

THE
University of Vermont
MEDICAL CENTER

By Electronic Mail & U.S. Mail

April 25, 2024

Ms. Donna Jerry
Senior Health Policy Analyst
Green Mountain Care Board
144 State Street
Montpelier, VT 05602
Donna.Jerry@vermont.gov

Re: Docket No. GMCB-004-23con, Development of Outpatient Surgery Center on Tilley Drive, Project Cost: \$129,640,703.

Dear Ms. Jerry:

Pursuant to the First Amended Scheduling Order, The University of Vermont Medical Center Inc. (“UVM Medical Center”) hereby responds to the March 20, 2024 assessments of UVM Medical Center’s proposed outpatient surgery center project prepared by consultants to the Green Mountain Care Board (the “Board”).

UVM Medical Center appreciates the Board’s consultants’ detailed and thoughtful analysis of the proposed project, with which we largely agree. In this response, we offer clarifications with respect to some mainly marginal issues to make sure the record is clear and accurate. The consultants’ reports together with the additional information contained herein support and should inform a Board decision to approve UVM Medical Center’s Certificate of Need application.

In the below Part I, we respond to Mathematica’s report on UVM Medical Center’s demand and capacity modeling supporting the proposed project. In the below Part II, we respond to Ascendient’s report on the proposed project’s financial performance.

UVM Medical Center has no comments on NEMD Architects’ report, which states that site, civil, and construction cost estimates are reasonable and within industry standards and did not identify any noncompliance with FGI Guidelines. UVM Medical Center also has no comments on ECRI’s report, which states that all the equipment on UVM Medical Center’s proposed equipment list is appropriate and the pricing is as expected.

I. Shanmugan, P., Gilman, B., Mathematica, *Assessment of University of Vermont Medical Center's Certificate of Need Application for a New Outpatient Surgical Center in Burlington, Volume I: Surgical Demand and Capacity Projections* (March 20, 2024).

The Mathematica report validates the OSC's proposed capacity (8 ORs and shell space for 4 additional ORs). Mathematica evaluated UVM Medical Center's OR demand and capacity projections and concludes that "UVM Medical Center provides a reasonable estimate of the future need for ORs at the hospital." Mathematica Report at vi.

Mathematica also comments on a few elements of UVM Medical Center's demand and capacity modeling methodology. While the report is clear that none of the noted issues affected Mathematica's ultimate opinion of the proposed project, UVM Medical Center responds to them as follows.

1. Mathematica was unable to fully evaluate the proprietary Sg2 Impact of Change® model, which UVM Medical Center used to project growth in demand for surgeries.¹

While Mathematica did not have access to all the data Sg2 factors into its proprietary model,² which UVM Medical Center uses by subscription, Mathematica's report notes that its independently produced outpatient surgical demand projections "offer assurance that the projections produced by Sg2 are reasonable." Mathematica Report at 16. Mathematica independently modeled outpatient surgical demand in UVM Medical Center's hospital service area and thereby predicted a higher rate of growth in demand for outpatient surgeries through 2030 than UVM Medical Center predicted using the Impact of Change® model. *Id.* at 15.

2. The Public Opinion Strategies ("POS") population growth rates UVM Medical Center used in the demand model Scenario 3 described in the CON Application may be high.

At the time UVM Medical Center generated the surgical demand projections described in the CON Application, Sg2's Impact of Change® model incorporated a Claritas demographic forecast that did not account for 2020 census data. UVM Medical Center therefore generated its demand Scenario 3, which it used to determine the necessary capacity of the OSC, using a modified version of Impact of Change® in which a more current POS forecast substituted for the Claritas forecast. This Impact of Change® modification was made in consultation with Sg2.

¹ Sg2 is a subsidiary of Vizient, Inc. The Impact of Change® model is in widespread use by UVM Medical Center's peer institutions; according to Sg2, over 250 health systems and other organizations nationwide use Impact of Change® in strategic and facility planning. UVM Medical Center has used Impact of Change® in its facilities planning process since 2018, and the Board has accepted use of this model to project demand for UVM Medical Center's services in support of multiple other Certificate of Need applications. *See e.g.*, Certificate of Need Application, New Philips Ingenia Elition 3.0 T X MRI, Docket No. GMCB-010-21con (May 25, 2021).

