Dunkiel Saunders
ELLIOTT | RAUBVOGEL | HAND

91 College Street, PO Box 545
Burlington, VT 05402-0545
tel 802.860.1003 | fax 802.860.1208
www.dunkielsaunders.com

Brian S. Dunkiel *
Eileen I. Elliott
Geoffrey H. Hand
John B. Kassel
Drew Kervick *
Alexander G. Lewis*
Kelly D. H. Lowry *
Justin W. McCabe *
Andrew N. Raubvogel
Jonathan T. Rose
Mark A. Saunders
Karen L. Tyler
Victoria M. Westgate

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Donna Jerry
Senior Health Policy Analyst
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Re: Docket No. GMCB-010-15con, Proposed Ambulatory Surgery Center
Response to Question posed 1.20.2016

Dear Donna:

Thank you for the questions in your letter of January 20, 2016. As requested, we have restated the questions in **bold** font and answered the questions in un-bolded font.

FINANCIAL

1. **Tables 1 and 2 must reflect the same total project cost. The $11,623,283.46 in total costs included in Table 1 for ongoing lease payments should be only be included in the profit and loss projections on a yearly basis on Table 3. Please revise and resubmit Tables 1 and 2 to reflect the same total project cost. If any changes to Tables 1 and 2 impact other financial tables and projections (Tables 3, 4, 5, 6, 7, and 9) please revise and resubmit the impacted tables and revised assumptions that support such tables.**

Once you remove the ongoing lease payment costs in Table 1, reconcile the new total project costs with funding sources. Project costs should total $1,609,875 (remove any operating lease expenses included in this figure) as included in Table 1 plus costs (not operating leases) such as Equipment costs (line 2) of $300,000, architect fees (line 3) of $10,500 and working capital fees of $681,540 (line 9) etc. The total funding sources should equal all of these costs.

See revised tables attached as Exhibit 1. The changes to Table 1 do not impact the other financial tables and projections. Table 2 remains unchanged, and reflects a project cost that is the same as the total project cost reflected on revised Table 1.

2. Provide detailed information concerning the working capital costs of $681,540 reflected in Table 1.

The working capital is a reserve calculated based on operating expenses (excluding depreciation and amortization) projected for the first 60 days of operation. Projected operating expenses include personnel costs of $331,968, clinical expenses of $173,457, facility costs of $81,567, administrative expenses of $86,700 and interest expense of $7,848.

3. For Table 3, answer the following:

(a) Provide a detailed explanation, assumptions and justification of the various expenses (i.e. clinical personnel and non-personnel expenses) which count for approximately 32% and 35% respectively of total expenses.

Clinical Personnel Expenses

Clinical personnel costs include the salaries, wages, payroll taxes, and benefits for the 22 project FTEs which are presented at Table 9 in the Application. Payroll taxes and benefits were calculated at 33% of salaries. We have budgeted for 8 non-MD FTEs and 14 direct service nurse FTEs. Based on number and mix, the non-MD FTEs' average salary is approximately $46,000 and the direct service nurse FTEs' average salary is approximately $71,000. The salaries we used in our calculations are reasonable and in-line with Chittenden County median salaries for the same or similar positions, as reflected in the following table:

Green Mountain Surgery Center
Table 9
Staffing Projections

	Proposed Year 1	Burlington VT Median Salary*	Median Salary Plus Benefits (33% of salary)	Median - Salary Total (col E*G)
Surgical Tech	3	$ 39,065	$ 51,956	$ 155,869.35
Instrument Tech	1	$ 43,807	$ 58,263	$ 58,263.31
RN Manager	1	$ 79,913	$ 106,284	$ 106,284.29
Receptionist	1	$ 30,167	$ 40,122	$ 40,122.11
Scheduler	1	$ 34,103	$ 45,357	$ 45,356.99
Business Office Manager	1	$ 60,907	$ 81,006	$ 81,006.31
Total Non-MD FTEs	**8**			**$ 486,902**
Physician FTEs	**0**			
Surgical RN	3	$ 78,935	$ 104,984	$ 314,950.65
Pre-Op RN	3	$ 65,448	$ 87,046	$ 261,137.52
PACU RN	4	$ 73,024	$ 97,122	$ 388,487.68
GI/Pain RN	4	$ 65,525	$ 87,148	$ 348,593.00
Direct Service Nurse FTEs	**14**			**$ 1,313,169**
Total FTEs	**22**			**$ 1,800,071**
Reserved for Recruiting Costs and/or Bonus Pool				$ 191,737
Table 3 Income Statement: Clinical Personnel Costs				**1,991,808**

