980	3.0%
BAD DEBT FREE CARE	(38,614,931)	(62,334,502)	61.4%	(54,738,345)	-12.2%	(69,681,406)	27.3%	(75,952,733)	9.0%	(78,990,842)	4.0%	(81,360,567)	3.0%	(83,801,385)	3.0%	(86,315,426)	3.0%
DEDUCTIONS FROM REVENUE	(1,922,786,867)	(2,120,449,812)	10.3%	(2,239,810,380)	5.6%	(2,477,198,404)	10.6%	(2,700,146,260)	9.0%	(2,808,152,110)	4.0%	(2,892,396,674)	3.0%	(2,979,168,574)	3.0%	(3,068,543,631)	3.0%
			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
NET PATIENT CARE REVENUE	1,133,578,363	1,323,626,086	16.8%	1,309,050,019	-1.1%	1,449,919,978	10.8%	1,580,412,776	9.0%	1,643,629,287	4.0%	1,692,938,165	3.0%	1,743,726,310	3.0%	1,796,038,100	3.0%
FIXED PROSPECTIVE PAYMENTS AND RESERVES	174,137,869	184,880,390	6.2%	188,414,129	1.9%	208,805,650	10.8%	227,598,158	9.0%	236,702,085	4.0%	243,803,147	3.0%	251,117,242	3.0%	258,650,759	3.0%
NET PATIENT CARE REV & FIXED PAYMENTS & RESERVES	1,307,716,232	1,508,506,476	15.4%	1,497,464,148	-0.7%	1,658,725,627	10.8%	1,808,010,934	9.0%	1,880,331,371	4.0%	1,936,741,312	3.0%	1,994,843,552	3.0%	2,054,688,858	3.0%
OTHER OPERATING REVENUE	301,030,443	213,583,061	-29.0%	328,165,497	53.6%	302,189,353	-7.9%	329,386,395	9.0%	342,561,851	4.0%	352,838,706	3.0%	363,423,868	3.0%	374,326,584	3.0%
TOTAL OPERATING REVENUE	1,608,746,674	1,722,089,536	7.0%	1,825,629,645	6.0%	1,960,914,981	7.4%	2,137,397,329	9.0%	2,222,893,222	4.0%	2,289,580,019	3.0%	2,358,267,419	3.0%	2,429,015,442	3.0%
OPERATING EXPENSE																	
SALARIES NON MD	547,014,092	551,773,862	0.9%	670,507,139	21.5%	669,997,312	-0.1%	730,297,070	9.0%	759,508,953	4.0%	782,294,221	3.0%	805,763,048	3.0%	829,935,940	3.0%
FRINGE BENEFITS NON MD	129,678,297	151,555,836	16.9%	138,497,328	-8.6%	156,970,328	13.3%	171,097,658	9.0%	177,941,564	4.0%	183,279,811	3.0%	188,778,205	3.0%	194,441,552	3.0%
PHYSICIAN FEES & SALARIES	195,160,314	205,922,158	5.5%	211,002,920	2.5%	229,986,745	9.0%	241,486,082	5.0%	247,523,234	2.5%	253,711,315	2.5%	260,054,098	2.5%	266,555,450	2.5%
FRINGE BENEFITS MD	38,634,427	40,418,719	4.6%	39,661,884	-1.9%	42,457,604	7.0%	44,580,484	5.0%	45,694,996	2.5%	46,837,371	2.5%	48,008,305	2.5%	49,208,513	2.5%
HEALTH CARE PROVIDER TAX	76,060,716	85,942,735	13.0%	85,420,044	-0.6%	96,127,311	12.5%	104,778,769	9.0%	108,969,920	4.0%	112,239,018	3.0%	115,606,188	3.0%	119,074,374	3.0%
DEPRECIATION AMORTIZATION	62,290,231	70,212,839	12.7%	68,233,037	-2.8%	66,201,582	-3.0%	66,201,582	0.0%	66,201,582	0.0%	66,201,582	0.0%	66,201,582	0.0%	66,201,582	0.0%
INTEREST - LONG/SHORT TERM	15,972,409	16,569,123	3.7%	16,144,190	-2.6%	16,282,548	0.9%	16,282,548	0.0%	16,282,548	0.0%	16,282,548	0.0%	16,282,548	0.0%	16,282,548	0.0%
									#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
OTHER OPERATING EXPENSE	507,413,632	540,356,407	6.5%	618,889,279	14.5%	643,589,944	4.0%	701,513,039	9.0%	729,573,560	4.0%	751,460,767	3.0%	774,004,590	3.0%	797,224,728	3.0%
BAD DEBT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL OPERATING EXPENSE	1,572,224,117	1,662,751,679	5.8%	1,848,355,820	11.2%	1,921,613,374	4.0%	2,076,237,232	8.0%	2,151,696,358	3.6%	2,212,306,633	2.8%	2,274,698,565	2.8%	2,338,924,686	2.8%
NET OPERATING INCOME (LOSS)	36,522,557	59,337,858	62.5%	(22,726,174)	-138.3%	39,301,607	-272.9%	61,160,097	55.6%	71,196,864	16.4%	77,273,385	8.5%	83,568,854	8.1%	90,090,756	7.8%
NON-OPERATING REVENUE	83,240,192	20,981,262	-74.8%	(154,168,560)	-834.8%	16,896,055	-111.0%	16,896,055	0.0%	16,896,055	0.0%	16,896,055	0.0%	16,896,055	0.0%	16,896,055	0.0%
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE	119,762,749	80,319,120	-32.9%	(176,894,734)	-320.2%	56,197,661	-131.8%	78,056,152	38.9%	88,092,919	-149.8%	94,169,440	67.6%	100,464,909	28.7%	106,986,811	6.5%
Operating Margin %	2.3%	3.4%		-1.2%		2.0%		2.9%		3.2%		3.4%		3.5%		3.7%	
Bad Debt & Free Care%	1.3%	1.8%		1.5%		1.8%		1.8%		1.8%		1.8%		1.8%		1.8%	
Compensation Ratio	57.9%	57.1%		57.3%		57.2%		57.2%		57.2%		57.2%		57.3%		57.3%	
Capital Cost % of Total Expenses	5.0%	5.2%		4.6%		4.3%		4.0%		3.8%		3.7%		3.6%		3.5%	

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Outpatient Surgery Center

INCOME STATEMENT

Table 3B

PROJECT ONLY

	2021 Actual	2022 Budget	% change	2022 Actual	% change	2023 Budget	% change	Proposed Yr 1 2025	% change	Proposed Yr 2 2026	% change	Proposed Yr 2 2027	% change	Proposed Yr 2 2028	% change	Proposed Yr 3 2029	% change
REVENUES																	
INPATIENT CARE REVENUE			#DIV/0!		#DIV/0!		#DIV/0!	19,654,789	#DIV/0!	39,759,229	102.3%	45,065,071	13.3%	48,753,367	8.2%	60,682,909	24.5%
OUTPATIENT CARE REVENUE			#DIV/0!		#DIV/0!		#DIV/0!	28,850,229	#DIV/0!	58,360,477	102.3%	66,148,642	13.3%	71,562,497	8.2%	89,073,243	24.5%
OUTPATIENT CARE REVENUE - PHYSICIAN			#DIV/0!		#DIV/0!		#DIV/0!	12,376,948	#DIV/0!	25,037,049	102.3%	28,378,226	13.3%	30,700,807	8.2%	38,213,038	24.5%
CHRONIC/SNF PT CARE REVENUE			#DIV/0!		#DIV/0!		#DIV/0!	365,800	#DIV/0!	739,968	102.3%	838,716	13.3%	907,360	8.2%	1,129,383	24.5%
SWING BEDS PT CARE REVENUE			#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
GROSS PATIENT CARE REVENUE	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	61,247,766	#DIV/0!	123,896,722	102.3%	140,430,655	13.3%	151,924,030	8.2%	189,098,573	24.5%
DISPROPORTIONATE SHARE PAYMENTS			#DIV/0!		#DIV/0!		#DIV/0!	354,804	#DIV/0!	717,724	102.3%	813,504	13.3%	880,084	8.2%	1,095,433	24.5%
BAD DEBT FREE CARE			#DIV/0!		#DIV/0!		#DIV/0!	(1,073,998)	#DIV/0!	(2,172,566)	102.3%	(2,462,493)	13.3%	(2,664,033)	8.2%	(3,315,899)	24.5%
DEDUCTIONS FROM REVENUE			#DIV/0!		#DIV/0!		#DIV/0!	(38,180,994)	#DIV/0!	(77,235,469)	102.3%	(87,542,490)	13.3%	(94,707,298)	8.2%	(117,881,384)	24.5%
NET PATIENT CARE REVENUE	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	22,347,578	#DIV/0!	45,206,411	102.3%	51,239,176	13.3%	55,432,784	8.2%	68,996,723	24.5%
FIXED PROSPECTIVE PAYMENTS AND RESERVES			#DIV/0!		#DIV/0!		#DIV/0!	3,218,316	#DIV/0!	6,510,259	102.3%	7,379,048	13.3%	7,982,977	8.2%	9,936,345	24.5%
NET PATIENT CARE REV & FIXED PAYMENTS & RESERVES			#DIV/0!		#DIV/0!		#DIV/0!	25,565,894	#DIV/0!	51,716,670	102.3%	58,618,224	13.3%	63,415,761	8.2%	78,933,069	24.5%
OTHER OPERATING REVENUE			#DIV/0!		#DIV/0!		#DIV/0!	0	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL OPERATING REVENUE	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	25,565,894	#DIV/0!	51,716,670	102.3%	58,618,224	13.3%	63,415,761	8.2%	78,933,069	24.5%
										q		r		s		t	
OPERATING EXPENSE																	
SALARIES NON MD			#DIV/0!		#DIV/0!		#DIV/0!	4,319,639	#DIV/0!	8,613,916	99.4%	8,872,333	3.0%	9,138,503	3.0%	11,497,555	25.8%
FRINGE BENEFITS NON MD			#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
FRINGE BENEFITS MD			#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
PHYSICIAN FEES & SALARIES			#DIV/0!		#DIV/0!		#DIV/0!	672,475	#DIV/0!	1,345,750	100.1%	1,379,394	2.5%	1,413,878	2.5%	2,762,152	95.4%
HEALTH CARE PROVIDER TAX			#DIV/0!		#DIV/0!		#DIV/0!	1,533,954	#DIV/0!	3,103,000	102.3%	3,517,093	13.3%	3,804,946	8.2%	4,735,984	24.5%
DEPRECIATION AMORTIZATION			#DIV/0!		#DIV/0!		#DIV/0!	3,420,907	#DIV/0!	6,841,815	100.0%	6,841,815	0.0%	6,841,815	0.0%	7,382,816	7.9%
INTEREST - LONG/SHORT TERM			#DIV/0!		#DIV/0!		#DIV/0!	5,000,000	#DIV/0!	5,000,000	0.0%	5,000,000	0.0%	5,000,000	0.0%	5,000,000	0.0%
OTHER OPERATING EXPENSE			#DIV/0!		#DIV/0!		#DIV/0!	10,458,975	#DIV/0!	20,816,076	99.0%	24,098,462	15.8%	27,049,713	12.2%	32,448,195	20.0%
TOTAL OPERATING EXPENSE	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	25,405,950	#DIV/0!	45,720,557	80.0%	49,709,097	8.7%	53,248,854	7.1%	63,826,703	19.9%
NET OPERATING INCOME (LOSS)	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	159,945	#DIV/0!	5,996,113	3648.9%	8,909,127	48.6%	10,166,907	14.1%	15,106,366	48.6%
NON-OPERATING REVENUE			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	159,945	#DIV/0!	5,996,113	3648.9%	8,909,127	48.6%	10,166,907	14.1%	15,106,366	48.6%

The business plan modeled net patient revenues, to populate rows 71-84 the same relationships of net patient revenue was utilized for each row base on without project relationships.

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Outpatient Surgery Center

Note: This table requires no "fill-in" as it is populated automatically

INCOME STATEMENT

Table 3C

WITH PROJECT

	2021	2022		2022		2023		Proposed Yr 1		Proposed Yr 2		Proposed Yr 2		Proposed Yr 2		Proposed Yr 3	
	Actual	Budget	% change	Actual	% change	Budget	% change	2025	% change	2026	% change	2027	% change	2028	% change	2029	% change
REVENUES																	
INPATIENT CARE REVENUE	1,040,515,780	1,140,061,944	9.6%	1,181,255,119	3.6%	1,275,210,726	8.0%	1,409,634,481	10.5%	1,485,338,108	5.4%	1,534,011,316	3.3%	1,582,367,999	3.2%	1,640,305,980	3.7%
OUTPATIENT CARE REVENUE	1,423,273,080	1,616,166,040	13.6%	1,692,993,784	4.8%	1,871,814,603	10.6%	2,069,128,146	10.5%	2,180,249,510	5.4%	2,251,694,347	3.3%	2,322,674,573	3.2%	2,407,718,681	3.7%
OUTPATIENT CARE REVENUE - PHYSICIAN	601,148,188	703,860,927	17.1%	687,368,255	-2.3%	803,021,428	16.8%	887,670,304	10.5%	935,342,139	5.4%	965,992,469	3.3%	996,443,477	3.2%	1,032,927,989	3.7%
CHRONIC/SNF PT CARE REVENUE	18,811,357	35,107,205	86.6%	21,736,148	-38.1%	23,733,230	9.2%	26,235,021	10.5%	27,643,958	5.4%	28,549,826	3.3%	29,449,803	3.2%	30,528,099	3.7%
SWING BEDS PT CARE REVENUE	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
GROSS PATIENT CARE REVENUE	3,083,748,404	3,495,196,116	13.3%	3,583,353,306	2.5%	3,973,779,987	10.9%	4,392,667,952	10.5%	4,628,573,715	5.4%	4,780,247,958	3.3%	4,930,935,852	3.2%	5,111,480,749	3.7%
DISPROPORTIONATE SHARE PAYMENTS	11,231,758	11,214,283	-0.2%	20,245,439	80.5%	23,019,801	13.7%	25,446,387	10.5%	26,812,971	5.4%	27,691,608	3.3%	28,564,531	3.2%	29,610,414	3.7%
BAD DEBT FREE CARE	(38,614,931)	(62,334,502)	61.4%	(54,738,345)	-12.2%	(69,681,406)	27.3%	(77,026,731)	10.5%	(81,163,408)	5.4%	(83,823,061)	3.3%	(86,465,417)	3.2%	(89,631,325)	3.7%
DEDUCTIONS FROM REVENUE	(1,922,786,867)	(2,120,449,812)	10.3%	(2,239,810,380)	5.6%	(2,477,198,404)	10.6%	(2,738,327,254)	10.5%	(2,885,387,580)	5.4%	(2,979,939,164)	3.3%	(3,073,875,872)	3.2%	(3,186,425,015)	3.7%
NET PATIENT CARE REVENUE	1,133,578,363	1,323,626,086	16.8%	1,309,050,019	-1.1%	1,449,919,978	10.8%	1,602,760,354	10.5%	1,688,835,698	5.4%	1,744,177,341	3.3%	1,799,159,094	3.2%	1,865,034,823	3.7%
FIXED PROSPECTIVE PAYMENTS AND RESERVES	174,137,869	184,880,390	6.2%	188,414,129	1.9%	208,805,650	10.8%	230,816,474	10.5%	243,212,343	5.4%	251,182,195	3.3%	259,100,219	3.2%	268,587,104	3.7%
NET PATIENT CARE REV & FIXED PAYMENTS & RESERVES	1,307,716,232	1,508,506,476	15.4%	1,497,464,148	-0.7%	1,658,725,627	10.8%	1,833,576,828	10.5%	1,932,048,041	5.4%	1,995,359,537	3.3%	2,058,259,313	3.2%	2,133,621,927	3.7%
OTHER OPERATING REVENUE	301,030,443	213,583,061	-29.0%	328,165,497	53.6%	302,189,353	-7.9%	329,386,395	9.0%	342,561,851	4.0%	352,838,706	3.0%	363,423,868	3.0%	374,326,584	3.0%
TOTAL OPERATING REVENUE	1,608,746,674	1,722,089,536	7.0%	1,825,629,645	6.0%	1,960,914,981	7.4%	2,162,963,223	10.3%	2,274,609,892	5.2%	2,348,198,243	3.2%	2,421,683,180	3.1%	2,507,948,511	3.6%
OPERATING EXPENSE																	
SALARIES NON MD	547,014,092	551,773,862	0.9%	670,507,139	21.5%	669,997,312	-0.1%	734,616,709	9.6%	768,122,868	4.6%	791,166,554	3.0%	814,901,551	3.0%	841,433,495	3.3%
FRINGE BENEFITS NON MD	129,678,297	151,555,836	16.9%	138,497,328	-8.6%	156,970,328	13.3%	171,097,658	9.0%	177,941,564	4.0%	183,279,811	3.0%	188,778,205	3.0%	194,441,552	3.0%
FRINGE BENEFITS MD	195,160,314	205,922,158	5.5%	211,002,920	2.5%	229,986,745	9.0%	241,486,082	5.0%	247,523,234	2.5%	253,711,315	2.5%	260,054,098	2.5%	266,555,450	2.5%
PHYSICIAN FEES & SALARIES	38,634,427	40,418,719	4.6%	39,661,884	-1.9%	42,457,604	7.0%	45,252,959	6.6%	47,040,746	4.0%	48,216,765	2.5%	49,422,184	2.5%	51,970,665	5.2%
HEALTH CARE PROVIDER TAX	76,060,716	85,942,735	13.0%	85,420,044	-0.6%	96,127,311	12.5%	106,312,723	10.6%	112,072,920	5.4%	115,756,111	3.3%	119,411,134	3.2%	123,810,358	3.7%
DEPRECIATION AMORTIZATION	62,290,231	70,212,839	12.7%	68,233,037	-2.8%	66,201,582	-3.0%	69,622,490	5.2%	73,043,397	4.9%	73,043,397	0.0%	73,043,397	0.0%	73,584,399	0.7%
INTEREST - LONG/SHORT TERM	15,972,409	16,569,123	3.7%	16,144,190	-2.6%	16,282,548	0.9%	21,282,548	30.7%	21,282,548	0.0%	21,282,548	0.0%	21,282,548	0.0%	21,282,548	0.0%
OTHER OPERATING EXPENSE	507,413,632	540,356,407	6.5%	618,889,279	14.5%	643,589,944	4.0%	711,972,014	10.6%	750,389,637	5.4%	775,559,230	3.4%	801,054,303	3.3%	829,672,923	3.6%
TOTAL OPERATING EXPENSE	1,572,224,117	1,662,751,679	5.8%	1,848,355,820	11.2%	1,921,613,374	4.0%	2,101,643,182	9.4%	2,197,416,914	4.6%	2,262,015,730	2.9%	2,327,947,419	2.9%	2,402,751,389	3.2%
NET OPERATING INCOME (LOSS)	36,522,557	59,337,858	62.5%	(22,726,174)	-138.3%	39,301,607	-272.9%	61,320,042	56.0%	77,192,978	25.9%	86,182,513	11.6%	93,735,761	8.8%	105,197,122	12.2%
NON-OPERATING REVENUE	83,240,192	20,981,262	-74.8%	(154,168,560)	-834.8%	16,896,055	-111.0%	16,896,055	0.0%	16,896,055	0.0%	16,896,055	0.0%	16,896,055	0.0%	16,896,055	0.0%
EXCESS (DEFICIT) OF REVENUE OVER EXPENSE	119,762,749	80,319,120	-32.9%	(176,894,734)	-320.2%	56,197,661	-131.8%	78,216,097	39.2%	94,089,033	20.3%	103,078,568	9.6%	110,631,816	7.3%	122,093,177	10.4%

Operating Margin %	2.3%	3.4%		-1.2%		2.0%		0.028350016		0.033936799		0.036701549		0.038706864		4.2%	
Bad Debt & Free Care%	1.3%	1.8%		1.5%		1.8%		1.8%		1.8%		1.8%		1.8%		1.8%	
Compensation Ratio	57.9%	57.1%		57.3%		57.2%		56.7%		56.5%		56.4%		56.4%		56.4%	
Capital Cost % of Total Expenses	5.0%	5.2%		4.6%		4.3%		4.3%		4.3%		4.2%		4.1%		3.9%	

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Outpatient Surgery Center

Balance Sheet

WITHOUT PROJECT

	3	4	5	6	7	8										
	2021	2022		2022		2023		2025		2026		2027		2028		2029	
	Actual	Budget	% change	Actual	% change	Budget	% change	Proposed Year 1	% change	Proposed Year 2	% change	Proposed Year 3	% change	Proposed Year 4	% change	Proposed Year 5	% change
ASSETS																	
CURRENT ASSETS																	
CASH & INVESTMENTS	198,774,513	180,903,823	-9.0%	128,530,453	-29.0%	121,859,317	-5.2%	143,717,807	17.9%	153,754,575	7.0%	159,831,096	4.0%	166,126,564	3.9%	172,648,466	3.9%
PATIENT ACCOUNTS RECEIVABLE, GROSS	220,893,078	214,224,870	-3.0%	224,304,753	4.7%	248,375,913	10.7%	248,375,913	0.0%	248,375,913	0.0%	248,375,913	0.0%	248,375,913	0.0%	248,375,913	0.0%
LESS: ALLOWANCE FOR UNCOLLECTIBLE ACCTS	(32,856,078)	(37,057,939)	12.8%	(44,646,600)	20.5%	(49,567,561)	11.0%	(49,567,561)	0.0%	(49,567,561)	0.0%	(49,567,561)	0.0%	(49,567,561)	0.0%	(49,567,561)	0.0%
DUE FROM THIRD PARTIES	38,887,352	37,425,396	-3.8%	48,249,245	28.9%	44,194,736	-8.4%	44,194,736	0.0%	44,194,736	0.0%	44,194,736	0.0%	44,194,736	0.0%	44,194,736	0.0%
ACO RISK RESERVE/SETTLEMENT RECEIVABLE	7,824,341	5,000,000	-36.1%	5,387,997	7.8%	2,633,283	-51.1%	2,633,283	0.0%	2,633,283	0.0%	2,633,283	0.0%	2,633,283	0.0%	2,633,283	0.0%
OTHER CURRENT ASSETS	91,947,303	106,016,163	15.3%	100,384,287	-5.3%	87,008,141	-13.3%	87,008,141	0.0%	87,008,141	0.0%	87,008,141	0.0%	87,008,141	0.0%	87,008,141	0.0%
TOTAL CURRENT ASSETS	525,470,509	506,512,313	-3.6%	462,210,136	-8.7%	454,503,828	-1.7%	476,362,318	4.8%	486,399,085	2.1%	492,475,606	1.2%	498,771,075	1.3%	505,292,977	1.3%
BOARD DESIGNATED ASSETS					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
FUNDED DEPRECIATION	623,698,615	633,297,209	1.5%	420,336,616	-33.6%	533,149,487	26.8%	533,149,487	0.0%	533,149,487	0.0%	533,149,487	0.0%	533,149,487	0.0%	533,149,487	0.0%
ESCROWED BOND FUNDS	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
OTHER	89,851,171	87,880,000	-2.2%	80,117,430	-8.8%	86,163,239	7.5%	86,163,239	0.0%	86,163,239	0.0%	86,163,239	0.0%	86,163,239	0.0%	86,163,239	0.0%
TOTAL BOARD DESIGNATED ASSETS	713,549,786	721,177,208	1.1%	500,454,046	-30.6%	619,312,726	23.8%	619,312,726	0.0%	619,312,726	0.0%	619,312,726	0.0%	619,312,726	0.0%	619,312,726	0.0%
PROPERTY, PLANT, AND EQUIPMENT																	
LAND, BUILDINGS & IMPROVEMENTS	917,753,544	957,180,476	4.3%	888,450,867	-7.2%	937,282,369	5.5%	937,282,369	0.0%	937,282,369	0.0%	937,282,369	0.0%	937,282,369	0.0%	937,282,369	0.0%
CONSTRUCTION IN PROGRESS	53,333,647	36,289,707	-32.0%	13,074,712	-64.0%	12,611,937	-3.5%	12,611,937	0.0%	12,611,937	0.0%	12,611,937	0.0%	12,611,937	0.0%	12,611,937	0.0%
MAJOR MOVABLE EQUIPMENT	494,082,075	525,773,537	6.4%	524,014,805	-0.3%	540,570,375	3.2%	540,570,375	0.0%	540,570,375	0.0%	540,570,375	0.0%	540,570,375	0.0%	540,570,375	0.0%
FIXED EQUIPMENT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
TOTAL PROPERTY, PLANT AND EQUIPMENT	1,465,169,266	1,519,243,720	3.7%	1,425,540,383	-6.2%	1,490,464,680	4.6%	1,490,464,680	0.0%	1,490,464,680	0.0%	1,490,464,680	0.0%	1,490,464,680	0.0%	1,490,464,680	0.0%
LESS: ACCUMULATED DEPRECIATION																	
LAND, BUILDINGS & IMPROVEMENTS	(453,534,588)	(492,874,419)	8.7%	(440,038,171)	-10.7%	(472,723,972)	7.4%	(472,723,972)	0.0%	(472,723,972)	0.0%	(472,723,972)	0.0%	(472,723,972)	0.0%	(472,723,972)	0.0%
EQUIPMENT - FIXED	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
EQUIPMENT - MAJOR MOVEABLE	(391,471,333)	(423,698,279)	8.2%	(379,773,321)	-10.4%	(407,269,970)	7.2%	(407,269,970)	0.0%	(407,269,970)	0.0%	(407,269,970)	0.0%	(407,269,970)	0.0%	(407,269,970)	0.0%
TOTAL ACCUMULATED DEPRECIATION	(845,005,921)	(916,572,698)	8.5%	(819,811,492)	-10.6%	(879,993,943)	7.3%	(879,993,943)	0.0%	(879,993,943)	0.0%	(879,993,943)	0.0%	(879,993,943)	0.0%	(879,993,943)	0.0%
TOTAL PROPERTY, PLANT AND EQUIPMENT, NET	620,163,346	602,671,022	-2.8%	605,728,891	0.5%	610,470,738	0.8%	610,470,738	0.0%	610,470,738	0.0%	610,470,738	0.0%	610,470,738	0.0%	610,470,738	0.0%
OTHER LONG-TERM ASSETS	58,978,368	65,947,792	11.8%	60,959,416	-7.6%	60,172,363	-1.3%	60,172,363	0.0%	60,172,363	0.0%	60,172,363	0.0%	60,172,363	0.0%	60,172,363	0.0%
TOTAL ASSETS	**1,918,162,009**	**1,896,308,335**	-1.1%	**1,629,352,489**	-14.1%	**1,744,459,654**	7.1%	**1,766,318,144**	1.3%	**1,776,354,912**	0.6%	**1,782,431,433**	0.3%	**1,788,726,902**	0.4%	**1,795,248,803**	0.4%
LIABILITIES AND FUND BALANCE																	
CURRENT LIABILITIES																	
ACCOUNTS PAYABLE	29,741,085	42,892,632	44.2%	28,276,421	-34.1%	34,611,306	22.4%	34,611,306	0.0%	34,611,306	0.0%	34,611,306	0.0%	34,611,306	0.0%	34,611,306	0.0%
CURRENT LIABILITIES COVID-19	58,085,251	-	-100.0%	(0)	#DIV/0!	-	-100.0%	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
SALARIES, WAGES AND PAYROLL TAXES PAYAB	92,047,675	83,759,092	-9.0%	90,046,728	7.5%	89,192,219	-0.9%	89,192,219	0.0%	89,192,219	0.0%	89,192,219	0.0%	89,192,219	0.0%	89,192,219	0.0%
ESTIMATED THIRD-PARTY SETTLEMENTS	28,767,385	3,165,681	-89.0%	8,050,436	154.3%	6,624,963	-17.7%	6,624,963	0.0%	6,624,963	0.0%	6,624,963	0.0%	6,624,963	0.0%	6,624,963	0.0%
OTHER CURRENT LIABILITIES	63,370,962	54,494,848	-14.0%	85,921,645	57.7%	82,330,819	-4.2%	82,330,819	0.0%	82,330,819	0.0%	82,330,819	0.0%	82,330,819	0.0%	82,330,819	0.0%
CURRENT PORTION OF LONG-TERM DEBT	19,833,768	22,322,022	12.5%	21,996,899	-1.5%	20,841,423	-5.3%	20,841,423	0.0%	20,841,423	0.0%	20,841,423	0.0%	20,841,423	0.0%	20,841,423	0.0%
TOTAL CURRENT LIABILITIES	291,846,125	206,634,275	-29.2%	234,292,130	13.4%	233,600,729	-0.3%	233,600,729	0.0%	233,600,729	0.0%	233,600,729	0.0%	233,600,729	0.0%	233,600,729	0.0%
LONG-TERM DEBT																	
LONG TERM LIABILITIES COVID-19	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
BONDS & MORTGAGES PAYABLE	417,399,831	394,909,193	-5.4%	393,967,431	-0.2%	368,667,665	-6.4%	368,667,665	0.0%	368,667,665	0.0%	368,667,665	0.0%	368,667,665	0.0%	368,667,665	0.0%
CAPITAL LEASE OBLIGATIONS	-	1,162,611	#DIV/0!	-	-100.0%	696,297	#DIV/0!	696,297	0.0%	696,297	0.0%	696,297	0.0%	696,297	0.0%	696,297	0.0%
OTHER LONG-TERM DEBT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
TOTAL LONG-TERM DEBT	417,399,831	396,071,804	-5.1%	393,967,431	-0.5%	369,363,962	-6.2%	369,363,962	0.0%	369,363,962	0.0%	369,363,962	0.0%	369,363,962	0.0%	369,363,962	0.0%
OTHER NONCURRENT LIABILITIES	55,311,830	67,303,398	21.7%	38,061,122	-43.4%	48,198,870	26.6%	48,198,870	0.0%	48,198,870	0.0%	48,198,870	0.0%	48,198,870	0.0%	48,198,870	0.0%
TOTAL LIABILITIES	**764,557,786**	**670,009,478**	-12.4%	**666,320,683**	-0.6%	**651,163,562**	-2.3%	**651,163,562**	0.0%	**651,163,562**	0.0%	**651,163,562**	0.0%	**651,163,562**	0.0%	**651,163,562**	0.0%
FUND BALANCE	1,153,604,222	1,226,298,857	6.3%	963,031,807	-21.5%	1,093,296,092	13.5%	1,093,296,092	0.0%	1,093,296,092	0.0%	1,093,296,092	0.0%	1,093,296,092	0.0%	1,093,296,092	0.0%
TOTAL LIABILITIES AND FUND BALANCE	**1,918,162,009**	**1,896,308,335**	-1.1%	**1,629,352,489**	-14.1%	**1,744,459,654**	7.1%	**1,744,459,654**	0.0%	**1,744,459,654**	0.0%	**1,744,459,654**	0.0%	**1,744,459,654**	0.0%	**1,744,459,654**	0.0%

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Outpatient Surgery Center

Balance Sheet

PROJECT ONLY

	2021 Actual	2022 Budget	% change	2022 Actual	% change	2023 Budget	% change	2025 Proposed Year 1	% change	2026 Proposed Year 2	% change	2027 Proposed Year 3	% change	2028 Proposed Year 4	% change	2029 Proposed Year 5	% change
ASSETS																	
CURRENT ASSETS																	
CASH & INVESTMENTS			#DIV/0!		#DIV/0!		#DIV/0!	(19,713,954)	#DIV/0!	(6,876,026)	-65.1%	8,874,916	-229.1%	25,883,637	191.6%	48,372,820	86.9%
PATIENT ACCOUNTS RECEIVABLE, GROSS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
LESS: ALLOWANCE FOR UNCOLLECTIBLE ACCTS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
DUE FROM THIRD PARTIES			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
ACO RISK RESERVE/SETTLEMENT RECEIVABLE			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
OTHER CURRENT ASSETS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL CURRENT ASSETS	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	(19,713,954)	#DIV/0!	(6,876,026)	-65.1%	8,874,916	-229.1%	25,883,637	191.6%	48,372,820	86.9%
BOARD DESIGNATED ASSETS					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
FUNDED DEPRECIATION			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
ESCROWED BOND FUNDS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
OTHER			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL BOARD DESIGNATED ASSETS	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
PROPERTY, PLANT, AND EQUIPMENT																	
LAND, BUILDINGS & IMPROVEMENTS			#DIV/0!		#DIV/0!		#DIV/0!	105,923,491	#DIV/0!	105,923,491	0.0%	105,923,491	0.0%	105,923,491	0.0%	105,923,491	0.0%
CONSTRUCTION IN PROGRESS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
MAJOR MOVABLE EQUIPMENT			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
FIXED EQUIPMENT			#DIV/0!		#DIV/0!		#DIV/0!	23,717,212	#DIV/0!	23,717,212	0.0%	23,717,212	0.0%	23,717,212	0.0%	32,473,960	36.9%
TOTAL PROPERTY, PLANT AND EQUIPMENT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	129,640,703	#DIV/0!	129,640,703	0.0%	129,640,703	0.0%	129,640,703	0.0%	138,397,451	6.8%
LESS: ACCUMULATED DEPRECIATION																	
LAND, BUILDINGS & IMPROVEMENTS			#DIV/0!		#DIV/0!		#DIV/0!	(1,679,556)	#DIV/0!	(5,038,667)	200.0%	(8,397,778)	66.7%	(11,756,889)	40.0%	(15,116,000)	28.6%
EQUIPMENT - FIXED			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
EQUIPMENT - MAJOR MOVEABLE			#DIV/0!		#DIV/0!		#DIV/0!	(1,741,352)	#DIV/0!	(5,224,056)	200.0%	(8,706,759)	66.7%	(12,189,463)	40.0%	(16,213,168)	33.0%
TOTAL ACCUMULATED DEPRECIATION	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	(3,420,907)	#DIV/0!	(10,262,722)	200.0%	(17,104,537)	66.7%	(23,946,352)	40.0%	(31,329,168)	30.8%
TOTAL PROPERTY, PLANT AND EQUIPMENT, NET	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	126,219,796	#DIV/0!	119,377,981	-5.4%	112,536,166	-5.7%	105,694,352	-6.1%	107,068,284	1.3%
OTHER LONG-TERM ASSETS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL ASSETS	**-**	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**106,505,842**	#DIV/0!	**112,501,955**	5.6%	**121,411,082**	7.9%	**131,577,989**	8.4%	**155,441,104**	18.1%
LIABILITIES AND FUND BALANCE																	
CURRENT LIABILITIES																	
ACCOUNTS PAYABLE			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
CURRENT LIABILITIES COVID-19			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
SALARIES, WAGES AND PAYROLL TAXES PAYABLE			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
ESTIMATED THIRD-PARTY SETTLEMENTS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
OTHER CURRENT LIABILITIES			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
CURRENT PORTION OF LONG-TERM DEBT			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL CURRENT LIABILITIES	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
LONG-TERM DEBT																	
LONG TERM LIABILITIES COVID-19			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
BONDS & MORTGAGES PAYABLE			#DIV/0!		#DIV/0!		#DIV/0!	100,000,000	#DIV/0!	100,000,000	0.0%	100,000,000	0.0%	100,000,000	0.0%	100,000,000	0.0%
CAPITAL LEASE OBLIGATIONS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
OTHER LONG-TERM DEBT			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL LONG-TERM DEBT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	100,000,000	#DIV/0!	100,000,000	0.0%	100,000,000	0.0%	100,000,000	0.0%	100,000,000	0.0%
OTHER NONCURRENT LIABILITIES			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
TOTAL LIABILITIES	**-**	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**100,000,000**	#DIV/0!	**100,000,000**	0.0%	**100,000,000**	0.0%	**100,000,000**	0.0%	**100,000,000**	0.0%
FUND BALANCE			#DIV/0!		#DIV/0!	-	#DIV/0!	6,505,842	#DIV/0!	12,501,955	92.2%	21,411,082	71.3%	31,577,989	47.5%	55,441,104	75.6%
TOTAL LIABILITIES AND FUND BALANCE	**-**	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**106,505,842**	#DIV/0!	**112,501,955**	5.6%	**121,411,082**	7.9%	**131,577,989**	8.4%	**155,441,104**	18.1%