² With Sg2's permission, UVM Medical Center did submit information concerning the underpinnings of the Impact of Change® model in response to the Board's requests for additional information in this proceeding. *See*, Response to Q.002, Q.25 (June 15, 2023); Response to Q.009, Q.1 (February 27, 2024)(Confidential).

At the Board’s request, UVM Medical Center recently projected demand using a version of Impact of Change® that incorporates the most current Claritas 2024 population forecast and projected its need for OR capacity using a slightly modified capacity model developed by the Board. This demand projection is only slightly lower than UVM Medical Center’s Scenario 3 projection using the POS data, and the projected number of incremental ORs UVM Medical Center will need in 2030 generated by the Board’s capacity model is higher:

Model	CON Application Scenario 3	GMCB Workbook Q.009, Q.3 (Rev.)(March 12, 2024)
Inputs Used to Project Surgery Volume	Sg2 Impact of Change® Model (POS population forecast)	Sg2 Impact of Change® Model (Claritas 2024 population forecast)
Projected Volume in 2029/ 2030	23,767	22,815
Incremental ORs Needed in 2030	5.6	6.04
Number of OSC ORs Needed (following closure of 5 ORs at Fanny Allen Campus)	10.6	11.04

3. The seventy-five percent OR utilization assumption UVM Medical Center used in its capacity modeling may be too low.

It is not possible to achieve 100% OR utilization (defined to include the time needed to turnover ORs between surgeries) for several reasons. It is necessary to hold unscheduled time to accommodate unexpected urgent and emergent cases, which will sometimes be scheduled in the OSC (for example, a traumatic wrist fracture in an otherwise healthy patient splinted in the emergency department could be scheduled in the OSC). It is also necessary to hold unscheduled time to accommodate inevitable delays and unpredictable variability in case length. Finally, it is not logistically possible to achieve 100% efficiency in scheduling cases and provider time; there will be some amount of OR time each day that cannot be used.

Mathematica cites a single published paper for the proposition that “peak efficiency in the OR results when utilization (defined as surgery time plus turnover time) is between 85 and 95 percent.” Mathematica Report at 11, *citing* Tyler, D., C.A. Pasquariello, and C.H. Chen. “Determining Optimum Operating Room Utilization.” *Anesth Analg*, Vol. 96, 2003, pp. 1114-21. This paper does not support that proposition. Rather, its authors describe a simple computer simulation whereby 85-90% utilization could be achieved, but then acknowledge that the simulation incorporates unrealistic assumptions, and real-world utilization will be less:

Our model creates a situation that is unlikely to be achieved in the real world. The cases are short, with a small coefficient of variation. In most of the situations studied, cases are of similar length. There are no patient-related delays and no case cancellations. Thus, the optimum utilization defined in this simulation is more than can reasonably be expected in a real OR. In real life, if these factors are taken into account, a smaller utilization may actually be achieved. . . . For the simplest situation studied here, a target utilization of 85% would approximate what we would like to achieve in terms of patient delay and overtime. This is perhaps the maximum utilization that can be achieved within the goals we have set. For more complex OR suites, the optimum utilization will be less. Any change, such as cases of different duration, changes in the variability of case duration, emergencies, cancellations, and so on, will decrease the optimum utilization.

Tyler, D., C.A. Pasquariello, and C.H. Chen. “Determining Optimum Operating Room Utilization.” *Anesth Analg*, Vol. 96, 2003, p. 1120.

UVM Medical Center followed the recommendation of its consultant Halsa Advisors (“Halsa”) in using seventy-five percent (75%) OR utilization (defined to include turnover time) in capacity modeling for its facility planning purposes.³ Halsa’s recommendation is based on real-life experience with healthcare providers, rather than a computer model. The Vizient Study results that UVM Medical Center submitted in response to the Board’s Requests for Additional Information Q.006 confirm that 75% is in fact a realistic benchmark for real-world OR utilization. See, Response to Q.006, Exh. A (thirty-four Vizient members reported OR utilization data for nineteen ambulatory surgical centers, and thirty-six hospital IP/OP departments; the 50th percentile was 64%, and the 75th percentile was 77%).

4. UVM Medical Center should have used actual turnover times at its facilities rather than assumptions in its OR capacity modeling.