*Source: Salary.com, using zip code 05401

We believe our proposed staffing levels are justified as they were based on and are consistent with industry norms. In particular, for nurse staffing we relied on ARON's (Association of PeriOperative Registered Nurses - www.aorn.org) recommendations for nurse to patient ratios. However, please note that the numbers will not tie back exactly because an FTE may not equate to one person but rather multiple people working different shifts. For projection purposes, we conservatively assumed a higher acuity than may actually be experienced to ensure that patient safety is never comprised. Aside from nurses, our staffing projections include one business office manager, one scheduler, one receptionist, one RN manager, three surgical techs, and one instrument tech.

Our staffing projections are based on the assumption that the GMSC will be open five days per week, Monday through Friday, from 6 AM to 5 PM. We further assume that the center will have two operating rooms and four procedure rooms, along with pre-operative, post-operative, and PACU areas. The projections also assume caseloads consistent with those shown in Table 5 on Page 27 of our Application.

Clinical Expenses (Non Personnel)

Non-personnel clinical expenses include medical drugs and supplies (89%), medical equipment repairs (3%), laundry and linens (4%), minor equipment (2%), and a small amount designated for other clinical expenses that are not personnel related (3%).

Non-personnel clinical expenses like medical drugs and supplies vary depending on the kind of surgery performed. Our consultant, Avanza Strategies, has developed and uses a proprietary database of supply costs for different medical procedures typically performed at ASCs. This supply cost data was applied to the surgery type and number information (which includes procedures) from the specialist physicians A through N. We multiplied the case volume and mix information found in our Application in Table 5, *Projected Cases by Physician* of the Application, page 27, with Avanza's cost per case information to arrive at our protections in Table 3.

This number also drives our laundry and linen number.

The non-personnel costs of minor medical equipment and equipment repairs is based on the number of operating and procedure rooms we intend to have. GMSC is designed to be a small center, with two operating rooms and four procedure rooms. Avanza provided the expense information associated with the operating and procedure rooms from its proprietary database.

(b) Your narrative states that the costs shown on the equipment expense line ($752,134) are lease expenses such as Plumbing, HVAC etc. Explain whether these costs are borne by the developer and paid for through the lease; if so, remove the costs from Table 1.

These costs are borne by the developer and paid for through the lease. They have been removed from Table 1.

(c) Provide itemized detail of the administrative expenses which make up approximately 15% of total expenses.

Administrative Expenses	% of Total Expenses
Legal and Accounting	0.3%
Insurance - D&O	0.8%
Marketing and PR	0.1%
Telephone and Communications	0.2%
Office Supplies and Expenses	0.8%
Transcription	0.7%
Equipment Maintenance	0.2%
Computer Expenses	0.4%
Mgt/Billing Fee	10.9%
Miscellaneous Expenses	0.6%
Total Administrative Expenses	14.9%

(d) Provide the fixed asset listing to support the depreciation expense.

The depreciation projected is based on the $200,000 purchase of initial furniture and fixtures. We have not itemized our particular furniture and fixture requirements at this time, but instead have established this budget for furniture and fixtures on advice from Avanza based on the needs of similarly situated ASCs nationally. Generally, this category will include waiting room furniture such as chairs, tables, artwork, and lamps, as well as office furniture, appliances, and fixtures such as filing cabinets, desks, and

office chairs. In budgeting for furniture and fixtures, we are assuming that we will purchase mid-range quality, moderately-priced models (as opposed to high-end or low-end models) at prices similar to those presently offered by national mid-range office furniture retailers.