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Outpatient Surgery Center

Note: This table requires no "fill-in" as it is populated automatically

Balance Sheet

WITH PROJECT

	2021 Actual	2022 Budget	% change	2022 Actual	% change	2023 Budget	% change	2025 Proposed Year 1	% change	2026 Proposed Year 2	% change	2027 Proposed Year 3	% change	2028 Proposed Year 4	% change	2029 Proposed Year 5	% change
ASSETS																	
CURRENT ASSETS																	
CASH & INVESTMENTS	198,774,513	180,903,823	-9.0%	128,530,453	-29.0%	121,859,317	-5.2%	124,003,853	1.8%	146,878,549	18.4%	168,706,012	14.9%	192,010,202	13.8%	221,021,286	15.1%
PATIENT ACCOUNTS RECEIVABLE, GROSS	220,893,078	214,224,870	-3.0%	224,304,753	4.7%	248,375,913	10.7%	248,375,913	0.0%	248,375,913	0.0%	248,375,913	0.0%	248,375,913	0.0%	248,375,913	0.0%
LESS: ALLOWANCE FOR UNCOLLECTIBLE ACCTS	(32,856,078)	(37,057,939)	12.8%	(44,646,600)	20.5%	(49,567,561)	11.0%	(49,567,561)	0.0%	(49,567,561)	0.0%	(49,567,561)	0.0%	(49,567,561)	0.0%	(49,567,561)	0.0%
DUE FROM THIRD PARTIES	38,887,352	37,425,396	-3.8%	48,249,245	28.9%	44,194,736	-8.4%	44,194,736	0.0%	44,194,736	0.0%	44,194,736	0.0%	44,194,736	0.0%	44,194,736	0.0%
ACO RISK RESERVE/SETTLEMENT RECEIVABLE	7,824,341	5,000,000	-36.1%	5,387,997	7.8%	2,633,283	-51.1%	2,633,283	0.0%	2,633,283	0.0%	2,633,283	0.0%	2,633,283	0.0%	2,633,283	0.0%
OTHER CURRENT ASSETS	91,947,303	106,016,163	15.3%	100,384,287	-5.3%	87,008,141	-13.3%	87,008,141	0.0%	87,008,141	0.0%	87,008,141	0.0%	87,008,141	0.0%	87,008,141	0.0%
TOTAL CURRENT ASSETS	525,470,509	506,512,313	-3.6%	462,210,136	-8.7%	454,503,828	-1.7%	456,648,364	0.5%	479,523,059	5.0%	501,350,522	4.6%	524,654,713	4.6%	553,665,797	5.5%
BOARD DESIGNATED ASSETS					#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
FUNDED DEPRECIATION	623,698,615	633,297,209	1.5%	420,336,616	-33.6%	533,149,487	26.8%	533,149,487	0.0%	533,149,487	0.0%	533,149,487	0.0%	533,149,487	0.0%	533,149,487	0.0%
ESCROWED BOND FUNDS	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
OTHER	89,851,171	87,880,000	-2.2%	80,117,430	-8.8%	86,163,239	7.5%	86,163,239	0.0%	86,163,239	0.0%	86,163,239	0.0%	86,163,239	0.0%	86,163,239	0.0%
TOTAL BOARD DESIGNATED ASSETS	713,549,786	721,177,208	1.1%	500,454,046	-30.6%	619,312,726	23.8%	619,312,726	0.0%	619,312,726	0.0%	619,312,726	0.0%	619,312,726	0.0%	619,312,726	0.0%
PROPERTY, PLANT, AND EQUIPMENT																	
LAND, BUILDINGS & IMPROVEMENTS	917,753,544	957,180,476	4.3%	888,450,867	-7.2%	937,282,369	5.5%	1,043,205,860	11.3%	1,043,205,860	0.0%	1,043,205,860	0.0%	1,043,205,860	0.0%	1,043,205,860	0.0%
CONSTRUCTION IN PROGRESS	53,333,647	36,289,707	-32.0%	13,074,712	-64.0%	12,611,937	-3.5%	12,611,937	0.0%	12,611,937	0.0%	12,611,937	0.0%	12,611,937	0.0%	12,611,937	0.0%
MAJOR MOVABLE EQUIPMENT	494,082,075	525,773,537	6.4%	524,014,805	-0.3%	540,570,375	3.2%	540,570,375	0.0%	540,570,375	0.0%	540,570,375	0.0%	540,570,375	0.0%	540,570,375	0.0%
FIXED EQUIPMENT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	23,717,212	#DIV/0!	23,717,212	0.0%	23,717,212	0.0%	23,717,212	0.0%	32,473,960	36.9%
TOTAL PROPERTY, PLANT AND EQUIPMENT	1,465,169,266	1,519,243,720	3.7%	1,425,540,383	-6.2%	1,490,464,680	4.6%	1,620,105,384	8.7%	1,620,105,384	0.0%	1,620,105,384	0.0%	1,620,105,384	0.0%	1,628,862,132	0.5%
LESS: ACCUMULATED DEPRECIATION																	
LAND, BUILDINGS & IMPROVEMENTS	(453,534,588)	(492,874,419)	8.7%	(440,038,171)	-10.7%	(472,723,972)	7.4%	(474,403,528)	0.4%	(477,762,639)	0.7%	(481,121,750)	0.7%	(484,480,861)	0.7%	(487,839,972)	0.7%
EQUIPMENT - FIXED	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
EQUIPMENT - MAJOR MOVEABLE	(391,471,333)	(423,698,279)	8.2%	(379,773,321)	-10.4%	(407,269,970)	7.2%	(409,011,322)	0.4%	(412,494,026)	0.9%	(415,976,730)	0.8%	(419,459,433)	0.8%	(423,483,138)	1.0%
TOTAL ACCUMULATED DEPRECIATION	(845,005,921)	(916,572,698)	8.5%	(819,811,492)	-10.6%	(879,993,943)	7.3%	(883,414,850)	0.4%	(890,256,665)	0.8%	(897,098,480)	0.8%	(903,940,294)	0.8%	(911,323,110)	0.8%
TOTAL PROPERTY, PLANT AND EQUIPMENT, NET	620,163,346	602,671,022	-2.8%	605,728,891	0.5%	610,470,738	0.8%	736,690,534	20.7%	729,848,719	-0.9%	723,006,904	-0.9%	716,165,089	-0.9%	717,539,022	0.2%
OTHER LONG-TERM ASSETS	58,978,368	65,947,792	11.8%	60,959,416	-7.6%	60,172,363	-1.3%	60,172,363	0.0%	60,172,363	0.0%	60,172,363	0.0%	60,172,363	0.0%	60,172,363	0.0%
TOTAL ASSETS	**1,918,162,009**	**1,896,308,335**	-1.1%	**1,629,352,489**	-14.1%	**1,744,459,654**	7.1%	**1,872,823,986**	7.4%	**1,888,856,867**	0.9%	**1,903,842,515**	0.8%	**1,920,304,891**	0.9%	**1,950,689,907**	1.6%
LIABILITIES AND FUND BALANCE																	
CURRENT LIABILITIES																	
ACCOUNTS PAYABLE	29,741,085	42,892,632	44.2%	28,276,421	-34.1%	34,611,306	22.4%	34,611,306	0.0%	34,611,306	0.0%	34,611,306	0.0%	34,611,306	0.0%	34,611,306	0.0%
CURRENT LIABILITIES COVID-19	58,085,251	-	-100.0%	(0)	#DIV/0!	-	-100.0%	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
SALARIES, WAGES AND PAYROLL TAXES PAYAB	92,047,675	83,759,092	-9.0%	90,046,728	7.5%	89,192,219	-0.9%	89,192,219	0.0%	89,192,219	0.0%	89,192,219	0.0%	89,192,219	0.0%	89,192,219	0.0%
ESTIMATED THIRD-PARTY SETTLEMENTS	28,767,385	3,165,681	-89.0%	8,050,436	154.3%	6,624,963	-17.7%	6,624,963	0.0%	6,624,963	0.0%	6,624,963	0.0%	6,624,963	0.0%	6,624,963	0.0%
OTHER CURRENT LIABILITIES	63,370,962	54,494,848	-14.0%	85,921,645	57.7%	82,330,819	-4.2%	82,330,819	0.0%	82,330,819	0.0%	82,330,819	0.0%	82,330,819	0.0%	82,330,819	0.0%
CURRENT PORTION OF LONG-TERM DEBT	19,833,768	22,322,022	12.5%	21,996,899	-1.5%	20,841,423	-5.3%	20,841,423	0.0%	20,841,423	0.0%	20,841,423	0.0%	20,841,423	0.0%	20,841,423	0.0%
TOTAL CURRENT LIABILITIES	291,846,125	206,634,275	-29.2%	234,292,130	13.4%	233,600,729	-0.3%	233,600,729	0.0%	233,600,729	0.0%	233,600,729	0.0%	233,600,729	0.0%	233,600,729	0.0%
LONG-TERM DEBT																	
LONG TERM LIABILITIES COVID-19	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
BONDS & MORTGAGES PAYABLE	417,399,831	394,909,193	-5.4%	393,967,431	-0.2%	368,667,665	-6.4%	468,667,665	27.1%	468,667,665	0.0%	468,667,665	0.0%	468,667,665	0.0%	468,667,665	0.0%
CAPITAL LEASE OBLIGATIONS	-	1,162,611	#DIV/0!	-	-100.0%	696,297	#DIV/0!	696,297	0.0%	696,297	0.0%	696,297	0.0%	696,297	0.0%	696,297	0.0%
OTHER LONG-TERM DEBT	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
TOTAL LONG-TERM DEBT	417,399,831	396,071,804	-5.1%	393,967,431	-0.5%	369,363,962	-6.2%	469,363,962	27.1%	469,363,962	0.0%	469,363,962	0.0%	469,363,962	0.0%	469,363,962	0.0%
OTHER NONCURRENT LIABILITIES	55,311,830	67,303,398	21.7%	38,061,122	-43.4%	48,198,870	26.6%	48,198,870	0.0%	48,198,870	0.0%	48,198,870	0.0%	48,198,870	0.0%	48,198,870	0.0%
TOTAL LIABILITIES	**764,557,786**	**670,009,478**	-12.4%	**666,320,683**	-0.6%	**651,163,562**	-2.3%	**751,163,562**	15.4%	**751,163,562**	0.0%	**751,163,562**	0.0%	**751,163,562**	0.0%	**751,163,562**	0.0%
FUND BALANCE	1,153,604,222	1,226,298,857	6.3%	963,031,807	-21.5%	1,093,296,092	13.5%	1,099,801,934	0.6%	1,105,798,047	0.5%	1,114,707,175	0.8%	1,124,874,081	0.9%	1,148,737,196	2.1%
TOTAL LIABILITIES AND FUND BALANCE	**1,918,162,009**	**1,896,308,335**	-1.1%	**1,629,352,489**	-14.1%	**1,744,459,654**	7.1%	**1,850,965,496**	6.1%	**1,856,961,609**	0.3%	**1,865,870,737**	0.5%	**1,876,037,643**	0.5%	**1,899,900,758**	1.3%

The University of Vermont Medical Center

Outpatient Surgery Center

UTILIZATION PROJECTIONS--TABLE 7

	3	4	5	6	7	8											
					WITHOUT PROJECT												
	2021 Actual	**2022 Budget**	**% change**	**2022 Actual**	**% change**	**2023 Budget**	**% change**	**Proposed Yr 1 2025**	**% change**	**Proposed Yr 2 2026**	**% change**	**Proposed Yr 2 2027**	**% change**	**Proposed Yr 2 2028**	**% change**	**Proposed Yr 3 2029**	**% change**
Inpatient Utilization																	
Acute Beds (Staffed)	450	450	0.0%	450	0.0%	450	0.0%	450	0.0%	450	0.0%	450	0.0%	450	0.0%	450	0.0%
Acute Admissions	19,886	21,231	6.8%	19,918	-6.2%	21,124	6.1%	21,124	0.0%	21,124	0.0%	21,124	0.0%	21,124	0.0%	21,124	0.0%
Acute Patient Days	124,822	124,288	-0.4%	135,054	8.7%	126,641	-6.2%	126,641	0.0%	126,641	0.0%	126,641	0.0%	126,641	0.0%	126,641	0.0%
Acute Average Length Of Stay	6.30	5.85	-7.0%	6.79	16.0%	6.00	-11.7%	6.00	0.0%	6.00	0.0%	6.00	0.0%	6.00	0.0%	6.00	0.0%
Outpatient																	
All Outpatient Visits	-	-	#DIV/0!	-	#DIV/0!	644,455	#DIV/0!	644,455	0.0%	644,455	0.0%	644,455	0.0%	644,455	0.0%	644,455	0.0%
Physician Office Visits	602,974	647,412	7.4%	651,123	0.6%	684,609	5.1%	684,609	0.0%	684,609	0.0%	684,609	0.0%	684,609	0.0%	684,609	0.0%
Ancillary																	
All Operating Room (hours)	42,704	47,413	11.0%	41,302	-12.9%	46,469	12.5%	46,469	0.0%	46,469	0.0%	46,469	0.0%	46,469	0.0%	46,469	0.0%
All Operating Room Cases	18,962	20,300	7.1%	19,043	-6.2%	20,800	9.2%	20,800	0.0%	20,800	0.0%	20,800	0.0%	20,800	0.0%	20,800	0.0%
Emergency Room Visits	56,119	57,000	1.6%	63,809	11.9%	62,527	-2.0%	62,527	0.0%	62,527	0.0%	62,527	0.0%	62,527	0.0%	62,527	0.0%
Cat Scan Procedures	56,038	58,869	5.1%	62,658	6.4%	61,681	-1.6%	61,681	0.0%	61,681	0.0%	61,681	0.0%	61,681	0.0%	61,681	0.0%
Magnetic Resonance Image Exams	17,813	21,174	18.9%	21,252	0.4%	22,213	4.5%	22,213	0.0%	22,213	0.0%	22,213	0.0%	22,213	0.0%	22,213	0.0%
Nuclear Medicine Procedures	6,412	7,043	9.8%	6,849	-2.8%	7,180	4.8%	7,180	0.0%	7,180	0.0%	7,180	0.0%	7,180	0.0%	7,180	0.0%
Radiology - Diagnostic Procedures	157,795	182,671	15.8%	179,781	-1.6%	178,834	-0.5%	178,834	0.0%	178,834	0.0%	178,834	0.0%	178,834	0.0%	178,834	0.0%
Laboratory Tests	2,539,159	2,448,931	-3.6%	2,697,060	10.1%	2,424,803	-10.1%	2,424,803	0.0%	2,424,803	0.0%	2,424,803	0.0%	2,424,803	0.0%	2,424,803	0.0%
			#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
			#DIV/0!		#DIV/0!		#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Adjusted Statistics																	
Adjusted Admissions	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Adjusted Days	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!

The University of Vermont Medical Center

Outpatient Surgery Center

UTILIZATION PROJECTIONS--TABLE 7

PROJECT ONLY

	2021 Actual	2022 Budget	% change	2022 Actual	% change	2023 Budget	% change	Proposed Yr 1 2025	% change	Proposed Yr 2 2026	% change	Proposed Yr 2 2027	% change	Proposed Yr 2 2028	% change	Proposed Yr 3 2029	% change
Inpatient Utilization																	
Acute Beds (Staffed)			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Acute Admissions			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Acute Patient Days			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Acute Average Length Of Stay			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Outpatient																	
All Outpatient Visits			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Physician Office Visits			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Ancillary																	
All Operating Room Procedure			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
All Operating Room Cases			#DIV/0!		#DIV/0!		#DIV/0!	1,689	#DIV/0!	3,071	81.8%	3,275	6.7%	3,224	-1.6%	4,341	34.7%
Emergency Room Visits			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Cat Scan Procedures			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Magnetic Resonance Image Exams			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Nuclear Medicine Procedures			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Radiology - Diagnostic Procedures			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Laboratory Tests			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Adjusted Statistics																	
Adjusted Admissions			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Adjusted Days			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!

The University of Vermont Medical Center

Outpatient Surgery Center

UTILIZATION PROJECTIONS--TABLE 7

Note: This table requires no "fill-in" as it is populated automatically

WITH PROJECT

	2021 Actual	2022 Budget	% change	2022 Actual	% change	2023 Budget	% change	Proposed Yr 1 2025	% change	Proposed Yr 2 2026	% change	Proposed Yr 2 2027	% change	Proposed Yr 2 2028	% change	Proposed Yr 3 2029	% change
Inpatient Utilization																	
Acute Beds (Staffed)	450	450	0.0%	450	0.0%	450	0.0%	450	0.0%	450	0.0%	450	0.0%	450	0.0%	450	0.0%
Acute Admissions	19,886	21,231	6.8%	19,918	-6.2%	21,124	6.1%	21,124	0.0%	21,124	0.0%	21,124	0.0%	21,124	0.0%	21,124	0.0%
Acute Patient Days	124,822	124,288	-0.4%	135,054	8.7%	126,641	-6.2%	126,641	0.0%	126,641	0.0%	126,641	0.0%	126,641	0.0%	126,641	0.0%
Acute Average Length Of Stay	6.30	5.85	-7.0%	6.79	16.0%	6.00	-11.7%	6.00	0.0%	6.00	0.0%	6.00	0.0%	6.00	0.0%	6.00	0.0%
Outpatient																	
All Outpatient Visits	-	-	#DIV/0!	-	#DIV/0!	644,455	#DIV/0!	644,455	0.0%	644,455	0.0%	644,455	0.0%	644,455	0.0%	644,455	0.0%
Physician Office Visits	602,974	647,412	7.4%	651,123	0.6%	684,609	5.1%	684,609	0.0%	684,609	0.0%	684,609	0.0%	684,609	0.0%	684,609	0.0%
Ancillary																	
All Operating Room Procedure	42,704	47,413	11.0%	41,302	-12.9%	46,469	12.5%	46,469	0.0%	46,469	0.0%	46,469	0.0%	46,469	0.0%	46,469	0.0%
All Operating Room Cases	18,962	20,300	7.1%	19,043	-6.2%	20,800	9.2%	22,489	8.1%	23,871	6.1%	24,075	0.9%	24,024	-0.2%	25,141	4.7%
Emergency Room Visits	56,119	57,000	1.6%	63,809	11.9%	62,527	-2.0%	62,527	0.0%	62,527	0.0%	62,527	0.0%	62,527	0.0%	62,527	0.0%
Cat Scan Procedures	56,038	58,869	5.1%	62,658	6.4%	61,681	-1.6%	61,681	0.0%	61,681	0.0%	61,681	0.0%	61,681	0.0%	61,681	0.0%
Magnetic Resonance Image Exams	17,813	21,174	18.9%	21,252	0.4%	22,213	4.5%	22,213	0.0%	22,213	0.0%	22,213	0.0%	22,213	0.0%	22,213	0.0%
Nuclear Medicine Procedures	6,412	7,043	9.8%	6,849	-2.8%	7,180	4.8%	7,180	0.0%	7,180	0.0%	7,180	0.0%	7,180	0.0%	7,180	0.0%
Radiology - Diagnostic Procedures	157,795	182,671	15.8%	179,781	-1.6%	178,834	-0.5%	178,834	0.0%	178,834	0.0%	178,834	0.0%	178,834	0.0%	178,834	0.0%
Laboratory Tests	2,539,159	2,448,931	-3.6%	2,697,060	10.1%	2,424,803	-10.1%	2,424,803	0.0%	2,424,803	0.0%	2,424,803	0.0%	2,424,803	0.0%	2,424,803	0.0%
	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Adjusted Statistics																	
Adjusted Admissions	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!
Adjusted Days	-	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!	-	#DIV/0!

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Outpatient Surgery Center

3 4 5 6 7 8

STAFFING REPORT - TABLE 8

WITHOUT PROJECT

	2021 Actual	2022 Budget	% change	2022 Budget	% change	2023 Budget	% change	Proposed Year 1 2025	% change	Proposed Year 2 2026	% change	Proposed Year 3 2027	% change	Proposed Year 4 2028	% change	Proposed Year 5 2029	% change
PHYSICIAN FTEs	**628.2**	**648.3**	3.2%	**634.5**	-2.1%	**677.5**	6.8%	**677.5**	0.0%	**677.5**	0.0%	**677.5**	0.0%	**677.5**	0.0%	**677.5**	0.0%
TRAVELERS	203.6	80.0	-60.7%	392.9	391.1%	228.0	-42.0%	228.0	0.0%	228.0	0.0%	228.0	0.0%	228.0	0.0%	228.0	0.0%
Residents & Fellows	356.9	369.2	3.4%	360.8	-2.3%	364.8	1.1%	364.8	0.0%	364.8	0.0%	364.8	0.0%	364.8	0.0%	364.8	0.0%
MLPs	236.7	260.1	9.9%	242.1	-6.9%	292.2	20.7%	292.2	0.0%	292.2	0.0%	292.2	0.0%	292.2	0.0%	292.2	0.0%
Non-MD FTEs	5,994.9	6,303.8	5.2%	6,031.8	-4.3%	6,410.3	6.3%	6,410.3	0.0%	6,410.3	0.0%	6,410.3	0.0%	6,410.3	0.0%	6,410.3	0.0%
TOTAL NON-MD FTEs	**6,588.5**	**6,933.1**	5.2%	**6,634.6**	-4.3%	**7,067.3**	6.5%	**7,067.3**	0.0%	**7,067.3**	0.0%	**7,067.3**	0.0%	**7,067.3**	0.0%	**7,067.3**	0.0%

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Outpatient Surgery Center

3 4 5 6 7 8

STAFFING REPORT - TABLE 8

PROJECT ONLY

	2021 Actual	2022 Budget	% change	2022 Budget	% change	2023 Budget	% change	Proposed Year 1 2025	% change	Proposed Year 2 2026	% change	Proposed Year 3 2027	% change	Proposed Year 4 2028	% change	Proposed Year 5 2029	% change
PHYSICIAN FTEs			#DIV/0!		#DIV/0!		#DIV/0!	**2.6**	#DIV/0!	**5.2**	100.0%	**5.2**	0.0%	**5.2**	0.0%	**7.2**	38.5%
TRAVELERS			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Residents & Fellows			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
MLPs			#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Non-MD FTEs			#DIV/0!		#DIV/0!		#DIV/0!	36.3	#DIV/0!	72.5	100.0%	72.5	0.0%	72.5	0.0%	92.3	27.3%
TOTAL NON-MD FTEs	**-**	**-**	#DIV/0!	**-**	#DIV/0!	**-**	#DIV/0!	**36.3**	#DIV/0!	**72.5**	100.0%	**72.5**	0.0%	**72.5**	0.0%	**92.3**	27.3%

THE UNIVERSITY OF VERMONT MEDICAL CENTER

Outpatient Surgery Center

3 4 5 6 7 8

Note: This table requires no "fill-in" as it is populated automatically

STAFFING REPORT - TABLE 8

WITH PROJECT

	2021 Actual	2022 Budget	% change	2022 Budget	% change	2023 Budget	% change	Proposed Year 1 2025	% change	Proposed Year 2 2026	% change	Proposed Year 3 2027	% change	Proposed Year 4 2028	% change	Proposed Year 5 2029	% change
PHYSICIAN FTEs	**628.2**	**648.3**	3.2%	**634.5**	-2.1%	**677.5**	6.8%	**680.1**	0.4%	**682.7**	0.4%	**682.7**	0.0%	**682.7**	0.0%	**684.7**	0.3%
TRAVELERS	203.6	80.0	-60.7%	392.9	391.1%	228.0	-42.0%	228.0	0.0%	228.0	0.0%	228.0	0.0%	228.0	0.0%	228.0	0.0%
Residents & Fellows	356.9	369.2	3.4%	360.8	-2.3%	364.8	1.1%	364.8	0.0%	364.8	0.0%	364.8	0.0%	364.8	0.0%	364.8	0.0%
MLPs	236.7	260.1	9.9%	242.1	-6.9%	292.2	20.7%	292.2	0.0%	292.2	0.0%	292.2	0.0%	292.2	0.0%	292.2	0.0%
Non-MD FTEs	5,994.9	6,303.8	5.2%	6,031.8	-4.3%	6,410.3	6.3%	6,446.5	0.6%	6,482.8	0.6%	6,482.8	0.0%	6,482.8	0.0%	6,502.6	0.3%
TOTAL NON-MD FTEs	**6,588.5**	**6,933.1**	5.2%	**6,634.6**	-4.3%	**7,067.3**	6.5%	**7,103.5**	0.5%	**7,139.8**	0.5%	**7,139.8**	0.0%	**7,139.8**	0.0%	**7,159.6**	0.3%

THE University of Vermont MEDICAL CENTER

Outpatient Surgery Center

Tilley Drive, South Burlington, Vermont

Guidelines For Design and Construction of Outpatient Facilities

2018 Edition

Outpatient Surgery Facilities Checklist

February 28, 2023
Rev-0[1]

e4h ENVIRONMENTS FOR HEALTH ARCHITECTURE

	Architectural Requirements	Building Systems Requirements	
2.7	**OUTPATIENT SURGERY FACILITIES**		
2.7-1.1	**APPLICATION**		
2.7-1.1.1	YES Outpatient facilities where same-day surgery is performed		
2.7-1.3.2	**PARKING**		
	YES Space reserved or designated for pickup of patients after recovery		
2.7-2	**ACCOMMODATIONS FOR CARE OF PATIENTS OF SIZE**		
2.1-2.1.1.2	☑ check if not included in project (only if a Patient Handling & Movement Assessment that determines that the outpatient service does not have a need for expanded-capacity lifts & architectural details that support movement of patients of size in patient areas is attached to the Project Narrative)		
2.1-2.1.2	Location:		
	N/A spaces designated for care of or use by patients of size are provided in locations to accommodate population expected to be served by facility		
2.1-2.5	**N/A** Handwashing stations		
2.1-2.5.2	**N/A** downward static force required for handwashing stations designated for patients of size accommodates maximum patient weight of patient population		
2.1-2.6	**N/A** Patient toilet room		
2.1-2.6.1	**N/A** expanded-capacity toilet	Ventilation:	
	N/A mounted min. 36 inches from finished wall to centerline of toilet on both sides (for caregiver assistance with lifts)	**N/A** Min. 10 air changes per hour	Table 8.1
		N/A Exhaust	
		N/A Negative pressure	
		N/A No recirculating room units	
	or		
2.1-2.6.2	**N/A** regular toilet		
	N/A mounted min. 44 inches from centerline of toilet on both sides to finished walls to allow for positioning of expanded-capacity commode over toilet		
2.1-2.6.3	**N/A** rectangular clear floor area min. 46” wide extends 72” from front of toilet		
2.1-2.7	**N/A** Single-patient exam/observation room		
2.1-2.7.1	Space Requirements:		
2.1-2.7.1.1(1)	**N/A** min. 5'-0" clearance at foot of expanded-capacity exam table	Ventilation:	
		N/A Min. 4 air changes per hour	Table 8.1
(2)	**N/A** min. 3'-0" clearance on non-transfer side of expanded- capacity exam table	Lighting:	
		N/A Portable or fixed exam light	2.1-8.3.4.3(1)

Architectural Requirements

(3)(a) ___ min. 5'-0" on transfer side of expanded-capacity exam table with ceiling- or wall-mounted lift

or

(3)(b) **N/A** min. 7'-0" on transfer side of expanded-capacity exam table in rooms without ceiling- or wall-mounted lift

2.1-2.8 **N/A** Equipment & supply storage

2.1-2.9 YES Waiting areas

2.1-2.9.1 ✓ seating for persons of size be provided in waiting areas in outpatient facilities

2.1-2.9.2 ✓ waiting areas be sized to accommodate expanded-capacity furniture required for patients & visitors of size

2.1-2.10.1 **N/A** All plumbing fixtures, handrails, grab bars, patient lift, equipment, built-in furniture & other furnishings designed to accommodate maximum patient weight

2.1-2.10.2 Door Openings:

2.1-2.10.2.1 **N/A** all door openings used for path of travel to public areas & areas where care will be provided for patients of size have min. clear width of 45.5"

2.1-2.10.2.2 **N/A** door openings to toilet rooms designated for patients of size have min. clear width of 45.5"

2.7-3 **PATIENT CARE & DIAGNOSTIC AREAS**

2.7-3.1.1 Location & Layout:

2.7-3.1.1.4 YES outpatient surgery facility is divided into unrestricted area, semi-restricted area & restricted area

YES areas defined by physical activities performed in each area

2.7-3.1.1.1 YES semi-restricted & restricted areas are arranged to prevent unrelated traffic through those spaces

2.7-3.1.1.2 YES patient care areas are designed to facilitate movement of patients & personnel into through & out of defined areas in surgery facility

2.7-3.1.1.3 YES signs that clearly indicate where surgical attire is required are provided at all entrances to semi-restricted areas

Building Systems Requirements

Power:

N/A Min. 8 receptacles Table 2.1-1

N/A 4 convenient to head of exam table or gurney

	Architectural Requirements	Building Systems Requirements	
2.7-3.2	NO Examination room ☑ check if not included in project		
2.7-3.2.2	(use of procedure room as examination room is permitted)		
2.7-3.2.1	**N/A** located in unrestricted area		
2.1-3.2.1.2	Space Requirements:		
(2)(a)	**N/A** min. clear floor area of 80 sf		
	N/A room size allows min. clearance 2'-8" at each side & at foot of exam table or recliner	Ventilation: **N/A** Min. 4 air changes per hour	Table 8.1
	N/A room arrangement shown in the plans for each exam room (Layout #1)	Power: **N/A** Min. 8 receptacles **N/A** 4 convenient to head of exam table or gurney	Table 2.1-1
(3)	Exam Room Features:		
(a)	**N/A** portable or fixed exam light		
(b)	**N/A** storage for supplies		
(c)	**N/A** accommodations for written or electronic documentation		
(d)	**N/A** space for visitor's chair		
(e)	**N/A** handwashing station		
2.7-3.3	NO Procedure room ☑ check if not included in project		
2.1-3.2.2.1(1)	**N/A** procedure room is designated for the performance of patient care that requires high-level disinfection or sterile instruments & some environmental controls but is not required to be performed with the environmental controls of an operating room		
	N/A Project Narrative states that a clinical assessment of procedures to be performed in facility has been conducted by medical director to determine appropriate room type & location for these procedures		
(2)(a)	**N/A** procedure room meet requirements of semi-restricted area		
2.1-3.2.2.2	Space Requirements:		
(1)(a)	**N/A** procedure rooms without anesthesia machine & supply cart	Ventilation:	
(3)	**N/A** min. clear floor area 130 sf (fixed encroachments allowed if they extend max. 12" into min. clear floor area & their width along each wall does not exceed 10% of wall length)	**N/A** Min. 15 air changes per hour **N/A** Positive pressure **N/A** No recirculating room units Power: **N/A** Min. 12 receptacles **N/A** 8 convenient to table placement **N/A** At least 1 on each wall	Table 8.1 Table 2.1-1
(2)(a)	**N/A** min. clearance 3'-6" on each side procedure table or chair **N/A** min. clearance 3'-0" at head & foot procedure table or chair	Medical Gases: **N/A** 1 OX, 1 VAC (may be portable)	Table 2.1-2
	or		