UVM Medical Center did use its actual IP and OP turnover times in its modeling:

- Inpatient. We used average turnover time at UVM Medical Center’s Main Campus in FY19 (37 minutes).⁴ Halsa advises that 37 minutes reflects reasonable operational performance, and the above-referenced Vizient Study confirms this – for hospital surgical

³ See, Response to Q.002, Exh. 1 (June 15, 2023).

⁴ Response to Q.006, Q.3 (November 16, 2023).

departments performing 10,000 or more surgeries per year, the 50th percentile was 41 minutes, and the 75th percentile was 32 minutes.⁵

- Outpatient. We used the average turnover time for UVM Medical Center’s Fanny Allen Campus ORs in FY19 (25 minutes).⁶ Twenty-five minutes is also Halsa’s recommended benchmark, and the above-referenced Vizient Study confirmed that it is reasonable – for ambulatory surgical centers operated by hospitals, the 50th percentile was 25 minutes, and the 75th percentile was 22 minutes.⁷ UVM Medical Center does hope to improve upon the Fanny Allen experience at the OSC, which includes several design elements that will facilitate more efficient patient throughput and scheduling as described in the CON Application, but Halsa advises that 25 minutes is an appropriately conservative assumption for facility planning purposes

* * *

Finally, UVM Medical Center wishes to correct the following misunderstandings of its analysis:

- The Mathematica Report states UVM Medical Center added an extra turnover time at the end of each OR day in the Board’s/Mathematica’s model that UVM Medical Center used to project its OR capacity needs in response to the Board’s Requests for Additional Information Q.009 (January 25, 2024). Mathematica Report at 13, Table 6. This is incorrect. Rather, UVM Medical Center subtracted a turnover time at the end of each OR day to avoid overstating turnover time. The time needed to reset the OR following the last surgery of the day is accounted for in the turnover time associated to the first surgery of the following day.
- The Mathematica Report states regarding UVM Medical Center’s OR demand model: “To establish baseline demand, UVMMC used data on the procedures performed on its main campus in 2019.” Mathematica Report at 4. This is incorrect. Procedures performed at both the Fanny Allen campus ORs and the Main Campus ORs in FY19 were included to establish the baseline.
- The Mathematica Report states at Table 4 that UVM Medical Center’s “Surgical Capacity in 2019 (per operating room)” was 17,561 cases. That is incorrect – 17,561 cases is UVM Medical Center’s total capacity for the ORs it modeled.

II. Flicek, G., Carter, D., Ascendient, *Assessment of University of Vermont Medical Center’s Certificate of Need Application for a New Outpatient Surgical Center in Burlington, Volume II: Financial Analysis (March 20, 2024).*

Ascendient assessed UVM Medical Center’s projections regarding the OSC’s financial performance. The Ascendient Report suggests that the operating income shown in the

⁵ Id.

⁶ Id.

⁷ Id.

incremental pro forma for the proposed project may be overstated if 1) the operating margin attributable to incremental inpatient cases is overstated; 2) the reimbursement reduction is understated for cases that will shift to the OSC from UVM Medical Center's main campus and Fanny Allen campus ORs; or 3) incremental surgeon compensation expenses should have been included. UVM Medical Center responds as follows.

1. The operating margin attributable to incremental inpatient cases is not overstated.

a. UVM Medical Center's surgical demand projections did not overstate inpatient volumes.

Both Mathematica and Ascendient speculate that UVM Medical Center's projected inpatient volumes may be high, but neither Mathematica nor Ascendient offers any evidence in support of this opinion, and Mathematica ultimately concludes that UVM Medical Center's surgical demand projections are reasonable. Ascendient Report at 4; Mathematica Report at 10; Mathematica Report at vi.

UVM Medical Center projects eleven percent (11%) growth in inpatient surgery volume from 2019 – 2029, which is significantly lower than the projected growth in outpatient surgeries, reflecting advances that allow more surgeries to be performed in the outpatient setting.⁸ Notably, Sg2 projects that a substantial majority of the projected growth in inpatient volume will occur in three specialties: cardiothoracic surgery, neurosurgery, and vascular surgery.⁹ Patients across our region depend on UVM Medical Center for timely delivery of these complex and often life-saving surgeries.