(e) Provide assumptions for revenue payer mix detail for the four years of revenue. Table 1.H is referenced for further detail, but was not provided with the submission. Please explain. Detailed assumptions must be provided to support all financial tables.

We provided detailed assumptions used in determining revenue, payer mix, and volume in the Application in Section I. Project Narrative – Subsection H, *Utilization, Revenues and Profitability*. The tables and discussion can be found on pages 26 – 32.

To briefly reiterate our assumptions:

- We used the actual, self-reported experience of 16 physicians (identified in the Application in Table 5, *Green Mountain Surgery Center Projected Cases by Physician* as Physicians A through P) who expressed interest in performing cases at the surgery center.
- The 16 physicians are specialists in GI, OB/GYN, Orthopedics, Pain Management, and General Surgery.
- We used the physicians' 2014 reported monthly volumes and case mix for our revenue projections.
- We determined a capture rate based on the percentage of surgical cases each physician plans to perform at the ASC.
- Based on this capture rate, we assumed that 67% of the surgical cases the physicians plan to perform will be done at the GMSC.
- We assumed a six month ramp up period in the first year of operations, which is typical when opening a new facility.
- We assumed a 1% annual rate of growth, the conservative estimate typically used for ASC financial modeling.
- We used the actual payer mix of the interested physician participants to model the ASC's payer distribution:
    - 40% reimbursable by Medicare
    - 12% reimbursable by Medicaid
    - 35% reimbursable by commercial payers
    - 8% self pay
    - 5% uncollectible/charity care
- We projected that based on anticipated case mix, 38% of net patient revenues will come from Medicare; 9.7% will come from Medicaid; and 52.3% will come from commercial payers.
- We used the 2014 ASC Payment Schedule published by the Ambulatory Surgery Center Association to determine the projected reimbursement (net revenue) that we would collect.

These assumptions explain how we calculated "patient revenues," as seen in our Income Statement in the Application at page 31 and again in Table 3.

4. For Table 4, answer the following:

(a) The application shows start-up funding of $1,132,838. Provide a summary of all such costs and associated dollar amounts to confirm that $1,132,838 is sufficient based on the updates to Tables 1 and 2, as requested above. Confirm whether financial checks have been performed for each individual included in the start-up funding analysis. Provide an update to include actual funding secured to date.

Start-Up Costs

CON Enterprise Value	$	240,000
Professional Services	$	300,000
Initial Wages/Benefits	$	191,038
Marketing	$	25,000
Printing	$	25,000
Initial Furniture/Fixtures	$	200,000
Financing fees and Costs	$	6,800
Staff Recruitment/Training	$	15,000
Initial Inventory	$	130,000
Total Start Up Expenses	$	1,132,838

We have already secured all of the $240,000 reflected in the CON Enterprise Value line item from our local investors. Prior to offering these investors the opportunity to invest in ACTD LLC, we confirmed their suitability as investors, financial and otherwise, under applicable securities laws.

(b) Explain the $200,000 of fixed asset additions at start-up. Include full assumptions.

Please see our answer to Question 3(d) above.

(c) Substantiate supply assets and provide estimated inventory turnover amounts.

Supply inventory and its turnover is projected based on 30 days of medical supplies and drugs. As we stated in response to Question 3(a), supply costs are a component of non-personnel clinical costs, and are projected based on the case mix and volume

projections from data obtained from Physicians A through N, as applied to Avanza's proprietary cost per case data.

The financial projections assume that the overall medical/supply costs will average $311 per case. This cost was weighted based on ASC benchmarks by physician specialty as this expense can vary significantly depending on the type of surgical procedure. The specialty benchmarks come from Avanza Strategies' proprietary client database that has been assembled over the years.

(d) Confirm and explain whether there have been any changes to banking and/or loan requirements.