	Architectural Requirements	Building Systems Requirements	
(b)	**N/A** procedure rooms with anesthesia machine & supply cart	Ventilation:	
	N/A min. clear floor area 160 sf	**N/A** Min. 15 air changes per hour	Table 8.1
(3)	(fixed encroachments allowed if they extend max. 12" into min. clear floor area & their width along each wall does not exceed 10% of wall length)	**N/A** Positive pressure ___ No recirculating room units	
		Power:	
		N/A Min. 12 receptacles	
		N/A 8 convenient to table placement	
		N/A At least 1 on each wall	
(2)(a)	**N/A** min. clearance 3'-6" on each side procedure table or chair	Medical Gases:	
		N/A 1 OX, 1 VAC (may be portable)	Table 2.1-2
(2)(b)	**N/A** min. clearance 6'-0" at head of procedure table or chair		
2.1-3.2.2.3	**N/A** documentation area		
(1)	**N/A** accommodations for written or electronic documentation		
(2)	**N/A** allows for direct observation of patient when in use		
2.1-3.2.2.4	**N/A** provisions for patient privacy		
2.1-3.2.2.5			
(1)	**N/A** handwashing station		
	or		
(2)	**N/A** hand scrub station		
	N/A directly accessible* to procedure room		
2.1-3.2.2.8	**Support Areas for Procedure Room:**		
(1)(b)	(may be shared with other clinical services in facility)		
(8)	**N/A** medication safety zones		
2.1-3.8.8.1(2)	Design Promoting Safe Medication Use:		
(a)	**N/A** medication safety zones located out of circulation paths		
(b)	**N/A** work space designed so that staff can access information & perform required tasks		
(c)	**N/A** work counters provide space to perform required tasks		
(e)	**N/A** sharps containers placed at height that allows users to see top of container		
2.1-3.8.8.2			
(1)	**N/A** medication preparation room	Ventilation:	
(a)	**N/A** work counter	**N/A** Min. 4 air changes per hour	Table 8.1
	N/A handwashing station		
	N/A lockable refrigerator		
	N/A locked storage for controlled drugs		
	N/A sharps containers		
	☐ check if not included in project		

	Architectural Requirements	Building Systems Requirements	
(b)	**N/A** self-contained medication dispensing units ☐ check if not included in project **N/A** room designed with space to prepare medications	Lighting: **N/A** Task lighting	2.1-2.8.8.1(2)(d)
	or		
(2)	**N/A** automated medication-dispensing unit		
(a)	**N/A** located at nurse station, in clean workroom or in alcove	Lighting: **N/A** Task lighting	2.1-3.8.8.1(2)(d)
(b)	**N/A** handwashing station or hand sanitation dispenser provided next to stationary medication-dispensing units		
(c)	**N/A** countertop or cart provided adjacent* to stationary medication-dispensing units		
2.1-3.2.2.8(11)	**N/A** clean storage		
(a)	**N/A** storage area for clean/sterile supplies		
2.1-3.8.11.2	NO clean workroom ☑ check if not included in project (only if facility does not have more than one procedure room)		
(11)(b)			
(1)	**N/A** work counter		
(2)	**N/A** handwashing station	Ventilation:	
(3)	**N/A** storage facilities for clean & sterile supplies	**N/A** Min. 4 air changes per hour **N/A** Positive pressure	Table 8.1
2.1-3.2.2.8(12)	**N/A** soiled holding **N/A** space for holding soiled materials **N/A** separate from clean storage area	Ventilation: **N/A** Min. 10 air changes per hour **N/A** Exhaust **N/A** Negative pressure **N/A** No recirculating room units	Table 8.1
2.1-3.2.3.8(16)	YES Facilities for on-site sterile processing ☐ check if not included in project (if sterile processing is performed off-site) NO Compliance Checklist OP4 has been submitted		

	Architectural Requirements	Building Systems Requirements
2.7-3.4	YES Outpatient operating rooms	
2.1-3.2.3.1(1)	Application:	
	✓ rooms designated for performance of invasive procedures as defined in Glossary	
2.1-3.2.3.1(2)	YES outpatient operating room meets requirements of restricted area	
2.1-3.2.3.2	Space Requirements:	Ventilation:
(3)	(may include minor wall encroachments of max. 12" deep by max. 10% of wall length)	✓ Min. 20 air changes per hour Table 8.1 ✓ Positive pressure ✓ No recirculating room units
(1)(a)	✓ min. clear floor area 255 sf	Power:
		✓ Min. 36 receptacles Table 2.1-1
(2)(a)	✓ min. clearance 6'-0" on each side	✓ 12 convenient to operating table ✓ 2 on each wall
	✓ min. clearance 5'-0" at head & foot	
	YES OR Includes Anesthesia Machine & Supply Cart:	Nurse Call System:
	☐ check if not included in project	✓ Staff assistance station ✓ Emergency call station Table 2.1-3
(1)(b)	✓ min. clear floor area 270 sf	Medical Gases:
(2)(b)	✓ min. clearance 6'-0" on each side	✓ 2 OX, 3 VAC ✓ 1 MA (may be portable) Table 2.1-2
	✓ 6'-0" x 8'-0" at head	
	✓ results in anesthesia work zone with clear floor area of 48 sf	
	✓ min. clearance 5'-0" at foot	
(1)(c)	OR Sized for Additional Staff & Equipment:	
	☐ check if not included in project	
	✓ min. clear floor area 400 sf	
(2)(c)	✓ min. clearance 8'-6" on each side	
	✓ min. clearance 6'-0" at head	
	✓ results in anesthesia work zone with clear floor area of 48 sf	
	✓ min. clearance 7'-0" at foot	
2.1-3.2.3.3	YES documentation area	
(1)	✓ accommodations for written and/or electronic documentation be provided in operating room	
(2)	✓ use of documentation area allows for direct observation of patient	
2.1-3.2.3.4	YES medical image viewers (e.g. X-ray film or digital)	

	Architectural Requirements	Building Systems Requirements	
2.1-3.2.3.5	YES hand scrub facilities		
2.1-3.8.6.1	✓ at least one hand scrub position located in semi-restricted area for each operating room		
2.1-3.8.6.2	✓ located next to entrance to each room (one hand scrub station consisting of two scrub positions may be shared if located adjacent* to entrance of each room)		
2.1-3.8.6.3	✓ placement of scrub stations does not restrict min. required corridor width		
2.1-3.2.3.8	**Support Areas for Operating Rooms:**		
2.1-3.2.3.8(8)	YES medication safety zone		
2.1-3.8.8.1(2)	Design Promoting Safe Medication Use:		
(a)	✓ medication safety zones located out of circulation paths		
(b)	✓ work space designed so that staff can access information & perform required tasks	Lighting: ✓ Task-specific lighting level min. 100 foot-candles	2.1-3.8.8.1(2)(d)
(c)	✓ work counters provide space to perform required tasks		
(e)	✓ sharps containers placed at height that allows users to see top of container		
2.1-3.8.8.2			
(1)	YES medication preparation room	Ventilation:	
(a)	✓ work counter ✓ handwashing station ✓ lockable refrigerator ✓ locked storage for controlled drugs ✓ sharps containers ☐ check if not included in project	✓ Min. 4 air changes per hour Lighting: ✓ Task lighting	Table 8.1 2.1-3.8.8.1(2)(d)
(b)	✓ self-contained medication dispensing units ☐ check if not included in project ✓ room designed with space to prepare medications		
	or		
(2)	YES automated medication-dispensing unit		
(a)	✓ located at nurse station, in clean workroom or in alcove	Lighting: ✓ Task lighting	2.1-3.8.8.1(2)(d)
(b)	✓ handwashing station or hand sanitation dispenser provided next to stationary medication-dispensing units		

	Architectural Requirements	Building Systems Requirements	
(c)	✓ countertop or cart provided adjacent* to stationary medication-dispensing units		
2.1-3.2.3.8(11)	Clean Storage:		
(a)	NO storage area for clean/sterile supplies (only in facilities with only one operating room)		
	or		
(b)	YES clean workroom		
2.1-3.8.11.2(1)	✓ work counter		
2.1-3.8.11.2(2)	✓ handwashing station	Ventilation:	
2.1-3.8.11.2(3)	✓ storage facilities for clean & sterile supplies	✓ Min. 4 air changes per hour ✓ Positive pressure	Table 8.1
2.1-3.2.3.8(12)	YES Soiled holding space		
2.1-3.2.2.8(12)	✓ space for holding soiled materials ✓ separate from clean storage area	Ventilation: ✓ Min. 10 air changes per hour ✓ Exhaust ✓ Negative pressure ✓ No recirculating room units	Table 8.1
2.1-3.2.3.8(16)	YES Facilities for on-site sterile processing ☐ check if not included in project (if sterile processing is performed off-site)		
2.7-3.5	**PRE- & POSTOPERATIVE PATIENT CARE**		
2.1-3.2.2.8(17)	☐ check if not included in project (only if pre- & post-procedure patient care station located in procedure room)		
2.1-3.7.1.1	✓ Patient care stations accommodate lounge chairs, gurneys or beds for pre- & post-procedure (recovery) patient care ✓ Patient care stations accommodate seating space for family/visitors		
2.1-3.7.1.2	✓ Location in unrestricted area		
2.1-3.7.1.3	Layout:		
(1)(a)	NO combination of pre- & post-procedure patient care stations in one patient care area **N/A** patient care stations combined in same area meet most restrictive requirements of areas to be combined		
	or		
(b)	NO separate pre-procedure patient care area & post-procedure recovery area		
	or		
(c)	YES three areas: pre-procedure patient care area, Phase I post-anesthesia care unit (PACU) & Phase II recovery area		

	Architectural Requirements	Building Systems Requirements	
2.1-3.7.1.4	Number of Patient Care Stations:		
(1)	NO pre- & post-procedure patient care stations combined in one area ☑ check if not included in project **N/A** at least one patient care station provided for each imaging procedure or operating room		
(2)	YES separate pre-procedure & recovery areas ☐ check if not included in project		
2.1-3.7.3	✓ pre-procedure patient care room or area provides min. of one patient care station per imaging room, procedure room or operating room		
2.1-3.7.5	✓ Phase II recovery room or area provides min. one Phase II patient care station per procedure room		
	(Prep and Phase 2 Recliner Bays)		
2.1-3.7.2.2	Space Requirements: (Prep and Phase 2 Recliner Bays)		
(2)	YES patient care bays ☐ check if not included in project		
(a)	✓ min. clearance 5'-0" between sides of patient beds/gurneys/lounge chairs ✓ min. clearance 3'-0" between sides of patient beds/gurneys/lounge chairs & adjacent* walls or partitions ✓ min. clearance 2'-0" between foot of patient beds/gurneys/lounge chairs & cubicle curtain	Ventilation: ✓ Min. 6 air changes per hour ✓ No recirculating room units Power: ✓ Min. 4 receptacles ✓ Convenient to patient Nurse Call System: ✓ Patient station ✓ Staff assistance station ✓ Emergency call station	Table 8.1 Table 2.1-1 Table 2.1-3
(b)	YES patient care cubicles ☐ check if not included in project ✓ min. clearance 3'-0" between sides of patient beds/gurneys/lounge chairs & adjacent* walls or partitions ✓ min. clearance 2'-0" between foot of patient beds/gurneys/lounge chairs & cubicle curtain	Ventilation: ✓ Min. 6 air changes per hour ✓ No recirculating room units Power: ✓ Min. 4 receptacles ✓ Convenient to patient Nurse Call System: ✓ Patient station ✓ Staff assistance station ✓ Emergency call station	Table 8.1 Table 2.1-1 Table 2.1-3
(c)	NO bays or cubicles face each other ☑ check if not included in project **N/A** aisle with min. clearance 8'-0" independent of foot clearance between patient stations or other fixed objects		

	Architectural Requirements	Building Systems Requirements	
	YES single-patient rooms ☐ check if not included in project ✓ min. clearance 3'-0" between sides & foot of beds/gurneys/lounge chairs & adjacent* walls or partitions	Ventilation: ✓ Min. 6 air changes per hour ✓ No recirculating room units Power: ✓ Min. 4 receptacles ✓ Convenient to patient Nurse Call System: ✓ Patient station ✓ Staff assistance station ✓ Emergency call station	Table 8.1 Table 2.1-1 Table 2.1-3
2.1-3.7.2.4	✓ Provisions made for patient privacy		
2.1-3.7.2.5			
2.1-3.8.7	YES Handwashing stations		
2.1-3.8.7.1	✓ located in each room where hands-on patient care is provided		
2.1-3.8.7.3	YES handwashing station serves multiple patient care stations (Phase 2) ☐ check if not included in project		
(1)	✓ at least one handwashing station provided for every four patient care stations or fewer & for each major fraction thereof		
(2)	✓ handwashing stations evenly distributed based on arrangement of patient care stations		
2.7-3.5.8	**Support Areas for Pre- & Postoperative Patient Care Areas:**		
2.7-3.5.8.1	✓ Provided in or directly accessible* to pre- & postoperative patient care areas		
2.7-3.5.8.2	YES Nurse station		
2.1-3.8.2.1	✓ work counter		
2.1-3.8.2.2	✓ means for facilitating staff communication		
2.1-3.8.2.3	✓ space for supplies		
2.1-3.8.2.4	✓ accommodations for written or electronic documentation		
2.1-3.8.2.5	✓ hand sanitation dispenser		
2.7-3.5.8.8	YES Medication safety zone		
2.1-3.8.8.1(2)	Design Promoting Safe Medication Use:		
(a)	✓ medication safety zones located out of circulation paths		
(b)	✓ work space designed so that staff can access information & perform required tasks	Lighting: ✓ Task-specific lighting level min. 100 foot-candles	2.1-3.8.8.1(2)(d)
(c)	✓ work counters provide space to perform required tasks		
(e)	✓ sharps containers placed at height that allows users to see top of container		

	Architectural Requirements	Building Systems Requirements	
2.1-3.8.8.2			
(1)	YES Medication preparation room	Ventilation:	
(a)	✓ work counter	___ Min. 4 air changes per hour	Table 8.1
	✓ handwashing station		
	✓ lockable refrigerator		
	✓ locked storage for controlled drugs		
	✓ sharps containers		
	☐ check if not included in project		
(b)	✓ self-contained medication dispensing units	Lighting:	
	☐ check if not included in project	✓ Task lighting	2.1-2.8.8.1(2)(d)
	✓ room designed with space to prepare medications		
	or		
(2)	YES Automated medication-dispensing unit		
(a)	✓ located at nurse station, in clean workroom or in alcove	Lighting:	
		✓ Task lighting	2.1-3.8.8.1(2)(d)
(b)	✓ handwashing station or hand sanitation dispenser provided next to stationary medication-dispensing units		
(c)	✓ countertop or cart provided adjacent* to stationary medication-dispensing units		
2.7-3.5.8.9	YES Nourishment area		
(1)	✓ directly accessible* to postoperative patient care area		
2.1-3.8.9.1	✓ handwashing station in or directly accessible* to nourishment area	Ventilation:	
		✓ Min. 2 air changes per hour	Table 8.1
2.1-3.8.9.2	✓ work counter		
2.1-3.8.9.3	✓ storage		
2.1-3.8.9.4	✓ fixtures & appliances for beverages & nourishment		
2.7-3.5.8.10	YES Ice-making equipment		
(2)	✓ not located in semi-restricted area		
2.1-3.8.10.1	✓ self-dispensing type		
	or		
2.1-3.8.10.2	___ ice-making equipment of bin-type		
	___ located in area restricted to staff		
2.7-3.7.12.1	YES Soiled workroom		
2.7-3.5.8.12	(may be combined with soiled workroom serving semi-restricted area if directly accessible* to pre- & postoperative patient care areas)		
(1)			
(a)	✓ handwashing station	Ventilation:	
(b)	✓ flushing-rim clinical service sink or equivalent flushing-rim fixture	✓ Min. 10 air changes per hour ✓ Exhaust	Table 8.1

	Architectural Requirements	Building Systems Requirements	
(c)	✓ work counter	✓ Negative pressure	
(d)	✓ space for separate covered containers for waste & soiled linen	✓ No recirculating room units	
2.7-3.5.8.13	YES Equipment & supply storage		
	✓ dedicated storage for equipment & supplies		
	or		
(2)	YES location of storage for equipment & supplies in Clean Equipment & Supply Storage Room		
	✓ storage room directly accessible* to pre- & post-operative patient care areas		
2.7-3.5.8.13(4)	YES Emergency equipment storage		
2.1-3.8.13.4(2)	✓ readily accessible*		
	✓ under staff control		
2.1-3.8.13.4(3)	✓ storage of battery-powered CPR cart		
	✓ electrical outlet for battery charging is provided		
	Support Areas for Staff:		
2.7-3.5.9.2	YES Staff toilet room (may be located in staff changing area)		
(2)			
(1)	✓ immediately accessible* to pre- & postoperative patient care areas		
2.7-3.5.10	**Support Areas for Patients & Visitors:**		
2.7-3.5.10.2	YES Patient toilet rooms	Ventilation:	
(1)(a)	✓ directly accessible* to each pre- & postoperative patient care area	✓ Min. 10 air changes per hour	Table 8.1
		✓ Exhaust	
		✓ Negative pressure	
		✓ No recirculating room units	
(c) + Errata	YES toilet rooms directly accessible* from single-patient rooms used for Airborne Infection Isolation (AII)		
	☐ check if not included in project (only if no AII room is provided)		
(2)(a)	YES additional shared toilets provided at ratio of 1 patient toilet for each 8 patient care stations or fewer & for each major fraction thereof		

	Architectural Requirements	Building Systems Requirements	
2.7-3.6	**SUPPORT AREAS IN SEMI-RESTRICTED AREA**		
2.7-3.6.2	YES Nurse or control station		
2.7-3.6.2.1	✓ located in semi-restricted area **or** ✓ located in unrestricted area NO directly accessible* to semi-restricted area		
2.7-3.6.2.2	YES permits direct visual observation of traffic into semi-restricted area		
2.7-3.6.2.3	YES access through all entries to semi-restricted area are controlled		
2.7-3.6.6	YES Hand scrub facilities		
2.1-3.8.6.1	___ at least one hand scrub position located in semi-restricted area for each operating room		
2.1-3.8.6.2	✓ located next to entrance to each room (one hand scrub station consisting of two scrub positions may be shared if located adjacent* to entrance of each room)		
2.1-3.8.6.3	✓ the placement of scrub station(s) does not restrict min. required corridor width		
2.7-3.6.13.4	YES Emergency equipment storage		
2.1-3.8.13.4(2)	✓ readily accessible*		
	✓ under staff control		
2.1-3.8.13.4(3)	✓ storage of battery-powered CPR cart		
	✓ electrical outlet for battery charging is provided		
2.7-3.6.14	YES Environmental services room		
2.7-3.6.14.1	✓ environmental services room is not shared with other areas	Ventilation:	
		✓ Min. 10 air changes per hour	Table 8.1/ Policy
2.7-3.6.14.2	✓ accessed from semi-restricted corridor	✓ Exhaust	
2.1-5.3.1.2(1)	✓ service sink or floor-mounted mop sink	✓ Negative pressure	
2.1-5.3.1.2(3)	✓ handwashing station or hand sanitation dispenser	✓ No recirculating room units	
2.7-3.6.15	YES Facilities for on-site sterile processing ☐ check if not included in project (if sterile processing is performed off-site)		

	Architectural Requirements	Building Systems Requirements	
2.7-3.7	**SUPPORT AREAS DIRECTLY ACCESSIBLE TO SEMI-RESTRICTED AREA**		
2.7-3.7.12	YES Soiled workroom or soiled holding room		
2.7-3.7.12.1(2)	✓ dedicated for use by semi-restricted area **or** **N/A** shared with unrestricted area or another semi-restricted area **N/A** direct access is provided from semi-restricted area **N/A** separate entrance is provided from unrestricted area		
2.7-3.7.12.1(3)	✓ no direct connection with operating rooms or other sterile activity rooms		
2.1-3.8.12.1	✓ no direct connection with clean workrooms or clean supply rooms		
2.7-3.7.12.1	NO soiled workroom		
2.7-3.7.12.1(1)	(may be combined with decontamination room in Facilities for On-Site Sterile Processing)		
(1)			
(a)	**N/A** handwashing station	Ventilation:	
(b)	**N/A** flushing-rim clinical service sink or equivalent flushing-rim fixture	✓ Min. 10 air changes per hour ✓ Exhaust	Table 8.1
(c)	**N/A** work counter	✓ Negative pressure	
(d)	**N/A** space for separate covered containers for waste & soiled linen	✓ No recirculating room units	
(2)	YES fluid management system ☐ check if not included in project		
(a)	✓ electrical & plumbing connections that meet manufacturer requirements		
(b)	✓ space for docking station		
	or		
2.1-3.8.12.3	YES soiled holding room		
(1)	✓ handwashing station or hand sanitation dispenser	Ventilation:	
		✓ Min. 10 air changes per hour	Table 8.1
(2)	✓ space for separate covered containers for waste & soiled linen	✓ Exhaust ✓ Negative pressure ✓ No recirculating room units	
2.7-3.7.12.2(2)	**N/A** other provisions for disposal of liquid waste are provided **N/A** described in Project Narrative		
2.7-3.7.13	YES Clean equipment & supply storage room(s) ✓ provided for clean equipment & supplies used in semi-restricted & restricted areas		
2.7-3.7.13.1	✓ separate from & has no direct connection with soiled workroom or soiled holding room		

	Architectural Requirements	Building Systems Requirements
2.7-3.7.13.2	✓ combined floor area of clean equipment & supply storage room(s) min. 50 sf for each OR up to two OR's + 25 sf per additional OR	
2.7-3.8	**OTHER SUPPORT AREAS IN OUTPATIENT SURGERY FACILITY**	
2.7-3.8.13.1	YES Clean linen storage (may be located in Clean Equipment & Supply Storage Room)	
2.7-3.8.13.5	YES Medical gas storage space (including space for reserve cylinders)	
	✓ provided & protected in accordance with NFPA 99	
2.7-3.8.16	YES Storage for blood, tissue & pathological specimens	
	☐ check if not included in project	
2.7-3.8.16.2	✓ equipment temperature controls alarms & monitoring	
2.7-3.8.16.3(1)	✓ refrigerator for storage of blood & other specimens	
2.7-3.8.16.3(2)	✓ refrigerator used to store blood for transfusions	
	☐ check if not included in project	
	✓ equipped with temperature-monitoring & alarm signals	
2.7-3.9	**SUPPORT AREAS FOR STAFF**	
2.7-3.9.1	YES Staff lounge	
	☐ check if not included in project (only in facilities with one or two operating rooms)	
2.7-3.9.4	YES Staff changing area	
2.7-3.9.4.1	✓ includes private areas for staff working in semi-restricted & restricted areas	
2.1-3.9.4.1(1)	✓ lockers	
2.1-3.9.4.1(2)	✓ toilets	Ventilation:
		✓ Min. 10 air changes per hour Table 8.1
		✓ Exhaust
		✓ Negative pressure
		✓ No recirculating room units
(3)	✓ handwashing stations	
(4)	✓ space for donning surgical attire	
(5)	✓ provision for separate storage for clean & soiled surgical attire	
2.1-3.9.4.2	✓ staff changing area included in unrestricted areas	
2.7-3.9.5	YES Staff shower	
2.7-3.9.5.2	(may be located in staff changing area)	
2.7-3.9.5.1	✓ readily accessible* to semi-restricted area & recovery areas	

	Architectural Requirements	Building Systems Requirements	
2.7-3.10	**SUPPORT AREAS FOR PATIENTS**		
	YES Patient changing & preparation area		
(1)	**N/A** space for patients to change from street clothing into patient gowns & to prepare for surgery		
2.7-3.10.3(1)(b)	✓ patient care stations in pre- & post-operative patient care area used for this function		
	or		
2.7-3.10.3(1)(a)	**N/A** separate changing area		
2.7-3.10.3(2)(a)	**N/A** provisions for secure storage of patients' belongings		
2.7-3.10.3(2)(b)	**N/A** access to toilet without passing through public space		
2.7-3.10.3(2)(c)	**N/A** space for changing or gowning		
2.7-3.10.4	YES secure storage for patient belongings		
2.7-4.3	**STERILE PROCESSING**		
2.7-4.3.2	YES Facilities for on-site sterile processing outside semi-restricted area		
	☐ check if not included in project		
	✓ two-room sterile processing facility is provided		
2.7-4.3.3	NO Support areas for facilities using off-site sterile processing		
	☑ check if not included in project (only if sterile processing is performed on-site)		
2.1-4.3.3.1	**N/A** room for breakdown (receiving/unpacking) of clean/sterile supplies		
2.1-4.3.3.2	YES room for on-site storage of clean & sterile supplies		
2.1-4.3.2.4(1)	✓ storage for sterile & clean instruments & supplies		
(a)	✓ separate equipment & supply storage room	Ventilation:	
	or	✓ Min. 4 air changes per hour	Table 8.1
	N/A designated equipment & supply storage area in clean workroom	✓ Positive pressure	
(b)	YES space for case cart storage		
	☐ check if not included in project (only if case carts are not used)		
(c)	✓ provisions to maintain humidity & temperature levels		
2.1-4.3.3.3	YES room with flush-type device for gross decontamination & holding of soiled instruments		
2.1-3.8.12.1	✓ does not have direct connection with clean workrooms or clean supply rooms		
2.1-3.8.12.2(1)			

	Architectural Requirements	Building Systems Requirements	
(a)	✓ handwashing station	Ventilation:	
(b)	✓ flushing-rim clinical service sink or equivalent flushing-rim fixture	✓ Min. 10 air changes per hour ✓ Exhaust	Table 8.1
(c)	✓ work counter	✓ Negative pressure	
(d)	✓ space for separate covered containers for waste & soiled linen	✓ No recirculating room units	
(2)	___ fluid management system ☑ check if not included in project		
(a)	**N/A** electrical & plumbing connections that meet manufacturer requirements		
(b)	**N/A** space for docking station		
2.7-5.3	**ENVIRONMENTAL SERVICES**		
2.7-5.3.1	YES Environmental services room		
2.1-5.3.1.1(1)	✓ min. one environmental services room per floor	Ventilation:	
2.1-5.3.1.1(2)	✓ additional ES rooms provided on floor according to needs of areas served	✓ Min. 10 air changes per hour ✓ Exhaust ✓ Negative pressure	Table 8.1/ Policy
2.1-5.3.1.2(1)	✓ service sink or floor-mounted mop sink	✓ No recirculating room units	
2.1-5.3.1.2(2)	✓ provisions for storage of supplies & housekeeping equipment		
2.1-5.3.1.2(3)	✓ handwashing station or hand sanitation dispenser		
2.7-6.2	**PUBLIC AREAS**		
2.1-6.2.1	YES Vehicular drop-off & pedestrian entrance		
2.1-6.2.1.1	✓ min. of one building entrance reachable from grade level		
2.1-6.2.1.2	✓ building entrances used to reach outpatient services be clearly marked		
2.1-6.2.1.3	✓ building entrances used to reach outpatient services located so patients need not go through other activity areas (except for shared lobbies in multi-occupancy buildings)		
2.1-6.2.2	YES Reception ✓ reception & information counter, desk or kiosk provided either at main entry or at each clinical service		
2.1-6.2.3	YES Waiting area		
2.1-6.2.3.2	✓ visible from staff area either by camera or direct staff sight line		
2.1-6.2.4	YES Public toilet room		
2.1-6.2.4.2	(may be located off public corridor in multi-tenant building)		
2.1-6.2.4.1	✓ readily accessible* from waiting area without passing through patient care or staff work areas	Ventilation: ✓ Min. 10 air changes per hour ✓ Exhaust ✓ Negative pressure ✓ No recirculating room units	Table 8.1
2.1-6.2.5	YES Provisions for telephone access ✓ access to make local phone calls		
2.1-6.2.6	YES Provisions for drinking water		

	Architectural Requirements	Building Systems Requirements
2.1-6.2.7.1	YES Wheelchair storage ☐ check if not included in project ✓ designated area located out of required corridor width ✓ directly accessible to entrance ✓ provided for at least one wheelchair	
2.1-6.2.7.2	YES Wheelchair parking space ☐ check if not included in project (only if facility provides services that do not require patients to transfer to facility chair, recliner, exam table or stretcher) ✓ designated area provided for parking at least one patient-owned wheelchair in non-public area ✓ located out of any required egress width or other required clearance	
2.7-6.3	**ADMINISTRATIVE AREAS**	
2.1-6.3.2	YES Interview space ☐ check if not included in project	
(2)	(may be combined with consultation room)	
(1)	✓ separate from public areas	
2.1-6.3.3	YES Office space for business, administrative & professional staffs	
2.1-6.3.5	YES Medical records space ✓ provisions be made for securing medical records of all media types used by facility	
2.1-6.3.5.1	✓ location restricted to staff access to maintain confidentiality of record	
2.1-6.3.5.2	Space Requirements:	
(1)	✓ space provided for medical records management	
(2)	✓ physical space for electronic storage of forms or documents	
2.1-6.3.6	YES Storage for office equipment & supplies	
2.7-6.3.4	YES Multipurpose or consultation room	
2.7-6.3.4.2	(may be combined with office or interview room)	
2.7-6.3.4.1	✓ located in unrestricted area	
2.7-6.4	**GENERAL SUPPORT AREAS FOR STAFF**	
2.1-6.4.2	NO Storage for staff personal effects **N/A** locking drawers cabinets or lockers **N/A** readily accessible* to individual work areas	

*LOCATION TERMINOLOGY:

Directly accessible: Connected to the identified area or room through a doorway, pass-through, or other opening without going through an intervening room or public space

Adjacent: Located next to but not necessarily connected to the identified area or room

Immediately accessible: Available either in or adjacent to the identified area or room

Readily accessible: Available on the same floor or in the same clinic as the identified area or room

2.1-7.2.2 **ARCHITECTURAL DETAILS**

CORRIDOR WIDTH:

2.1-7.2.2.1 IBC 1018.2
- ✓ Min. 44”

or

- ___ Detailed code review incorporated in Project Narrative

421 CMR 6.00
- ✓ Corridors include turning spaces for wheelchairs

2.7-7.2.2.1(1)
- ✓ At least one corridor that connects surgical suite & PACU to exit has min. width of 6’-0” for stretcher transport

2.7-7.2.2.1(2)
- ✓ Corridor connecting semi-restricted area & pre- & postoperative patient care area has min. width of 8’-0” for stretcher transport

2.1-7.2.2.2 CEILING HEIGHT:

(2)
- ✓ Min. height 7’-0” in procedure rooms & operating rooms from floor to lowest protruding element of equipment or fixture in stowed position

(4)
- ✓ Min. height 7’-6” above floor of suspended tracks, rails & pipes located in traffic path
- ✓ Min. ceiling height 7’-10” in other areas

2.1-7.2.2.3 DOORS & DOOR HARDWARE:

(1) Door Type:

(a)
- ✓ doors between corridors, rooms, or spaces subject to occupancy swing type or sliding doors

(b)
- ~~YES~~ ~~NO~~ sliding doors
  - ☐ check if not included in project
  - ~~N/A~~ manual or automatic sliding doors comply with NFPA 101
  - ~~N/A~~ ~~N/A~~ detailed code review incorporated in Project Narrative
  - ~~N/A~~ no floor tracks

(2) Door Opening:

(a)
- ✓ min. 34” clear door width
- ✓ min. 83.5” clear door height

(b) Rooms with Gurney Access:
- ✓ 41.5” min. clear door width
- ✓ 79.5” min. clear door height

(3) Door Swing:

(a)
- ✓ doors do not swing into corridors except doors to non-occupiable spaces (e.g. environmental services rooms & electrical closets) & doors with emergency breakaway hardware

(4)
- ✓ Lever hardware or push/pull latch hardware

(5) Doors for Patient Toilet Facilities:

(a)
- ✓ door that swings outward

or

- ___ door equipped with emergency rescue hardware (permits quick access from outside the room to prevent blockage of the door)

or

- ✓ sliding door other than pocket door

(b)
- ✓ toilet room opens onto public area or corridor
  - ☐ check if not included in project
  - ✓ visual privacy is maintained

2.1-7.2.2.8 HANDWASHING STATIONS:

(3)(a)
- ✓ Handwashing station countertops made of porcelain, stainless steel, solid-surface materials or impervious plastic laminate assembly

(3)(b)
- ✓ Countertops substrate
  - ☐ check if not included in project
  - ✓ marine-grade plywood (or equivalent material) with impervious seal

(4)
- ✓ Handwashing station casework
  - ☐ check if not included in project
  - ✓ designed to prevent storage beneath sink

(5)
- ✓ Provisions for drying hands
  - ☐ check if not included in project

(only at hand scrub facilities)

(a)
- ✓ hand-drying device does not require hands to contact dispenser

(b)
- ✓ hand-drying device is enclosed to protect against dust or soil

(6)
- ✓ Liquid or foam soap dispensers

2.1-7.2.2.9 GRAB BARS:

(1)
- ✓ Grab bars anchored to sustain concentrated load 250 pounds

(3)
- ✓ Ends of grab bars constructed to prevent snagging clothes of patients staff & visitors

2.1-7.2.2.10 HANDRAILS:
- ☐ check if not included in project

(2)
- ✓ Rail ends return to wall or floor

(3)
- ✓ Handrail gripping surfaces & fasteners are smooth with 1/8-inch min. radius

(4)
- ✓ Handrails have eased edges & corners

(5)
- ✓ Handrail finishes are cleanable

2.1-7.2.3 **SURFACES**

2.1-7.2.3.1 FLOORING & WALL BASES:

(1) ✓ Flooring surfaces cleanable & wear-resistant for location

(3) ✓ Smooth transitions provided between different flooring materials

(4) ✓ Flooring surfaces including those on stairways are stable, firm & slip-resistant

(5) ✓ Floors & wall bases of all areas subject to frequent wet cleaning are constructed of materials that are not physically affected by germicidal or other types of cleaning solutions

(6)(a) ✓ Floors are monolithic & integral coved wall bases are at least 6" high & tightly sealed to wall in rooms listed below

- operating room
- procedure rooms where cystoscopy, urology & endoscopy procedures are performed
- airborne infection isolation (AII) room & any anteroom

☐ check if not included in project

2.1-7.2.3.2 WALLS & WALL PROTECTION:

(1)(a) ✓ Wall finishes are washable

(1)(b) ✓ Wall finishes near plumbing fixtures are smooth, scrubbable & water-resistant

(2) ✓ Wall surfaces in areas routinely subjected to wet spray or splatter (e.g. environmental services rooms) are monolithic or have sealed seams that are tight & smooth

(4) ✓ Wall protection devices & corner guards durable & scrubbable

2.1-7.2.3.3 CEILINGS:

(1) ✓ Ceilings provided in all areas except mechanical, electrical & communications equipment rooms

(a) ✓ Ceilings cleanable with routine housekeeping equipment

(b) ✓ Acoustic & lay-in ceilings where used do not create ledges or crevices

(2) Semi-Restricted Areas:

☐ check if not included in project

(a) ✓ ceiling finishes are scrubbable, non absorptive, non perforated, & capable of withstanding cleaning with chemicals

(b) ✓ lay-in ceilings

✓ gasketed or each ceiling tile weighs at least 1 Lbs/sq. ft.