Ascendient highlights UVM Medical Center's projected 16.1% increase in inpatient volumes from 2023 to 2024. Ascendient Report at 3 (Table 2). Year-over-year volumes are variable from the 2019 baseline through 2023 due to unusual circumstances discussed in the CON Application and UVM Medical Center's responses to the Board's requests for additional information, including the Covid-19 pandemic and the closure of Fanny Allen ORs due to air quality problems. Note, however, that the 2024 volume shown in Ascendient's Table 2 reflects 5.5% 5-year growth from the 2019 baseline, which is consistent with the 1.1% year-over-year growth shown for 2024-2029. Also, note that the 2024 volume shown in Table 2 is a projection of demand, whereas volumes shown for 2019-2023 are actual volumes, which may not capture true demand in a system that is at capacity.

b. UVM Medical Center did not attribute inpatient revenue to the proposed project that the hospital could realize without expanding its OR capacity by building the OSC.

⁸ See, CON Application at 13.

⁹ In the projections UVM Medical Center produced in response to the Board's Q.009 using the Sg2 Impact of Change® model incorporating the Claritas 2024 population forecast, the growth between 2019 and 2030 in these three specialties exceeds total growth over the same time period, as inpatient surgical volumes in some other specialties are static or decline.

Ascendient notes that the project’s incremental pro forma should not include inpatient cases that UVM Medical Center could accommodate without building the OSC. The incremental pro forma does not include any such cases. UVM Medical Center cannot accommodate the incremental inpatient volumes it included in the pro forma without building the OSC because its existing ORs are operating at capacity.¹⁰

- c. *It is not appropriate to allocate the proposed project’s depreciation and interest expense only to revenues derived from the incremental volumes because five (5) of the proposed ORs replace existing facilities.*

Depreciation and interest expenses cannot be fairly allocated only to revenues resulting from the incremental cases, because the OSC project includes five (5) ORs to replace those at the Fanny Allen campus, plus additional ORs to meet anticipated surgical demand. The incremental ORs are necessary to realize both the incremental outpatient and inpatient margin.

The following is a restatement of the Ascendient Report Table 4 showing the EBIDA margin impact associated with the incremental inpatient and outpatient volumes.

	FY25 (Half Year)	FY26	FY27	FY28	FY29
Incremental IP EBIDA Contribution Margin	\$5,149,915	\$11,955,611	\$13,984,089	\$15,869,670	\$17,892,985
Incremental OP EBIDA Operating Margin	\$3,430,601	\$5,887,274	\$6,776,877	\$6,496,848	\$10,200,010
Total Incremental EBIDA Operating Margin	\$8,580,516	\$17,842,885	\$20,760,966	\$22,366,518	\$28,092,995
Depreciation & Interest Expense	\$7,078,959	\$11,849,711	\$11,849,711	\$11,849,711	\$12,382,816
Incremental Operating Margin	\$1,501,557	\$5,993,174	\$8,911,255	\$10,516,807	\$15,710,179

- d. *The proposed project’s profitability as a free-standing business unit does not depend on the incremental inpatient volumes.*

Finally, the profitability of the OSC as a standalone business unit does not rely on the incremental inpatient margin. UVM Medical Center’s internal business planning process examined the financial impact of the proposed OSC project using both an incremental pro forma and an OSC standalone pro forma. The standalone pro forma is shown in the business plan document included in the CON Application and estimated the OSC’s 5-year total operating margin at \$65M.¹¹

2. The reimbursement adjustment included in the incremental pro forma for cases that will shift from the Main Campus and Fanny Allen Campus ORs to the OSC is not understated.

¹⁰ See, Response to Q.006, Q.4 (November 16, 2023)(the 25 ORs accounted for in UVM Medical Center’s demand and capacity modeling operated at 75% utilization from May-September, 2023, and hit 77% utilization in October 2023); Response to Q.006, Q.3 (November 16, 2023)(75% is a realistic benchmark for real-world OR utilization, and UVM Medical Center assumed 75% OR utilization in its demand and capacity modeling at the recommendation of its consultant Halsa).

¹¹ CON Application, Exhibit 4 at 29.

The incremental pro forma includes a reduction in reimbursement for the cases that will shift from UVM Medical Center's Fanny Allen or Main Campus ORs to the OSC due to the change in the site of service. [REDACTED]

Ascendient translated UVM Medical Center's projected \$ [REDACTED] per case reduction to a [REDACTED] reduction in total reimbursement for the shifted cases with reference to the average reimbursement per OSC case reported in the response to Q.002, Q.10 (June 15, 2023)(Confidential). Ascendient Report (Confidential) at 6.