There have been no changes to our banking/loan requirements from those stated in Section III of our Application. We continue to expect to raise an aggregate amount of $1,132,838 through equity. Our anticipated debt needs are accordingly $680,000, as noted on page 58-59. We have requested and obtained an updated pre-approval letter from a community bank for a loan in the amount of $680,000. Our present pre-approval conditions include the following material terms:

- Term: 20 years
- Interest Rate: Prime Rate of Interest (as published in the WSJ) plus 3.5% variable as Prime changes.
- Repayment: Monthly payments of interest only for first 5 years of loan; monthly payments of principal and interest for the remainder of the term.

(e) Explain the decrease in capital contributions from $1,132,838 to $1,247,838 between start-up and year 1.

Table 4 reflects an increase in capital contributions between start-up and Year 1, from $1,132,838 to $1,247,838. We plan to raise this $115,000 in additional capital during this period by selling additional ownership interests in ACTD LLC. It is our intention that these ownership interests will be sold to local physicians or health care providers.

5. For Table 6, provide assumptions used in determining payor mix and volume figures.

Detailed assumptions used in determining revenue, payer mix, and volume were provided as part of the original application in Section I. Project Narrative – Subsection H. Utilization, Revenues and Profitability. The tables and discussion can be found on pages 26 – 32 of the original Application. Also, please see our response to question 3(e), above, which contains a summary of these assumptions.

6. For Table 9, explain why no increase in FTEs is shown from Year 1 to Year 4 to support the increases in volumes over that same time period.

For patient safety reasons, a minimum level of staffing is required for the ASC to initiate operations. Because this is a small center, this results in a need to slightly overstaff the facility during the first few years. Therefore, the initial staffing level can accommodate more volume than is projected in Years 1-3. See additional detail on staffing in our answer to Question 3(a) above.

7. The FTEs reflected in Table 9 correlate to amounts shown in Table 3. Explain whether increases to salary for cost of living only, or if other factors or additional employees are included.

An annual inflationary (cost of living) adjustment of 2.0% was applied to the salaries, wages, and benefits for all FTEs. There were no other factors that contributed the staffing cost increase.

8. Explain if there will be measures in place to avoid selective referral of the most profitable patients (commercially insured and private pay) to the ASC. Specifically, explain whether the entity will institute any policies to avoid and monitor this issue as it relates to physicians with a financial interest in the ASC.

Yes. The policy of the GMSC is not to make determinations of whether to accept or not to accept a patient based on the patient's insurance status, as stated in our Application at page 21. The following language will be included in our Medical Staff Bylaws: "Non-Discrimination. The Company and all Members utilizing the ASC shall treat patients receiving medical benefits or assistance under any Federal health care program in a non-discriminatory manner." The Medical Staff Bylaws will apply to and govern all physicians who become credentialed at and use the GMSC to perform surgeries.

Also, to ensure the GMSC is providing sufficient access to the least profitable patients the GMSC will provide quarterly reports to Vermont's Department for Disabilities, Aging and Independent Living (DAIL) documenting the amount of free care and charity care provided at the center and the total amount of patient revenues generated so the agency can ensure the charity care provided is a stable portion of the revenue generated. DAIL has regulated the Eye Surgery Center in this manner for the past seven years since the center opened. As part of this reporting process, the amount and value of services provided to patients on Medicaid can also be provided. Other states have implemented reporting requirements for ASCs that include documenting the amount of Medicaid services provided, in addition to free care and total patient revenue, to help ensure that ASCs are not selectively providing access to services to only the most profitable patients.

It is important to note that an ASC's value in the health care system is to "right size" health care by providing an alternative, lower-cost setting for routine, low-risk surgeries. Only certain surgeries in specific specialties are performed at ASCs, leading to greater efficiency and predictability around supply, personnel and equipment costs. Additionally, only patients who are determined to be no risk or low-risk by their physician are eligible to have their surgeries performed at an ASC.[1] ASCs also have lower overhead costs as they have no emergency rooms nor are they equipped to provide overnight care. Yet, these same factors that reduce health care costs (and lead to reduced reimbursement by Medicare) may have unpredictable consequences on payer mix. While we can guard against our owners and members intentionally referring only privately insured patients to the ASC, we cannot forgo the cost efficiencies that define an ASC and may unintentionally drive whether a patient is considered "profitable" or not.