(c) ✓ no perforated tegular serrated or highly textured tiles in semi-restricted areas

or

✓ ceilings of monolithic construction

(3) Restricted Areas:

☐ check if not included in project

(a) ✓ ceilings of monolithic construction (except for central diffuser array)

(b) ✓ ceiling finishes scrubbable & capable of withstanding cleaning & disinfecting chemicals

(c) ✓ access openings are gasketed

2.1-7.2.4.3 ✓ Privacy curtains in patient care areas are washable

2.1-8.2 **HEATING VENTILATION & AIR-CONDITIONING (HVAC) SYSTEMS**

Part 3/6.1 UTILITIES:

Part 3/6.1.1 Ventilation Upon Loss of Electrical Power:

✓ space ventilation & pressure relationship requirements of Table 8.1 are maintained for AII Rooms & Operating Rooms in event of loss of normal electrical power

Part 3/6.1.2 Heating & Cooling Sources:

Part 3/6.1.2.1 ✓ heat sources & essential accessories sufficient to accommodate facility needs (reserve capacity) even when any one of heat sources or essential accessories is not operating due to breakdown or routine maintenance

✓ capacity of remaining source or sources is sufficient to provide heating for operating rooms & recovery rooms

Part 3/6.1.2.2 Central cooling systems greater than 400 tons (1407 kW) peak cooling load

☐ check if not included in project

✓ cooling sources & essential accessories sufficient to support facility operation plan upon breakdown or routine maintenance of any one of cooling sources

Part 3/6.2 AIR-HANDLING UNIT (AHU) DESIGN:

Part 3/6.2.1 ✓ AHU casing is designed to prevent water intrusion, resist corrosion & permit access for inspection & maintenance

.

Part 3/6.3 OUTDOOR AIR INTAKES & EXHAUST DISCHARGES:

Part 3/6.3.1 Outdoor Air Intakes:

Part 3/6.3.1.1
- ✓ located min. of 25'-0" from cooling towers & all exhaust & vent discharges
- ✓ outdoor air intakes located such that bottom of air intake is at least 6'-0" above grade
- ✓ air intakes located away from public access
- ✓ all intakes are designed to prevent entrainment of wind-driven rain

Part 3/6.3.1.3
- ✓ intakes on top of buildings
  - ☐ check if not included in project
  - ✓ located with bottom of air intake min. of 3'-0" above roof level

Part 3/6.3.1.4
- ___ intake in areaway
  - ☑ check if not included in project
  - ___ bottom of areaway air intake opening is at least 6'-0" above grade
  - ___ bottom of air intake opening from areaway into building is at least 3'-0" above bottom of areaway

Part 3/6.3.2 Contaminated Exhaust Discharges:
- ☐ check if not included in project

Part 3/6.3.2.1
- ✓ ductwork within building is under negative pressure for exhaust of contaminated air (i.e. air from AII rooms or HD sterile compounding pharmacy)
- ✓ exhaust discharge outlets with contaminated air located such that they reduce potential for recirculation of exhausted air back into building

Part 3/6.3.2.2
- ✓ exhaust discharge outlets with contaminated air is arranged to discharge to atmosphere in vertical direction at least 10 feet above adjoining roof level
- **N/A** exhaust discharge outlets from laboratory work area chemical fume hoods discharge with stack velocity of at least 2500 fpm
- **N/A** exhaust discharge outlets from AII rooms bronchoscopy & sputum collection exhaust & laboratory work area chemical fume hoods is located not less than 25 feet horizontally from outdoor air intakes, openable windows/doors & areas that are normally accessible to public

Part 3/6.4 FILTRATION:
- ✓ Two filter banks for operating rooms, ambulatory diagnostic & therapeutic radiology (see Table 6.4)
  - ✓ Filter Bank No. 1: MERV 7
  - ✓ Filter Bank No. 2: MERV 14
- ✓ All other outpatient spaces one filter bank MERV 7
- **N/A** One filter bank MERV 13 for laboratories
- ✓ Each filter bank with efficiency of greater than MERV 12 is provided with differential pressure measuring device to indicate when filter needs to be changed

Part 3/6.4.1 ✓ Filter Bank No. 1 placed upstream of heating & cooling coils

Part 3/6.4.2 ✓ Filter Bank No. 2 placed downstream of all wet-air cooling coils & supply fan

Part 3/6.5 HEATING & COOLING SYSTEMS:

Part 3/6.5.3 YES Radiant heating systems
- ☐ check if not included in project
- ✓ ceiling or wall panels with exposed cleanable surfaces or radiant floor heating are provided in AII room, OR or procedure room

Part 3/6.7 AIR DISTRIBUTION SYSTEMS:

Part 3/6.7.1
- ✓ Maintain pressure relationships required in tables 7.1 in all modes of HVAC system operation
- ✓ Spaces that have required pressure relationships are served by fully ducted return systems or fully ducted exhaust systems
- ✓ Recovery rooms are served by fully ducted return or exhaust systems

Part 3/6.7.2 Air Distribution Devices:
- ✓ supply air outlets comply with Table 6.7.2

Part 3/6.7.3 Smoke Barriers:
- ✓ HVAC zones coordinated with compartmentation to minimize ductwork penetrations of fire & smoke barriers.

Part 3/6.8 ENERGY RECOVERY SYSTEMS:
☐ check if not included in project
Part 3/6.8.1 ✓ Located upstream of Filter Bank No. 2
Part 3/6.8.2 ✓ AII room exhaust systems are not used for energy recovery

Part 3/6.8.3 ✓ Energy recovery systems with leakage potential
☐ check if not included in project
✓ arranged to minimize potential to transfer exhaust air directly back into supply airstream
✓ designed to have no more than 5% of total supply airstream consisting of exhaust air
✓ not used from these exhaust airstream sources: waste anesthesia gas disposal, central medical & surgical supply, soiled or decontamination room

Part 3/7 SPACE VENTILATION:
Part 3/7.1.a ✓ Complies with Table 8.1
Part 3/7.1.a.1 ✓ Air movement is from clean to less-clean areas
Part 3/7.1.a.3 ✓ Min. number of total air changes required for positive pressure rooms is provided by total supply airflow
✓ Min. number of total air changes required for negative pressure rooms is provided by total exhaust airflow
Part 3/7.1.a.4 ✓ Entire minimum outdoor air changes per hour required by Table 8.1 for each space meet filtration requirements of Section 6.4

Part 3/7.1a.5 ✓ Air recirculation through room unit
☐ check if not included in project
✓ complies with Table 8.1
✓ room unit receive filtered & conditioned outdoor air
✓ serve only a single space
✓ provides min. MERV 6 filter located upstream of any cold surface so that all of air passing over cold surface is filtered

Part 3/7.2 ADDITIONAL ROOM-SPECIFIC REQUIREMENTS:
Part 3/7.2.1 Airborne Infection Isolation (AII) Rooms
☐ check if not included in project
✓ AII rooms have permanently installed device and/or mechanism to constantly monitor differential air pressure between room & corridor
✓ Local visual means is provided to indicate whenever negative differential pressure is not maintained
✓ Air from AII room is exhausted directly to outdoors
✓ Exhaust air from AII rooms, associated anterooms & toilet rooms is discharged directly to outdoors without mixing with exhaust air from any other non-AII room or exhaust system
✓ Exhaust air grille or register in patient room is located directly above patient bed on ceiling or on wall near head of bed
___ Anteroom
☑ check if not included in project
___ AII room is at negative pressure with respect to anteroom
___ Anteroom is at negative pressure with respect to corridor

Part 3/7.4.1 Operating Rooms
☐ check if not included in project
✓ Each OR has individual temperature control
✓ OR is provided with primary supply diffuser array designed as follows:
✓ airflow is unidirectional downwards & average velocity of diffusers is 25 to 35 CFM/ft^2
✓ diffusers are concentrated to provide airflow pattern over patient & surgical team
✓ coverage area of primary supply diffuser array extends min. 12” beyond footprint of surgical table on each side
✓ no more than 30% of portion of primary supply diffuser array is used for non-diffuser uses
✓ additional supply diffusers provided within room outside of primary supply diffuser array
☐ check if not included in project
✓ each OR has at least two low sidewall return or exhaust grilles spaced at opposite corners or as far apart as possible with bottom of these grilles installed approximately 8” above floor

2.1-8.3 **ELECTRICAL SYSTEMS**

2.1-8.3.2 **ELECTRICAL DISTRIBUTION & TRANSMISSION**

2.1-8.3.2.2 Panelboards:

(1) ✓ all panelboards accessible to health care tenants they serve

(2) ✓ panelboard serving critical branch circuits serve floors on which they are located

(3) ✓ panelboards serving life safety branch circuits serve floors on which they are located & floors immediately above & below

(4) ✓ panelboards not located in exit enclosures or exit passageways

2.1-8.3.2.3 Ground-Fault Circuit Interrupters in Critical Care Areas:

☐ check if not included in project

(2) ✓ each receptacle individually protected by single GFCI device

2.1-8.3.3 **POWER-GENERATING & -STORING EQUIPMENT**

2.1-8.3.3.1 ✓ Essential electrical system or emergency electrical power

(1) ✓ essential electrical system complies with NFPA 99

(2) ✓ emergency electrical power complies with NFPA 99

2.1-8.3.5 **ELECTRICAL EQUIPMENT**

2.1-8.3.5.1 ✓ Handwashing sinks & scrub sinks that depends on building electrical service for operation are connected to essential electrical system

☐ check if not included in project

2.1-8.3.6 **ELECTRICAL RECEPTACLES**

✓ Receptacles in patient care areas are provided according to Table 2.1-1

2.1-8.4 **PLUMBING SYSTEMS**

2.1-8.4.2 Plumbing & Other Piping Systems:

2.1-8.4.2.1(3) ✓ no plumbing piping exposed overhead or on walls where possible accumulation of dust or soil may create cleaning problem

2.1-8.4.2.5 Heated Potable Water Distribution Systems:

(2) ✓ heated potable water distribution systems serving patient care areas are under constant recirculation

✓ non-recirculated fixture branch piping length max. 25'-0"

(3)(a) ✓ no installation of dead-end piping (except for empty risers

(3)(c) mains & branches for future use)

(3)(b) ✓ any existing dead-end piping is removed

☐ check if not included in project

(4)(a) ✓ water-heating system supplies water at following range of temperatures: 105–120°F

2.1-8.4.2.6 Drainage Systems:

(1)(a) ✓ drainage piping installed above ceiling of or exposed in rooms listed below piping have special provisions to protect space below from leakage & condensation

- operating rooms
- procedure rooms
- sterile processing facilities
- electronic data processing areas
- electrical rooms

(1)(b) ✓ drip pan for drainage piping above ceiling of sensitive area

☐ check if not included in project

___ accessible

___ overflow drain with outlet located in normally occupied area that is not open to restricted area

(2) Floor Drains:

(a) ✓ no floor drains in procedure rooms & operating rooms,

(b) ___ floor drain in dedicated cystoscopy procedure room

☑ check if not included in project

___ recessed floor sink w/ automatic trap primer

2.1-8.4.3 **PLUMBING FIXTURES**

2.1-8.4.3.1(1) ✓ Materials used for plumbing fixtures are non-absorptive & acid-resistant

2.1-8.4.3.2 Handwashing Station Sinks:

(1) ✓ sinks are designed with basins that will reduce risk of splashing to direct patient care areas, sterile procedures areas & medication preparation areas

(2) ✓ sink basins have nominal size of no less than 144 square inches

✓ sink basins have min. dimension 9 inches in width or length

(3) ✓ sink basins are made of porcelain, stainless steel or solid-surface materials

(5) ✓ water discharge point min. 10" above bottom of basin

(7) ✓ anchored so that allowable stresses are not exceeded where vertical or horizontal force of 250 lbs. is applied

(8) ✓ sinks used by staff, patients, & public have fittings that can be operated without using hands (may be single-lever or wrist blade devices)

(a) ✓ blade handles

☐ check if not included in project

✓ at least 4 inches in length

✓ provide clearance required for operation

(b) ✓ sensor-regulated water fixtures

☐ check if not included in project

✓ meet user need for temperature & length of time water flows

✓ designed to function at all times and during loss of normal power

2.1-8.4.3.4 Ice-Making Equipment:

✓ copper tubing provided for supply connections to ice-making equipment

2.1-8.4.3.5 Clinical Flushing-Rim Sinks:

(1) ✓ trimmed with valves that can are operated without hands

(a) (may be single-lever or wrist blade devices)

(b) ✓ handles are at least 6 in. long

(2) ✓ integral trap wherein upper portion of water trap provides visible seal

2.1-8.4.3.6 Scrub Sinks:

(1) ✓ freestanding scrub sinks are trimmed with foot, knee or electronic sensor controls

(2) ✓ no single-lever wrist blades except for temperature pre-set valve

2.1-8.4.4 **MEDICAL GAS & VACUUM SYSTEMS**

✓ Station outlets provided as indicated in Table 2.1-2

2.1-8.5.1 **CALL SYSTEMS**

2.1-8.5.1.1(1) ✓ Nurse call stations provided as required in Table 2.1-3

2.7-8.5.2 **EMERGENCY COMMUNICATION SYSTEM**

✓ operating rooms & Phase I post-anesthesia recovery room are equipped with emergency communication system that incorporates push activation of emergency call switch

2.1-8.7 **ELEVATORS**

☐ check if not included in project

2.1-8.7.3 Dimensions of Elevators Used for Transport of Outpatients on Gurneys:

✓ min. interior car dimensions 5'-8" wide by 7'-9"deep

2.1-8.7.4 ✓ Elevators are equipped with two-way automatic level-maintaining device with accuracy of ± 1/4 inch

2.1-8.7.5 Elevator Controls:

2.1-8.7.5.1 ✓ elevator call buttons & controls not activated by heat or smoke

2.1-8.7.5.2 ✓ light beams if used for operating door reopening devices without touch are used in combination with door-edge safety devices & are interconnected with system of smoke detectors

2.1-8.7.5.3 ✓ elevator controls, alarm buttons & telephones are accessible to wheelchair occupants & usable by the blind

UVM Medical Center Operating Rooms 8.25.2022

Site Code	Building Code	Floor Code	Room Code	OR Number	Room Category	Room Type	Room Area ft²	Division Code	Department Code	
FA	FA	1	1106	1	OPERATING RM	PATIENT	394.80	PERIOP SRVCS	OR FA	
FA	FA	1	1102	2	OPERATING RM	PATIENT	386.67	PERIOP SRVCS	OR FA	
FA	FA	1	1097	3	OPERATING RM	PATIENT	431.67	PERIOP SRVCS	OR FA	
FA	FA	1	1098	4	OPERATING RM	PATIENT	449.50	PERIOP SRVCS	OR FA	
FA	FA	1	1101	5	OPERATING RM	PATIENT	377.96	PERIOP SRVCS	OR FA	
MCHV	MCCLURE	3	3418	1	OPERATING RM	PATIENT	503.36	PERIOP SRVCS	OR MC	acute care surgery mostly
MCHV	MCCLURE	3	3421	2	OPERATING RM	PATIENT	449.41	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3444	3	OPERATING RM	PATIENT	449.41	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3445	4	OPERATING RM	PATIENT	511.83	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3413	5	OPERATING RM	PATIENT	531.86	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3416	6	OPERATING RM	PATIENT	676.69	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3437	7	OPERATING RM	PATIENT	399.34	CARDIOLOGY	EP SERVICES	Cardriology; excluded from OR demand
MCHV	MCCLURE	3	3423	8	OPERATING RM	PATIENT	820.02	PERIOP SRVCS	OR MC	hybrid; excluded from OR demand
MCHV	MCCLURE	3	3412	9	OPERATING RM	PATIENT	542.50	PERIOP SRVCS	OR MC	ortho trauma mostly
MCHV	MCCLURE	3	3435	11	OPERATING RM	TRAINING	400.31	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3450	14	OPERATING RM	PATIENT	510.03	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3452	15	OPERATING RM	PATIENT	544.05	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3462	16	OPERATING RM	PATIENT	586.18	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3451	17	OPERATING RM	PATIENT	591.61	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3453	18	OPERATING RM	PATIENT	585.59	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3455	19	OPERATING RM	PATIENT	580.51	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3465	20	OPERATING RM	PATIENT	596.07	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3478	21	OPERATING RM	PATIENT	575.23	PERIOP SRVCS	OR MC	
MCHV	MCCLURE	3	3479	22	OPERATING RM	PATIENT	602.93	PERIOP SRVCS	OR MC	
							12,497.53			

Max	820.02
Min	377.96
Average All	520.73
Average MC	550.36

Exhibit 4

BUSINESS PLAN
Planning Department

THE University of Vermont HEALTH NETWORK

UVMMC Outpatient Surgery Center

Expanding Access to Same-Day Surgeries

Prepared By
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Stephen Leffler MD
President and COO, UVMMC

December 01, 2022

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1. Executive Summary

The University of Vermont Medical Center (UVMMC) proposes the development of an Outpatient Surgery Center (OSC).

This proposal addresses the following needs:

- demographic changes in our region, particularly the significant increase in our 65-and-over population, that drive projected growth in outpatient surgeries in a large number of specialties;
- patient preferences and reported outcomes that are shifting surgery from the inpatient to outpatient setting;
- modernization of outpatient surgery facilities with sufficiently sized operating rooms and peri-operative spaces;
- retention and recruitment of surgeons and care teams for our region;
- surgical care delivery efficiencies to achieve value-based care goals;
- prioritization of UVMMC's inpatient facilities for complex procedures and greater than 24-hour stays.

The proposed OSC will enable patients in our region to receive timely access to the surgeries they need, with the convenience of an easily accessible facility located on Tilley Drive in South Burlington. The new center will compare favorably with other academic medical centers and support the recruitment and retention of high-quality providers, surgical staff and learners. Development of a new OSC that provides timely access to care for our patients, at the appropriate site of care, is a critical element of the UVM Health Network's high value care strategy.

Key Facility Highlights:

- The proposed project consists of purchasing 13.5 acres of land located at 119 Tilley Drive, South Burlington, and constructing an approximately 84,000 GSF OSC that meets UVMMC's standards for environmentally sustainable facility construction. Considerations for incorporation of diversity, equity, and inclusion were integrated into the facility planning process.
- The surgical core of the facility will consist of eight operating rooms, 12 prep rooms and 36 recovery spaces, including eight extended stay (23-hour) recovery rooms as well as shell space for four additional ORs and 14 pre- and post-operative spaces. The identically-sized ORs are designed for flexibility to address current and future outpatient surgical needs across many specialties and to accommodate technologies, including robotics, available today and in the future.
- The perioperative spaces are designed to support higher patient throughput and greater provider efficiency, both contributing to better patient access to care.
- The OSC is strategically located in close proximity to existing UVMMC services at Tilley Drive, offering a potentially integrated patient experience. The location is served by a newly-enhanced public transportation system.
- Support spaces include areas for lab and pathology services, pharmacy services, and physical therapy, in addition to a central sterile reprocessing (CSR) space located on the basement level.
- The estimated construction time is 18 months, with an anticipated opening in April 2025.

Operational and Human Resource Highlights:

- The OSC will be a highly flexible multi-specialty center, allowing for a variety of surgical cases to be performed. Surgical cases will come from four sources: current outpatient cases at the Fanny Allen campus, current outpatient cases at the Main Campus that can transition to the modern OSC, current inpatient cases at the Main Campus that can shift safely to the outpatient setting, and incremental growth of outpatient surgeries projected as our population continues to age.
- The initial eight-ORs will be able to accommodate approximately 8,000 cases annually.
- Staffing for the new facility at its opening will total 166 FTEs, with 50% of those positions expected to transition from similar positions at the Fanny Allen campus and Main Campus. An additional 78 FTEs will be needed to provide care in the new facility. Workforce recruitment will start at least 18 months in advance of the first patient day, aligned with the expected start of construction.
- The project timeline includes two months for operationalizing the new facility prior to the first patient day in April 2025.

Key Financial Highlights:

- The project's capital cost is $129.6M, including $6.4M in capitalized interest. Most of the capital cost for completion of the full 12 OR facility is borne in this first phase of the project; we estimate that $8.8M of additional capital will be needed to fit up and operationalize the four shelled ORs and pre- and post-op spaces at a later date.
- Project funding includes debt financing for $100M of the capital cost. A philanthropy funding goal will be determined following business plan approval.
- From an incremental financial impact perspective, the operating pro forma financials with eight ORs in use show a modest return in the first six months of operations, followed by a $5M annual margin for FY26. Margins increase to $12M in FY29 ($24M EBIDA margin) when we expect surgical demand to grow to volumes that require the fit-up of the shelled space and opening of two additional ORs. Operating expenses for planning, transition and start-up costs prior to first patient day are estimated to be $1M.
- Margins include a decrease in average reimbursement from current for surgical cases performed at the OSC.

Financial Metrics	FY25 (Half Year)	FY26	FY27	FY28	FY29	5 Yr. Total
Capital Costs	**$ 129,640,703**					**$ 129,640,703**
Construction + Capitalized Interest	*$ 100,773,333*					*$ 100,773,333*
Land Acquisition	*$ 5,150,158*					*$ 5,150,158*
Equipment	*$ 22,062,928*					*$ 22,062,928*
IT	*$ 1,654,284*					*$ 1,654,284*
Incremental Volume	1,482	3,071	3,275	3,224	4,341	15,394
Incremental Net Revenue	$ 21,641,322	$ 47,544,462	$ 52,738,689	$ 55,689,165	$ 68,907,452	$ 246,521,090
Incremental Operating Costs	$ 15,269,464	$ 31,257,456	$ 34,071,933	$ 36,333,574	$ 44,755,460	$ 161,687,886
EBIDA	**$ 6,371,858**	**$ 16,287,006**	**$ 18,666,757**	**$ 19,355,591**	**$ 24,151,992**	**$ 84,833,204**
Depreciation and Interest	$ 6,275,938	$ 11,673,691	$ 11,591,321	$ 11,504,737	$ 11,954,725	$ 53,000,412
Incremental Margin from Operations	**$ 95,920**	**$ 4,613,315**	**$ 7,075,436**	**$ 7,850,854**	**$ 12,197,267**	**$ 31,832,792**

Timeline Highlights:

Key Project Milestones	Date
Town and Act 250 Permitting	January 2023
CON Application	January 2023
Expected CON Approval Date	July 2023
Construction Start	August 2023
Certificate of Occupancy	February 2025
First Patient Day	April 2025

2. Project Scope and Rationale

Project Summary

This is a business plan for the development of a new OSC supporting the UVM Medical Center and the people for whom it cares.

With a projected capital cost of $129.6 million, we recognize the significance of this proposal, especially in view of the ongoing fiscal and workforce constraints faced by our organization and many other health care systems around the country. We have placed emphasis on analyzing the dual needs of our clinical and academic mandate, while considering a host of possible alternatives. We believe the implementation of this project is critical to our mission to provide local access to care, while strengthening our function as a community hospital, tertiary care center and academic medical center.

The proposed OSC is also a reflection of the contemporary care that our patients and communities deserve – care informed by academic medicine and research, provided in a facility that supports the providers and technology necessary to deliver leading-edge procedures safely and cost effectively. Offering the convenience of an outpatient setting – and helping more of our patients to recover at home – also aligns with contemporary practice and the expectations of our patients.

Our business plan is driven by 10 practical considerations:

1. The population we serve is growing and aging; it is essential that we are prepared to respond to their evolving needs and preferences. Our current surgical facilities are not equipped to meet these needs.

2. Demographic changes will increase demand for both inpatient and outpatient surgeries. Our demand model indicates that by 2030 we will fall short of meeting surgical demand by nearly 4,800 cases i.e., 1 in 5 patients would likely experience a significant delay in having a surgery performed.

3. It is not possible to increase our surgical capacity by adding ORs to our Main Campus or Fanny Allen. Moreover, the size and design of many of the ORs we operate today make them incompatible with many of the complex, contemporary surgical procedures that are increasingly common in the outpatient setting. Fanny Allen's ORs have reached the end of their life as a useful surgical environment and cannot be upgraded to meet current standards or code requirements.

4. We cannot look to other Network affiliate hospitals to fill the void in UVMMC's surgical capacity without risks to local patient access. Demographic changes will increase surgical demand at all of our affiliates. We need to increase UVMMC capacity to serve Burlington-area patient demand and support higher-acuity referrals and transfers from our network partners and regional institutions.

5. We can and should perform a wider range of complex procedures in an outpatient setting that can accommodate advanced surgical technologies, including robotics. This will benefit our patients, providers, and learners and should only become more commonplace as we advance our surgical capabilities to keep pace with contemporary practice.

6. Our health system needs a multi-disciplinary OSC, not a highly specialized, ambulatory surgery center. We expect demand to grow significantly across a number of specialties by 2030, which means we will need the flexibility and capacity to offer a broad range of outpatient surgical procedures at the OSC. The proposed size and cost of the OSC reflects this reality.

7. By emphasizing convenience and state-of-the-art care, the OSC can improve the experience for our patients, providing them with the highest quality of care.

8. The OSC's flexible and provider-informed design will help us meet demand, improve the efficiency of our care delivery and support our providers and staff to deliver high-quality care cost-effectively.

9. A modern OSC is critical to the recruitment and retention of much-needed surgical staff and health care providers. Without state-of-the-art facilities, we will struggle to attract top-level professionals. In similar fashion, learners expect access to OR time and the latest surgical technologies, and their absence will discourage talented students and residents from pursuing their education and training with us.

10. Finally, there are few viable alternatives to the OSC described herein. Doing nothing, meanwhile, will threaten our ability to provide timely, high-quality care to Vermonters and may exacerbate issues around access, workforce and finance that we face today.

The OSC envisioned in this business plan is an 84,000 GSF facility that will initially accommodate 8,000 surgical cases annually. Designed with interoperability and flexibility in mind, the OSC will handle a wide variety of complex and technologically advanced surgeries to satisfy the growing demand we see across a host of surgical specialties. And as outpatient surgeries now performed on the Main Campus migrate to the OSC, it will vacate space for much-needed additional inpatient surgical capacity.

The OSC will be located on a 13.5-acre lot at 119 Tilley Drive, South Burlington. It will consist of:

- Eight identical 650 GSF ORs.
- Shell space for an additional four ORs and 14 pre- and post-operative spaces that will be outfitted when patient demand increases as projected.
- Adjacent pre-operative spaces and clinical support areas that can accommodate days with heavy patient volumes and provide greater privacy for patients and family members.
- Private post-operative recovery areas that include 23-hour stay rooms for patients who require extended recovery time. These include space for visitors and shared bathrooms.
- Areas for key clinical support services, including lab/pathology, an on-site CSR area and pharmacy.
- A comfortable waiting room, including outdoor patio space, as well as convenient on-site parking and public transportation access, for patients and visitors.

The CSR area supports the onsite sterilization of instruments and space for sterile storage. Studies undertaken to assess the capacity of the CSR area at the Main Campus concluded that there was not available capacity to serve the OSC and recommended that the new facility house its own CSR function. While a significant additional capital and operating expense, the presence of onsite CSR reduces the risk of instrumentation-related case delays and provides redundancy to the Main Campus CSR service (for further Facilities details, see Section 4).

Improving Access, Patient Experience & Ensuring High Quality Care

As Vermont's largest community hospital and academic medical center, it is incumbent upon us to have surgical capacity that will meet the needs of the community for the long term, while providing a high-quality educational environment that is consistent with our academic mission. The size and number of our outpatient ORs cannot meet these needs, and we need to think differently about how we provide care and how to deliver it in the most appropriate setting. This is a central tenet of our strategy at the UVM Health Network: to provide our patients with the right care, at the right time and in the right place.

1. Our growing and aging population will increase the surgical needs of our communities

UVMMC serves a population that is growing and whose needs are changing. In the years to come, as our population ages, more of our patients will require a wide range of surgical procedures. At the same time, patient preferences and expectations are evolving, with more of our patients keen to pursue their health care in the convenience of an outpatient setting that is close to home and allows them to return to their daily lives safely and more quickly.

Demographic forecasters Claritas and Public Opinion Strategies have independently projected overall 10-year population growth for Chittenden County between 4% and 8% by 2030, with significantly higher 10-year growth estimates — from

30% to 60% — for the 65+ segment of the population. Similar growth estimates for total population and for the Medicare-eligible segment are forecast for the surrounding counties in northwestern Vermont, including Franklin, Grand Isle, Lamoille, Washington and Addison counties.

The demographic growth for the region will drive increased demand for both outpatient and inpatient surgeries. UVMMC surgical demand is expected to grow between 14% and 22% by 2030. For context, such growth would mean that the 25 ORs currently in operation at the two UVMMC locations would fall short of meeting demand in 2030 by nearly 4,800 cases or approximately a year's worth of outpatient surgeries at Fanny Allen.

With this, UVMMC will require between 8-12 additional ORs to meet overall surgical demand. Section 3 of this business plan describes our OR demand and surgical volume projections in detail.

2. Fanny Allen and UVMMC Main Campus cannot accommodate expected growth in demand for surgeries

The OSC is a practical necessity. Recent analysis of our Master Facilities Plan (MFP) indicates that we must move outpatient surgeries and other services from the UVMMC Main Campus in order to create room for much-needed clinical and surgical services that cannot be located elsewhere. Meanwhile, it is not feasible to create the additional outpatient surgical capacity that we need by renovating or upgrading existing facilities. Our ORs cannot accommodate the changes we need to make to streamline and modernize our surgical capacity and prepare for the future, and extending their hours of operation would still leave us unable to meet demand.

a. Fanny Allen ORs

Full replacement of Fanny Allen's surgical facilities, which have not been significantly renovated in 30 years, has been part of UVMMC's MFP since 2017. The OSC plays a key role in this plan, which includes moving services off the UVMMC Main Campus if it will serve the community better and lead to sensible service distribution.

Fanny Allen's ORs closed in December of 2019 for several weeks, and again in November 2020, due to indoor air quality deficiencies. While mitigations have been implemented, allowing these ORs to reopen in February 2022, the events of the past several years have made it clear that this facility is near the end of its life as a useful surgical environment.

Renovating Fanny Allen's ORs to meet contemporary standards and provide additional capacity would be prohibitively expensive, particularly with its lease set to expire in 2026. Its ORs are significantly undersized, which makes them inappropriate for many contemporary interventions. Fanny Allen's ORs range in size from 378 GSF to 450 GSF – in contrast, the OSC will have ORs that are nearly 650 GSF in size. As such, the Fanny Allen ORs cannot accommodate the installation of required air handling systems, contemporary surgical equipment such as robotics and inter-operative imaging necessary for the array of procedures performed.

The preoperative and postoperative spaces at the Fanny Allen facility are also limiting. The preoperative and postoperative bays are small, narrow and shallow, and there is limited space for personnel to access the patient and for families to fit at the patient's bedside. In addition, the limited space curtain bays and close proximity to others could compromise patients' privacy to their health care information. The OSC's larger, more modern and intentionally designed OSC pre- and post- operative spaces will support staff efficiency, patient safety and privacy.

With the development of the OSC, Fanny Allen's ORs would close and its surgical staff would migrate to the new facility.

b. UVMMC Main Campus

For similar reasons, the Main Campus of UVMMC is also an unsuitable option for augmenting our outpatient surgical capacity. While UVMMC has newer ORs that support hybrid cases, several ORs are small and not conducive to contemporary surgery. The ceilings and walls of many ORs cannot accommodate mounted equipment, which requires providers and surgical staff to roll equipment in on carts, decreasing efficiency and increasing congestion in the operating rooms. As more procedures come to rely on specialized equipment and technology, it will become increasingly difficult to schedule these procedures in an appropriate OR.

Finally, there is simply no space on the Main Campus to add the ORs necessary to support projected demand – which also forecasts a steady rise in inpatient surgeries – particularly when taking into account the additional pre-op and recovery spaces that would be required.

3. Preserving local access is critical

As the community hospital serving Vermont's most populous region, we would be doing our communities a disservice if we inadequately prepare for the future. Any loss of inpatient or outpatient capacity may send our patients farther afield for the high-quality and timely care they deserve, with additional cost and inconvenience related to travel. Safeguarding local access to such care will help keep our communities healthy, while solidifying our region's position as a desirable place to live and work.