Ascendient opined that a [REDACTED] reduction is too low based on the following rough estimate of the expected percent reduction:

- [REDACTED]
- [REDACTED]
- [REDACTED]

Ascendient Report (Confidential) at 6.

UVM Medical Center does not disagree with the formula Ascendient used to calculate its estimate of the reimbursement reduction. Ascendient used the wrong figures, however, for a) the percentage of UVM Medical Center's outpatient reimbursement that comes from Medicare and from commercial payers, and b) the percent reduction in commercial reimbursement for the shifted cases.

Ascendient pulled the numbers for percent outpatient reimbursement from Medicare (28%) and commercial payers (55%) from the CON Tables UVM Medical Center submitted in response to Q.002.¹³ These numbers represent the payer mix for combined inpatient and outpatient cases. For outpatient cases alone, the split is 75% commercial and 11% Medicare. UVM Medical Center reported these figures in its response to Q.009, Q.10 (February 27, 2024).

Ascendient took the anticipated percent reduction in the commercial facility fee for shifted cases from UVM Medical Center's response to Q.009, Q.9 (February 27, 2024)(Confidential), [REDACTED]

¹² See, Response to Q.002, Q.11 (June 15, 2023)(Confidential); Response to Q.005, Q.14 (August 15, 2023)(Confidential).

¹³ See, Ascendient Letter (April 12, 2024)(Confidential).

[REDACTED]. UVM Medical Center has determined that its description of this element of its response to Q.009, Q.10 is incorrect. UVM Medical Center anticipates a [REDACTED] reduction in commercial reimbursement for all the OSC cases, both “shifted” cases and incremental cases (relative to what UVM Medical Center would be paid for these cases if services were performed at Fanny Allen or the Main Campus). The anticipated reduction in commercial reimbursement for the subset of shifted cases is [REDACTED]. This is the assumption factored into UVM Medical Center’s calculation of the above-referenced [REDACTED] reimbursement reduction. The reduction is different for the shifted cases because the payer mix and case mix is different for the shifted cases.

Ascendient’s estimate of the probable total percent reduction in reimbursement recalculated using the correct figures is [REDACTED]:

[REDACTED]

3. UVM Medical Center agrees with Ascendient that it will incur additional expenses to compensate surgeons for the additional volume of cases they will perform after the OSC opens.

UVM Medical Center agrees with Ascendient that the incremental pro forma should include additional wRVU compensation that UVM Medical Center will pay surgeons for performing the incremental outpatient surgeries. Note that incremental surgeon compensation for incremental inpatient surgeries was previously included in the IP Direct Cost expense line.

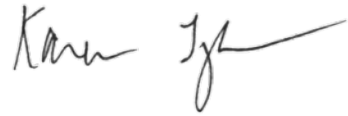
Additional wRVUs were estimated by specialty and translated into cost using Sullivan Cotter wRVU compensation benchmarks by specialty. The resulting additional cost and impact to margin is shown below in a revised incremental pro forma.