9. The application represents that the highest volume cases are expected to be screening and diagnostic colonoscopies. Confirm that the projected volumes are based on the most current recommended colorectal cancer screening (every ten years for average risk and persons that fall into the first tier Grade 2B category) and explain the protocols that GMSC will have in place to assure that unnecessary colonoscopies are not performed. Based on the projected volumes in each year, provide the assumptions for each year, including the volumes that would fall in each of the screening Grade categories.

We confirm that the projected volumes provided are based on the most current recommended colorectal cancer screening guidelines. The Green Mountain Surgery Center will follow the American College of Gastroenterology clinical guidelines for Colorectal Cancer Screening. Colonoscopy procedures are categorized most commonly according to ICD-10 (International Classification of Diseases) codes. Below is a table showing volumes by code and by year for the first four years of operation at the center. The following table shows the projected stable mix of procedures. Our assumptions are that the mix of different colonoscopy procedures in the future remains consistent with the actual mix of different types of colonoscopy procedures that was recorded by local gastroenterologists in base year 2014.

The protocols that GMSC will have in place to ensure that unnecessary colonoscopies are not performed are documented in our response to Question 10 from the questions the board posed on 08/28/2015, which include a description of our Peer Review Policy, Quality Improvement Strategy, participation in ACO networks, and the "open access" nature of colonoscopy procedure scheduling.

[1] 42 C.F.R. § 416.166 establishes that covered surgical procedures are those that are not expected to pose a significant safety risk to a patient when performed in an ASC and for which standard medical practice dictates that the patient would not typically be expected to require active medical monitoring and care at midnight following the procedure.

ICD-10 Codes	Code Description	Year 1	Year 2	Year 3	Year 4
V76.51	Average Risk Screening	1,598	1,844	1,863	1,881
V12.71	Surveillance for Personal HX Colon Polyps	790	912	921	930
Multiple	Diagnostic	461	532	537	542
V16.0	Screening for Family HX Colon Cancer	264	305	308	311
V10.05	Surveillance for Personal HX Colon Cancer	37	43	43	44
Total		3,150	3,636	3,672	3,709

ICD-10 Codes	Code Description	Year 1	Year 2	Year 3	Year 4
V76.51	Average Risk Screening	51%	51%	51%	51%
V12.71	Surveillance for Personal HX Colon Polyps	25%	25%	25%	25%
Multiple	Diagnostic	15%	15%	15%	15%
V16.0	Screening for Family HX Colon Cancer	8%	8%	8%	8%
V10.05	Surveillance for Personal HX Colon Cancer	1%	1%	1%	1%
Total		100%	100%	100%	100%

Mechanical, Electrical, Plumbing and Fire Protection (MEP/FP)

HVAC:

1. Clarify constant volume AHU and electric reheats for control. This seems to be a violation of the Energy Code. Explain whether VAV boxes and a hot water boiler be incorporated to meet control, air exchange rate and energy efficiency needs.

The project will be designed with a constant volume AHU and ducted return to enable the required room pressure relationships required by ASHRAE Standard 170 and the ventilation requirements. Electric reheat is being suggested for temperature control because of low first cost. An alternate for hydronic reheat will be taken for operating

efficiency and to comply with the energy code if necessary. 'Electrical reheat' is a supplementary system to support the main HVAC system particularly during morning warm up. An electrical reheat system is an inexpensive cost for equipment and installation (i.e. first cost) although will result in marginally higher electrical bill over time. At time of design and engineering, comparative analyses will be made of various system configurations and energy sources to find the right balance between first dollar cost and long term costs (i.e. payback analysis)

2. Describe the temperature and humidity conditions to be provided in the surgical suites.

Relative humidity 20-60%, temperature 68-75 degrees F. per Guidelines for Design and Construction of Health Care Facilities, 2014 edition and ASHRAE Standard 170-2013, Ventilation of Health Care Facilities.