While the UVM Health Network wields substantial shared services and resources, we cannot look to other Network hospitals to permanently fill the void in our surgical capacity, now or in the future. Any unused OR capacity at adjacent Network hospitals, such as Central Vermont Medical Center (CVMC) or Champlain Valley Physicians Hospital (CVPH), will not be sufficient to meet the estimated need for 8 to 12 new ORs by 2030. This is evident when we consider that population growth in the CVMC and CVPH service areas will increase surgical demand at those facilities as well. In other words, such a move would degrade their ability to meet their own community needs, compounding patient access problems already in existence today.

4. The OSC supports high-quality care and better patient access and experience

The proposed OSC is a reflection of our current and future OR needs and the clinical programs and patients that will be served there. It supports more clinically complex outpatient surgical procedures in an efficient and modern environment for patients, providers and learners.

a. The benefits of an outpatient setting

We are committed to improving access to appropriate local care in the communities of Vermont and northern New York. As part of this effort, we constantly work to improve the environments where we provide care. Through medical villages, urgent care centers, rural specialty care clinics (cardiology, dermatology, colonoscopy, endoscopy, women's health and orthopedics), renovating existing spaces or building modern facilities, we aim to support the most up-to-date practices and respond to the changing needs of our patients.

With this in mind, we are looking to move more cases to outpatient settings, which, when supported by new clinical techniques and equipment, is more convenient for our patients and more efficient for our health system.

Away from the hustle and bustle of the UVMMC Main Campus, the OSC will provide a less hectic environment for our patients in all stages of their care. Easy access to public transportation and dedicated parking will make coming and going easier. Right-sized pre- and post-operative spaces – as well as waiting and outdoor spaces – will make it more comfortable and inviting for visiting family and friends. Meanwhile, the very nature of the OSC will help more of our patients to recover in the comfort of their own home.

For our providers, staff and learners, the site is conveniently located just over three miles from the Main Campus. Its proposed location also means that the full capabilities of UVMMC are nearby in the event of a medical emergency.

b. Designed with flexibility and interoperability in mind

A fundamental principle of the facility design is that all ORs will be the same size and have an identical set up to increase the center's efficiency and allow for a broad spectrum of surgical cases to be performed at the OSC (for more detail see Facility section). New instrument setup rooms are a key piece of the facility design. These sterile rooms adjacent to ORs enable rapid and efficient room turnover and preparation, enhancing patient access and experience.

The facility is designed with patient-centered care in mind, emphasizing patient privacy, safety and comfort while creating surgical suites that are efficient and flexible. As new technologies and techniques allow more types of procedures to be performed in an outpatient setting, OSCs must be designed to accommodate these procedures. Joint replacement surgery, spinal fusions, and other advanced procedures require larger ORs with in-OR imaging equipment and advanced air handling to minimize infection risk.

The floor plan itself has been designed with hundreds of hours of provider, perioperative team and supporting staff input to produce an efficient flow as patients proceed from check-in to pre-op, to surgery, and finally to post-operative care. In response to surgeon input, the facility design promotes easy and quick access to post-operative spaces for providers to check in on patients, and easy access to quiet spaces for procedure documentation.

We considered smaller and less homogenous designs in the course of facility planning, so we might have been able to reduce our overall capital expenditure in the development of facility. For example, pairing a collection of smaller ORs with larger, more flexible ORs would reduce the square footage and cost of the facility. The omission of a CSR area would reduce the facility's square footage and operating costs even more dramatically. Yet in both cases, the upfront capital savings of building a smaller facility would be offset in the long term by the loss of operational efficiency and flexibility that our current design ensures. Moreover, the UVMMC Main Campus CSR simply does not have the capacity to support the needs of an OSC.

c. Location benefits

The proposed location of the OSC was determined after considering where the best patient and provider experience could be achieved in an area that integrates well with existing UVMMC services. The parcel's strategic location, 3.3 miles from the Main Campus, is served by a newly-enhanced public transportation system and sits in close proximity to a number of current and proposed UVMMC outpatient clinics, including Orthopedics, Cardiology, Ophthalmology, Dermatology and Rehabilitation. This makes the location convenient, familiar and accessible for patients. The South Burlington site is also suitable because it can accommodate the long-term need for additional space.

For our providers, staff and learners, the site's convenient location will make it easier to travel between the OSC and the Main Campus. Its proposed location also means that the tertiary-level care of the Main Campus is nearby in the event of a medical emergency.

d. Enabling inpatient capacity and modernization

Though not directly linked to ongoing efforts to increase our inpatient capacity, the development of the OSC will free up space that will allow for future OR upgrades on the UVMMC Main Campus. Decanting a portion of surgical cases from the Main Campus to the OSC will enable us to modernize the existing ORs and surgical suites – some of which have not been updated in 30 years – including enlarging a limited amount of ORs to support complex cases that require fixed imaging technology. For example, we have one hybrid OR on the Main Campus that is approaching the end of its life as a useful surgical environment. Replacing the equipment in that OR will cause significant downtime and the suspension of surgical procedures for several weeks, if not months. With the OSC up and running, we could establish an additional hybrid OR on the Main Campus by combining two existing smaller ORs, thereby ensuring no disruption of hybrid imaging procedures and minimal disruption of vital inpatient services.

5. The OSC will support recruitment and retention

The new OSC will also provide an improved surgical environment for our providers that compares favorably with other academic medical centers and supports recruitment and retention of quality providers and learners to the region.

The quality of our facilities is a significant consideration for the talented surgeons, physicians, nurses, scientists and students who contemplate joining the UVM Medical Center. When weighing where to practice and study, these professionals are often considering a host of distinguished institutions with top-of-the-line facilities. The construction of the new OSC would meet the level of our renowned patient care, innovative research and forward-thinking training programs – known throughout the region and the nation as a model for 21st-century health care.

6. There are few viable alternatives

In the course of the facility planning process, we considered a range of alternatives to the construction of a new OSC, including the development of different sites, renovating existing facilities, or reducing capital costs through adjustments to the OSC's design and/or size. Our conclusion remains: the development of a new OSC is the best option to help us prepare for the future and provide the care our patients need and deserve.

We cannot afford to underestimate the future health care needs of our communities, nor risk undermining our capacity to provide them with timely, high-quality care. Among the many lessons learned during the pandemic, we have seen that delayed care only costs more for everyone in the long run. Investing in the OSC now is the most feasible way to encourage timely access without incurring undo increases in the cost of care for the people of our communities.

3. Surgical Volume and Operating Room Demand Analysis

UVM Health Network (UVMHN) Planning partnered with Halsa Advisors to develop a comprehensive OR demand model both for inpatient (IP) and outpatient (OP) surgical cases. The FY19 IP and OP surgical data – which includes volumes, procedure time and turnover time, both from the Main Campus ORs and Fanny Allen ORs – were used as a baseline in planning for the future OSC. FY19 was used as the baseline as it provides the last full year of data not interrupted by COVID, the cyber-attack or closing of the Fanny Allen ORs.

Data for specialty ORs (labor & delivery, cardiology and hybrid OR) and special purpose procedure spaces[1] were excluded from this analysis, as the objective for the analysis was to identify future demand for surgeries that are performed in general-purpose OR spaces; two larger procedure rooms at the Main Campus met the criteria in use, so their volumes were included in the analysis. As Figure 3.1 shows, there are currently 20 ORs located at UVMMC Main Campus, which includes 18 ORs and two larger procedure rooms (PRs). In addition, there are 5 ORs located at the Fanny Allen campus, for a total of 25 general-purpose ORs.

Between FY15 and FY19, growth of the combined IP and OP surgical volume for these ORs was essentially flat. At the same time, wait times for surgeries grew, indicating that our ORs are capacity constrained.

Annually, approximately 19,000 surgical cases are performed in UVMMC ORs. Those cases significantly vary in complexity, and therefore in procedure time, from the longest Neurosurgery and Transplant surgeries to shorter ENT and Ophthalmology surgeries.

Figure 3.1 highlights the FY19 OR supply, surgery type performed at each location and the approximate number of surgical cases by location.

In FY19, approximately 13,000 OP surgical cases were performed at the Main Campus and Fanny Allen. The majority of these surgical cases were for Orthopedics, Urology, ENT, OB/GYN and Ophthalmology. Most of the OP surgery patients came from the Burlington area (51.4%) and were commercially insured (53%).

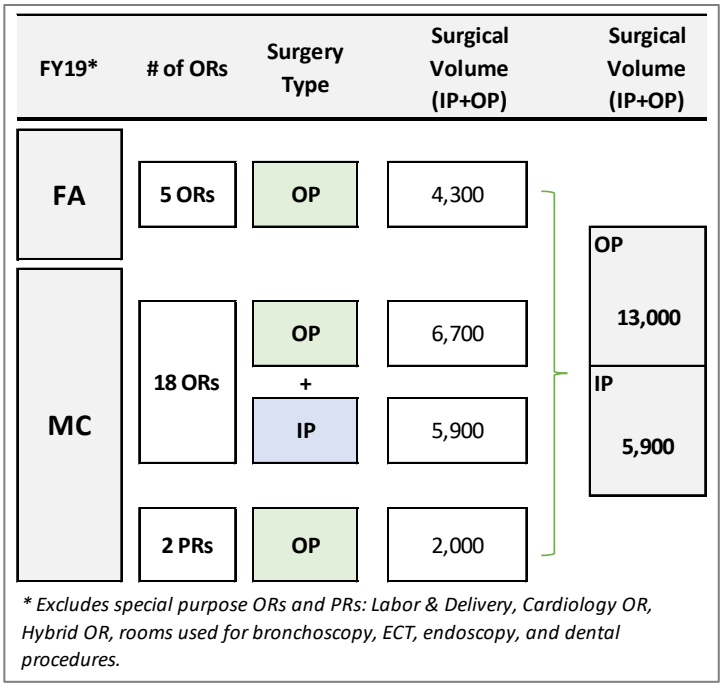

Figure 3.1 FY19 general purpose OR supply and cases by location and

	FY19		
Service Line	# of Cases	% of Cases	% of Time
Orthopedics	3,431	26%	24%
Urology	1,717	13%	13%
ENT	1,670	13%	12%
OB/Gyn	1,610	12%	15%
Ophthalmology	1,364	10%	7%
Other	3,260	25%	28%
Total	**13,052**	**100%**	**100%**

Figure 3.2 FY19 OP cases by Service Line.

FY19 Patient Origin (HSA)	Pat. Origin Distr.
Burlington, VT	51.4%
St. Albans, VT	8.8%
Berlin, VT	7.7%
Plattsburgh, NY	7.6%
Middlebury, VT	5.6%
Other	18.8%

FY19 Payer	Payer Distr.
Commercial	53.0%
Medicare	26.0%
Medicaid	14.0%
Other	7.0%

Figure 3.3 FY19 OP OR cases by patient origin and payer.

[1] *Procedure rooms used for bronchoscopy procedures, ECT (Electroconvulsive therapy) procedures, endoscopy, and dental procedures.*

Surgical Volume Demand Forecast

Our surgical volume demand model projects only the growth of UVMMC's FY19 surgical volume, by applying market growth projections by service line for IP and OP surgeries to the baseline volumes for UVMMC described above. Said in another way, this model reflects the assumptions that UVMMC's market share remains the same by service line over the forecast period.

Projection through 2030

The surgical volume demand methodology projects both IP and OP case volumes by service line to 2030. In order to account for uncertainty inherent in this exercise, the model reflects three sets of volume growth assumptions (three scenarios), as noted below.

Scenario 1: Sg2 Forecast for Surgical Demand. This set of assumptions powered the original version of the demand model, developed in early 2021, and is based on Sg2 forecasting. The forecast reflected demographic projections from Claritas available as of 2020, projections for cases that would shift from the IP to the OP setting and other factors impacting demand including changes to policy, epidemiological trends, the impact of the economy and consumerism, and changes related to improvements in population health. It is important to note that the Claritas demographic forecast for our region did not yet reflect 2020 census data (the census data were not yet published).

In the summer of 2021, Public Opinion Strategies (POS) shared its Vermont demographic forecasts to inform the UVM Health Network's 2022 budget work. The POS population growth estimates were significantly greater than the Claritas 2020 estimates. In the fall of 2021, 2020 Census data by state and county provided confirmation that the Claritas 2020 forecast had significantly underestimated population growth to 2020 for Vermont, as well as for Chittenden County and surrounding counties. The table below reflects POS growth rates for Chittenden County, VT split by age group.

Population Growth by Age Group	2019	2030	2040	10 yr growth	20 yr growth
Chittenden, VT	162,646	171,718	181,506	6%	12%
Under 65	*138,839*	*133,197*	*124,185*	*0%*	*-11%*
Over 65	*23,807*	*38,521*	*57,321*	*62%*	*141%*

Figure 3.4 Chittenden, VT population growth projections by Public Opinion Strategies.

Public Opinion Strategies also projected growth rates for the surrounding counties. As shown in the table below, the populations of Vermont's Franklin, Grand Isle and Washington counties are projected to grow, with significant growth in the over-65 age cohort.

Population Growth by Age Group	2019	2030	2040	10 yr growth	20 yr growth
Franklin, VT	49,116	55,647	59,821	13%	22%
Under 65	*41,473*	*41,777*	*39,259*	*1%*	*-5%*
Over 65	*7,643*	*13,870*	*20,562*	*81%*	*169%*
Grand Isle, VT	7,022	10,708	12,678	52%	81%
Under 65	*5,621*	*7,326*	*6,809*	*30%*	*21%*
Over 65	*1,401*	*3,382*	*5,869*	*141%*	*319%*
Washington, VT	58,350	62,372	63,931	7%	10%
Under 65	*47,270*	*45,122*	*40,564*	*-5%*	*-14%*
Over 65	*11,080*	*17,250*	*23,367*	*56%*	*111%*

Figure 3.5 Franklin, VT, Grand Isle, VT and Washington, VT population growth projections by Public Opinion Strategies.

Based on the POS demographic forecast, in the summer of 2021 we updated the demand model with two additional scenarios:

Scenario 2: Utilization for Updated Demographic Growth: This is an age-adjusted utilization scenario based on POS population growth estimates and our FY19 baseline data utilization by age cohort.

Scenario 3: Sg2 Growth Rates Adjusted for Updated Demographic Growth: This scenario combines the updated demographic growth projections from Scenario 2 with the additional Sg2 factors from Scenario 1. This scenario

reflects the expected shift from the IP setting to the OP setting for selected surgeries, with significant forecasted growth for a subset of these surgeries driving lower IP and higher OP growth as compared to Scenario 2.

Each of the three scenarios contains a slightly different set of assumptions that, together, are intended to capture the range of likely growth in demand for surgeries at UVMMC by 2030. A detailed OR demand model overview, including how projected surgical cases were translated into ORs, is included in the Appendix.

The overall surgical volumes demand projections call for 10-year growth between 14% and 22% depending on the growth scenario. The table and the chart below highlight differences in surgical volume demand projections based on the three scenarios.

	10 year OR Volume Projections Based On:								
	Scenario 1: Sg2 Growth Rates			Scenario 2: Utilization or Updated Demographic Growth			Scenario 3: Sg2 Growth Rates Adjusted for Updated Demographic Growth		
	2030		2030	2030		2030	2030		2030
	IP	OP	IP + OP	IP	OP	IP + OP	IP	OP	IP + OP
Total Cases	6,231	15,938	**22,169**	7,226	15,980	**23,206**	6,717	17,050	**23,767**
Growth from 2019	2%	20%	14%	18%	20%	19%	10%	28%	22%

Figure 3.6 Ten-year surgical volume demand projections based on three growth scenarios.

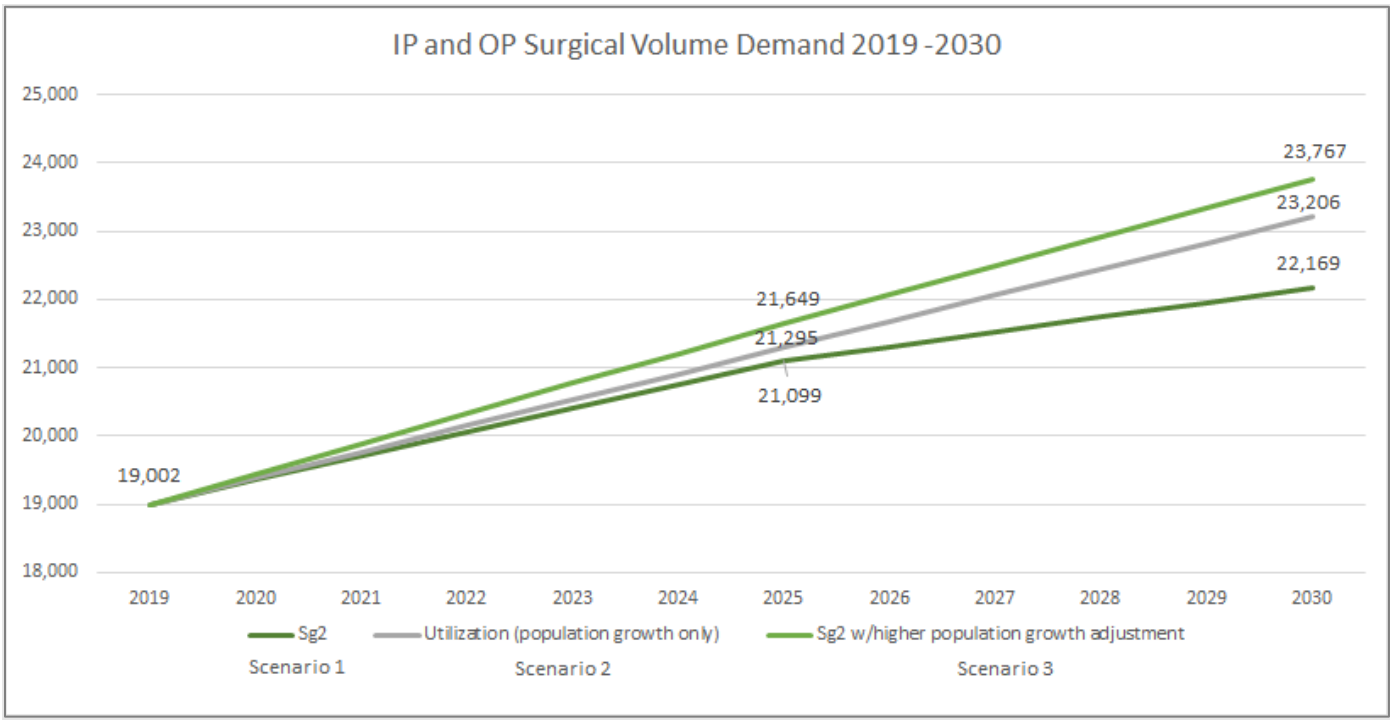

Figure 3.7 Ten-year surgical volume demand projections based on three growth scenarios.

Conclusions:

The need for additional OP ORs is driven by the expected growth in both IP and OP surgeries for the following reasons:

- Forecasted increase in need for surgical capacity for IP surgeries: Inpatient surgical volumes are expected to grow between 2% and 18% by 2030, requiring additional ORs at the Main Campus. While this growth is not expected across all health care services, we should expect to see increased demand ranging from 125 to 950 cases per year. IP growth is driven by three key factors: population growth, population aging and a modest growth in tertiary care IP surgeries, i.e., highest acuity surgery for UVMMC Hospital Referral Region population. Additional capacity will be required at UVMMC to perform these surgeries. Given that UVMMC is currently unable to expand its OR area at the Main Campus, this necessitates moving a significant number of OP surgeries currently performed at the Main Campus to another site.

- Forecasted growth in OP volumes by service line: As our demand analysis shows, OP surgeries are expected to grow between 20% and 28% by 2030. It is important to note that OP surgical growth is projected across a number of health care specialties, with the highest projected growth are Ophthalmology, Orthopedics, General Surgery and Urology. A detailed table with projected volumes by service line is included in the Appendix.
- Overall growth in surgical volume, as compared with the FY19 baseline, ranges from approximately 3,200 to 4,800 cases per year by 2030.

Demographics Note:
2020 Census data by state and county became available in fall 2021, showing higher growth for Vermont and in particular, for counties in our region, than census estimates for 2020 had indicated. For example, Chittenden County's 2020 census reflected 8% growth from 2010-2020, significantly higher than Claritas and other demographic forecasters' projections for 2020. Similar higher growth rates were shown for surrounding counties in UVMMC's service region. These 2020 census data confirmed our decision to apply the POS population growth projections in Scenarios 2 and 3. Claritas 5 yr. population forecasts released in fall 2022 now reflect higher population growth expectations and in fact, project the population for Chittenden County will be 172,400 by 2023. Note that this population forecast is higher than the POS forecast for Chittenden County for 2030. The significant change in population projections is important to note. It puts the POS population projections into a relatively more conservative light and was a factor in our recommendation to include shelled space for an additional 4 ORs.

Operating Room Demand Estimates

Halsa's demand model estimates OR room demand based on the surgical volume growth projected under each of the three scenarios. This work is described in detail in the Appendix. In summary, the model projects that by 2030, the UVM Medical Center will need 28.5 to 30.6 general purpose ORs to meet the expected growth in IP and OP surgeries. With 20 ORs in supply (Fanny Allen ORs have reached the end of their life), UVMMC will need to increase capacity by between 8.5 and 10.6 additional ORs[2].

	10 year OR Volume Projections Based On:								
	Scenario 1. Sg2 Growth Rates			**Scenario 2: Utilization for Updated Demographic Growth**			**Scenario 3: Sg2 Growth Rates Adjusted for Updated Demographic Growth**		
	2030		**2030**	**2030**		**2030**	**2030**		**2030**
	IP	OP	IP + OP	IP	OP	IP + OP	IP	OP	IP + OP
Total Cases	6,231	15,938	**22,169**	7,226	15,980	**23,206**	6,717	17,050	**23,767**
Growth from 2019	7%	17%	14%	24%	17%	19%	15%	25%	22%
Total # of ORs needed	**10.9**	**17.6**	**28.5**	**12.3**	**17.6**	**29.9**	**11.9**	**18.8**	**30.6**
Incremental # of ORs needed			**8.5**			**9.9**			**10.6**

Figure 3.8 Projected OR need for the three growth scenarios.

Extrapolation through 2035

We also extrapolated our FY 2030 projections in each of the three scenarios on a straight-line basis[3] out to 2035 in order to better understand the number of ORs we will likely need by that date. Although these longer-term projections are by their nature less precise, they helped guide our project planning, which must look well beyond the first six years of operation since the useful life of the new building is 30 years.

[2] To determine OR need the total of projected OR minutes (volumes x avg. case time) was divided by annual available minutes per OR (assuming 10 hours of operation at the new OSC). See Appendix for detail.

[3] Methodology consistent with the POS population projections, especially the 65+ growth projections.

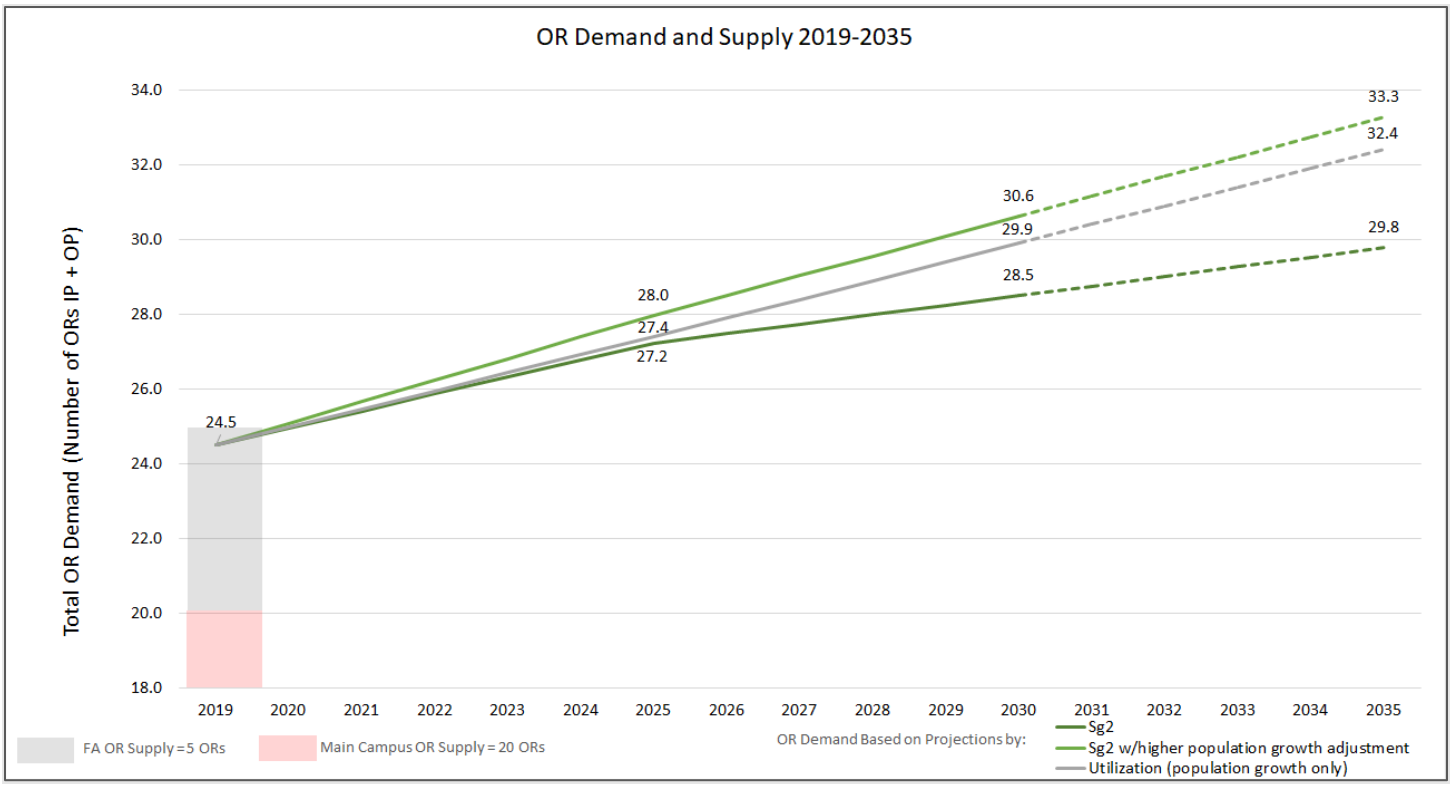

Figure 3.9 2019 to 2035 OR Demand and Supply based on three growth scenarios.

This extrapolation shows that by 2035, need for additional OR capacity could increase to between 9.8 and 13.3 ORs. Based on the OR demand and surgical volume projections, the planning workgroup recommended an OSC program that was designed to 1) replace the 5 outdated and undersized ORs on the Fanny Allen campus, 2) build additional capacity to meet projected 2030 demand, and 3) build additional shell space to more nimbly address increases in the demand for additional OR capacity expected to 2035. The group recommended to UVMHN and UVMMC senior leadership a facility with 8 ORs with shell space for an additional 4 ORs.

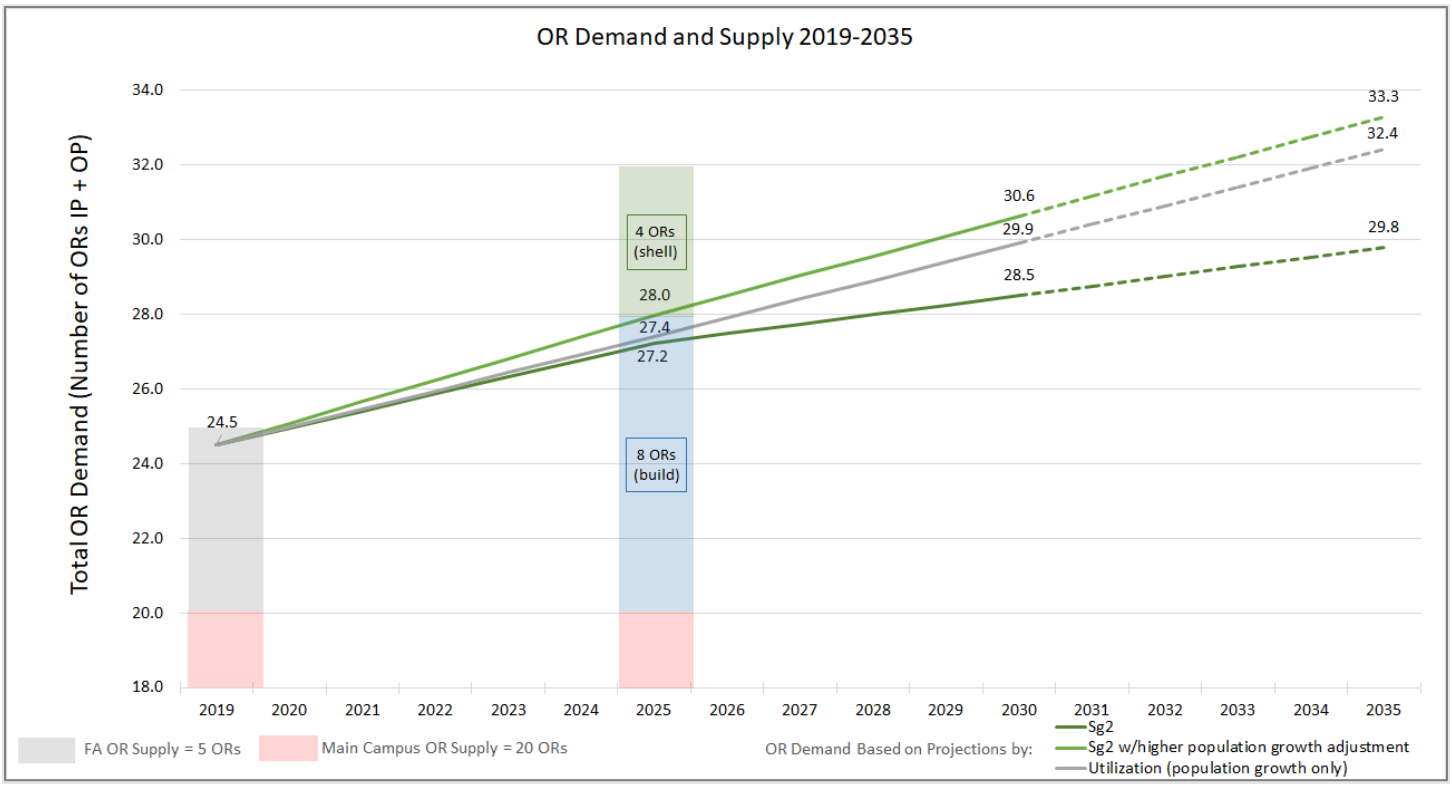

Figure 3.10 2019 to 2035 OR Demand and Supply based on three growth scenarios with proposed OSC ORs overlay.

Projected OSC Volumes (2025-2030)

For OSC planning purposes, we have selected Scenario 3 from OR and surgical demand analysis as the baseline for OSC volume projections, as this scenario combines the POS population growth projections with Sg2's forecasting for the shift from IP to OP sites of care, with other Sg2 forecast factors will drive growth or decline as explained above. As part of the process for the 8 OR facility (with shelled space for additional 4 ORs) we have estimated the future surgical volume for the new OSC. This process was done in two steps: 1) we determined what types and mix of surgeries are appropriate for the new OSC, and 2) based on projected OP surgical demand and OSC capacity, we estimated future OSC volumes.

OSC surgical case mix

Through multiple conversations with service line surgical and administrative leaders, we evaluated each surgical specialty to determine if the future OSC is the appropriate setting for those cases. We took into consideration the following factors:

- current location where surgeries are performed,
- need to be in close proximity to an IP setting, and
- novel procedures or technologies that could influence sites of care.

The new OSC is designed as a highly flexible, multi-specialty surgical center. As a result, it will accommodate a broad variety of surgical cases, from shorter ENT and Ophthalmology cases to more complex Orthopedics surgeries. For the full list of surgical specialties and a number of surgical cases projected for the OSC, see Appendix.

OSC Volume (surgical cases)

To determine future OSC volume we had to:

1. Estimate Main Campus capacity: knowing that future growth in IP surgical cases will take priority over OP cases, we had to estimate future OP surgery capacity at the Main Campus, taking the projected growth in IP surgeries into consideration. In other words, the projected growth in IP surgical demand will necessitate a shift of OP surgeries outside of the Main Campus ORs.
2. Compare estimated Main Campus OP surgical capacity to UVMMC total OP surgical demand. As mentioned in the prior section, we have used Scenario 3 to determine future OSC surgical volume.
3. Determine future OSC capacity based on the number of available ORs and surgical case mix.
4. Compare estimated OSC capacity with OSC demand to determine future surgical volume at the OSC for 2025-2030.

The table below presents a high-level overview of the steps we took to determine OSC cases between 2025 and 2030. Approximately 8,000 cases will be performed in eight fitted ORs at the new OSC in its first four years of operation.

Year	2025	2026	2027	2028	2029	2030
UVMMC Total OP Demand	15,287	15,639	15,992	16,345	16,697	17,050
Main Campus OP Capacity	7,977	7,855	7,733	7,611	7,489	7,367
OSC Demand	**7,310**	**7,785**	**8,259**	**8,734**	**9,209**	**9,683**
# of OSC ORs	**8**	**8**	**8**	**8**	**10**	**10**
OSC Capacity	**8,040**	**8,040**	**8,040**	**8,040**	**10,055**	**10,055**
Total of OSC Cases	**7,310**	**7,785**	**8,040**	**8,040**	**9,209**	**9,683**

Figure 3.11 2025 to 2030 OSC surgical volume projections.

The projected OSC volume will include the increase in surgical volume due to demographic factors, as explained above, as well as the shift of OP surgeries from Fanny Allen and the Main Campus to the new facility. The increase in OP surgical capacity generated by the OSC will allow UVMMC to decant the Main Campus ORs (a portion of those OP cases will shift to OSC) and therefore accommodate increased IP surgical demand at the Main Campus.