INCREMENTAL Pro-Forma: Outpatient Surgery Center

	FY25 (Half Year)	FY26	FY27	FY28	FY29	5 Yr. Total
Incremental Volume						
Total Volume	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	206.4208709	483.6704953	554.4992488	625.3280023	696.1567558	2,566
Incremental Revenue						
OP: Total Gross Patient Revenue + FPP	\$ 31,641,303	\$ 67,502,611	\$ 79,499,997	\$ 75,935,538	\$ 106,520,168	\$ 361,099,617
Gross Patient Revenue: Facility	\$ 24,441,447	\$ 52,142,653	\$ 61,410,080	\$ 58,656,700	\$ 82,281,916	\$ 278,932,795
Gross Patient Revenue: Professional	\$ 7,199,856	\$ 15,359,958	\$ 18,089,917	\$ 17,278,838	\$ 24,238,253	\$ 82,166,822
IP: Total Gross Patient Revenue + FPP	\$ 30,129,000	\$ 57,586,289	\$ 62,110,180	\$ 70,043,801	\$ 77,977,421	\$ 297,846,691
Gross Patient Revenue: Facility	\$ 29,122,298	\$ 55,662,155	\$ 60,034,889	\$ 67,703,423	\$ 75,371,957	\$ 287,894,721
Gross Patient Revenue: Professional	\$ 1,006,702	\$ 1,924,134	\$ 2,075,291	\$ 2,340,378	\$ 2,605,464	\$ 9,951,969
Deductions from Gross Revenue	\$ (34,568,441)	\$ (70,029,229)	\$ (79,469,419)	\$ (78,269,010)	\$ (100,680,610)	\$ (363,016,709)
Contractual Discounts	\$ (33,557,228)	\$ (67,981,869)	\$ (77,147,173)	\$ (75,981,842)	\$ (97,738,533)	\$ (352,406,646)
Bad Debt	\$ (643,961)	\$ (1,303,799)	\$ (1,478,851)	\$ (1,456,513)	\$ (1,873,571)	\$ (6,756,694)
Provision for Charity	\$ (367,253)	\$ (743,562)	\$ (843,395)	\$ (830,655)	\$ (1,068,505)	\$ (3,853,369)
OP: Net Reimb. adjustment on current vol. shifted to OSC	\$ (1,636,303)	\$ (3,338,044)	\$ (3,512,510)	\$ (3,692,210)	\$ (3,877,301)	\$ (16,056,368)
Total Operating Revenue	\$ 25,565,559	\$ 51,721,627	\$ 58,628,248	\$ 64,018,118	\$ 79,939,679	\$ 279,873,231
Incremental Expenses						
Salaries/Wages and Other	\$ 6,227,418	\$ 12,836,524	\$ 13,336,933	\$ 13,572,746	\$ 18,489,414	\$ 64,463,035
Physician Base	\$ 672,475	\$ 1,345,750	\$ 1,379,394	\$ 1,413,878	\$ 2,762,152	\$ 7,573,649
Physician RVU	\$ 1,235,304	\$ 2,876,859	\$ 3,085,206	\$ 3,020,365	\$ 4,229,707	\$ 14,447,440
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	\$ 1,533,954	\$ 3,103,000	\$ 3,517,093	\$ 3,841,087	\$ 4,796,381	\$ 16,791,515
Provider Tax	\$ 1,533,954	\$ 3,103,000	\$ 3,517,093	\$ 3,841,087	\$ 4,796,381	\$ 16,791,515
Med/Surg/Pharmaceutical Supplies	\$ 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	\$ 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	\$ -	\$ 333,281	\$ 465,821	\$ 484,465	\$ 1,064,915	\$ 2,348,482
Miscellaneous non-Dept. Other Expense	\$ -	\$ 333,281	\$ 465,821	\$ 484,465	\$ 1,064,915	\$ 2,348,482
IP Direct Cost	\$ 7,076,153	\$ 16,427,407	\$ 19,214,602	\$ 22,289,163	\$ 25,374,794	\$ 90,382,119
IP direct cost	\$ 7,076,153	\$ 16,427,407	\$ 19,214,602	\$ 22,289,163	\$ 25,374,794	\$ 90,382,119
Total Depreciation and Interest	\$ 7,078,959	\$ 11,849,711	\$ 11,849,711	\$ 11,849,711	\$ 12,382,816	\$ 55,010,908
Depreciation and Amortization	\$ 3,424,856	\$ 6,849,711	\$ 6,849,711	\$ 6,849,711	\$ 7,382,816	\$ 31,356,805
Interest Expense	\$ 3,654,103	\$ 5,000,000	\$ 5,000,000	\$ 5,000,000	\$ 5,000,000	\$ 23,654,103
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Expenses	\$ 35,299,305	\$ 48,605,311	\$ 52,802,200	\$ 56,521,677	\$ 68,459,206	\$ 251,687,700
Incremental Operating Margin	\$ 266,254	\$ 3,116,316	\$ 5,826,048	\$ 7,496,441	\$ 11,480,473	\$ 28,185,531
EBIDA Operating Margin	\$ 7,345,213	\$ 14,966,027	\$ 17,675,759	\$ 19,346,152	\$ 23,863,289	\$ 83,196,439

Thank you for your attention to this matter.

Sincerely,

A handwritten signature in black ink, appearing to read "Karen Tyler". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Karen Tyler
Associate General Counsel
The University of Vermont Health Network

cc. Interested Parties (via email)