3. Describe how these conditions will be accomplished with straight DX cooling. It is our concern that without some type of desiccant dehumidification, it may be difficult to attain surgical suite conditions.

By lowering the discharge air temperature to 50-55 degrees F. through a 6-row coil, and closing the outside air to minimum required for ventilation in warm humid weather conditions, it is possible to control humidity in the surgical suite. AMB has successfully employed this system on surgery centers nationwide.

4. Describe strategy to avoid re-entrainment of building exhaust through the AHU.

The air intake louvers of the roof-mounted air handler will be a minimum of 25 feet away from all exhausts and plumbing vents. The intake will also be kept 36 inches above the roof elevation.

5. Describe how outside air flow will be monitored.

The outside air intake will have an air measuring station tied to the temperature control system.

6. Describe water source for humidification system.

There will be a steam humidifier in the AHU supplied with reverse osmosis water to prevent scale buildup.

Electrical:

1. Narrative indicates the proposed incoming primary service to be extended to building by utility company. Will the utility company be providing site related trenching, duct banks, conduit & feeders?

Green Mountain Power will provide the primary side of the electrical service including the utility transformer and meter. The electrical contractor will provide the transformer vault and the remaining site related trenching, duct bank, conduit, and feeders from the transformer into the building to the incoming service section of the switchboard.

2. Narrative indicates primary electrical conductors to terminate on a freestanding switchboard within building. Where will the utility transformer be located? Will it be located within the switchboard?

The utility transformer is shown on site to the north of the building. It will not be located within the switchboard.

3. Explain whether coordination or approval of the proposed design been initiated by the utility company.

Neither coordination nor approval of the suggested design has been initiated with the utility company at this time.

4. Clarify whether the electric room will be rated as a utility vault to contain utility transformer.

The transformer will not be in the electric room so rating the room as a utility vault will not be necessary.

5. Secondary service & switchboard to be rated for 800 amp 480Y/277 volt and feed numerous branches. Please clarify the intent and installation of this switchgear with utility co. equipment within room.

There will be no utility company equipment in the room so coordination will not be necessary. The transformer and utility meter will be exterior.

6. Narrative indicates that the main switchboard is to have a dedicated section for possible fire pump. If a fire pump is required, this service & feeder shall be tied into utility service ahead of main service breaker. Please confirm.

Confirmed.

7. Please confirm that motors ½ hp or greater fed with 3-phase power shall be provided with a dedicated disconnect switch at unit.

Confirmed.

8. Please confirm that motors less than ½ hp fed with single phase power shall be provided with a dedicated motor rated toggle switch with thermal overloads at unit.

Confirmed.

9. Confirm whether there is use of mineral insulated (M.I.) cable or an approved equivalent 2-hour rated feeder assembly.

Confirmed.

10. Feeders are indicated as "Copper" or "Aluminum. It is recommended that copper constructed feeders shall be used throughout building as base bid. The use of aluminum constructed feeders as a value engineering means should be considered only as a cost savings measure.

Noted.

<u>Emergency Power Distribution System</u>

1. Narrative indicates a proposed emergency generator with associated branches. Please describe sizes, ratings and equipment.

The emergency generator will be approximately 120KW or 150KVA in size, with 105 degree C. rise alternator, natural gas fired or diesel as an alternative, 480Y / 277 volt, with a single automatic transfer switch feeding Life Safety, Critical, and Equipment panels.

2. Please describe the intended service of the emergency generator. Which building loads will be tied into emergency power?

The generator will feed Life Safety, Critical, and Equipment loads as required in NFPA 99 – Health Care Facilities.

3. Generator must be provided with on-site fuel storage to be considered "Life Safety". Confirm whether there is a diesel generator unless the local (AHJ) and natural gas utility company approves the use of natural gas as a reliable uninterruptable fuel source.

Yes, there will be a diesel generator if the natural gas utility company does not approve the use of natural gas as a reliable uninterruptable fuel source.