4. Facilities Plan

Facility Planning Objectives

A large group of stakeholders participated in the planning process. The group included physicians, nurses and periop leaders, patient and family advisors, and leaders from Lab & Pathology, CSR, Imaging, Pharmacy, Registration, IT, Supply Chain, Environmental Services, Nutrition, Security, Emergency Care & Access Services and Hospital Services. Below we share the guiding principles that shaped the programming phase of our planning work, facilitated by our partners Halsa Advisors and e4H Architecture.

1. Always put the needs of the patient first.
2. Patient and staff safety will always guide operational and design approaches.
3. Explore innovative approaches; incorporate program and design elements to improve performance and minimize cost per case.
4. Create a facility that supports our staff in doing the right thing – for our patients, their families, and for ourselves.
5. Support our academic mission, both research and teaching – the OSC itself should create research opportunities.
6. Build in (reasonable) flexibility.
7. Set the standard for patient-centered surgical care in the Burlington market.
8. Support the quadruple aim.
9. Maximize our community's return on this investment.
10. Retain a focus on our stewardship of community and natural resources.
11. Plan using lean/six sigma principles.
12. Design Phase 1 to minimize disruption of constructing the already designed Phase 2.
13. It is not intended to use this site as a back-up or redundant site for support services.
14. Manage storage so no long term and (just in case) storage is maintained at this site.
15. Meet needs of diverse patient and staff populations (including learners).

The Building Site

The project includes the purchase of approximately 13.5 acres of land located at 119 Tilley Drive, South Burlington. The site is currently under a purchase option agreement, contingent upon successful permitting and site due diligence, and would be acquired once the Certificate of Need (CON) application is approved by the Green Mountain Care Board.

The site selection process included the evaluation of several sites in Chittenden County. The proposed site was chosen after careful analysis of the location, proximity with other health care facilities, pedestrian, vehicular and public transportation access, permitting, proximity to utilities (including water and sewer infrastructure) and the site's capacity to meet initial construction size requirements and future growth needs.

The site design incorporates 270 onsite parking spaces located on the west and north sides of the building. An existing windmill will be relocated to a parking island. There are landscaping elements around the building, along the driveway to screen the site from abutting properties, and at parking islands. In addition, two elevated berms provide additional screening near abutting residential properties. A small exterior patio with outside seating is located adjacent to the family waiting area which will be accessible through an exterior entrance door. A staff outdoor area is located on the northern side of the building. A future overlook with connection to a city multi-use path to the east is shown on the northern end of the site.

Figure 4.1 Outpatient Surgery Center Site Plan at 119 Tilley Dr. in South Burlington.

Access to Public Transportation

UVMMC has worked in collaboration with the Special Services Transportation Agency (SSTA) to ensure that there is consistent, affordable and reliable public transportation available for patients to access Tilley Drive health care services. As of April 4, 2022, SSTA now offers free, direct shuttle service from the Green Mountain Transit (GMT) Downtown Transit Center on Cherry Street in Burlington to Tilley Drive. The shuttles stop at each of the medical office buildings along Tilley Drive, dropping off and picking up riders on their way to or returning from appointments. (Shuttle Web Link).

The Building

The design and program for the proposed +/- 84,006 GSF building will include eight operating rooms and shell space for four additional operating rooms and adjacent pre-surgery and post-operative recovery spaces to be located on the ground level floor. The building features a covered drop-off area with separate ingress and egress paths for the convenience of arriving and departing patients. A registration area with an adjoining waiting room will be located immediately inside the building entrance. Discharged patients will leave through a separate, discrete exit. The facility will have a partial basement level that will host a CSR area for the onsite sterilization of instruments and space for sterile storage. The building includes a material handling area with loading dock for the delivery of clean linen and surgery supplies and the pick-up of solid waste and recycled materials. The building will be designed to accommodate the internal expansion of four additional operating rooms. The shell space for the four additional ORs as well as 14 pre- and post-operative spaces will be built out during the construction phase. The costs for shelled spaces are included in the financial assessment.

Figure 4.2 Early Iteration of OSC's Exterior View.

The proposed space is designed to be flexible and expandable to meet future needs. When the site opens, the anticipated initial patient surgical volume will be approximately +/-8,000 surgical cases per year. This translates to an average of 32 surgical patients per day served by the initial eight operating rooms. The number of prep and recovery spaces are designed for the facility's expected peak volume days, when we might expect 55 patients during a single day. The building is designed to allow for the fit-up of four additional operating rooms and 14 pre- and post-op spaces to further expand surgical capacity.

Patient flow through the site was carefully analyzed to ensure privacy, safety and convenience during each patient care encounter. To ensure patient privacy and reduce noise and incidental traffic, the building design separates the surgical, pre- and post-surgical spaces from public and back-of-the-house support areas. See Section 5 for more information on patient flow.

The building design features shared offices and work spaces to ensure maximum flexibility and use of the space. It provides ample space for providers, support staff and learners who are anticipated to be present in the new facility. The building will feature a separate entrance for employees at the basement level, which includes an employee changing area, locker and shower rooms, as well as a lactation room for staff use. The diversity, equity and inclusion principles were taken into consideration during the facility design process to create safe space for both patients and employees.

A conference/class room will be provided on the basement level to support staff meetings and training activities.

The building design emphasizes enhanced and convenient patient access and a focus on patient-centered care to ensure privacy, safety and comfort while creating surgical suites that are efficient and flexible.

The list below itemizes the functional program and spaces to be housed in the proposed building:

1. The **ground floor level** will include the following clinical spaces:
    - 8 new ORs and adjacent instrument set-up rooms with the infrastructure and capacity to expand to 12
    - 8 extended recovery rooms with the infrastructure and capacity to expand to 12
    - 12 prep areas with the infrastructure and capacity to expand to 17
    - 13 Phase 1 recovery areas and 1 Isolation Patient Room
    - 14 Phase 2 recovery areas with the infrastructure and capacity to expand to 19
    - Clinical spaces for anesthesiology, lab/pathology

Figure 4.3 OSC Floor Plan: Ground Floor Level.

2. The partial **basement level** will provide the following support services:
   - CSR with the infrastructure and capacity to support future expansion to 12 ORs
   - Locker and changing Rooms
   - Sterile supply storage
   - Mechanical and electrical rooms
   - Shipping and receiving/loading dock
   - Bio-med support
   - Information services support
   - Environmental service equipment room
   - Conference/education room
   - Bicycle storage

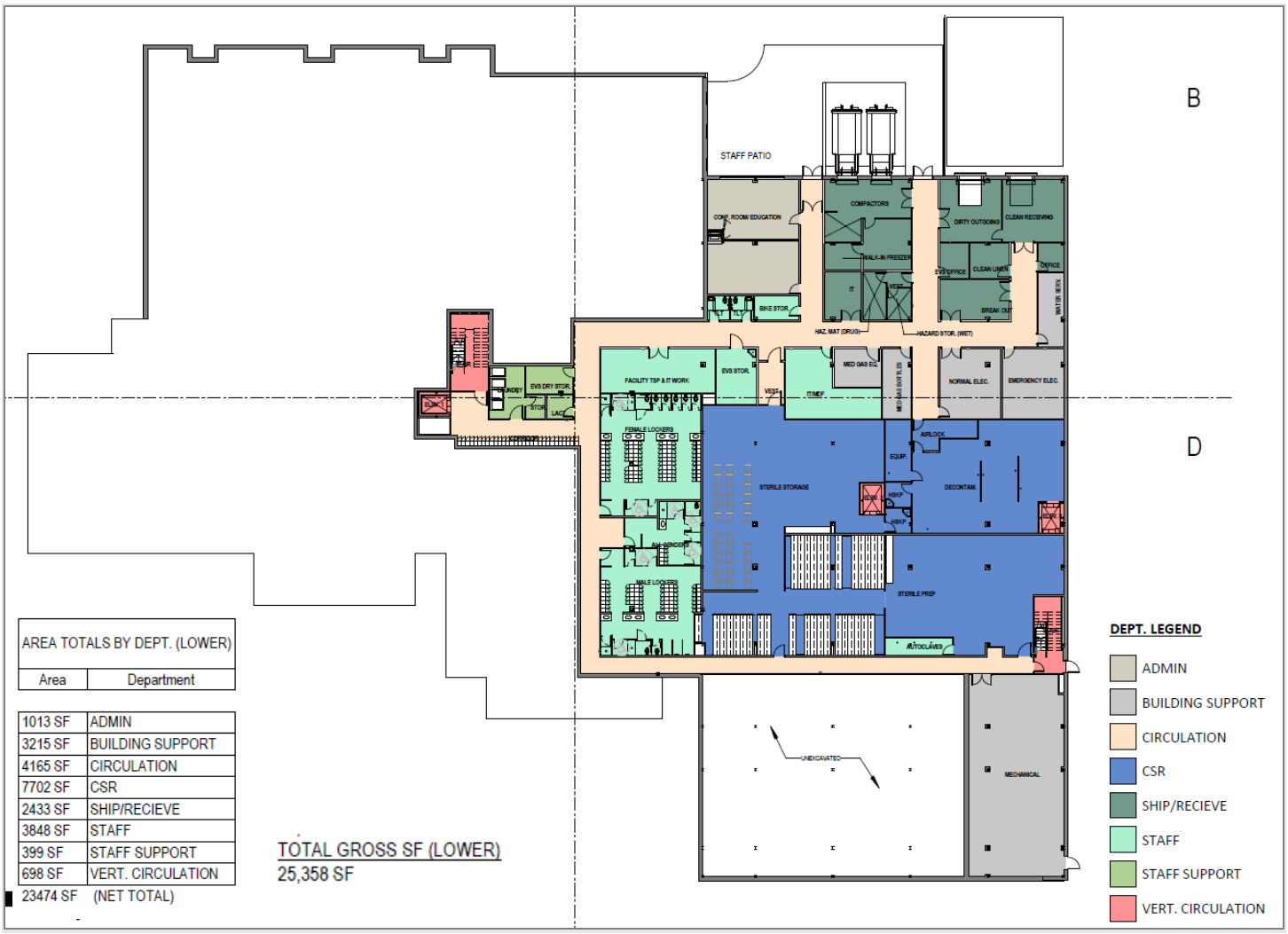

Figure 4.4 OSC Floor Plan: Basement Level.

3. Additional Building Features:

- Front entrance, free standing architectural drop-off canopy
- Open check-in/check-out lobby with family lounge
- Designated CLEAN elevator from Surgical Clean Core to lower-level CCSR
- Designated DIRTY elevator from Surgery to lower level
- Service elevator
- Exit stair tower extends to roof level
- Medical gas manifold room/Oxygen farm
- Emergency power

The new building will be energy efficient. The design of the building reflects UVM Medical Center's overarching commitment to environmental sustainability goals. This project will seek LEED certification and is designed to meet or exceed Vermont Energy Code requirements and EnergyStar standards.

Consistent with the guiding principles used in planning the project, the table below reflects the priority given to space for direct patient care, with additional space only as needed for supporting services. This lean approach to planning the OSC also results in reduced indirect operating costs.

OSC Building by Square Footage		
	SF	% of Total
Operating Room	7946	10%
Patient Space	6601	8%
Shell	9367	12%
Staff	7927	10%
Public	3661	5%
Staff Support	7228	9%
CSR	7702	10%
Admin	2050	3%
Ship/Receive	2433	3%
Building Support	4081	5%
Circulation	17283	22%
Vert. Circulation	1395	2%
Net Total	**77674**	100%
Gross Total	**83602**	

During planning process, we have completed benchmark analysis to validate key facility related assumptions: construction cost, building size, operating room size, total number of operating rooms and pre- and postoperative spaces. The proposed OSC is unique amongst the facilities we evaluated and as such simple benchmarking was not achievable without unreasonable contortion of the available data. Stroudwater Associates, a national healthcare consulting firm, who we consulted with to seek a second opinion reached the same conclusion.

A more technical description of the building, site and benchmark analysis is included in the Appendix.

Project Timeline and Milestones

The proposed schedule outlined below reflects our efforts to optimize the commencement of construction, minimize the impacts of winter conditions, and ensure completion of the project in the early spring of 2025. Our schedule assumes that we can continue design efforts after the CON application is submitted so that we can break ground and start the project site work soon as the CON is approved. The proposed schedule will allow us to begin construction in July/August of 2023. This construction start date is contingent upon a six-to-seven-month CON review and approval timeline. A later CON approval date would delay the first patient day by six months and complicate construction, extend the construction duration, and increase construction costs (contingency for delayed construction start date is built into project's contingency). The construction is projected to last 18 months and April of 2025 is targeted as the first patient day. For a more detailed project timeline and milestones, see the Appendix.

Key Project Milestones	Date
CON Application Submission	January 2023
Town and Act 250 Permitting	January 2023
Construction Documents Completed	February 2023
Expected CON Approval Date	July 2023
Construction Start	August 2023
Certificate of Occupancy	February 2025
Pre-Occupancy Readiness Completion	April 2025
First Patient Day	April 2025

Figure 4.5 OSC project timeline and key milestones.

5. Operational and Human Resource Assessment

Services and Hours of Operation

As previously mentioned in the Facility section, the OSC's design will provide outstanding patient experience in a highly efficient care delivery environment. Uniform ORs and pre- and post-operative areas will promote efficiency. The OSC will provide high-quality, multi-specialty outpatient surgical care, from patient preparation through discharge, for a wide variety of surgical specialties.

The center will be limited to OP care and all patients are expected to be discharged in less than 24 hours. 23-hour stays will be accommodated when clinically necessary. In case of an emergency or if an observation patient fails to meet the discharge criteria, the patient will be transferred to UVMMC based on established protocols.

The center will open for first patient arrival on weekday mornings at 5:30 a.m. The Prep unit will begin preparing patients for surgery at 6:00 a.m. The first surgical case will begin at 7:00 a.m. The normal surgical day will be scheduled from 7:00 a.m. until 5:00 p.m. (10-hour operating day).

Scheduled closing time for the PACU/Stage 2 Recovery Unit will be 8:00 p.m. every evening. 23-hour cases will be scheduled Mondays through Thursdays, allowing the center to close completely by 8:00 p.m. on Fridays.

Patients

The new OSC will serve patients who, through pre-assessment screening and testing, meet the patient criteria for OP surgery. In general, patients with an American Society of Anesthesiology (ASA) score of 3 or below, with low risk for complications and infection, are considered appropriate for surgical care at an OSC.

Key Operational Characteristics

Patient and Visitor Experience

Pre-Procedural Arrangements

In order to optimize the resources of our surgical teams and other supporting staff at the OSC, all requirements for the patient's surgery should be completed prior to the day of surgery. These requirements include ensuring that the patient's financial responsibility is known (e.g., that any insurance coverage for the procedure is approved by the payer) and that the patient has completed Pre-Assessment Screening and Pre-Assessment Testing (PAT) prior to arrival at the OSC. Patients needing any assistance with translation or any other special needs will be identified in the PAT process, allowing us to preschedule the appropriate resources to accommodate the patient.
Having these requirements satisfied in advance of the patient's day of surgery enables a simple and fast check-in process for the patient and staff and minimizes the staffing required for the check-in area.

Procedure Day

When the patient and their companion arrive, they will check-in at the reception desk or at a kiosk in the reception area and will be directed to the lounge area, consisting of a waiting room and outdoor patio. From there, patients will be taken to the pre-op area, prepared for surgery (including consultation with the surgeon and anesthesia) and transported to the OR. Upon completion of the surgery, the patient will be transported to one of the following post-surgical environments, as appropriate:

- Phase 1 recovery, higher acuity care post anesthesia emersion,
- Phase 2 recovery, lower acuity care post anesthesia emersion, or
- 23-hour observation area, for patients after a higher complexity surgery.

During the recovery, the surgeon will visit the patient and their companion (as relevant) to provide a post-procedural consultation.

The OSC will provide Meds-to-Beds services to its patients as well as physical therapy when applicable. The nursing staff will finalize the post-procedural teaching, provide written instructions, and discharge the patient.

A member of the clinical team will assist the patient and their companion to their transportation via the private discharge exit (post-procedural patients will not reenter the waiting room on their way out). A more detailed patient flow sequence is included in the Appendix.

Staff and Provider Experience

The new OSC is designed to maximize the most valuable human and facility resources: the surgeon, the surgical team and the OR. By streamlining and eliminating variations in the patient preparation, surgery and post-surgery processes, the OSC aims to improve performance and outcomes, and to minimize cost per case. The goal, both from the design and operational perspectives, is to make it easy for the staff to do the right thing, every time.

The OSC will strive to minimize room turn-around time by quickly vacating a room following surgery completion ("wheels out") and allowing the room to be cleaned, set up for the next case, and positioning/set-up to occur and start the next case ("wheels-in") as rapidly and as safely as possible.

Two factors will minimize downtime for the surgical teams:

- First, making sure the next patient is always "on-deck" and prepared for surgery – eliminating excess time spent by the team waiting for the next patient.
    - This approach allows the surgical team to hold a patient whose nerve block or local anesthetic is failing to establish as expected in pre-op, while a later scheduled patient accelerates and takes the newly open OR time. This approach will likely be most useful for shorter cases. All prep rooms will be capable of serving as a "block room," and patients will not be transferred to a distinct location. This eliminates a handoff and unnecessary patient movement.
- Second, advance opportunities to prepare instrumentation and equipment for the next case, and accelerate cleanup post-procedure.
    - Providing sterile set-up rooms adjacent to the ORs allows instruments and supplies for the next case to be set up before the current case is finished. Additionally, break down areas where soiled instruments and trash can be separated and processed are readily accessible from the ORs, minimizing the use of an OR itself as a trash and soiled instruments processing room.

Both of these approaches follow Lean principles by eliminating steps that do not add value and by utilizing the scarce resource, the clinical team, to the fullest. In addition to Lean principles, the OSC will be operationalized using the STEEP model, described in more detail in Section 9.

As mentioned in the Facility section, the new OSC is designed to provide appropriate and efficient space for providers and staff to deliver the best care possible for patients and their families. Consistent with this premise, the new facility is planned with diversity, equity and inclusion in mind. From appropriately-sized locker rooms and changing areas, to meeting spaces, break room and outdoor rest areas and accommodations for learners, the new OSC will be an example of a modern surgical center built to accommodate surgical and patient care innovations well into the future.

OSC Staffing Model

This section describes the staffing plan for the new OSC. The plan includes the direct and indirect staffing models needed to support the eight-OR facility. We also highlight additional staffing needs when two more ORs are operationalized. These models guided business planning and preparation of the financial pro forma.

Direct Staffing

The direct staffing model for the new OSC was developed using the American Society of Perianesthesia Nurses (ASPAN) benchmark for Perianesthesia staffing and the Association of Perioperative Registered Nurses (AORN) benchmark for OR staffing. The administrative support staff and CSR staff are also included in the direct staffing model.

Based on key assumptions used in the model (hours and days of operations, shift hours, Combined Time Off backfill etc.) the new eight-OR OSC will require approximately 107 FTEs in direct staff, with 57.5 of those being incremental additions to the organization. Approximately 50 current or already budgeted FTEs will shift to the new OSC from either the Fanny Allen OP OR area or the Main Campus. When two additional ORs open, the center will need an additional 18 FTEs.

		Job Category	Total FTE Need (8 ORs)	Incremental FTE Need (8 ORs)	Incremental FTE Need (+2 more ORs)
Perianesthesia	Admin	Assistant Director of Perianesthesia	0.6	0.6	-
		Nurse Manager	1.1	1.1	-
	PREOP	RN (10h days)	10.2	2.9	2.2
		US/LNA's (10h days)	4.4	1.9	-
		Care Coordinator (8h days)	1.1	1.1	-
		APRN (8h days)	1.1	1.1	-
	PACU Phase 1	RN (10h days)	7.3	1.0	-
		RN (12h days)	3.5	3.5	-
		US/LNA's (10h days)	1.5	-	-
	PACU Phase 2	RN (10h days)	7.3	7.3	2.2
		US/LNA's (10h days)	2.9	1.0	1.1
	PACU 23h stay	RN (12h days)	6.9	6.9	1.1
		US/LNA's (12h days)	5.2	5.2	1.1
OR	OR Staff	RN OR (10h days)	20.4	7.0	3.3
		Surgical Tech (10h days)	8.7	2.9	3.3
	Admin	Assistant Director	0.6	0.6	-
		OR Manager	1.1	1.1	-
		Team Leads (SL Leader)	2.2	1.1	-
		Unit Secretary	1.1	-	-
		Equipment Specialist/Laser safety	1.1	1.1	-
		Educator	1.1	1.1	-
		Anesthesia Tech	2.2	1.1	1.1
		Patient Care Associate	2.2	-	-
CSR		CSR Tech	12.2	7.8	2.2
		CSR Supervisor	1.1	-	-
Total			**107.1**	**57.5**	**17.8**

Figure 5.1. Future OSC total and incremental direct staff FTEs.

Providers

As mentioned previously, the new eight-OR facility will allow for multi-specialty OP surgical care. We project that a number of specialty surgeons, residents, fellows, learners and community providers will utilize the OSC. Based on extensive discussions with the UVMHN Medical Group, we are confident that current surgeons and community physicians will fill the incremental capacity, without the need to hire additional surgeons. However, additional Anesthesia staffing beyond those who will come from the Fanny Allen ORs will be needed to support the increased surgical cases at the OSC; one additional Anesthesiologist and four Anesthesia APPs are required to support the 8 OR facility. This need grows by one additional MD and one APP when 10 ORs are open. The plan assumes that one Pathologist and one Pathology PA will relocate to the new center and will support both OSC work in-person and UVMHN work remotely.

		Job Category	Total FTE Need (8 ORs)	Incremental FTE Need (8 ORs)	Incremental FTE Need (+2 more ORs)
Providers & Learners	Physicians	MDs	8.0	-	
		Residents	8.0	-	
	Anesthesiology	MDs	3.2	1.2	1.0
		APPs	8.0	4.0	1.0
		Block Team	1.0	-	
	Other	Pathologist	1.0	-	
		Pathology PA	1.0	-	
		Medical Students	3.0	-	
Total			**33.2**	**5.2**	**2.0**

Figure 5.2 Future OSC total and incremental provider FTEs.

Indirect/Ancillary Staffing

The indirect/ancillary staffing model, necessary to support the new facility, was created in collaboration with a number of supporting departments. An estimated 15 additional FTEs will be needed to maintain operations of the new eight OR OSC, primarily in the Environmental Services, Security, Facility, Radiology, IT and Pharmacy departments. Two additional FTEs will be needed to support two more ORs.

	Job Category	Total FTE Need (8 ORs)	Incremental FTE Need (8 ORs)	Incremental FTE Need (+2 more ORs)
Ancillary	Check In / Patient Access Specialist	2.0	1.0	-
	Housekeeping / EVS	7.0	2.0	2.0
	Security	1.5	1.5	-
	Facility	6.0	2.5	-
	Supply Tech	1.0	1.0	-
	Pharmacy technician	1.0	1.0	-
	Radiology Technician	2.0	2.0	-
	IT	2.0	2.0	-
	Technical Services Program	2.0	2.0	-
	Food Services	1.0	-	-
Total		**25.5**	**15.0**	**2.0**

Figure 5.3 Future OSC total and incremental indirect FTEs.

Recruiting and Workforce Coordination

In total, the new OSC will initially require 78 incremental FTEs. Most of them, 57.5 FTEs, are needed for direct Perianesthesia, OR and CSR staffing. Opening two more ORs will require approximately 22 FTEs more.

Type	Incremental FTE Need (8 ORs)	Incremental FTE Need (+2 more ORs)
Direct Staff	57.5	17.8
Providers	5.2	2.0
Indirect Staff	15.0	2.0
Total	**77.7**	**21.8**

Figure 5.4 Future OSC incremental FTE needs for eight and ten OR facility.

Given the staffing shortages in several roles, the staffing numbers reflect assumptions that we will utilize travelers for 25% of OR RN and Surgical Techs FTEs and 10% of Perianesthesia RN FTEs. These assumptions, along with costs for those contracted FTEs by role, are built into the operating staffing cost pro forma.

A strong recruiting plan executed well in advance of the First Patient Day in April 2025 will be essential to the project's success. We believe that the project goals and facility plan will be positive assets in attracting potential candidates for available positions. We plan to utilize an already established program for training OR nurses, in which new nursing graduates are hired for a yearlong program preparing them for work as an operating room RN.

In order to create a workforce recruitment plan, we will use the forecast model for the number of employees needed to recruit and train. Using our current vacancy rates and data related to current and projected workforce availability in Chittenden County, we will project our local hires and the number of early career and experienced hires we may need to relocate to Vermont to meet the OSC's staffing needs.

Our work to increase housing and childcare opportunities in the area will be an asset in recruiting and retaining staff. We have recently taken the opportunity to enter into a partnership with a developer to make housing available for our employees in the Burlington area. Under the agreement, UVMHN will take a 10-year master lease on 61 newly constructed one-, two- and three-bedroom apartments which will be made available first to its workers, with a potential subsidy for eligible employees (Article link).

Expenses for the initial recruitment of additional staff are estimated at $373K and included in the start-up costs. The financials also include the recruitment costs for when we open two more ORs in year five of operations.

6. Financial Assessment

Project Capital Cost Estimate

After completion of the schematic design and reconciliation phase of project planning, the estimated total capital cost of the project is $129.6M. This includes capitalized interest of $6.4M.

The project's construction capital cost is estimated at $94.4M. The estimate includes not only the construction cost for the 8 OR facility with sufficient pre-and post-operative spaces, but also the construction cost of shelled spaces intended for the future expansion (4 additional ORs and 14 pre- and post-operative spaces). The estimated fit-up cost of shelled spaces is approximately $8.8M, to be executed as the 8 OR facility nears capacity, which we forecast may occur by FY28[4].

Capital Expense Summary: Outpatient Surgery Center

Capital Costs	
Construction	$ 94,427,436
Land Acquisition	$ 5,150,158
Equipment	$ 22,062,928
IT	$ 1,654,284
Total	**$ 123,294,807**

Capitalized Interest	
Interest	$ 6,345,897
Grand Total	**$ 129,640,703**

Capital Cashflow Schedule	FY22	FY23	FY24	FY25	Total
Project Expense	$ 2,891,990	$ 11,662,208	$ 71,680,687	$ 37,059,921	**$ 123,294,807**

Yrs. Of Depr.	Depreciation Schedule	FY25 (Half Year)	FY26	FY27	FY28	FY29	FY30	FY31	....	FY55	TOTAL
30	Construction	$ 1,679,556	$ 3,359,111	$ 3,359,111	$ 3,359,111	$ 3,359,111	$ 3,359,111	$ 3,359,111		$ 1,679,556	***$ 100,773,333***
7	Equipment	$ 1,575,923	$ 3,151,847	$ 3,151,847	$ 3,151,847	$ 3,151,847	$ 3,151,847	$ 3,151,847		$ -	***$ 22,062,928***
5	IT	$ 165,428	$ 330,857	$ 330,857	$ 330,857	$ 330,857	$ 165,428			$ -	***$ 1,654,284***
	Total	***$ 3,420,907***	***$ 6,841,815***	***$ 6,841,815***	***$ 6,841,815***	***$ 6,841,815***	***$ 6,676,386***	***$ 6,510,958***		***$ 1,679,556***	***$ 124,490,545***

Depreciation Schedule	FY25 (Half Year)	FY26	FY27	FY28	FY29	FY30	FY31	....	FY59	TOTAL
Future Fit-up cost	$ -	$ -	$ -	$ -	$ 541,001	$ 541,001	$ 541,001		$ 216,076	***$ 8,756,748***

Figure 6.1 Capital Expense Summary: Outpatient Surgery Center.

The total estimated capital cost of the project includes a notably high average contingency of 17% (~$17.5M). While most of the capital cost categories include a 10% contingency, we find it prudent to include a 20% contingency ($14.6M), including $4M for an unexpected delay of construction, in the new construction category. August 2023 is the targeted construction start date.

Detailed construction and equipment costs are listed in the tables below. This equipment capital includes typical medical equipment, instrumentation, CSR equipment and other items needed to support the OSC. It also includes capital for a Mako robot, a surgical robot utilized by the Orthopedic surgeons for joint replacement procedures (~$1M).

Construction Category	Capital Cost	Contingency
New Construction	$ 71,708,913	$ 14,635,886
Architectural / Engineering Fees	$ 4,127,319	$ 412,732
Administrative Expenses and Permits	$ 1,305,214	$ 130,521
Other	$ 1,915,319	$ 191,532
Total	**$ 79,056,765**	**$ 15,370,671**
Grand Total	**$94,427,436**	

Equipment Category	Capital Cost	Contingency
Medical Equipment	$ 10,363,365	$ 1,036,337
Instrumentation	$ 1,922,945	$ 192,295
Robotics	$ 950,000	$ 95,000
Radiology	$ 830,000	$ 83,000
Pathology	$ 133,700	$ 13,370
Other	$ 2,081,795	$ 208,180
Telemetry (fixed)	$ 1,743,674	$ 174,367
CSR (fixed)	$ 1,677,728	$ 167,773
Nurse Call (fixed)	$ 354,000	$ 35,400
Total	**$ 20,057,208**	**$ 2,005,721**
Grand Total	**$22,062,928**	

Figure 6.2 Construction and equipment capital cost detail.

[4] *Please note that the OR and surgical volume demand analysis calls for two more ORs to be open in year five of OSC operations. The operating financial pro forma reflects that scenario, accounting for increased surgical capacity, revenues and costs, as well as incremental depreciation expense on the estimated $8.8M fit-up capital costs for the shelled space.*

Project Funding and Capital Allocation

The estimated capital allocation for this project has been included in UVMMC's five-year capital budgets going back to FY15. The scope and timing of the project has changed over this period as demand, location, on-site services and procedure mix have been refined. Currently, there is approximately $119.1M included in the UVMHN five-year capital allocation framework allocated to this project, spread between FY23 and FY24, with a larger portion allocated to FY24. The budget structure will allow for adjustments to the total project cost utilizing capital contingencies and other unallocated capital funds set aside for use in situations where preliminary budgets may have been underestimated.

Debt financing is planned for $100M of the capital expense. Interest on this debt adds approximately $4.8M per year to the OSC Operating Pro Forma, shown later in the pro forma section.

Upon board approval of the project, a plan to secure philanthropic investments will be developed, with implementation beginning shortly thereafter. Potential lead and major gift donors will be identified and their inclination to invest in the project will inform our strategy and fundraising goal. Naming opportunities should encourage philanthropy at multiple levels from donors and prospects. Our fundraising strategy will be closely integrated with communications about the project to the broader community to ensure maximum success.

Operating Pro Formas

The financial assessment for this initiative was prepared from two points of view:

1. The total OSC pro forma focuses on the total surgical volume proposed at the new OSC and accounts for all revenues and costs associated with the future Surgery Center to assess the projected financial performance of the facility.
2. The incremental project pro forma focuses on the incremental financial impact of additional volume, revenue and costs associated with this project to UVMMC's financials. As mentioned in Section 3 of this business plan, the new OSC will not only allow us to expand outpatient surgical capacity, but also increase inpatient surgical capacity by shifting some outpatient cases to the new OSC. The incremental pro forma takes into account both the additional outpatient and inpatient volumes, revenues and costs expected as a result of the project.

Various workgroups composed of internal finance leaders and external partners contributed to the development and review of the reimbursement model, which included volumes, surgical case mix, reimbursement, and cost assumptions. The model reflects the recommendations from Stroudwater Associates for future reimbursement assumptions by service line; using a reduced from current average reimbursement to reflect continued downward pressure from government and commercial payers on reimbursements to outpatient surgery centers, as CMS is expected to continue efforts toward site-neutral payments. Stroudwater utilized the VMG Intellimarker Multi-Specialty ASC Benchmarking Survey to determine appropriate rates for each specialty.

Some related cost and revenue impacts have been excluded from this analysis. The cost and revenue for pre-surgery and post-surgery services (e.g., imaging, labs, office visits) are not included in the financial pro formas. Margins from those services would likely further increase the margins in the financial analyses. Also excluded from the pro forma analyses were future estimates of revenue opportunities or expense savings at the vacated OR area at Fanny Allen campus created by this project, given that planning work for that follow-on project has not yet begun.

Important note: The pro forma approach below reflects revenues in a traditional fee-for-service reimbursement world, but we fully expect that by FY2025, our reimbursement mix will reflect more value-based and fixed payment arrangements with government and other payers, reducing the focus on fee-for-service reimbursement and emphasizing the importance of delivering timely access to care at the appropriate site of service. We expect the shift to more value-based and fixed payment arrangements will increase during the pro forma timeframe. Traditional incremental pro forma analyses do not reflect the value of these projects to the organization in the context of our high value care strategy.

Total OSC Pro Forma

The OSC operating pro forma indicates that the facility will produce a significant positive margin for the organization beginning in its first year of operations, reaching approximately $14M per year when at full capacity in year three, despite including reduced reimbursement in our modeling. Even higher margins of $17.8M per year are expected as the

additional two ORs become operational. Note that FY25 includes only six months of operations, reflecting the opening of the surgery center in April 2025.