4. **What is the room construction ratings containing emergency branch equipment.**

   The emergency branch electrical room will have a 1-hour rating and be upgraded to a 2-hour rating if required

5. **Explain the routing and ratings of feeders.**

   Routing will parallel the building structural grid. Feeder ratings will relate to the over current protection devices.

Lighting

1. **Provide descriptive of type of lighting and control of the common area lighting low voltage system.**

   Common area lighting will be LED, low voltage switched, and be controlled by a programmable lighting control panel.

2. **Confirm that general indoor lighting fixtures are provided with LED lamping (in lieu of fluorescent), and that these fixtures are DLC approved and qualify for utility co. rebates.**

   Confirmed.

3. **Confirm whether day-light harvesting sensors & dimmable fixtures in general public areas are planned.**

   Confirmed.

4. **Confirm whether site lighting fixtures are provided with LED lamping (in lieu of metal halide), integral motion sensors and bi-level drivers and that these fixtures shall be DLC approved and qualify for utility co. rebates.**

   Confirmed.

Receptacles

1. **Explain the reason behind not installing isolated ground receptacles for computer (PC) loads.**

   The facility IT room housing the servers and routers will have isolated ground receptacles. The PCs located at workstations do not require isolated ground receptacles.

Telecommunication System

1. **Explain the intent, wiring and device locations of the proposed system.**

   Intent is to provide voice and data connections to all personnel at their workstations, in all other occupied spaces, and in operating rooms and procedure rooms. Wiring will typically be CAT 6e cabling, home running back to the IT room servers in equipment racks.

2. **Narrative mentions that the service will be required to be re-routed. Will this service be pulled back to existing IT/data room or will the new addition have a new location for this equipment? Please explain.**

   This project is a new building on a green-field site. It will have its own independent IT/data room.

3. **Describe how the telecommunications service will interface between the new addition and the existing building.**

   This is a freestanding building. There are no existing building connections.

Verify and describe each of the following:

1. Security System
2. Sound System
3. Clock System
4. Uninterruptable Power Supply (UPS)
5. CATV System
6. Temporary Light and Power

Security: The main entrance will be unlocked during hours of operation and all other access points will be locked with proximity card access. Selective rooms within the surgery center will also be access controlled.

Sound: A paging system will be incorporated through the telephone system. Music will be provided through iPod type transmitters with Bluetooth connected speakers.

Clock: The use of battery-powered quartz clocks will be provided.

UPS: Will be provided in the IT / data room to carry the rack-mounted equipment for a short duration of time until the emergency generator comes on line (within 10 seconds of normal power failure).

CATV: Will be provided in waiting areas.

Temporary Light and Power: Instantaneous lighting will be provided in all procedure rooms until the generator comes on line. More general power and lighting will be provided by the emergency generator.

Materials and Methods

1. Describe the scope of work to provide both normal and emergency power to the elevator(s).

The proposed project is a single story building on grade.

2. Clarify the use of color coded fire alarm MC type cable.

All boxes and conduit will be marked in red.

3. Clarify the use of different colors & markings to provide clear indication between normal / emergency / critical receptacles, wiring, conduit & junction boxes.

Systems will be color coded appropriately to distinguish them. Normal power, no markings, emergency power will be red per NFPA 70 – National Electrical Code and per NFPA 99 – Health Care Facilities.

4. Clarify the color coding of the fire alarm wiring system.

Red conduit and boxes.

5. Clarify the use of stainless steel cover plates in procedure rooms.

Will be provided.

6. Clarify the labeling of all receptacles, switches, electrical switchgear, etc.

Each outlet and light switch will be labeled with the panel and circuit feeding it. Normal switchgear panels will be labeled with white placards engraved with black letters.

Generator backed panels will be red placards with white letters.

7. Confirm that all wiring in patient care areas are hospital grade type MC cable and associated installations.

Confirmed.