Pro-Forma: Outpatient Surgery Center

	FY25 (Half Year)	FY26	FY27	FY28	FY29	5 Yr. Total
Number of Operating Rooms						
Operating Rooms	8	8	8	8	10	
Volume						
Total Volume [1]	4,020	7,785	8,040	8,040	9,209	37,093
Annual OP Surgical Volume	*4,020*	*7,785*	*8,040*	*8,040*	*9,209*	*37,093*
Revenue						
Total Net Patient Revenue [2]	$ 34,050,911	$ 65,938,689	$ 68,101,822	$ 68,101,822	$ 78,000,704	$ 314,193,947
Net Patient Revenue: Facility	*$ 26,013,987*	*$ 50,375,398*	*$ 52,027,973*	*$ 52,027,973*	*$ 59,590,455*	*$ 240,035,786*
Net Patient Revenue: Professional	*$ 8,036,924*	*$ 15,563,291*	*$ 16,073,848*	*$ 16,073,848*	*$ 18,410,249*	*$ 74,158,161*
Total Operating Revenue	$ 34,050,911	$ 65,938,689	$ 68,101,822	$ 68,101,822	$ 78,000,704	$ 314,193,947
Expenses						
Salaries/Wages and Other [3]	$ 11,891,808	$ 23,783,617	$ 23,783,617	$ 23,674,418	$ 26,979,494	$ 110,112,954
Physicians	*$ 4,244,083*	*$ 8,488,167*	*$ 8,488,167*	*$ 8,488,167*	*$ 9,769,071*	*$ 39,477,655*
Staff Direct	*$ 6,191,651*	*$ 12,383,301*	*$ 12,383,301*	*$ 12,274,103*	*$ 14,205,704*	*$ 57,438,060*
Staff Indirect	*$ 1,456,074*	*$ 2,912,148*	*$ 2,912,148*	*$ 2,912,148*	*$ 3,004,719*	*$ 13,197,239*
Health Care Provider Tax [4]	$ 2,043,055	$ 3,956,321	$ 4,086,109	$ 4,086,109	$ 4,680,042	$ 18,851,637
Provider Tax	*$ 2,043,055*	*$ 3,956,321*	*$ 4,086,109*	*$ 4,086,109*	*$ 4,680,042*	*$ 18,851,637*
Med/Surg/Pharmaceutical Supplies [5]	$ 4,710,455	$ 9,121,672	$ 9,420,911	$ 9,420,911	$ 10,790,279	$ 43,464,229
Medical & Surgical Supplies	*$ 4,117,860*	*$ 7,974,127*	*$ 8,235,720*	*$ 8,235,720*	*$ 9,432,816*	*$ 37,996,243*
Pharmaceuticals	*$ 592,595*	*$ 1,147,545*	*$ 1,185,191*	*$ 1,185,191*	*$ 1,357,463*	*$ 5,467,986*
Other Dept. Operating Expense [6]	$ 1,679,577	$ 1,206,774	$ 1,206,774	$ 1,206,774	$ 1,532,067	$ 6,831,965
Miscellaneous Other Expense	*$ 510,134*	*$ 1,020,267*	*$ 1,020,267*	*$ 1,020,267*	*$ 1,180,475*	*$ 4,751,410*
Maintenance	*$ 93,253*	*$ 186,506*	*$ 186,506*	*$ 186,506*	*$ 215,792*	*$ 868,564*
Start-up Costs	*$ 1,076,191*				*$ 135,800*	*$ 1,211,991*
Other non-Dept. Operating Expense [7]	$ 1,653,083	$ 3,626,628	$ 3,745,600	$ 3,745,600	$ 4,290,039	$ 17,060,950
Miscellaneous non-Dept. Other Expense	*$ 1,653,083*	*$ 3,626,628*	*$ 3,745,600*	*$ 3,745,600*	*$ 4,290,039*	*$ 17,060,950*
Total Expenses	$ 21,977,979	$ 41,695,012	$ 42,243,011	$ 42,133,812	$ 48,271,921	$ 196,321,734
EBIDA [8]	$ 12,072,932	$ 24,243,677	$ 25,858,811	$ 25,968,010	$ 29,728,783	$ 117,872,213
Total Depreciation and Interest [9]	$ 6,275,938	$ 11,673,691	$ 11,591,321	$ 11,504,737	$ 11,954,725	$ 53,000,412
Depreciation and Amortization	*$ 3,420,907*	*$ 6,841,815*	*$ 6,841,815*	*$ 6,841,815*	*$ 7,382,816*	*$ 31,329,168*
Interest Expense	*$ 2,855,031*	*$ 4,831,876*	*$ 4,749,506*	*$ 4,662,922*	*$ 4,571,908*	*$ 21,671,244*
Margin from Operations	$ 5,796,994	$ 12,569,986	$ 14,267,490	$ 14,463,272	$ 17,774,058	$ 64,871,801

Notes:

General Assumptions:

> All values represented in constant dollars in relation to FY2022 Budget, with no increases for future revenue rate changes or expense inflation.
> Volume estimates are based on OR and surgical volume demand analysis; see section 3 of the plan for detail.
> FY25 reflects the April 2025 expected start to operations.
> Changes in revenues & expenses are related to changes in volume assumptions only.
> Estimated cost and revenue not included for additional imaging or other ancillary services.
> There were no estimates built into this pro-forma for revenue opportunities or expense savings for vacated space at the FA campus created by this move.

Specific Assumptions:

1: Volume based on OP surgical cases demand analysis.

2: Revenue based on average reimbursement per case per specialty, recommended by Stroudwater Associates.

3: Salaries and wages for providers and staff based on FY22 averages. 20% of physician salary added as physician benefits. 33.1% of staff salary added as staff benefits.

4: Calculated at 6% of Total NPR + FPP.

5: Cost based on FY22 avg. supply cost per OP surgical case and applied to OSC volume.

6: Costs based on operating budget for the new OSC plus one time operating start-up cost incurred from FY21-FY25.

7: Non-salary expenses assigned to the future OSC cost center. Based on cost accounting analysis.

8: Earnings before interest, depreciation and amortization.

9: Capital depreciation for this project and Interest expense on a loan to fund this project. Includes additional depreciation for $8.8M fit-up costs for shelled spaces.

Incremental Pro Forma

When viewed from the perspective of incremental impact on UVMMC's financials, the project shows a positive margin impact, but a lower positive margin impact than the analysis above. The estimated margin impact is close to $7.5M in year three of operations. This lower incremental margin impact is due to 1) change in reimbursement for those surgeries projected to move from the Fanny Allen or Main Campus ORs to the OSC, and 2) large depreciation and interest cost reflected on the incremental pro forma.

INCREMENTAL Pro-Forma: Outpatient Surgery Center

	FY25 (Half Year)	FY26	FY27	FY28	FY29	5 Yr. Total
Incremental Volume						
Total Volume [1]	**1,482**	**3,071**	**3,275**	**3,224**	**4,341**	**15,394**
OP Surgical Volume @ OSC	*1,276*	*2,587*	*2,721*	*2,599*	*3,645*	*12,828*
IP Surgical Volume @ Main Campus	*206*	*484*	*554*	*625*	*696*	*2,566*
Incremental Revenue						
OP: Total Net Patient Revenue + FPP [2]	**$ 11,209,990**	**$ 22,731,734**	**$ 23,903,738**	**$ 22,831,991**	**$ 32,028,055**	**$ 112,705,508**
Net Patient Revenue: Facility	*$ 8,659,200*	*$ 17,559,216*	*$ 18,464,535*	*$ 17,636,660*	*$ 24,740,195*	*$ 87,059,805*
Net Patient Revenue: Professional	*$ 2,550,790*	*$ 5,172,518*	*$ 5,439,203*	*$ 5,195,331*	*$ 7,287,860*	*$ 25,645,703*
IP: Total Net Patient Revenue + FPP [2]	**$ 11,932,528**	**$ 27,959,438**	**$ 32,053,821**	**$ 36,148,204**	**$ 40,242,587**	**$ 148,336,577**
Net Patient Revenue: Facility	*$ 11,533,825*	*$ 27,025,228*	*$ 30,982,805*	*$ 34,940,382*	*$ 38,897,959*	*$ 143,380,198*
Net Patient Revenue: Professional	*$ 398,702*	*$ 934,210*	*$ 1,071,016*	*$ 1,207,822*	*$ 1,344,628*	*$ 4,956,379*
OP: Reimb. adjustment on current vol. shifted to OSC [3]	**$ (1,501,195)**	**$ (3,146,710)**	**$ (3,218,870)**	**$ (3,291,030)**	**$ (3,363,190)**	**$ (14,520,995)**
Total Operating Revenue	**$ 21,641,322**	**$ 47,544,462**	**$ 52,738,689**	**$ 55,689,165**	**$ 68,907,452**	**$ 246,521,090**
Incremental Expenses						
Salaries/Wages and Other [4]	**$ 4,603,424**	**$ 9,206,848**	**$ 9,206,848**	**$ 9,206,848**	**$ 12,511,924**	**$ 44,735,890**
Physicians	*$ 640,452*	*$ 1,280,904*	*$ 1,280,904*	*$ 1,280,904*	*$ 2,561,808*	*$ 7,044,972*
Staff Direct	*$ 3,432,744*	*$ 6,865,488*	*$ 6,865,488*	*$ 6,865,488*	*$ 8,797,089*	*$ 32,826,296*
Staff Indirect	*$ 530,228*	*$ 1,060,456*	*$ 1,060,456*	*$ 1,060,456*	*$ 1,153,027*	*$ 4,864,622*
Health Care Provider Tax [5]	**$ 1,298,479**	**$ 2,852,668**	**$ 3,164,321**	**$ 3,341,350**	**$ 4,134,447**	**$ 14,791,265**
Provider Tax	*$ 1,298,479*	*$ 2,852,668*	*$ 3,164,321*	*$ 3,341,350*	*$ 4,134,447*	*$ 14,791,265*
Med/Surg/Pharmaceutical Supplies [6]	**$ 1,495,022**	**$ 3,031,622**	**$ 3,187,927**	**$ 3,044,993**	**$ 4,271,428**	**$ 15,030,991**
Medical & Surgical Supplies	*$ 1,306,942*	*$ 2,650,231*	*$ 2,786,872*	*$ 2,661,920*	*$ 3,734,064*	*$ 13,140,028*
Pharmaceuticals	*$ 188,080*	*$ 381,391*	*$ 401,055*	*$ 383,073*	*$ 537,364*	*$ 1,890,963*
Other Dept. Operating Expense [7]	**$ 1,380,655**	**$ 634,542**	**$ 634,542**	**$ 634,542**	**$ 959,835**	**$ 4,244,116**
Miscellaneous Other Expense	*$ 291,657*	*$ 583,314*	*$ 583,314*	*$ 583,314*	*$ 743,522*	*$ 2,785,122*
Maintenance	*$ 12,807*	*$ 51,228*	*$ 51,228*	*$ 51,228*	*$ 80,514*	*$ 247,004*
Start-up Costs	*$ 1,076,191*				*$ 135,800*	*$ 1,211,991*
Other non-Dept. Operating Expense [8]	**$ -**	**$ 320,463**	**$ 439,435**	**$ 439,435**	**$ 983,873**	**$ 2,183,205**
Miscellaneous non-Dept. Other Expense		*$ 320,463*	*$ 439,435*	*$ 439,435*	*$ 983,873*	*$ 2,183,205*
IP Direct Cost [9]	**$ 6,491,884**	**$ 15,211,314**	**$ 17,438,860**	**$ 19,666,407**	**$ 21,893,953**	**$ 80,702,418**
IP direct cost	*$ 6,491,884*	*$ 15,211,314*	*$ 17,438,860*	*$ 19,666,407*	*$ 21,893,953*	*$ 80,702,418*
Total Expenses	**$ 15,269,464**	**$ 31,257,456**	**$ 34,071,933**	**$ 36,333,574**	**$ 44,755,460**	**$ 161,687,886**
EBIDA [10]	**$ 6,371,858**	**$ 16,287,006**	**$ 18,666,757**	**$ 19,355,591**	**$ 24,151,992**	**$ 84,833,204**
Total Depreciation and Interest [11]	**$ 6,275,938**	**$ 11,673,691**	**$ 11,591,321**	**$ 11,504,737**	**$ 11,954,725**	**$ 53,000,412**
Depreciation and Amortization	*$ 3,420,907*	*$ 6,841,815*	*$ 6,841,815*	*$ 6,841,815*	*$ 7,382,816*	*$ 31,329,168*
Interest Expense	*$ 2,855,031*	*$ 4,831,876*	*$ 4,749,506*	*$ 4,662,922*	*$ 4,571,908*	*$ 21,671,244*
Incremental Margin from Operations	**$ 95,920**	**$ 4,613,315**	**$ 7,075,436**	**$ 7,850,854**	**$ 12,197,267**	**$ 31,832,792**

Notes:

General Assumptions:

> All values represented in constant dollars in relation to FY2022 Budget, with no increases for future revenue rate changes or expense inflation.
> Volume estimates are based on OR and surgical volume demand analysis; see section 3 of the plan for detail.
> FY25 reflects the April 2025 expected start to operations.
> Changes in revenues & expenses are related to changes in volume assumptions only.
> Estimated cost and revenue not included for additionsl imaging or other ancillary services.
> There were no estimates built into this pro-forma for revenue opportunities or expense savings for vacated space at the FA campus created by this move.

Specific Assumptions:

1: Volume based on OR cases. Incremental OP and IP cases due to this project.
2: Revenue based on average reimbursement per case per specialty, recommended by Stroudwater Associates.
3: Reduced reimbursement from HOPD rates for current OP cases projected to be moved to the new OSC. Reimbursement for OP cases adjusted down from current state to Stoudwater Associates recommended rates.
4: Salaries and wages for incremental providers and staff based on FY22 averages. 20% of physician salary added as physician benefits. 33.1% of staff salary added as staff benefits.
5: Calculated at 6% of Total NPR + FPP.
6: Cost based on FY22 avg. supply cost per case and applied to incremental OP OSC volume.
7: Incremental costs based on operating budget for the new OSC plus one time operating start-up cost incurred from FY21-FY25.
8: Incremental non-salary expenses assigned to the future OSC cost center. Based on cost accounting analysis.
9: Incremental IP direct costs for incremental IP cases.
10: Earnings before interest, depreciation and amortization.
11: Capital depreciation for project and Interest expense on a loan to fund this project. Includes additional depreciation for $8.8M fit-up costs for shelled spaces.

From an incremental perspective, the aggregate cash flow from this investment turns positive in year seven.

Incremental OSC	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8
Margin from Operations	$ 95,920	$ 4,613,315	$ 7,075,436	$ 7,850,854	$ 12,197,267	$ 12,197,267	$ 12,197,267	$ 12,197,267
Depreciation	$ 6,275,938	$ 11,673,691	$ 11,591,321	$ 11,504,737	$ 11,954,725	$ 11,954,725	$ 11,954,725	$ 11,954,725
Total Project Cost	$ (129,640,703)							
Cap Interest	$ 6,345,897							
Annual Cash Flow	**$ (116,922,949)**	**$ 16,287,006**	**$ 18,666,757**	**$ 19,355,591**	**$ 24,151,992**	**$ 24,151,992**	**$ 24,151,992**	**$ 24,151,992**
Project Aggregate Cash Flow @ End of Each Yr.	**$ (116,922,949)**	**$ (100,635,942)**	**$ (81,969,186)**	**$ (62,613,594)**	**$ (38,461,603)**	**$ (14,309,611)**	**$ 9,842,381**	**$ 33,994,372**

The Net Present Value summary shows a negative value of -$45.6M over five years.

	FY25 (Half Year)	FY26	FY27	FY28	FY29	5 Yr. Total
Margin from Operations	$ 95,920	$ 4,613,315	$ 7,075,436	$ 7,850,854	$ 12,197,267	***$ 31,832,792***
Depreciation	$ 6,275,938	$ 11,673,691	$ 11,591,321	$ 11,504,737	$ 11,954,725	***$ 53,000,412***
Cap Interest	$ 6,345,897					***$ 6,345,897***
Total Project Cost	$ (129,640,703)					***$ (129,640,703)***
Annual Cash Flow	**$ (116,922,949)**	**$ 16,287,006**	**$ 18,666,757**	**$ 19,355,591**	**$ 24,151,992**	***$ (38,461,603)***
Project Aggregate Cash Flow @ End of Each Yr	**$ (116,922,949)**	**$ (100,635,942)**	**$ (81,969,186)**	**$ (62,613,594)**	**$ (38,461,603)**	
NPV	($45,609,738)					

Facility Start-Up Operating Costs

Operational costs related to project planning and transition to the new facility are not considered capital expenses and can affect operating financials before the opening of the new facility. Those costs are related to transition planning, moving, recruitment and training. These costs, estimated at approximately $1M, will be incurred through operating dollars and budgeted for the period prior to, and during construction. A more extensive evaluation of these costs and activities will be completed as project planning continues.

Expense Category	2021-2024	2025	Total
Admin Expenses	$ 171,000	$ 13,000	$ 184,000
Recruitment cost	$ 373,691	$ -	$ 373,691
Operational Planning	$ 20,000	$ 10,000	$ 30,000
Transitioning and Moving	$ 125,000	$ 130,000	$ 255,000
Other Misc. Expenses	$ 2,500	$ -	$ 2,500
Communications	$ -	$ 135,000	$ 135,000
IT Set up	$ -	$ 96,000	$ 96,000
Total	**$ 692,191**	**$ 384,000**	**$1,076,191**

All start up costs included in financial pro forma

7. Information Technology Review

Information Technology (IT) capital costs and design elements related to the overall construction of the facility have been included in schematic design budget estimates outlined in this business plan. Additional impacts related to IT applications, new hardware technology, resource allocation related to project implementation, Technical Standards Review Board process (TSRB), employee training and Cyber Security have also been evaluated as part of the business plan development. It is important to note that due to the speed at which planning teams are working to ensure an on-time CON submission, there are components of the technology plan for this facility that are not fully developed. As such, there may be elements not known at this time that may or may not have a material impact on IT in the form of resource needs or operating expenses. IT may identify additional impacts that will need to be addressed as further detailed planning takes place after this business plan is complete, though it is unlikely there will be significant impact on the overall financial performance of this project.

IT leadership has reviewed the current design elements related to technology needs and the programming details utilized by the design advisory groups and architects and has identified the following impacts and additional operating costs related to implementation/construction. Any non-budgeted operating expenses identified below have been highlighted as start-up costs and are included in the construction budget for implementation of this project.

As an incremental resource needed for the Outpatient Surgery Center, the Information Technology team has identified:

- two permanent additional IT Techs and,
- six temporary IT Techs for the duration of two months to complete one time setup activities (e.g., building workstations, Windows on wheels portable stations, conference room setup and similar activities).

No new IT staff training is anticipated based on the current understanding that no new applications are planned for this site. Epic training for additional new staff at the facility will be managed using existing training resources and fall within the normal Epic training budget. Cybersecurity efforts specific to this project are not anticipated although UVMHN's posture in this area continues to evolve and IT will seek to address any concerns that are presented by the opening of the project, including license expansion.

8. Integrated Communications and Engagement Strategy

From development to operationalization, the Communications and Engagement Strategies will work in partnership on internal and external communication to create awareness and understanding of the 'why' of the new facility as part of our longer-term strategy to provide the highest quality care in the right place and at the right time for our patients. The team will also work in partnership to identify opportunities to drive patient volume and revenue aligned with project goals. We will also work in partnership with leaders and the Government and Community Relations team to proactively message and navigate additional scrutiny that comes with a major capital project amid our current financial and workforce scenario.

Throughout our efforts, we will work to:

- Create awareness, understanding and a connectedness to the overall UVM Health Network strategy by illustrating the benefits of a contemporary outpatient facility for our patients, providers and workforce.
- Highlight improvements to the patient experience and the provider experience advanced within the new facility.
- Collaborate with Government and Community Relations to ensure that key message points are iterated and shared ongoing.
- Bring media and other key influencers along with us as the project develops.
- Align our internal and external marketing efforts' business goals.
- Use communications to support smooth operational transition to the new space.
- Drive home the purpose and patient/staff advantages of a new Outpatient Surgical Center through key messages, including:

    a. Quality care in the most appropriate, cost-effective setting.
    b. Enhanced patient and provider experience in a contemporary health care facility where technology enables the best in care.
    c. Improved access and shorter wait times for surgical services that can be done on an outpatient basis.
    d. Additional revenue stream to support the nonprofit mission of UVM Medical Center and the UVM Health Network.
    e. Connection to future facility need and master facilities planning.

Target Audiences

Internal	External
• Board of Trustees – UVMHN, UVMMC, UVMMG primary and other affiliate boards secondary • Senior Network and Clinical Leadership/Affiliate Presidents • UVMMG Physicians and Providers • All staff • Staff who will work in the new facility • Volunteers	• Patients • Private practice surgeons • Community and referring providers • Community leaders, media, other influencers • Regulators/Legislators/Business • Media and other Influencers • Donors; Job applicants for provider and staff roles • Health care Consumers • General Public - Statewide • Community Partners

Figure 8.1 OSC communication target audiences.

Tactics by Plan Phase

This plan is built in current assumptions in 2022. It will be scaled throughout the project to align with business needs and access goals.

CON Application and Construction Phase – Awareness Building *Outcomes: Staff and community know a facility is planned/under construction and understand its benefits to patients and overall access to health care.*		
Internal	**External**	**Costs**
• House-wide communication at key project milestones • Internal communications highlight key milestones, staff profiles, etc. • Leader awareness and talking points • As/if needed, presentations and materials for leaders, providers and staff who will deliver care in the new facility • Patient focused materials – collateral for physician offices, at point of service counters • Informational collateral/hard cards for patients inside the facility • Branding, signage, wayfinding, digital signage	• One pager on the project and milestones • Social media • News releases highlighting key milestones • Patient and Media Materials • Consumer facing website pages	$5K
Grand Opening – Engagement *Outcomes: Staff and community are engaged and understand the benefits of a state-of-the-art outpatient surgical facility for patients, providers and overall access to health care.*		
Internal	**External**	**Costs**
• House-wide communication • Internal events – potential partnerships with Development, GCR and Media • CEO communication • Trustee Communication • Internal communication and engagement - highlight key milestones, staff profiles, etc. • Leader prep and talking points • Branded patient/staff commemorative items	• Media behind the scenes/first look event • Social media/Paid social media • Paid content placements in local newspapers • News release • Consumer facing website pages • Paid search “capture campaign” relative to competitors • Video tour • TV spot/radio ad/cinema ads • Community & referring provider outreach • Print and digital ad campaign • Potential outdoor advertising (bus/bus stops) • Collateral for patients and wayfinding • On hold messages • Outbound newsletters • Community leader communication • Dr. Podcast episode • Open house/dedication ceremony	$100K
Ongoing Operationalization – first 6 months		
Internal	**External**	**Costs**
• All Exchange Celebrating First Patient Milestone	• Continued placement of TV spot, paid social and digital/print advertising	$30K

• Highlights of operational milestones and impact • Highlights of providers/staff/patient experience	• Ongoing paid search "capture campaign" relative to competitors • Print ad campaign • Radio • Community & referring provider B2B outreach • On hold messages • *Vermont Medicine* profile of the facility	

Figure 8.2 Communication tactics by OSC plan phase.

Government and Community Relations

This project will require local and state engagement prior to and concurrent with the CON submission, with the opportunity to explain its benefits during and post construction.

Pre-Announcement/Pre-Filing Stakeholders
• GMCB chair & members • AHS secretary and deputies • Legislative health committees (Rep. Bill Lippert, Sen. Ginny Lyons) • Local legislators • VAHHS • Chambers and business groups • Mayor of Burlington • South Burlington City Manager and City Council • Colchester City Manager • Abutting neighbors • Transportation partners

Figure 8.3 OSC Government and community stakeholders.

9. Quality and Success Measures

Intended Measures and Model Used:

Intended measures are set using best practices and industry standards. Quality improvement measures are categorized by the Institute of Medicine's (IOM) six aims of health framework. These are known as the STEEEP model, defined below:

- **Safe**: avoiding injuries to patients from the care that is intended to help them
- **Timely**: reducing waits and sometimes harmful delays for both those who receive and those who give care
- **Efficient**: avoiding waste, including waste of equipment, supplies, ideas and energy
- **Effective**: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit
- **Equitable**: providing care that does not vary in quality or accessibility because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status
- **Patient/Family-centered**: providing care that is respectful of and responsive to individual patient preferences, needs, and values, including an additional measure to look at staff/employee satisfaction through retention and recruitment.

Measurement of Success:

Goals will be set using current state data to determine appropriate and achievable targets, using best practice benchmarks.

Best Practice Resources:

Best practice resources are industry standards and provide national benchmarking. These are:

- Centers for Medicare and Medicaid Services (CMS) Ambulatory Surgical Center Quality Reporting (ASCQR) Program
- National Healthcare Safety Network (NHSN) Same Day Outcome Measures (SDOM)
- Association of Perioperative Registered Nurses (AORN) and the Association for the Advancement of Medical Instrumentation® (AAMI)
- American Hospital Association (AHA) Health Equity, Diversity & Inclusion Measures for Hospitals and Health System (HHS) Dashboards
- Agency for Healthcare Research and Quality (AHRQ)

Responsible Mechanism:

Identifies the data source to obtain the measurements.

Outpatient Surgery Center Measures

Intended Measure	Measurement of Success	Best Practice	Responsible Mechanism	STEEEP
# of encounters or admissions experiencing a burn prior to discharge	Meets or exceeds identified benchmark based on current state	ASCQR; NHSN SDOM	Epic	Safe
# of encounters experiencing wrong site, wrong side, wrong patient, wrong procedure, wrong implant	Meets or exceeds identified benchmark based on current state	ASCQR; NHSN SDOM	Epic	Safe
# of patient falls at OSC	Decrease from baseline	ASCQR	Epic/ Safe Reports	Safe
# of post-operative visits to ED within 48 hours of discharge	Meets or exceeds identified benchmark based on current state	ASCQR	Epic	Effective

# of transfers back to Main Campus	Meets or exceeds identified benchmark based on current state	ASCQR; NHSN SDOM	Epic	Effective
# of readmissions from OSC within 48 hours of discharge	Meets or exceeds identified benchmark based on current state	ASCQR; NHSN SDOM	Epic	Effective
# of reoperations within 48 hours of discharge	Meets or exceeds identified benchmark based on current state	ASCQR	Epic	Effective
# of reported SSI (include 30-day and 90-day implants)	Decrease from baseline	ASCQR	Infection Prevention – NHSN/Epic	Effective
% of Immediate Use Steam Sterilization or IUSS	Between 1-3% **identify current state to ensure above is achievable**	AAMI and AORN IUSS standards	SPM	Efficient
Throughput -On-time starts	Meets or exceeds identified benchmark based on current state	AHRQ and Leading industry practices	Epic	Timely
Throughput –Time in PACU	Meets or exceeds identified benchmark based on current state	AHRQ and Leading industry practices	Epic	Timely
Utilization of surgery block times	Meets or exceeds identified benchmark based on current state	AHRQ and Leading industry practices	EPIC	Equitable
For all metrics – look by health equity: race, gender, sexual orientation, language, disability, veteran	Meets or exceeds identified benchmark based on current state	AHA Health Equity, Diversity & Inclusion	NA	Equitable
Patient satisfaction with OSC results	Meets or exceeds identified benchmark based on current state	HCAHPS Survey for Ambulatory care centers	HCAHPS/ Press Ganey	Patient/Fam Centered
Retention and recruitment of OSC employees	Meets or exceeds identified benchmark based on current state	Leading industry practices	Workday	Workforce

Figure 9.1 OSC Quality Measures.

10. Risk Assessment

Risks identified during the business planning process are listed below for consideration. Most are expected from a project of this magnitude and importance, but we have listed the known risks here to assist in its evaluation. Mitigations are identified where possible.

Human Resource Risks

Significant Incremental Staff Needs- Our potential inability to fully staff the new Outpatient Surgery Center is a clear risk to the success of this project. While the first patient day would be 20 months (18 Construction, 2 Readiness) from the start of construction, the current Network experience emphasizes the need to be proactive about staffing the unit well in advance of project completion. Furthermore, although there will be increase in patient demand based on growth of the population, the population growth will not necessarily translate to a larger available local talent pool. We will need to recruit nationally to close staffing gaps which will create a demand for more housing in the area that is already constrained. Mitigations in the form of recruitment and retention strategies for a number of key roles, as well as expansion of training and educational programs, are discussed in Section 5 of this business plan.

Tradesperson Supply- Sufficient trade workforce for construction has been identified as a risk to the project timeline and the construction costs. The current market conditions have strained the construction labor force nationally and locally. To mitigate labor shortfalls, we have engaged with design assist Key Trade Partners (major subcontractors) to secure the available labor force well in advance of the construction start date. For example, we have engaged with the electrical, plumbing, fire protection, mechanical, door/hardware, roofing and building exterior subcontractors that employ the current workforce to dedicate to our project.

Financial Risks

Given the current unprecedented environment of construction cost inflation, supply chain disruption and critical labor resource shortages, we felt it prudent and essential to retain Key Trade Partners (key subcontractors) early in the planning and design phase of the project. Key Trade Partners will advise UVMMC and the design team during the design development process to suggest design considerations, materials, and construction methods to make the project more constructible and less costly to construct from a builder's perspective. They will assist the team in developing mitigation measures to reduce the impact of cost volatility, supply chain disruptions and labor and materials scarcity. Taken together, these measures should ensure that only reasonable, necessary and affordable scope, design and construction options are considered throughout the planning and construction of the OSC.

These cost control techniques and measures should yield the following benefits:

- Reduced design time
- Increased accuracy of the construction documents
- Minimized design errors and omissions
- Value-management alternatives can be conceived and developed throughout the design and construction phases
- Reduced construction schedule and project timeline
- Timely and direct feedback from the contractors to the design team
- Higher quality design documents due to on-going contractor input
- Reduced potential for design and scope changes

Despite the best cost control practices to defend against materials and commodity cost escalation and material and labor scarcity, there still is risk that the project cost could exceed our best efforts to prepare accurate cost estimates.

Future Cost Escalation Volatility - The current combination of world events (Pandemic, Supply chain, war in Eastern Europe) makes future predictions about the price of goods and services even less dependable. Suppliers have said that markets should stabilize throughout the next year especially as the U.S. Federal Reserve increases interest rates to combat inflation, but the continued conflict in the Ukraine, and lockdowns in Asia due to Covid-19 may hinder that process. Beyond the best practices discussed above, the only other mitigation for cost instability is increasing the escalation (bidding) contingency percentage in the cost estimates, which is also an imperfect tool, given recent supply chain delays causing unavailability and cost increases for many construction materials. Based on the guidance of our construction managers and an independent cost estimator, we have included a 6% escalation contingency and a 6.8%

bidding contingency in our cost estimate. To put that in context, prior to the pandemic, the standard escalation contingency was approximately 2-4%.

Early Materials Procurement- Current supply chain delays indicate the need for early procurement of long lead-time items. To date, the following items have been identified: structural steel (raw material), doors/ frames/ hardware, chillers, and switch gear. The Construction Manager is actively monitoring the lead times, associated early commitments, and cost risks that are likely to be needed to complete the project on the proposed schedule. At this point, we have identified several long-lead items (table below) which will require procurement commitments before CON approval is secured. As a result, we expect to seek GMCB permission to make the required commitments during the pendency of the CON application.

UVMMC Outpatient Surgery Center

Financial Commitments Needed Before Likely CON Approval In order to Maintain the Construction Schedule Start Date of August 15, 2023

Scope Item	Required Commitment Date	Cost to Release	July 23 Cancelation Cost	Total Pre-CON Cost Liability
Switch Gear	March 2023	$0	$20,000	$20,000
Chiller (Shop drawings)	April 2023	$0	$21,942	$21,942
Structural Steel (Shop drawings)	May 2023	$136,509	N/A	$136,509
Door/Frame/Hardware (Shop drawings)	June 2023	$2,500	N/A	$2,500
		$139,009	$41,942	$180,951

Figure 10.1 Commitments needed before the CON approval.

Staffing Costs- The cost to staff the Outpatient Surgery Center could exceed expectations (approximately $373K) if we are unable to recruit and retain permanent staff at levels necessary to run the Center safely. The use of travelling nurses and surgical technicians in the business plan is projected between 10-25% depending on the position. UVMMC has also seen considerable clinical staff salary inflation; if this trend should continue it will negatively impact the projected OSC margins.

Reimbursement- There is a risk that payer reimbursement strategies will continue to evolve in ways that reduce hospital outpatient revenues. At its November public meeting, the Medicare Payment Advisory Commission (MedPAC) continued to recommend alignment of Medicare payment rates across hospital outpatient departments, ambulatory surgical centers, and physician office settings when appropriate. While it is impossible to mitigate significant revenue reductions, the financial assessment in this business plan recognizes the changing landscape by projecting a realistic revenue picture. Our reimbursement modeling reflects the recommendation of independent consultant Stroudwater Associates to project lower reimbursement rates in our pro formas.

Inpatient Bed Capacity- This business plan accounts for the projected growth in demand for both inpatient and outpatient surgeries. However, the modelling does not attempt to consider whether UVMMC inpatient bed capacity will be sufficient to accommodate the needs of all UVMMC's inpatient care and surgical recoveries. Inpatient bed capacity is a standing Medical Center issue that we hope will be positively influenced by the Path Forward's through-put improvement work. Many patients cannot be discharged from UVMMC because there is not enough residential and skilled nursing care to support demand. By boosting the availability of skilled nursing care, we will improve inpatient capacity.

Permitting and Zoning Risks

Our deliberate planning process has allowed us to secure most of the necessary permits, however the zoning permit from the City of South Burlington and the Act 250 permit are not yet in hand. Our final South Burlington Development Review Board Meeting was on November 15, 2022 and we expect a zoning permit to be approved for the project by the end of December 2022. We have submitted our Act 250 Permit application and anticipate it will be handled as a Minor Review. Public notice of our application was published by November 15th at which time interested parties may request an Act 250 hearing within a 30-day time frame. If no hearing is requested, a draft permit will be issued for final public review. Until these permits are obtained, there is a risk of project delay.

11. Business Plan Contributors and Approvals

Planning Group	Name
Executive Sponsor, UVMMC President and COO	Stephen Leffler, MD
Network Director Comm & Engage Shared Svcs	Elliott Bent
Network VP Revenue Strategy	Abe Berman
Network VP, Comm & Engagement Strategies	Bonita Brodt
Sr. Quality Improvement Partner	Geera Demers
VP Integration and Strategy	Chris Dillon
Nursing Director Perioperative Services	Monica Goldwater
Sr. Quality Improvement Partner	Linda Gruppi
Network Dir Strategic & Business Planning	Cory Gustafson
Legal Department Consultant	Judy Henkin
Network VP Strategic & Business Planning	Eve Hoar
Network Director PMO	Charlie Jones
Network Director Facilities & Real Estate	Dave Keelty
Communications Specialist Shared Svcs	Roland Kielman
Vice President Managed Care Contracting	Kelly Lange
Network VP/Corporate Controller	Melissa Laurie
Strategic Planning Consultant	Joanna Lemieux
SVP/Network General Counsel	Eric Miller
Network VP Treasury and Financial Services	Marc Stanislas
Associate General Counsel	Karen Tyler
Network Dir. Revenue Finance & Reimb	Amy Vaughan
Network SVP Strategic Communications	Anya Wallack

Reviews and Approvals	Date	Complete
UVMHN Executive Leadership	11/23/2022	✓
UVMHN Planning Committee of the Board	12/7/2022	
UVMHN Board of Trustees	12/14/2022	

12. OSC Planning Participants

Steering Committee Participants	Title
Aslakson, MD, Rebecca	Chief, Anesthesiology
Boisjoli, Lori	Network VP, Application Portfolio
Borrazzo, MD, Edward	Chief, General Surgery
Broadworth, Mary	Vice President, Human Resources
Clauss, MD, David	Network Chief Medical Officer
Davidson, MD, Melissa	Associate Dean for Graduate Medical Education, Designated Institutional Official, Interim Chief, Anesthesiology
Deschamps, MD, Claude	President & CEO, UVMHN MG
Desjardins, MD, Isabelle	Chief Medical Officer, UVMMC
Dillon, Chris	VP, Integration & Strategy, UVMHN MG
Gagne, Peg	Chief Nursing Officer, UVMMC
Gobeille, Al	EVP, Network Operations
Goldwater, Monica	Nursing Director Perioperative Services
Gustafson, Cory	Network Director Strategic & Business Planning
Hoar, Eve	VP Strategic & Business Planning
Jones, Charlie	Network Director Project Management Office
Keelty, Dave	Network Director Facilities & Real Estate
Krompf, Brad	Executive Director, UVMHN MG
Lemieux, Joanna	Strategic Planning Consultant, Planning & Business Development
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Morris, Dan	E4H Architecture
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Appendix 1: OR Demand Detail

Methodology

Our Demand Model projects the growth of UVM Medical Center's existing operating room and procedure room volumes. It does not project the growth of existing OR procedure volume at non-UVM Medical Center facilities. Nor does it assume that UVM Medical Center's market share will change – i.e., it does not assume that UVM Medical Center will capture any growth in existing procedure volume in non-UVM Medical Center facilities, or vice versa.

Projection through 2030

The need for additional outpatient ORs is driven by the expected growth in both inpatient (IP) and outpatient (OP) procedures for the following reasons:

- Forecasted increase in need for surgical capacity for IP surgeries: Inpatient surgical volumes are expected to grow between 2% and 18% by 2030, requiring up to two additional ORs at the Main Campus. Given that UVMMC is unable to expand its OR area at the Main Campus, this necessitates moving a significant number of outpatient surgeries currently performed there to another site.
- Forecasted growth in OP volumes by service line: As our demand analysis shows, outpatient surgeries are expected to grow between 20% and 28% by 2030, requiring between 3.5-4.5 additional ORs (or 8-9 ORs including the 5 Fanny Allen OR replacements).

To account for these factors, our methodology projects OR case volumes by service line, including both inpatient and outpatient cases, to FY 2030 from FY 2019 baseline data. In order to account for uncertainty inherent in this exercise, **we modeled three different growth scenarios**. Each of the three scenarios contains a slightly different set of assumptions that, together, are intended to capture the range of likely growth in demand for ORs:

a) **Sg2 Growth Rates: <u>growth by 2030: IP = 2% and OP = 20%</u>**
FY 2019 case volumes were projected based on volume growth forecasts developed by national consultancy group Sg2. UVM Medical Center subscribes to an Sg2 database and analytics tool, which it uses to generate demand projections for purposes of its business planning and CON applications. Sg2's volume forecasts account for demographic changes using Claritas population data, as well as multiple other "impact factors," including:
   - Epidemiology – impacts of changes in disease rates over time due to behavioral, sociocultural, and environmental influences, and public health interventions;
   - Economics – the macroeconomic factors that affect health care utilization;
   - Health care policy – macro-level impacts of third-party payment innovations and health policy on service utilization;
   - Technology and innovation – adoption of new technology and clinical innovations that may affect the use of health care services, or the site of care delivery; and
   - Systems of care – efficiency resulting from care coordination and service integration.

   The Sg2 "impact factors" relevant to OR demand include a projected shift between IP and OP settings (for example, a 50% shift from IP to OP for joint replacements by 2030).

b) **Chittenden County, VT Pop. Growth for Under and Over 65: <u>growth by 2030: IP = 18% and OP = 20%</u>**
This is a simple age-adjusted utilization scenario. FY 2019 case volumes were projected by service line based on population growth forecasts for the Burlington MSA for both the over-65 age group and the under-65 age group, developed by Public Opinion Strategies (POS), which UVM Medical Center previously submitted to the Board as part of its 2022 Budget Presentation in August 2021. The population growth forecasts produced by POS differ in two significant ways from the Claritas population forecast utilized in the Sg2 forecast models: First, the POS forecast estimates the overall population growth to 2030 for Chittenden County at 8%, where the Claritas forecast estimates a 4% overall population growth rate. Comparison of the overall population growth of Chittenden County and our region as reported in the recently released 2020 Census data lends weight to the POS forecasts. Second, POS calculates a significantly higher growth rate for the 65+ segment of the population in our service region from 2020 to 2030: approximately 60% as compared to the nearly 30% growth forecast for the same region and timeframe from

Claritas. Actual 2020 census data by age segment and region is not yet available for comparison. Given the impact on both inpatient and outpatient surgery demand from the 65+ cohort, we believed it was important to model the impact of this higher growth rate on the need for surgical capacity.

c) **Sg2 Growth Rates w/ adj. for Higher Population Growth: growth by 2030: IP = 10% and OP = 28%**
FY 2019 case volumes were projected based on the Sg2 forecasts, with the population impact factor for age group segments adjusted based on the Public Opinion Strategies growth rates for the over-65 age group and the under-65 age group.

The number of ORs needed based on FY 2030 projected OR case volumes was determined by:

a) Translating OR case volume into OR minutes. IP OR cases for each service line were multiplied by average IP case length for that service line, and OP OR cases for each service line were multiplied by average OP case length for that service line. This approach accounts for time variations between case types (service line) and settings (IP vs OP).
b) Translating OR minutes into the number of ORs needed. The total of projected OR minutes was divided by annual available minutes per OR. The following formula was used to calculate annual available minutes per OR: 250 days * 10 hours/day * 60 minutes/hour * 75% utilization.[5]

As demonstrated in the table below, this detailed model projects that by 2030, our patients and providers will need the UVM Medical Center to operate between 8.5 and 10.6 more ORs than the UVM Medical Center operates today (20 ORs).

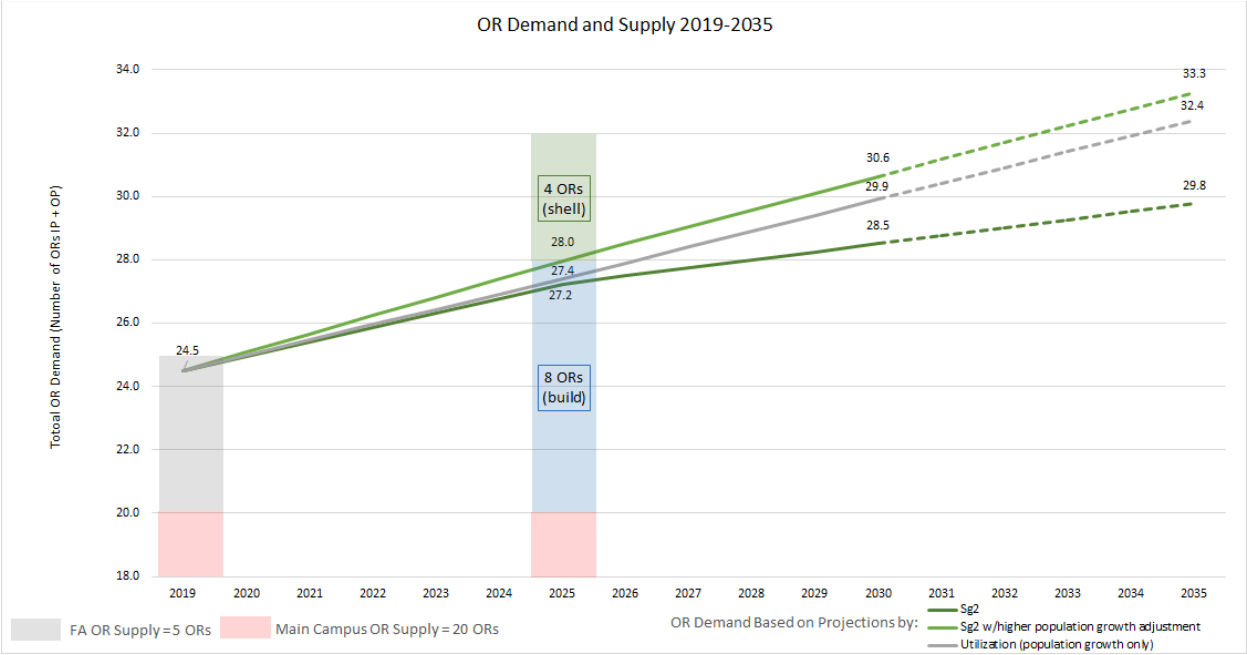
	UVMMC Current OR Volumes			10 year OR Volume Projections Based On:								
				Sg2 Growth Rates			Chittenden County, VT Pop. Growth for Under and Over 65			Sg2 Growth Rates w/ adj. for Higher Population Growth		
	FY 2019		2019	2030		2030	2030		2030	2030		2030
Service Line	IP	OP	IP + OP	IP	OP	IP + OP	IP	OP	IP + OP	IP	OP	IP + OP
Cardiology	2	1	3	2	1	4	2	2	4	3	1	4
Cardiothoracic	539	5	544	665	6	671	698	6	704	779	7	786
Derm	0	44	44	0	49	49	-	47	47	-	52	52
ENT	150	1,670	1,820	130	1,605	1,735	175	1,805	1,980	137	1,659	1,796
General	1,419	1,046	2,465	1,419	1,270	2,689	1,686	1,219	2,905	1,419	1,367	2,786
Neurosurgery	621	328	949	756	353	1,110	785	395	1,180	868	392	1,260
OB/Gyn	161	1,610	1,771	130	1,713	1,843	177	1,770	1,947	130	1,713	1,843
Ophthalmology	12	1,364	1,376	12	1,758	1,770	14	1,902	1,916	13	1,986	1,999
Oral/Maxillofacial	18	78	96	18	94	112	19	79	99	19	100	119
Ortho	1,895	3,470	5,365	1,780	4,564	6,343	2,064	4,249	6,314	1,977	4,962	6,938
Foot/Ankle	119	813	932	119	949	1,068	151	913	1,064	135	1,025	1,160
General	66	280	346	67	327	394	83	315	398	75	353	428
Joints	712		712	623	502	1,125	585	374	959	694	562	1,256
Spine	409	214	623	369	262	630	497	256	753	402	295	697
Sports	69	698	767	71	815	886	85	713	798	80	880	960
Trauma	390	319	709	409	372	781	491	357	847	468	402	870
Upper Extremity	130	1,146	1,276	122	1,338	1,459	172	1,322	1,495	122	1,445	1,566
Pediatrics	150	306	456	138	374	512	150	306	456	138	294	432
Plastics	166	410	576	170	496	666	179	442	621	170	533	704
Pulmonary	13	133	146	13	163	176	16	164	181	14	187	201
Surg/Onc	27	408	435	26	517	543	30	510	541	30	581	611
Transplant	90	6	96	92	7	100	100	9	109	92	7	100
Urology	381	1,962	2,343	340	2,358	2,698	471	2,471	2,942	375	2,519	2,894
Vascular	470	495	965	536	608	1,145	655	604	1,259	551	687	1,239
Total	6,116	13,336	**19,452**	6,231	15,938	**22,169**	7,226	15,980	**23,206**	6,717	17,050	**23,767**
		Growth from 2019		2%	20%	14%	18%	20%	19%	10%	28%	22%
		Total # of ORs needed		**10.9**	**17.6**	**28.5**	**12.3**	**17.6**	**29.9**	**11.9**	**18.8**	**30.6**
		Incremental # of ORs needed				**8.5**			**9.9**			**10.6**

**FY19 Spine and Urology cases in demand model were adjusted.*

Extrapolation through 2035

We also extrapolated our FY 2030 projections in each of the three scenarios on a straight-line basis out to 2035 in order to better understand the number of ORs we will likely need by that date. Although these longer-term projections are by their nature less precise, they will help guide our planning and our CON application, both of which must look well beyond the first six years of operation.

[5] *Our experience, and that of other hospitals nationally, has demonstrated that greater than 75% planned OR/PR utilization does not contribute to, and often detracts from, the efficiency of the system.*



This extrapolation shows that by 2035, our patients and providers will need the UVM Medical Center to operate a total of between 9.8 and 13.3 more ORs than we do today.

Model May Understate Demand

We believe a scenario-based approach to estimating OR need is especially appropriate in today's environment. While it might be tempting to dismiss the highest growth scenario as aggressive, we believe it may actually understate demand due to several factors for which the model does not account:

- As mentioned above, the Demand Model projects UVM Medical Center's FY 2019 baseline volumes. If other Vermont health care providers cannot increase their capacity to accommodate their patients' increased need for services, it is likely that some of these patients will seek care at UVM Medical Center.
- The 2019 baseline volume data does not account for the fact that wait times for some surgeries in 2019 exceeded target wait times, resulting in lost volume in 2019, and effectively understating the baseline demand.
- Finally, it is possible that some patients will prefer to have their surgery done in an outpatient surgery center, and UVM Medical Center may draw more patients from surrounding regions than it did in 2019 once an outpatient surgery center is available.

OSC Surgical Case Mix for planning purposes.

During the planning process we have identified a list of surgical specialties and a number of surgical cases projected for the OSC. The financial assessment is built based on reimbursement and costs assumptions for each of those surgical specialties.

Service Line	2025 OP Cases Total	% of OP Cases moved to OSC	2025 OSC Cases
Cardiology	1	0%	-
Cardiothoracic	6	0%	-
Derm	47	0%	-
ENT	1,634	73%	1,193
General	1,210	32%	387
Neurosurgery	351	0%	-
OB/Gyn	1,661	40%	664
Ophthalmology	1,677	100%	1,677
Oral/Maxillofacial	89	0%	-
Ortho	*4,293*		*3,555*
Foot/Ankle	918	95%	872
General	316	100%	316
Joints	346	75%	259
Spine	271	0%	-
Sports	788	100%	788
Trauma	360	25%	90
Upper Extremity	1,294	95%	1,229
Pediatrics	297	0%	-
Plastics	473	50%	237
Pulmonary	160	0%	-
Surg/Onc	498	25%	124
Transplant	7	0%	-
Urology	2,303	0%	-
Vascular	580	35%	203
Total OP Cases	**15,287**		**8,040**

Appendix 2: Technical Description of the Building and Site

General:

The building will be designed primarily in accordance with applicable NFPA Sections, IBC 2015, and the adopted section of the Vermont Division of Fire Safety Code. The building use shall be an IBC B-Business Occupancy, NFPA 101 New Ambulatory Healthcare Occupancy, Vermont Energy Code and follow the clinical requirements of FGI 2018, more specifically, FGI 2018 Guidelines for Design and Construction of Outpatient Facilities.

Site, Civil, and Architectural Landscaping:

Civil engineering will bring utilities such as electrical, storm-water, and natural gas from the Tilley Drive roadway to within 10ft of the building perimeter. A storm-water gravel wetland will be constructed on the eastern portion of the site. Civil engineering will also provide exterior signage and access roadways from Tilley Drive to the front entrance pedestrian drop-off canopy, patient and employee parking, and the loading dock and delivery entrances. Patient, employee, and ADA parking, site drainage, and pedestrian circulation sidewalks and landings will be part of the civil site plan. Site lighting along roadways, parking, and sidewalks will be part of civil engineering but coordinated with the electrical engineer and landscape architect. Retaining walls up to 5ft in height will be part of the civil engineering design. An exterior oxygen farm will be required so fencing and sitework will be required to support this system.

Landscape architecture incorporates landscaping and shrubbery elements around the building, along the driveway to screen the site from abutting properties, and at parking islands. A small exterior patio with outside seating located adjacent to family waiting, accessible through an exterior entrance door, will be part of the landscape design. A landscaped public space will be constructed in the northern portion of the property and is anticipated to be linked to the future pedestrian and bicycle path to be constructed.

Parking: There will be a total of 266 spaces.

Architectural:

The new building will be comprised of one Main Grade Level with a partial Lower Level. At grade, the Level will provide the main entrance, lobby, check-in/check-out and the ambulatory surgery center. A Stair and 3 separate elevators will connect the First Level with the Lower Level. The stair tower will communicate between the Lower Level, Grade Level, and Roof Level.

Structural:

The structural system for the building will utilize a steel frame for columns, girders and beams supported by a spread footing concrete foundation system. Lateral loads will be resisted by a combination of braced frames and moment connections. The floor system will be slab on grade at the Lower Lever, Partial slab on grade at Grade Level with a composite metal deck with concrete topping. The Roof deck will also be a composite metal deck with concrete topping. Roof deck steel will have wide flange members to provide a stiff frame to support surgical equipment and booms.

Spray fireproofing will be utilized to provide the required fire rating protection for all structural steel. Slab between Lower Level and Grade Level to be 2 hr., roof level to be 1 hr. fire resistive rating. Foundation walls will be insulated to R20 below grade with appropriate waterproofing and drainage. Any slab on grade areas, which will be minimal, will have R20 insulation with a 15-mil minimum under slab vapor barrier. Retaining walls greater than 5ft will be part of the structural design.

Exterior:

The exterior shell of the building will feature the following materials and construction. The roof will be a thermoplastic polyolefin (TPO) adhered membrane that will be Energy Star and CCRC certified installed over tapered R50 insulation sloped to interior roof drains. Architectural screening at the roof level, primarily at the west end, will hide rooftop equipment. The exterior wall construction will be comprised of a steel stud back up system, with a combination of brick veneer and an aluminum composite metal panel system. A combination of continuous exterior insulation to reduce thermal bridging and cavity insulation will be used to achieve an effective R30 wall performance. A continuous air/vapor barrier across the entire building envelope will maintain air tightness and prevent water infiltration. A curtain wall system and a punched window system with interior solid surface sills will make up the building's fenestration. The systems will be thermally broken and triple glazed providing a U factor of 0.25. The front entrance vehicular and

pedestrian drop off canopy will be clad with composite metal panel and a suspended ceiling with a wood look appearance and integrated overhead lighting.

Benchmark Analysis:

A total of four dozen Ambulatory Surgery Centers (ASC) projects constructed nationwide since 2005 were analyzed and compared. The projects' benchmarked ranged from 2,100 to 110,000 SF which housed 1 up to 10 operating rooms. We sought to compare construction cost, building size, operating room size and total number of operating rooms and facility size seeking data on comparable facilities.

The sites ranged from physician owned private facilities with limited surgical services to hospital-based and operated surgical facilities designed to manage more sophisticated surgical procedures. Several of the sites identified were converted retail spaces (grocery store) or existing renovated business occupancies; these tended to be smaller limited capacity facilities.

Findings and take away:

- We were unable to locate comparable sites. There is a dearth of site information for facilities similar to our proposed Outpatient Surgery Center (OSC). We observed huge variations in construction costs, site quality and facilities sizes as well as the number of ORs, amenities and ancillary/support spaces making benchmarking difficult.
- Cost analysis did not yield any reliable comparable data due to the variability of size, quality, and vintage of construction of the various sites. Very few of the facilities analyzed were constructed within the last two- three "Covid Years" during which time there has been major increases in construction costs and volatility driving costs up by as much as 30-35%.
- Our proposed OSC will be constructed with eight operating rooms though the building will eventually house 12 operating rooms. The building designed for twelve operating rooms making the building about 50% larger than necessary to support the initial 8 ORs. Ideally, we would like to benchmark to similar ASCs with twelve operating rooms, but we were not able to identify comparable sites.
- The proposed OSC includes provisions for a full service central sterile reprocessing department, onsite patient pharmacy, pathology laboratory, teaching space for residents, students, and other learners as well as equipment and procedure staging space to enable maximum surgical case throughput. Alternatively, many of the sites we analyzed including for profit and physician owned ASCs typically offered limited, low risk, high turnover, high margin surgical procedures of minimal complexity with minimal support, sterile and instrument reprocessing and staff space with no provisions for pharmacy dispensing, teaching resources or laboratory. These facilities were constructed to meet only minimum code requirements for a "business occupancy" building classification and constructed with limited lifecycle duration in mind.
- We are proposing 650 SF operating rooms which we believe are appropriately sized and will provide the space needed to safely support sophisticated orthopaedic and other equipment intensive surgical procedures. The current minimum code mandated operating room SF is 400. Contemporary health care planners are recommending 600 SF as a minimum for operating rooms hosting complex procedures. As a reference, our newest ORs in the Ambulatory Care Center created 20 years ago average 600 SF while three of the Fanny Allen's operating rooms do not meet the minimum threshold of 400 SF. We rejected a potential reduction of operating room space (550-600 SF) as the proposed reduction would have little impact on the overall project size and would hinder future flexibly and adaptability to host future and emerging surgical technologies.

In conclusion, the proposed OSC is unique amongst the facilities we evaluated and as such simple benchmarking was not achievable without unreasonable contortion of the available data. Stroudwater Associates, a national healthcare consulting firm, who we consulted with to seek a second opinion reached the same conclusion.

Appendix 3: Outpatient Surgery Center Project Timeline and Milestones (as of Nov. 2023)

Activity	Status and Scheduled Completion Dates
Planning CON Approved	Complete
Functional Programming	Complete
Exterior Design Concept and Site Selection	Complete
Room by Room Programming	Complete
Design Assist Key Trade Partners On Board	Complete
Schematic Design Documents Completed	Complete
City DRB Sketch Plan 1st Review	Complete
Schematic Design Estimate-Reconciled	Complete
Equipment Cost Estimating	Complete
Project Budget Prepared for Business Plan	Complete
Business Plan Submission	Dec-22
Board Project Approval	Dec-22
CON Application Submission	Jan-23
City Zoning Permitting	Dec. 22-Jan. 23
Early Release 1 package long lead items	Dec. 22-Feb. 23
Act 250 Permitting	Jan-23
Construction Document Estimate and Reconciliation	Feb-23
CON Approval	Jul-23
Land Purchase	Aug-23
Execute GMP Contract Amendment	Aug-23
City and Ag Soil Impact Fee Payments	Aug-23
DEW Procures Trade Permits	Aug-23
DEW Mobilizes to Commence Construction	Aug-23
Ground Breaking	Aug-23
Steris and Sky-Tron Equipment Installation	Oct. - Dec. 2024
UVMMC Misc. Fit-up And Equipment Installation	Nov. - Dec 2024
Substantial Construction Complete	February 5, 2025
Certificate of Occupancy	February 12, 2025
FFE Installation	Sep. – Mar. 2025
Staff Training and Orientation	Feb. – Mar. 2025
Pre-move Supply Change Stocking Supplies and Linen	Feb. – Mar. 2025
Day in the Life	Apr-25
Staff Event	Apr-25
Press Event ‘Grand Opening”	Apr-25
Move in	Apr-25
1st Patient Procedure	April 21, 2025

Appendix 4: Patient Flow Sequence

1. Patients and their companions arrive and patients will check in at the reception desk or the kiosk. All patients will be pre-registered and administratively pre-approved for surgery, so check-in time should require only about 10 minutes.

   Check-in kiosks will be provided. Patients who use the kiosk will also have their signatures captured digitally at the kiosk.

   Wrist bands will be affixed by the registrar, as well as any collections made and /or verified.

Point of Arrival Admission:

If pre-admitted:

a. Patient identification
b. Deductible/co-insurance collections
c. Forms execution via eSignature (Admission agreement, financial consent, IM/Tricare if IP)
d. Scanning of documents (insurance cards / advance directive)
e. Printing of forms / disbursement (IM/Tricare, Patient Rights/Ethics)
f. Encounter/registration workflow processed
g. Printing face sheet labels / wristbands – affixing wristband

If not pre-admitted:

Additional responsibilities listed below occur with patients who are not pre-admitted. This occurs when we're unable to reach a patient and they do not return our calls. This happens with higher frequency for cases booked within 72 hours of service.

a. Full patient registration
    i. Demographics, religion/pow, address, contacts, insurance, guarantor, alternate payer coverage, MPSQ, etc.
    ii. Insurance eligibility
    iii. Informed of benefits / out of pocket responsibility
    iv. Attempt OOP collections
    v. Advance directive Q&A
    vi. Verification of authorization (if not on file and required / execution of waiver
b. Hardship referral sent to financial advocates
c. Patient identification
d. Deductible/co-insurance collections
e. Forms execution via eSignature (Admission agreement, financial consent, IM/Tricare if IP)
f. Scanning of documents (insurance cards / advance directive)
g. Printing of forms / disbursement (IM/Tricare, Patient Rights/Ethics)
h. Encounter/registration workflow processed
i. Printing face sheet labels / wristbands – affixing wristband

2. The patient and their companions will be directed to the patient and companion lounge to wait until the pre-op clinical preparation sequence begins.
3. When ready to begin the clinical prep process, a clinical member of the team will escort the patient, who will generally walk with the clinician, (and up to 2 companions) to a preoperative room.
4. Upon arrival in the pre-op room, the pre-op nurse will verify the patient's identity, double-check the wrist-band, and confirm the patient's paperwork and PAT/H&P status. The patient will change into their gown, if required. The nursing assessment will be completed, and pre-operative orders fulfilled.
5. Patient belongings will be put in a patient locker.
6. The surgeon and anesthesiologist/anesthetist will consult with the patient, surgical site will be marked, and any final pre-procedural discussions/consultations will occur.
7. Anesthesia administered in the prep room if appropriate type
8. When the surgical team is ready, the patient will be transported to the OR via appropriate transportation such as walking, recliner or stretcher based on clinical and physical need.

9. OR time starts with patient entry (Wheels-in).
10. The patient will transfer/be transferred to the operating table, desired anesthetic state achieved and patient prepped for surgery.
11. The surgical case occurs.
12. Upon completion of surgery and extubation (if relevant) the patient is prepared for transport to the appropriate post-surgical environment as determined by anesthesia – either Phase 1 or Phase 2 recovery
13. Exit time is documented.
14. After "wheels-out," that patient may be transferred to the appropriate recovery area.
    a. Phase 1 is higher acuity care post anesthesia emersion. Patients are recovered in Phase 1 until Modified Aldrete scores are appropriate for transfer to Phase 2 care.
    b. Phase 2 Post Anesthesia Care is a location where patients are moved to; eat, drink, review discharge instructions and DME, have 1-2 companions present. All same day patients are discharged via Phase 2 when discharge criteria are met.
        i. Phase 2 care admission can occur in 2 manners
            1. Direct admit to Phase 2 based on lower acuity i.e.; local, topical or regional blocks, or possibly moderate sedations. The patient meets a Modified Aldrete score of 10 upon exit of the OR
            2. Via Phase 1 recovery for higher acuity cases when Modified Aldrete score is 10 or higher.
    c. 23-hour Observation
        i. Can occur via 2 circumstances; planned or clinically necessary due to failure to reach discharge criteria
        ii. 23-hour-Observation Patients will be homed in appropriate suites with 4 walls, an en-suite, call bell, TV, food, etc.
        iii. See appendix re: food.
        iv. All 23-hour Observation patients will be medically stable requiring minimal intervention
        v. 23-hour Observation patients are discharged no later than 0800 next day
            1. Should an observation patient fail to meet discharge criteria after 0800 and require continued care or higher level of care they will be transferred to an admitting hospitalist based on established protocols and agreements with the hospitalist service.
15. The surgeon visits the patient and companion (as relevant), and provides a post-procedural consultation.
16. Surgeons and anesthesia providers will have access to the EHR to document the outcomes of the case. As with prep beds preparing patients for the ORs, adequate stations will be provided so clinicians' time is not wasted queuing for access to a PC and dictation station.
17. Meds to Beds is planned and will be serviced. For the majority of cases, we will have the medications as needed on site stored in a Pyxis Machine. For instances where medication changes, we will be able to deliver medications from the nearby retail pharmacy, if open when the OSC goes live or from Holly Court.
18. Physical Therapy will visit and evaluate/instruct relevant patients prior to discharge (typically orthopedics patients).
19. Nursing will finalize post-procedural teaching, provide written instructions, and discharge the patient.
20. A member of the clinical team will assist the patient and their companion to transportation via the private discharge exit (post-procedural patients will not reenter the waiting room on their way out).

Clinical Food and Nutrition

The OSC does not include a kitchen for meal preparation. However, the OSC includes kitchenettes, which will stock two types of food, in addition to beverages and frozen snacks, for OSC patients:

- Standard OP snacks for short-stay patients, similar to what has historically been provided at the Fanny Allen OP surgery area.
- Pre-packaged meals that are either shelf-stable/ready to eat or frozen and can be microwaved for 23-hour stay patients.

Specialty meals will also be available for some general surgery patients (clear liquid diet) and ENT patients (no sharp edge food like chips, small nuts, etc.). Patients with allergies, pre-existing medical conditions, or other diet restrictions will be identified prior to surgery through the pre-screening process and will also be provided with appropriate meals and snacks. Standard meals meeting the most typical conditions will be stocked at the OSC.

Visitors will be able to purchase food and beverages in the Red Barn Market & Deli located next door to the OSC.

Exhibit 5

January 6, 2023

Dave Keelty
Network Director Real Estate and Facilities
UVM Health Network
199 Main Street
Burlington, Vermont 05401

RE: UVMMC Outpatient Surgery Center (OSC) – ***Operating Room Square Footage***

Dear Dave,
For Operating Rooms that meet our types of procedures, the 2018 FGI Outpatient Facilities Guidelines requires Operating Rooms to be a minimum of 400 square feet. The average Operating Room square footage for the new Surgery Center is 630 square feet, compared to the industry standard of 600 to 650 square feet. There are several key factors and considerations that will require the Operating Room square footage to be increased. I have listed them below:

Operating Room Space Requirements
Determining the square footage and space requirements of an Operating Room is based on the current FGI Guideline minimum requirements. Additional considerations shall include specialized procedures, industry standards, equipment layout, future changes, needs, and growth.

FGI Guidelines
The current FGI Guideline minimum requirements for Operating Rooms with anesthesia, typical equipment, and staff is 400sf. Space requirements for Operating Rooms that require additional personnel and large equipment may need to have a clear floor area of 600sf.

Specialized Procedures
Operating Rooms designed for specialized surgery and advanced orthopedic procedures generally require more equipment and are recommended to be at least 600sf. Specialized surgery also require more personnel, instruments, and more perimeter space outside the surgical zone.

Industry Standards
The industry standard for Specialized and Orthopedic Operating Rooms is 600 to 650sf.

Equipment and General Layout
Each Operating Room will use specific equipment that will require additional square footage. Surgery related portable X-Ray and mobile C-Arm imaging equipment will have significant Operating Room layout impacts and warrant additional square footage.

Once the Operating Room has been built, the size will determine which procedures, current and future, will be safe to perform. Therefore now, in the planning and design of the Operating Rooms, it will be critical to capture the square footage requirements in excess of the minimum requirements.

Please let me know if you need any additional information concerning Operating Room square footage.

Sincerely,

Thomas Morris
Partner, E4H Architecture

Exhibit 6

Efficiency Vermont

www.efficiencyvermont.com
888-921-5990 | 802-860-4095

December 23, 2022

Ms. Sarah Greer
UVM Medical Center
111 Colchester Ave
Burlington VT 05401

Re: UVMMC – Outpatient Surgery Center, Efficiency Vermont Project #6014-J061

Dear Ms. Greer,

Please let this letter confirm Efficiency Vermont's participation with UVM Medical Centers' Outpatient Surgery Center new construction project located at Lot 6 Tilley Drive, South Burlington, VT.

We have been included in preliminary design team meetings, reviewed drawings, and provided comments. We anticipate that the building will include the following energy-efficiency improvements:

- Where feasible, energy-recovery balanced ventilation with a minimum sensible recovery efficiency of 70%
- Where feasible, reduced interior lighting power density (20% or better)
- Very low air leakage (≤0.13cfm75 per square foot of exterior surface area)
- Energy Star or DLC qualified LED lighting
- Above-code mechanical system efficiencies
- Building envelope and mechanical systems commissioning

Upon certification of electricity-saving systems and equipment installed we expect to provide financial incentives to help defray the incremental costs of energy-efficient construction.

I look forward to our continued collaboration on this project. Thank you for your continued interest in energy-efficient building practices!

Sincerely,

Steve O'Malley
somalley@veic.org
Lead Engineering Consultant
(802) 540-7687