Fire Protection: General

1. **Provide insurance underwriters information.**

   We have consulted our insurance broker on the project but have not yet identified an underwriter for the project. We have been advised by our broker that the most suitable underwriter is typically not identified until a contract has been agreed upon to start the build process.

2. **Clarify what edition of NFPA 13 and 24 apply to this project.**

   NFPA 13 – Edition 2010. NFPA 24 will not apply. A private fire service main will not be necessary. The building will connect to City water.

3. **Define and address *"other State of Vermont Regulations"***

   Regulations being other Vermont requirements pertaining to ambulatory surgery centers not covered in the adopted codes, i.e.: Health Department Regulations. Statement made to clarify that all regulations are met, whether or not cited in the narrative.

Sprinkler System

1. **Provide elevation information for building and fire hydrants.**

   Building on grade floor elevation 315.0', fire hydrant elevation 314.0'

2. **Verify that if fire pump is required, it shall be connected to emergency generator.**

   If a fire pump is required, it will be connected to the emergency generator only if required.

   See Electrical question 6 and response.

3. **Verify that an exterior fire hydrant is within 100' of new Fire Department Connection.**

   Exterior fire hydrant is within 100' of new Fire Department Connection.

4. **Provide current flow test data listing static and residual pressures as well as Pitot tube pressure. Also list size of ports on hydrant and coefficient of orifice.**

   Fire hydrant: static 82psi, Residual 80psi, Pitot Tube 68psi, port size 2.5", Coefficient 0.9.

Sprinklers

1. **Verify that all new sprinklers will be quick response.**

   Verified.

2. **Confirm whether or not whether there are concealed type pendant sprinklers in the procedure and O.R. rooms with "dust-resistant" sealed cover plates.**

   Confirmed.

Drawings and Hydraulic Calculations

1. **We recommend that the final documents include requirements stating that drawings and hydraulic calculations must be stamped and signed by a Professional Engineer (PE) registered in the state of Vermont.**

   Noted.

Plumbing:

Sanitary Drain & Vent

1. **Provide listing and applicable year for Plumbing Code.**

   IPC 2012 edition and the 2012 Vermont Plumbing Rules, 2013 edition.

Storm and Clear Water Drainage

1. **Provide listing and applicable year for Plumbing Code.**

   IPC 2012 edition and the 2012 Vermont Plumbing Rules, 2013 edition.

2. **Provide rainfall rate for area.**

   Maximum hourly rainfall rate based on 100 year storm = 2.1 inches.

Medical Gas Systems

1. **Verify medical gas systems will be designed according to NFPA 99.**

   Verified.

2. **Verify all fittings are to be brazed.**

   Verified.

3. **Verify that after systems have been installed a third party testing company will test all system to verify compliance with NFPA 99.**

   Verified.

Plumbing Fixtures

1. **Confirm use of microbial handles for bacterial protection where applicable.**

   Confirmed.

2. **Confirm all plumbing fixtures comply with current "NO LEAD" criteria.**

   Confirmed.

3. **Confirm bariatric plumbing fixtures are not required.**

   Confirmed.

Domestic Cold Water, Hot Water and Hot Water Return Systems

1. **Verify that domestic hot water is stored at 140 deg. F to prevent Legionella. bacteria from developing.**

   Verified.

2. **Verify systems will be coordinated with local health department.**

   Verified.

3. **Verify all fixtures and faucets will be hospital grade.**

   Verified.

Please let us know if you have any additional questions or need clarification regarding any of these responses.

Sincerely,

Eileen Elliott

cc: Judy Henkin, Health Policy Director
Michael Donofrio, Esq., GMCB
Lauren Layman, Esq., Vermont Association of Health and Hospital Systems
Anne Cramer, Esq., Vermont Association of Health and Hospital Systems
Jill Berry Bowman, RN, Northwestern Medical Center
Jonathan Billings, Northwestern Medical Center
Julia Shaw, Office of the Healthcare Advocate
Lila Richardson, Esq., Office of the Healthcare Advocate
Kaili Kuiper, Esq., Office of the Healthcare Advocate